

ACU 2017 ANNUAL CONFERENCE PROGRAM GUIDE



Excellence in Team-Based Care for the Underserved

July 30 - August 2, 2017
Four Seasons Hotel, Washington, DC



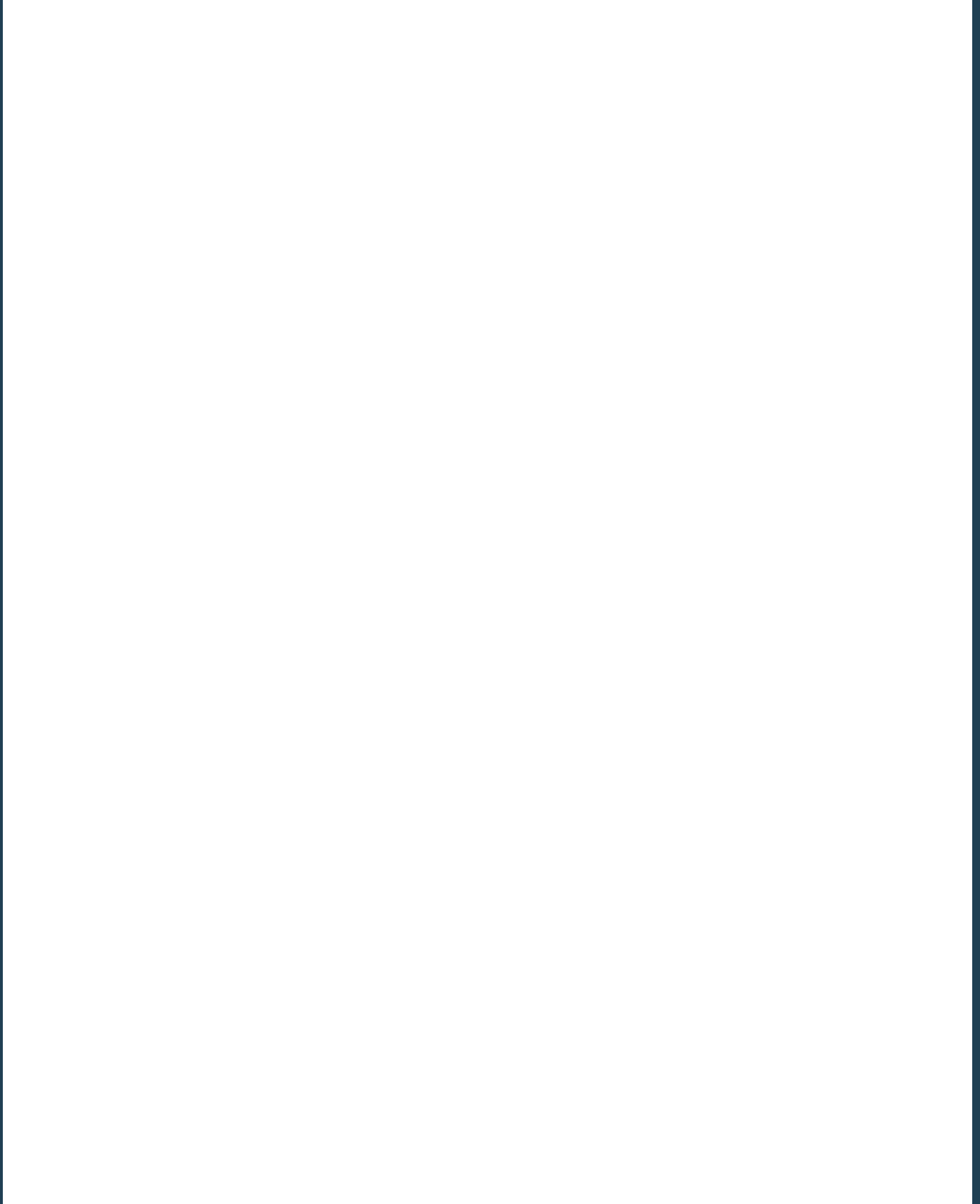
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Registrants can earn 1 Continuing Medical Education credit for each Educational Workshop attended. No more than 4 CME credits can be earned per day. Registrants can earn a maximum of 8 CME credits.

Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

Welcome



Keynote Speakers

MONDAY



Bruce Lesley

Bruce Lesley is the President of First Focus, a nonpartisan advocacy organization dedicated to making children and families the priority in federal policy and budget decisions. Mr. Lesley has more than 25 years of public policy experience at all levels of government and a demonstrated commitment to making children's lives better. In 12 years on Capitol Hill, Lesley worked on health care, education, human services, and immigration issues in several different capacities. Prior to his work at First Focus, he served as Senior Health Policy Advisor on the Senate Finance and Health, Education, Labor and Pensions Committees for U.S. Senator Jeff Bingaman.

**Monday, July 31
8:30am - 9:30am**



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Keynote Speakers

MONDAY



Ursula Whiteside, PhD

Dr. Ursula Whiteside is a licensed clinical psychologist, CEO of NowMattersNow.org and Clinical Faculty at the University of Washington. Dr. Whiteside is national faculty for the Zero Suicide initiative, a practical approach to suicide prevention in health care and behavioral healthcare systems. Dr. Whiteside serves on the faculty of the National Action Alliance Zero Suicide Academy. She is also a founding board member of United Suicide Survivors International and a member of the National Suicide Prevention Lifeline Standards Trainings and Practices Committee. As a person with Lived Experience, she strives to decrease the gap between "us and them" and to ensure that the voices of those who have been there are included in all relevant conversations: nothing about us without us.



Jerry Reed, PhD

A nationally recognized leader in the field of suicide prevention, Jerry Reed, PhD, is a senior vice president and a director at EDC. Through advocacy, authorship, and effective program leadership, he has raised awareness about suicide as a leading cause of death and driven public policy changes at the state and national levels. Reed directs the Suicide Prevention Resource Center and the Center for the Study and Prevention of Injury, Violence, and Suicide at EDC. An outspoken advocate of the importance of both a public health and mental health approach to suicide prevention, Reed participates on the World Health Organization's Violence Prevention Alliance and serves on the executive committee of the National Action Alliance for Suicide Prevention.



Bart Andrews, PhD

Bart Andrews, PhD, is Vice President of Clinical Practice/Evaluation at Behavioral Health Response. Dr. Andrews is the President of the National Association of Crisis Line Directors, Co-Chair of the Suicide Lifeline's Standards, Training and Practices committee, a member of the Suicide Prevention Resource Center's (SPRC) Steering Committee and an SPRC ZeroSuicide Academy Faculty member. Dr. Andrews is a suicide attempt survivor and a proponent embracing of lived expertise in our suicide prevention efforts. Dr. Andrews believes that the path to suicide prevention must be framed in the context of relationships, community and culture. Dr. Andrews has over 20 years of experience providing behavioral health services.

Acronym & Abbreviation Key

MH	Mental Health
BH	Behavioral Health
PH	Public Health
SA	Substance Abuse
HIT	Health Information Technology
FQHC	Federally Qualified Health
CHC	Center Community Health
Med. Ed.	Center Medical Education
Team	Team-Based Care
NHSC	National Health Service Corps
HRSA	Health Resources and Service Administration

Keynote Speakers

TUESDAY



Suma Nair
MS, PhD, RD

Suma Nair is the Director of the Office of Quality Improvement in the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC). Prior to joining BPHC, Dr. Nair worked on program evaluation and performance improvement programs impacting more than 80 different grant programs across HRSA. Dr. Nair earned a Bachelor of Arts degree in Nutrition and a Master of Science degree in Public Health Nutrition from Case Western Reserve University, and a Doctor of Philosophy degree in Health Services Administration from the University of Maryland, College Park.

Tuesday, August 1
8:30am - 9:30am

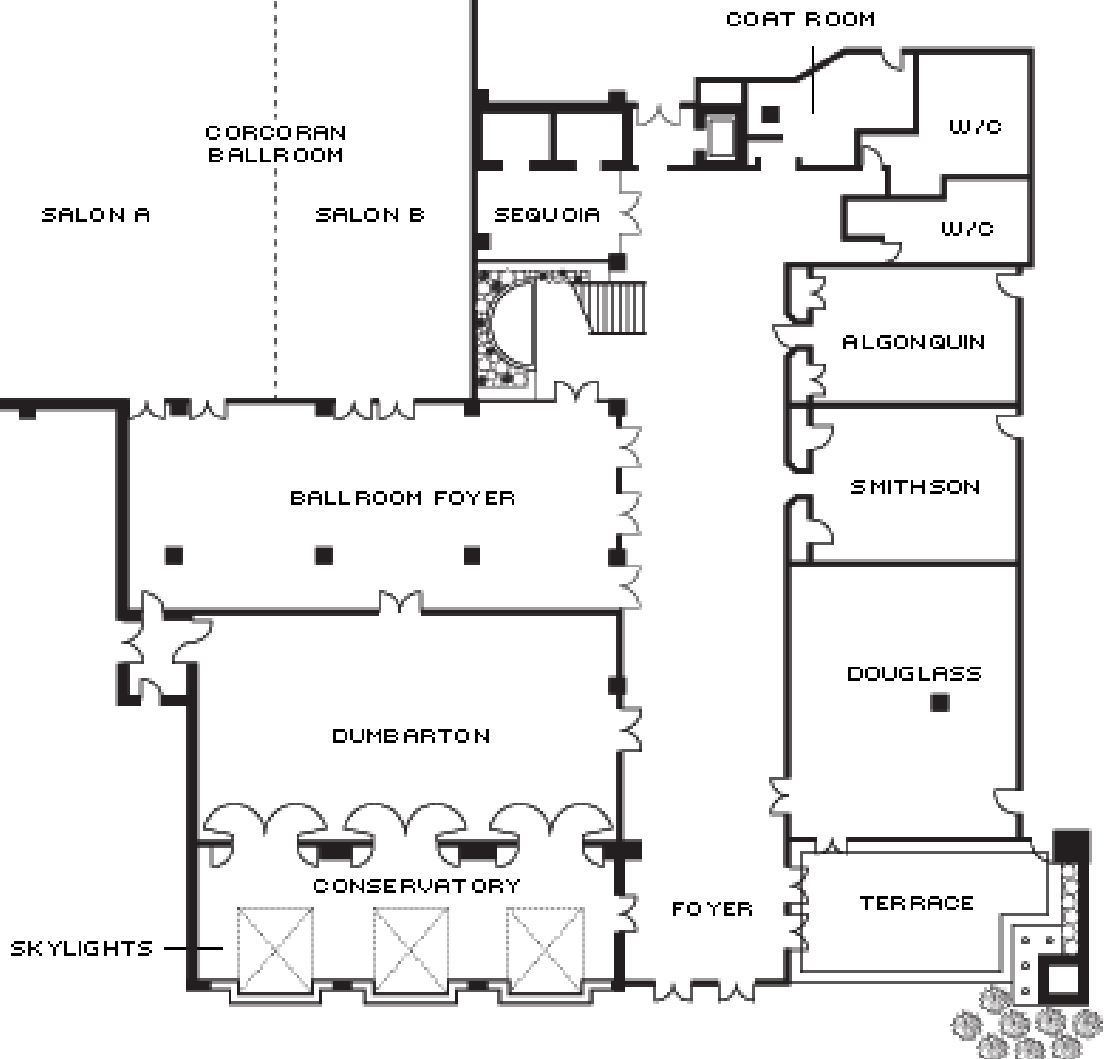


Kyu Rhee
MD, MPP

Dr. Kyu Rhee serves as the Chief Health Officer of IBM, where he has global responsibilities for Watson Health and assuring a Culture of Health at IBM. Prior to joining IBM, Dr. Rhee was Chief Public Health Officer at the Health Resources and Services Administration (HRSA). He also served as the Director of the Office of Innovation and Program Coordination at the National Institutes of Health (NIH). Prior to his federal government service, he worked in community healthcare settings as the CMO of Baltimore Medical System Inc., the largest network of FQHCs in Maryland. In addition, Dr. Rhee served five years as a National Health Service Corps Scholar and Medical Director at Upper Cardozo Health Center, the largest community health center in Washington, DC.

Tuesday, August 1
2:30pm - 4:00pm

Four Seasons Hotel



Treat
Yourself!

Don't forget to take some time for self care! We have wellness activities available throughout the Conference:

The Relaxation Room sponsored by Centene: The Relaxation Room will be available all weekend in the Conservatory. Sign up for a massage or simply take a load off and relax in a quiet, comfortable space.

Morning Walk: Join ACU staffers on **Tuesday, August 1** for an early morning 2 mile walk. We'll leave from the lobby at 6:30am.

Corepower Yoga: Want to work up a sweat? Corepower Yoga is located just a few blocks from the hotel at **1055 Thomas Jefferson St NW**. Hot yoga classes are available in the mornings and evenings.

SCHEDULE AT A GLANCE

SUNDAY, JULY 30, 2017

EVENTS LEVEL FOYER	1:30 PM	Registration Opens
EXPO HALL	3:00 PM	Exhibitors Set-Up Begins
DUMBARTON	3:00 PM - 6:00 PM	ACU Board Meeting

PRECLINICAL WORKSHOPS

ALGONQUIN	3:00PM - 6:00PM	Assessing & Documenting Readiness & Medical Necessity of Gender Confirmation Surgeries: The Role of Behavioral Health Clinicians in the Interdisciplinary Treatment of Transgender & Gender Expansive Individuals
DOUGLASS	3:00PM - 6:00PM	An Overview of Mental Health First Aid
DUMBARTON	3:00PM - 6:00PM	Integrating Patient Engagement Techniques and Strategies into Care Coordination: Best Practices in Reaching our "Hard to Reach" Patients

AWARDS RECEPTION

LOWER LOBBY LEVEL	6:30PM - 8:30PM	Awards Recipient Presentations MC: Kathy Brieger, RD
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MONDAY, JULY 31, 2017



8:00AM - 8:30AM

BREAKFAST BUFFET

CORCORAN
BALLROOM

8:30AM - 9:30AM

Opening General Session

MC: Felix Nunez, MD, MPH

Blessing: Keaulana Holt, Director, Native
Hawaiian Health Scholarship Program

Keynote Speaker: Bruce Lesley

WORKSHOP SESSION #1

ALGONQUIN

9:30AM - 10:30AM

Achieving Health Equity by Addressing Social
Determinants of Health: Locally, Regionally, and
Statewide

POLICY

SMITHSON

9:30AM - 10:30AM

Diabetes Education and Exercise Program
(DEEP): A Team-Based Intervention to
Maximize Patient Engagement and Lifestyle Change

TEAM

DOUGLASS

9:30AM - 10:30AM

Web-Based Medication Assisted Treatment Support:
An Innovative Tool for Team Opioid Use Disorder
Care Engagement

MENTAL
HEALTH/
BH

DUMBARTON

9:30AM - 10:30AM

Identifying and Responding to Trauma in the
Primary Care Setting

TRAUMA

10:30AM - 11:00AM

REFRESHMENT BREAK

WORKSHOP SESSION #2

ALGONQUIN

11:00AM - 12:00PM

Educating the Team to Improve Well Child Visits - "A
Patient Is A Patient Is A Patient"

TEAM

SMITHSON

11:00AM - 12:00PM

Screening for High Blood Pressure in Ohio's FQHC's
Dental Practices

TEAM:
DENTAL

DOUGLASS

11:00AM - 12:00PM

Training MAs: Forget the For Profits - Train Our Own

MED.
ED.

DUMBARTON

11:00AM - 12:00PM

Utilizing the Team: Integrating Behavioral Health
into Primary Care Using an Interprofessional
Collaborative Practice Model

BH

MONDAY, JULY 31, 2017



12:00PM - 1:30PM

LUNCH BUFFET

CORCORAN
BALLROOM

Lunch Session: Suicide Prevention

Moderator: Virna Little, PsyD, LCSW - R

Keynote Speakers:

Jerry Reed, PhD, MSW

Ursula Whiteside, PhD

Bart Andrews

WORKSHOP SESSION #3

ALGONQUIN

1:30PM - 2:30PM

Integrating HIV Prevention into Primary Medical Care Services for the Underserved Utilizing a Team-Based Approach

TEAM

SMITHSON

1:30PM - 2:30PM

Improved Recruitment and Retention Through Arizona's State Loan Repayment Program

POLICY

DOUGLASS

1:30PM - 2:30PM

Transforming and Implementing Suicide Care Management

MENTAL
HEALTH

DUMBARTON

1:30PM - 2:30PM

Interprofessional Learning in Underserved Practice: Preceptors in the Nexus

MED.
ED.

2:30PM - 3:00PM

REFRESHMENT BREAK

WORKSHOP SESSION #4

ALGONQUIN

3:00PM - 4:00PM

Collaborative Care: An Evidence Based Model for Primary Care

MENTAL
HEALTH:
PAYMENT

SMITHSON

3:00PM - 4:00PM

Bringing Social Determinants of Health to the Forefront to Inform Collaborate Care for the Underserved - the FIU NHELP Model

MED.
ED.

DOUGLASS

3:00PM - 4:00PM

Maximizing Interprofessional Team Work to Minimize Re-hospitalizations: The Johns Hopkins After Care Clinic

TEAM

DUMBARTON

3:00PM - 4:00PM

The Fourth Aim: It's Not About Provider Support Groups

BURNOUT

TUESDAY, AUGUST 1, 2017

CORCORAN BALLROOM	8:00AM - 8:30AM	Poster Session Presentations & Judging
8:00AM - 8:30AM BREAKFAST BUFFET		
CORCORAN BALLROOM	8:30AM - 9:30AM	Federal Panel MC: Jim Hotz, MD Keynote Speaker: Suma Nair PhD, MS, RD



WORKSHOP SESSION #5

ALGONQUIN	9:30AM - 10:30AM	Key Principles of Shortage Designation	POLICY
SMITHSON	9:30AM - 10:30AM	Creating Effective Spaces for Primary Care Teams	FINANCING & DESIGN
DOUGLASS	9:30AM - 10:30AM	Innovative Coaching in Team-Based Care: A Data-Driven Practice Facilitation Model of Technical Support to Drive Clinical, Operational and Technical Transformation	HIT
DUMBARTON	9:30AM - 10:30AM	What does Team-Based Care Have to do with it?	TEAM

10:30AM - 11:00AM REFRESHMENT BREAK		
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WORKSHOP SESSION #6

ALGONQUIN	11:00AM - 12:00PM	Weight Management for Optimal Health (Session #1)	TRAINING
SMITHSON	11:00AM - 12:00PM	Change is in the Air: Building Partnerships to Support Public Housing Residents in Their Smoking Cessation Efforts	TEAM: PH
DOUGLASS	11:00AM - 12:00PM	The Federal Budget and Appropriations: Funding Outlook for the National Health Service Corps	POLICY
DUMBARTON	11:00AM - 12:00PM	The Use of Data in a Population Health Project at a CHC in SW Missouri	HIT

TUESDAY, AUGUST 1, 2017

12:00PM - 12:30PM

LUNCH BUFFET

CORCORAN
BALLROOM

12:00PM - 1:30PM

Collaboration Lunch

MC: Kirsten Thomsen, PA-C

Discussion Tables

WORKSHOP SESSION #7

ALGONQUIN

1:30PM - 2:30PM

Weight Management for Optimal Health
(Session #2)

TRAINING

SMITHSON

1:30PM - 2:30PM

Behavioral Health and Primary Care Integration in
Health Care for the Homeless

MED.
ED.

DOUGLASS

1:30PM - 2:30PM

Thriving as a Learning Health Care System in
Primary Care

HIT

DUMBARTON

1:30PM - 2:30PM

Innovative Integrated Behavioral Health
Workforce Development in a Federally Qualified
Health Center

MED.
ED.

2:30PM - 3:00PM

DESSERT

CORCORAN
BALLROOM

2:30PM - 4:00PM

Closing General Session: HIT

MC: Earle Rugg

Keynote Speaker: Kyy Rhee MD, MPP



WEDNESDAY, AUGUST 1, 2017

HILL DAY

FOUR
SEASONS
LOBBY

8:30AM - 9:30AM

Buses to Capitol Hill

Meet ACU staff in the Lobby of the Four Seasons for packet pick up

121
CANNON
HOUSE
OFFICE
BUILDING

10:00AM - 11:00AM

Congressional Briefing on the Future of the NHSC Program

Funding for the National Health Service Corps program will expire this Fall without Congressional action. This panel of national experts – including clinicians and policy influencers – will provide programmatic and policy solutions to protect and strengthen the NHSC.

Join the Campaign to

STRENGTHEN
the NHSC

WORK TO SUPPORT
PRIMARY CARE

CAPITOL
HILL

9:30AM - 4:00PM

Hill Meetings

ACU Conference attendees have the opportunity to meet with policy decision-makers and your Congressional representatives. Make your voice heard in Congress! Meetings are arranged by attendees.

4:00PM

END OF CONFERENCE



Thank you for your commitment to the underserved!

2017 AWARD RECIPIENTS

Clinician of the Year Award



DR. CHERYL HO

Dr. Cheryl Ho has worked in homeless healthcare as a primary care physician for over a decade. Dr. Ho led the effort to start Santa Clara County's Medical Respite Program, a unique public-private partnership that serves clients discharged from seven community hospitals, clients who needed a place to continue healing other than the streets. Using her skills from her addiction medicine board certification, she led the effort to start a multi-disciplinary Buprenorphine clinic to help individuals struggling with opiate addiction.

Valuing outreach to all communities, Dr. Ho spearheaded the creation of a mobile clinic for migrant farmworkers, an outreach clinic for homeless teens, and a multi-disciplinary clinic where medical, mental, and social needs are all addressed in one place. Together with her team, she also started a Social Medicine course, where she teaches and mentors providers-in-training about the social determinants of health.

Dr. Ho is an outstanding healthcare provider who is committed to reducing healthcare disparities in the community as well as hospital setting, while mentoring the future generation of providers to provide highest quality care for the underserved. ACU is proud to present Dr. Ho with the 2017 Clinician of the Year award.

Organizational Excellence



ACU is proud to recognize Finger Lakes Community Health for their dedication to providing high quality, comprehensive health care to underserved and special populations. As a primary care health center, they are committed to treating the whole patient collaboratively, focusing on wellness and prevention and coordinating primary care. They work directly with the community to provide education about preventive care and to affect policies that help improve access and quality of care. They are a passionate group of individuals, dedicated to providing culturally competent, team-based health care services to 42 rural counties in upstate New York.

CONGRESSIONAL CHAMPION



Honorable Chris Stewart

Congressman for Utah's 2nd district

ACU is honored to recognize Congressman Chris Stewart as the Congressional Champion of the Year for his efforts to protect and strengthen the National Health Service Corps. Congressman Stewart represents Utah's Second District in the U.S. House of Representatives. Congressman Stewart is leading the bipartisan effort urging the 115th Congress to reauthorize funding for the National Health Service Corps.

Poster Sessions

TUESDAY, AUGUST 1, 2017

8:00AM - 8:30AM

Exploring Ways to Improve Breast Cancer Screening Rates in a Southwest Georgia FQHC

Hannah Bowe

Medical Student at Albany Area Primary Health Care

Fighting Cervical Cancer in FQHCs with Proper Population Management

Millie Foster

Medical Student at Mercer University Medical School

Reaching 80% Colorectal Cancer Screening in a FQHC

William Spencer Grigg

Medical Student at the Georgia Campus - Philadelphia College of Osteopathic Medicine

Innovative Population Health: Using Analytical Tools to Improve Preventive Screening Rates in Rural FQHCs

William Spencer Grigg

Medical Student at the Georgia Campus - Philadelphia College of Osteopathic Medicine

Health Beliefs and Cervical, Breast and Colorectal Cancer Screening Rates in Baltimore's Muslim Women

Awa Sanneh

Medical Student at Johns Hopkins University School of Medicine

Sickle Cell Disease in Florida: Geographic Disparities in Access to Care

Eric Walker

Medical Student at Florida State University College of Medicine

When Less is More: A Brief Scale to Rate Interprofessional Team Competencies

Desiree Lie

Clinical Professor at the University of Southern California

Implementing Opt Out HIV Screening in a Community Health Center

Ziad Hemzawi, MD

Pediatrician at El Rio Health Center in Tucson, AZ

Implementing Screening for Hepatitis C for all Baby Boomers in a Community Health Center

Ziad Hemzawi, MD

Pediatrician at El Rio Health Center in Tucson, AZ

Vaccines are for all Ages: How to Get Your Adults Vaccinated

Jennifer Genuardi

Clinical Director of Clinical Best Practices and Clinical Education at Urban Health Plan, Inc.

Geospatial Analysis Between Neighborhood Characteristics and Bystander CPR Initiation Rates

Rohit Abraham

Graduate Research Assistant at the Michigan State University College of Human Medicine

Interprofessional Student Patient Advocates in Safety-Net Clinics and Hospital Emergency Departments

Janet Buelow

Professor of Health Sciences at Armstrong State University

Workshop Directory

Monday, July 31

WORKSHOP SESSION #1

9:30am - 10:30am

ACHIEVING HEALTH EQUITY BY ADDRESSING SOCIAL DETERMINANTS OF HEALTH: LOCALLY, REGIONALLY, AND STATEWIDE

Algonquin
Policy

California Primary Care Association

Mike Witte, MD, *Chief Medical Officer and Vice-President*

Nataly Diaz, *Senior Program Coordinator of Workforce Development*

Janelle Sauz, *Quality Improvement Coordinator, Life Long Medical Care*

California's community health centers (CHC) provide comprehensive, quality health care services to nearly 6 million low-income, uninsured and underserved Californians. Their innovation has become a model for how the health care system, clinicians, and healthcare teams, can play a role in addressing health inequities and the social determinants of health. This presentation will discuss care team involvement and leadership in three public health and policy campaigns: (1) alternative payment methodologies and value-based care, (2) sugar sweetened beverage tax, and (3) homelessness initiatives. Participants will hear about the genesis of these projects and their successes in creating a healthier California.

LEARNING OBJECTIVES

1. Describe California's community health centers and their providers' roles in addressing health disparities and social determinants of health.
2. Discuss local, regional, and statewide examples of recent and ongoing activities that are placing patients, health center provider teams and leadership, at the center of system change.
3. Identify opportunities for collaboration between researchers, clinicians, and public health professionals invested in addressing the health inequities and upstream factors impacting the health of our most vulnerable communities.

DIABETES EDUCATION AND EXERCISE PROGRAM (DEEP) - A TEAM-BASED INTERVENTION TO MAXIMIZE PATIENT ENGAGEMENT AND LIFESTYLE CHANGE

Smithson
Team-Based Care

El Rio Community Health Center

Holly Bryant, MPH, RD, *Program Manager*

Shelly Whitlach, MS, *Employee and Patient Wellness Manager*

Join this session to hear about a successful program coordinated and led by the Health and Wellness Team in collaboration with the healthcare team. The Diabetes Education and Exercise Program (DEEP) includes a weekly education session combined with exercise, resulting in a healthy lifestyle support group for patients with pre-diabetes and diabetes. Over 12 weeks, session provides basic information by Clinical Pharmacists, Dieticians, Behavioral Health Advisors, and Fitness Instructors. Sessions speakers will cover the exercise protocol, role of glucose checks, evaluative data, and more.

LEARNING OBJECTIVES

1. Learn the components of a comprehensive team-based diabetes lifestyle intervention that includes key members of an FQHC, including what skills and personnel are important to patient engagement and long-term compliance.
2. Determine which areas of the care team are critical to motivating and caring for pre-diabetics and diabetics, and which department(s) might work best together to provide a successful behavior-change intervention including barriers in process and data collection.
3. Understand the process of provider referral into the DEEP program and the marketing and promotional aspects to both engage providers and patients.

Workshop Directory

Monday, July 31

WORKSHOP SESSION #1

9:30am - 10:30am

WEB-BASED MEDICATION ASSISTED TREATMENT SUPPORT: AN INNOVATIVE TOOL FOR TEAM OPIOID USE DISORDER CARE ENGAGEMENT

Douglass

Mental Health/Substance Abuse

Center for Social Innovation

Wayne Centrone, NMD, MPH Senior Health Advisor

Steven Samra, MPA, Deputy Director of BRSS TACS

The United States is experiencing a public health epidemic of record proportions. The opioid epidemic is impacting people at all levels of society. This is particularly true for people living in socially and economically underserved situations. Under funding from SAMHSA, subject matter experts, researchers, clinicians and people in recovery developed an innovative web based tool to help change the conversation about opioid use disorder and medication assisted treatment. The presentation will review how underserved care peer providers and clinicians can use a web based shared decision making tool to better support people living in socially and economically underserved situations gain access to evidence based treatment for opioid use disorders.

LEARNING OBJECTIVES

1. Describe an innovative approach to responding to the opioid use epidemic with special emphasis on populations experiencing complex social and economic challenges and living with co-occurring opioid use disorder.
2. Discuss three ways clinicians can use a web-based shared decision making tool to support people in recovery from opioid use disorder.
3. Define three ways a web-based tool can link clients, clinicians and providers to medication-assisted treatment and help address the opioid use disorder epidemic.

IDENTIFYING AND RESPONDING TO TRAUMA IN THE PRIMARY CARE SETTING

Dumbarton

Behavioral Health: Trauma

The Institute for Family Health

Jason Marchwinski, LCSW, Trauma-Informed Care
Committee Chairman / Mental Health Clinician

Adverse life experiences can have a profound impact on one's mental and physical well-being. Research has shown a positive correlation between trauma exposure and heart disease, liver disease, smoking, alcohol abuse/dependence, depression, and more. Primary care providers play a front-line role in identifying and responding to trauma. This session will discuss ways to ask about trauma, how to respond to trauma disclosures, educating the patient about their symptoms, and linking them to appropriate behavioral health services. Participants will learn about the risk of re-traumatization in primary care and develop ways to resist it so that the relationship between patient and provider is experienced as safe rather than a source of distress.

LEARNING OBJECTIVES

1. Learn about the prevalence of trauma and its impact on mental and physical health.
2. Develop ways to ask about trauma and respond to trauma disclosures and symptoms
3. Resist re-traumatization by learning about potentially triggering procedures and integrate trauma-informed principles into the primary care visit.

Workshop Directory

Monday, July 31

WORKSHOP SESSION #2

11:00am - 12:00pm

EDUCATING THE TEAM TO IMPROVE WELL CHILD VISITS - "A PATIENT IS A PATIENT IS A PATIENT"

Algonquin

Team-Based Care

Urban Health Plan, Inc.

Acklema Mohammad, *Chair of Pediatrics*

Jacqueline Zayas, MD, *Associate Medical Director of Pediatrics*

Alanna Vasquez, RN, *Pediatrics Coordinator*

For children to grow up healthy and well rounded, Well Child Visits (WCV) and preventive care are vital. To increase the number of patients receiving WCV at Urban Health Plan, a network of federally qualified community health centers in NYC, the organization adopted a slogan "a patient is a patient is a patient" signifying that comprehensive physical exams will be performed with or without an appointment, sick or not sick. A revised work flow and EMR template was implemented, and data was routinely shared. As a result, WCV rates improved at the two sites with the largest number of children from 80% to 91% and from 79% to 87% (N=6,632), and made an organization-wide improvement of 10% (N=9,000).

LEARNING OBJECTIVES

1. To demonstrate new work flows and EMR templates that prompt health care team to conduct WCV at all visits.
2. To raise health care team awareness regarding the importance of the Well Child Visit (WCV) and reduce missed opportunities.
3. To use data on Well Child Visit rate to drive improvement.

SCREENING FOR HIGH BLOOD PRESSURE IN OHIO'S FQHCs DENTAL PRACTICES

Smithson

Team-Based Care: Dental

Ohio Association of Community Health Centers

Susan Lawson, *Oral Health Program Manager*

Theodore Wymslo, MD, *Chief Medical Officer*

Tiffany Blair, *Quality Improvement Coordinator*

The enhanced integration of oral health and primary care continues to be a goal for many healthcare organizations. While Federally Qualified Health Centers (FQHCs) have espoused this philosophy for years, the Ohio Association of Community Health Centers has recently built upon this principle through an initiative that makes blood pressure (BP) screening part of the intake process for all oral health patients in Ohio's FQHCs. Many patients see a dentist more frequently than a physician, giving the dental team the opportunity to inform their patients of their blood pressure reading and how it may affect their overall health. As partners in patient-centered care, oral health and primary care providers working together can provide better healthcare for patients.

LEARNING OBJECTIVES

1. Demonstrate the importance of screening for hypertension as part of the intake process for all oral health patients.
2. Demonstrate how oral health can be better integrated in comprehensive primary care.
3. Demonstrate how blood pressure measurement in the dental setting can improve hypertensive management in a patient population.

Workshop Directory

Monday, July 31

WORKSHOP SESSION #2

11:00am - 12:00pm

BRINGING SOCIAL DETERMINANTS OF HEALTH TO THE FOREFRONT TO INFORM COLLABORATIVE CARE FOR THE UNDERSERVED - THE FIU NHELP MODEL

Douglass

Medical Education

Florida International University

Frederick Anderson, *Assistant Professor*

Eduardo Camps-Romero, MD, *Assistant Professor*

The Green Family Foundation Neighborhood Health Education and Learning Program (NHELP) is a longitudinal service learning program at Florida International University. Interdisciplinary student teams and faculty work with community health workers (CHW) to provide care and address social determinants of health (SDH) in underserved Miami communities. FIU has a collaborative care program for primary care and behavioral health to focus on patients with depression, diabetes, and other chronic illnesses while integrating SDHs. A Business Intelligence tool links info from the EHR and a data system where our team of Community Health Workers (CHWs) track important SDHs. A registry tracks these SDHs along biomarkers for chronic disease to inform medical care and strengthen collaboration with CHWs.

LEARNING OBJECTIVES

1. Describe a collaborative care model for the underserved which incorporates social and behavioral determinants in primary care.
2. Learn of an innovative data system to promote inclusion of social determinants of health into the assessment and plan for an underserved patient population with chronic diseases.
3. Discuss methods for evaluation of care management approaches that incorporate social determinants of health.

UTILIZING THE TEAM: INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE USING AN INTERPROFESSIONAL COLLABORATIVE PRACTICE MODEL

Dumbarton

Behavioral Health

UAB School of Nursing

Erin Clarkson, *Patient Support Services Manager*

Karmie M. Johnson, DNP, RN, PMHNP, *Instructor in Mental Health Nursing*

Mental health diagnoses are among the most common and disabling health conditions worldwide, and are often comorbidities with chronic medical conditions and can substantially worsen associated health outcomes. Through recent funding by the Health Resources Services Administration, the Heart Failure Clinic and the Providing Access to Healthcare (PATH) Clinic for diabetes are expanding access to behavioral health services into community-based primary care and chronic disease management for uninsured patients in Birmingham, Alabama. Both clinics are nurse-led interprofessional collaborative practices with a commitment to improved care coordination and patient engagement. Discussed in this presentation will be the integration of behavioral health services into the interprofessional clinics to: expand patient access, develop provider knowledge, and foster strategies used to decrease stigma using culturally appropriate interventions, and to improve patient engagement and outcomes.

LEARNING OBJECTIVES

1. To discuss dynamics of PATH and HRSA Heart Failure Clinics.
2. To describe integration of behavioral health into interprofessional team members.
3. To discuss effective strategies of utilization of these services.

Workshop Directory

Monday, July 31

WORKSHOP SESSION #3

1:30pm - 2:30pm

INTEGRATING HIV PREVENTION INTO PRIMARY MEDICAL CARE SERVICES FOR THE UNDERSERVED UTILIZING A TEAM-BASED APPROACH

Algonquin
Team-Based Care

Primary Care Development Corporation
Denise Anderson, *Senior Program Manager*

There are more than 1.2 million people living with HIV/AIDS in the U.S. of which 1 in 8 do not know they are HIV infected. The CDC recommends that patients between the ages of 13 and 64 be screened for HIV at least annually. Primary care providers are pivotal in achieving a more coordinated response to the HIV epidemic and reducing the HIV-related disparities and health inequities. Team-based care is a multidisciplinary approach to meeting the needs of patients in a culturally and linguistically appropriate manner which maximizes continuity of care. Implementing and/or maximizing team-based care enables a more seamless integration and/or enhancement of HIV prevention integration into primary health care settings to include HIV testing, pre-exposure prophylaxis (PrEP) and non-occupational post exposure prophylaxis (nPEP).

LEARNING OBJECTIVES

1. Describe the need and latest recommendations for implementing routine HIV screening in health care settings.
2. Discuss the characteristics of team-based care while identifying the challenges and offering practical solutions.
3. Examine the usefulness of team-based care in integrating and/or optimizing primary care services with integrated HIV prevention.

IMPROVED RECRUITMENT AND RETENTION THROUGH ARIZONA'S STATE LOAN REPAYMENT PROGRAM

Smithson
Policy

Arizona Department of Health Services
Ana Roscetti, *Workforce Section Manager*

Arizona had been successful in enacting a legislation that enhances the Arizona State Loan Repayment Program (SLRP). Prior to this legislation, SLRP was less desirable among primary care practitioners than its federal counterpart, the National Health Service Corps Loan Repayment Program (NHSC). The program was in fact underutilized and less competitive than NHSC. Since the legislation passed in February 24, 2015, immediate impact in recruiting providers to underserved communities was evident within the first 3 months of implementation. This session will provide the steps undertaken to enhance the SLRP and the impact of the new legislation.

LEARNING OBJECTIVES

1. Understand the legislative and rulemaking process in enhancing the Arizona State Loan Repayment Program.
2. Learn the requirements set forth in the new SLRP legislation and program policies.
3. Learn the program's accomplishments to-date since implementing the legislation.

Workshop Directory

Monday, July 31

WORKSHOP SESSION #3

1:30pm - 2:30pm

TRANSFORMING AND IMPLEMENTING SUICIDE CARE MANAGEMENT

Douglass
Mental Health

The Institute for Family Health

Virna Little, PsyD, LCSW-R, MBA, CCM, SAP, *Senior Vice President Psychosocial Services/Community Affairs*

Centerstone

Becky Stoll, *Vice President for Crisis and Disaster Management*

The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge. Presenters will share strategies and techniques for transforming your health center's policies and actions around suicide prevention. During this session, participants will learn about identifying populations at risk for suicide, strategies to implement suicide prevention work, and how the modification of sites' electronic health records can be used to track and monitor this patient population.

LEARNING OBJECTIVES

1. Identify strategies and assessment tools to address suicide prevention work in primary and behavioral health centers.
2. Identify the importance of training staff to confidently identify patients at risk.
3. Identify options for use, modify, and expend your Electronic Health Record to assess and track patients with current or past suicidal ideation.

INTERPROFESSIONAL LEARNING IN UNDERSERVED PRACTICE: PRECEPTORS IN THE NEXUS

Dumbarton
Medical Education

University of Kansas School of Medicine

Jana Zaudke, MD, MA, *Associate Professor of the Department of Family Medicine*

Developed in primary care settings for underserved populations, the National Center for Interprofessional Practice and Education - Kansas University Medical Center Preceptor provides tools for clinicians to learn knowledge, skills and behaviors to facilitate interprofessional, team-based learning IN practice in clinical settings. The interprofessional team will share how they engage students, residents and clinicians to work to impact organizational culture and transform practice every day. The presenters will share the early findings from the data that they are collecting with the National Center to document learner and patient outcomes. In addition, they will also share how they have scaled the learning in practice model to rural FQHCs and how it can be adapted to a variety of clinical settings.

LEARNING OBJECTIVES

1. Define the key concepts of interprofessional learning IN underserved practice.
2. Describe how dysfunctional behaviors related to hierarchy and power affect interprofessional learning IN underserved practice
3. Explore readily available Preceptors in the Nexus resources to acquire interprofessional learning IN practice skills to use in clinical practice with underserved populations, including the National Center's Resource Center

Workshop Directory

Monday, July 31

WORKSHOP SESSION #4

3:00pm - 4:00pm

COLLABORATIVE CARE: AN EVIDENCE BASED MODEL FOR PRIMARY CARE

Algonquin

Mental Health: Payment

The Institute for Family Health

Zachary Bodenweber, *Implementation Specialist and Depression Care Clinician*

Collaborative Care is an evidence-based model of integrated care that treats common mental health conditions such as depression and anxiety with a systemic primary care based approach. Based on principles of effective chronic illness care, Collaborative Care focuses on measurement-based practice, treatment to target, and defined patient populations tracked in a registry. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication and psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustments for patients who are not improving as expected. This session will provide a better understanding of Collaborative Care and its Medicare payment mechanics so that participants can understand why this is now the chosen model of depression care in many states.

LEARNING OBJECTIVES

1. Develop an understanding of the Collaborative Care approach, including its history, guiding principles, and evidence base.
2. Recognize the team structure of Collaborative Care and learn about each team member's role.
3. Assess the difference between your organization's current care model compared to a Collaborative Care model and learn the necessary steps to implement Collaborative Care in your practice.

TRAINING MAs: FORGET THE FOR PROFITS. TRAIN OUR OWN.

Smithson

Medical Education

Salud Family Health Center

Tillman Farley, MD, *Executive Vice President for Medical Services*

The National Institute for Medical Assistant Advancement (NIMAA) is a new charitable enterprise that is building a national program to train Medical Assistants (MAs) to effectively participate in high-functioning, team-based primary care delivery systems while simultaneously providing students an effective and low-cost educational program with exposure to high-demand career pathways in the healthcare industry. The NIMAA MA certificate program is designed as two overlapping 7 month programs each year, offering concurrent on line and in-clinic experiences. We do this by offering a best in class on line instruction program. We combine this with experiential learning in "host clinics". Each host clinic organization participates in the selection and on-site training of 5-10 students, and thus creates an MA "pipeline" for itself, "training our own".

LEARNING OBJECTIVES

1. How safety net clinics can "train their own."
2. A new training model for upskilling existing medical assistants.
3. Advancing practice transformation and provider retention with MA change agents.

Workshop Directory

Monday, July 31

WORKSHOP SESSION #4

3:00pm - 4:00pm

MAXIMIZING INTERPROFESSIONAL TEAM WORK TO MINIMIZE RE-HOSPITALIZATIONS: THE JOHNS HOPKINS AFTER CARE CLINIC

Douglass
Team-Based Care

The Johns Hopkins Hospital After Care Clinic
Sophia Pemberton, MSN, BSN, CRNP, *Department of General Internal Medicine*
Caitlin Dowd-Green, *Clinical Pharmacist*
Rosalyn Stewart, *Physician/Director*
Jennifer Rice-Assenza, *Social Worker*

Approximately 20% of Medicare patients are re-hospitalized within 30 days following discharge. One cost-effective intervention to minimize post-discharge adverse events is to improve hospital-to-home care transitions. The Johns Hopkins After Care Clinic (ACC) minimizes care delays and supports healthcare continuity from an acute setting to a medical home for low income urban patients. The interprofessional clinical team – including pharmacists, nurses, physicians, nurse practitioners, physician assistants, medical assistants, and social workers– collaboratively focuses on disease education, medication reconciliation, and coordination of services. The ACC avoided 297 ED visits and 62 hospitalizations; amounting to more than \$1 Million in savings for 13 months of operations.

LEARNING OBJECTIVES

1. Identify transitional care barriers for patients recently discharged from the hospital or ED who need rapid follow-up and support as a bridge to appropriate primary care.
2. State social determinants that give rise to health disparities in low-income urban communities.
3. Apply objectives 1-2 to interprofessional team collaboration as a means for supporting low-income urban communities attain and sustain health.

THE FOURTH AIM: IT'S NOT ABOUT PROVIDER SUPPORT GROUPS

Dumbarton
Burnout

Human Diagnosis Project
Shantanu Nundy, MD, MBA, *Director*

The Triple Aim of better care, better population health, and lower per capita cost resulted in unintended negative impacts on the workforce, including burnout. Reasons for clinician stress, burnout, and turnover include how we learn medicine, how we practice it, and the health care system that pushes clinicians to ignore work-life balance. In order to change this we need to fundamentally challenge and change the way we view clinicians as resources and how we embrace technology. The Human Diagnosis Project (Human Dx) is the first nation-scale “AI for good” initiative created with and led by the global medical community to build an online system that maps the best steps to help any patient. By combining collective intelligence with machine learning, Human Dx intends to enable more accurate, affordable, and accessible care for all.

LEARNING OBJECTIVES

1. Understand the Quadruple Aim as an important framework for the success of our healthcare system.
2. Describe factors contributing to clinician burnout.
3. Understand how collective intelligence and machine learning can support clinicians in the safety net.

Workshop Directory

Tuesday, August 1

WORKSHOP SESSION #5

9:30am - 10:30am

KEY PRINCIPLES OF SHORTAGE DESIGNATION

Algonquin
Policy

Health Resources Services Administration

Melissa Ryan, Operations Director, Bureau of Health Workforce

As part of an ongoing project to increase transparency, accountability, and parity among Health Professional Shortage Area (HPSA) designations, in 2014 HRSA's Bureau of Health Workforce (BHW) rolled out the new Shortage Designation Management System (SDMS). SDMS leverages standard national data sets, and has given BHW the ability to reexamine how it designates HPSAs. This session will review some of the key concepts of HPSA designation and how HPSAs are used, the progress to date in the adoption of SDMS, as well as the potential impact on HPSA designation processes in the future.

LEARNING OBJECTIVES

1. Understand how the federal government designates health professional shortage areas (HPSAs).
2. Understand the system and data changes to the shortage designation system proposed by the Bureau of Health Workforce, and what changes have already occurred.
3. Recognize the potential impact on current and future HPSA designated areas and facilities and how ACU and BHW are working together to address priority areas of concern.

CREATING EFFECTIVE SPACES FOR PRIMARY CARE TEAMS

Smithson
Financing and Design

Capital Link

Cindy Barr, EDAC, Operations & Facilities Planner

Highly functional primary care teams are crucial to effective engagement with our communities. Spaces that support daily function, facilitate interdisciplinary relationships, encourage creative problem solving and respect individual strengths, needs and contributions enhance team development. Participants will explore specific challenges they are facing in their current and planned environments: 1. Understanding the role of place in facilitating engagement, supporting relationship and sustaining impact with our patient population, 2. Expanding options for patient engagement zones in team based care, 3. Creating team work zones that support focused work, clinical collaboration and coordination of care within a stress reducing environment., 4. Re-defining the role and design of team respite zones, 5. Addressing common functional challenges in existing spaces.

LEARNING OBJECTIVES

1. Create and/or optimize existing clinical spaces that comfortably and effectively engage patients, family members and caregivers in the primary care visit experience.
2. Create and/or optimize existing team work zones to support the three types of team work within a stress reducing environment.
3. Optimize available resources to create spaces for staff development and respite that complement team work zones and facilitate recruitment and retention initiatives.

Workshop Directory

Tuesday, August 1

WORKSHOP SESSION #5

9:30am - 10:30am

INNOVATIVE COACHING IN TEAM-BASED CARE: A DATA-DRIVEN PRACTICE FACILITATION MODEL OF TECHNICAL SUPPORT TO DRIVE CLINICAL, OPERATIONAL AND TECHNICAL TRANSFORMATION

Douglass

Team-Based Care

Community Health Care Association of New York State

Ava Rose, LMSW, Assistant Director of Clinical Quality Improvement Program

Amy Zarr, MPH, Project Manager of of Clinical Quality Improvement Program

Ilana Sackler-Berner, MPH, Project Manager of of Clinical Quality Improvement Program

In 2016, the Community Health Care Association of New York State (CHCANYS) implemented an innovative coaching model to coincide with the state's transition to value based payment systems. The coaching model is built upon HIT-enabled clinical decision supports and systematic workflow changes to adopt team based care. It is implemented in the form of a data-driven practice facilitation model of technical support to drive clinical, operational and technical transformation. To date, CHCANYS has helped 21 health centers establish a data strategy and build QI capacity via individually tailored technical assistance over at least 12 months. The quantitative and qualitative result of the impact on health centers' clinical and operational excellence as a result of this coaching framework will also be discussed and illustrated.

LEARNING OBJECTIVES

1. Understand the coaching model framework and paradigm for achieving team based care concepts along with leadership buy-in.
2. Understand strategies for improving staff engagement in HIT management.
3. Identify interactive activities that build team based care processes and strengthen staff relationships.

WHAT DOES TEAM BASED CARE HAVE TO DO WITH IT?

Dumbarton

Team-Based Care

Primary Care Development Corporation

Angela Fernandez, Training and Curriculum Development Specialist

Yael Lipton, MPH, MCHES, Training and Curriculum Development Specialist

While the rationale for team-based care may seem straight forward and logical, the implementation is not. Primary Care Development Corporation (PCDC) has been training healthcare providers (clinical and non-clinical) in the skills needed to adopt these models and has also been providing coaching and technical assistance to leaders in organizations who are in the process of transforming their practices to become more person- centered through team-based care. As a result of this work, PCDC has learned many lessons over the years about the challenges facing both front-line and management staff. Come here about those lessons and hear strategies that may be effective in addressing them.

LEARNING OBJECTIVES

1. Briefly describe the main components of care management and team-based care.
2. List common challenges to implementing effective and successful team-based care.
3. List strategies to overcome challenges in your team-based care model.

Workshop Directory

Tuesday, August 1

WORKSHOP SESSION #6

11:00am - 12:00pm

WEIGHT MANAGEMENT FOR OPTIMAL HEALTH (SESSION #1)

Algonquin
Training

El Rio Community Health Center

Joy Mockbee, MD, MPH

Diane Haeger, MBA, *Weight Management Program
Facilitator*

Speakers will highlight a successful team-based, multifaceted primary care approach to weight management in an FQHC. The program combines behavioral support for lifestyle change in nutrition, physical activity, stress & sleep. The team replaces existing medications that cause weight gain and use weight loss medications as appropriate. The team also refers & prepares for bariatric surgery when indicated. This interactive session will include tools & resources you can use related to overcoming weight bias, physiology, nutrition, physical activity, sleep, stress, medications, surgery, and a program curriculum.

LEARNING OBJECTIVES

1. Understand the physiologic and societal barriers to long-term weight loss and strategies for overcoming them.
2. Learn the components of a team-based medical program for weight management and effective roles for each team member.
3. • Understand how to create synergy for weight management success through a multifaceted approach.

CHANGE IS IN THE AIR: BUILDING PARTNERSHIPS TO SUPPORT PUBLIC HOUSING RESIDENTS IN THEIR SMOKING CESSATION EFFORTS

Smithson
Team: Public Health

CAPITAL LINK

Cindy Barr, EDAC, *Operations & Facilities Planner*

On December 5, 2016, HUD published a final rule requiring all Public Housing Agencies (PHAs) administering low-income, conventional public housing to initiate a smoke-free policy. The Rule was effective on February 3, 2017 with an 18-month implementation period. During the 18-month implementation period, PHAs anticipate that their main challenge will be implementing the ban without smoking cessation programs in place. Health Centers in or immediately accessible to public housing have an opportunity to partner with PHAs and support public housing residents in their efforts to quit smoking. This session will discuss the tobacco use of public housing residents and provide examples of smoking cessation strategies and resources used at Health Centers located in or immediately accessible to public housing.

LEARNING OBJECTIVES

1. Describe the health status of public housing residents and HUD's rule banning smoking in public housing.
2. Compare the prevalence of tobacco use in public housing with prevalence of tobacco use by state.
3. Identify strategies to collaborate with Public Housing Authorities to deliver smoking cessation resources to public housing residents.

Workshop Directory

Tuesday, August 1

WORKSHOP SESSION #6

11:00am - 12:00pm

THE FEDERAL BUDGET AND APPROPRIATIONS: FUNDING OUTLOOK FOR THE NATIONAL HEALTH SERVICE CORPS

Douglass
Policy

The Association of Clinicians for the Underserved
Craig A. Kennedy, MPH, *Executive Director*

An interactive session on the history of funding for the National Health Service Corps (NHSC) program, and how the federal budget and appropriations process has impacted the program. The workshop will review the original authorization of the NHSC, the American Recovery and Reinvestment Act (ARRA), the Affordable Care Act (ACA), the Medicare Access and CHIP Reauthorization Act (MACRA), as well as provide updates on the future of the program. The NHSC has transitioned from a traditional discretionary program that was authorized and annually appropriated, to a program that is permanently authorized and funded through a mandatory Trust Fund mechanism. Unfortunately, the trust fund expires after fiscal year 2017. This workshop will include advocacy tips and discussion to ensure the future of this important federal workforce program.

LEARNING OBJECTIVES

1. Understand the federal budget and appropriations process.
2. Recognize the various mandatory and discretionary funding streams for the National Health Service Corps (NHSC) program.
3. Understand the role of advocacy in the funding of the NHSC and how individuals can impact the process.

THE USE OF DATA IN A POPULATION HEALTH PROJECT AT A CHC IN SW MISSOURI

Dumbarton
Health Information Technology

The RCHN Community Health Foundation
David Hartzband, D.Sc. *Director of Technology Research*

Access Family Care
Debra Davidson, COO

Access Family Care has been executing a project to improve outcomes for patients with diabetes by focusing on transitions of care & lowering HbA1c levels. This project has required the use of data from the CHC's EHR & a variety of other sources. The acquisition, quality & specific use of this data for the project will be followed as well as the constraints & limitations imposed by the data, its sources & how it is collected.

LEARNING OBJECTIVES

1. What are the advantages, constraints & limitations of using EHR data for population health & clinical improvement projects?
2. How can data quality issues with EHR data be ameliorated so that such data can be used for actionable projects by healthcare organizations?
3. How can population level data available to the healthcare organization be used to facilitate care transitions & improve HbA1c levels for diabetic patients?

Workshop Directory

Tuesday, August 1

WORKSHOP SESSION #7

1:30pm - 2:30pm

WEIGHT MANAGEMENT FOR OPTIMAL HEALTH (SESSION #2)

Algonquin
Training

El Rio Community Health Center

Joy Mockbee, MD, MPH

Diane Haeger, MBA, Weight Management Program
Facilitator

*This session is the second half of the this two part
training. See the description on page*

BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION IN HEALTH CARE FOR THE HOMELESS

Smithson
Medical Education

National Health Care Council for the Homeless

Pia Valvassori, PhD, ARNP, Steering Committee Member

A high incidence of behavioral health disorders in those with chronic disease who are experiencing homelessness as warranted a successful model of integrated care. Limited access to mental health services has led to a number of negative health related outcomes in those with undiagnosed or untreated behavioral disorders. This has made it incumbent on primary care providers to address these issues which are often times stigmatized. Over 70% of all related health disorders have a psycho-social cause, in addition over 75% of those experiencing homelessness have an substance use or mental health disorder. Traditionally, primary care, mental health and addictions treatment have been fragmented. This has led to a system that is difficult to navigate by those experiencing homelessness. Working as team to address these issues has proven to be an effective model of health care delivery in health care for the homeless.

LEARNING OBJECTIVES

1. Discuss the rationale for employing an integrated model of care in health care for the homeless.
2. Describe models of integrating behavioral health and primary care in health care for the homeless.
3. Explain and explore health related outcomes associated with a team based approach to care.

Workshop Directory

Tuesday, August 1

WORKSHOP SESSION #7

1:30pm - 2:30pm

THRIVING AS A LEARNING HEALTH CARE SYSTEM IN PRIMARY CARE

Douglass

Health Information Technology

Alliance Chicago

Fred Rachman, MD, Chief Executive Officer

The Learning Healthcare System (LHS) is an innovative model to engage Community Health Centers in quality improvement, research, and dissemination. This model emphasizes a collaborative approach to utilizing health information technology (HIT) to drive higher quality, more efficient, evidence-based clinical practice and patient care. This session will explore lessons learned and best practices in successful models of LHSs in primary care to promote research and evidence-based practice, harness HIT infrastructure to advance patient and provider engagement, and to improve dissemination efforts. We will explore the potential of care teams to create a sustainable, learning healthcare system that delivers comprehensive care in a timely fashion.

LEARNING OBJECTIVES

1. Understand the fundamental principles of an LHS, including the importance of collaboration and team based approaches to successfully adopting this model.
2. Learn of concrete examples and best practices where principles of the LHS were adopted by primary care centers to enhance the quality of care for patients. This will be an opportunity to consider replicating or scaling these efforts.
3. Understand how implementing the LHS can better prepare primary care centers for payment reform.

INNOVATIVE INTEGRATED BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT IN A FEDERALLY QUALIFIED HEALTH CENTER

Dumbarton

Medical Education

Sheridan Health Services

**Mary Kay Meintzer, LPC, LAC, Behavioral Health
Program Director**

**Emily Gamm, LCSW, CACII, Behavioral Health Provider &
Graduate Trainee Program Coordinator**

Sheridan Health Services is a non-profit organization of The University of Colorado College of Nursing that provides quality integrated healthcare to underserved populations as a nurse-managed health center. Strategic development of the behavioral health workforce helped increase the team by 3 FTE providers and 13 graduate level behavioral health students over 3 years. This session provides social justice and academic training approaches essential to expanding a skilled integrated behavioral health workforce. It covers strategies to ensure recruitment and retention of masters level students and behavioral health providers whose passion aligns with the delivery of culturally informed team-based care. Participants will explore how a model of collaboration between academia and community organizations can serve as a model of inclusive, integrated, multi-disciplinary care.

LEARNING OBJECTIVES

1. Learn about a training/education model that supports the acquisition of core competencies fundamental to the delivery of integrated behavioral healthcare to underserved populations.
2. Explore strategies proven to support not only the tenets of team-based care but also culturally informed practices.
3. Participants will gain an understanding of the successes and lessons learned from our community building efforts.

EXHIBITORS

Exhibit Hours:
Monday, 10:00AM - 5:00PM
Tuesday, 8:30AM - 3:30PM



ARIZONA DEPARTMENT
OF HEALTH SERVICES



The Arizona Alliance for Community Health Centers (AACHC) has served as Arizona's Primary Care Association since 1985 and continuously strives to address the needs of Arizona's Community Health Centers, as well as the diverse populations they serve. Arizona's CHCs are local, nonprofit, healthcare providers serving people of all income levels in medically underserved communities. They serve over 610,000 patients and provide over 2,200,000 annual visits and focus on improving the health of individual patients, as well as improving the health status of the entire community.



Asthma and Allergy
Foundation of America

The Asthma and Allergy Foundation of America (AAFA) is the nation's oldest nonprofit advocacy organization. AAFA offers patient support via an 800 helpline; email support where patients can Ask the Allergist general questions about allergies and asthma; and peer support via our online communities. AAFA also offers educational materials in digital and print format, news updates and online courses for those newly diagnosed with food allergies or asthma. Visit aafa.org and kidswithfoodallergies.org to learn more.



The Christopher and Dana Reeve Foundation is dedicated to finding treatments and cures for paralysis caused by spinal cord injury and other neurological disorders. It also works to improve the quality of life for people living with disabilities.



COMMONWEALTH
PURCHASING GROUP, LLC

CommonWealth Purchasing Group is the leading group purchasing organization for community health centers and other non-profit organizations. With 500 members and a portfolio of over 50 vendors, we save organizations millions on the products and services they use every day.

DENTRIX ENTERPRISE

Dentrix® Enterprise from Henry Schein is the best-in-class dental software for public health organizations. Its dental-specific workflow, complete feature set and interoperability with over 40 medical solutions through HL7 interface increase organizational efficiency. A robust database facilitates federal reports required for organizations to receive funds for quality patient care.



NATIONAL CENTER for
INTERPROFESSIONAL
PRACTICE and EDUCATION

The National Center for Interprofessional Practice and Education is a unique public-private partnership charged by its funders to provide the leadership, evidence and resources needed to guide the nation on the use of interprofessional education and collaborative practice as a way to enhance the experience of health care, improve population health and reduce the overall cost of care. We do this by aligning interprofessional education and collaborative practice (the "new IPE") with transforming health care delivery.



The NHSC is a Federal government program administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Workforce that helps bring health care to those who need it most. Since 1972, we have been building healthy communities by connecting primary health care providers to areas of the U.S. with limited access to care. Today, 10,400 NHSC members provide culturally competent care to more than 11 million people. We provide this care at more than 5,000 NHSC-approved health care sites in urban, rural, and frontier areas.

EXHIBITORS

Exhibit Hours:
Monday, 10:00AM - 5:00PM
Tuesday, 8:30AM - 3:30PM



To provide access to low-cost prescriptions to the medically underserved, and to support eligible safety net providers in maximizing the use of the 340B drug discount program.



Telehealth365's mission is to make health care affordable and accessible to everyone. We partner with Insurance Companies, FQHCs, Rural Health Centers and Critical Access Hospitals to provide our OmniPresence Clinic to the Underserved. Using the latest technology, OmniPresence Clinic is a total solution that provides a HIPAA compliant audio/video connection with integrated medical devices, medical specialists (Cardiology, Endocrinology, Orthopedics, Psychology, Dermatology, Neurology), and medical billing.



Based in Fort Lauderdale, Florida, Trividia Health, Inc. is a leading developer, manufacturer and marketer of diabetes monitoring and management products. The company offers a portfolio of high-quality blood glucose monitoring systems and diabetes management products available around the world. Trividia Health is the exclusive supplier of blood glucose monitoring systems, co-branded under the TRUE brand and store brand names, to the world's leading pharmacies, distributors and mail service providers.



Pfizer RxPathways connects eligible patients to assistance programs that offer insurance support, co-pay assistance, and medicines for free or at a savings. For more than 30 years, Pfizer has empowered patients in need with assistance & information so they can get access to the Pfizer medicines prescribed by their doctor. Pfizer RxPathways helps eligible patients find a path to assistance by connecting them to Pfizer programs or resources that best fit their unique needs. To learn more about Pfizer RxPathways and find out if your patients are eligible for assistance, visit www.PfizerRxPathways.com to use our Program Finder, or call a Medicine Access Counselor at 1-844-989-PATH (7284).



The Weitzman Institute is the first community-based research center established by a Federally Qualified Health Center. We are dedicated to quality improvement and research in primary care for the underserved. We test promising innovations in primary care delivery and establish research priorities for Community Health Center, Inc. (CHCI).



3RNet works to improve rural and underserved communities' access to quality health care through recruitment of physicians and other health care professionals, development of community based recruitment and retention activities, and national advocacy relative to rural and underserved health care workforce issues.



The Weitzman Institute is the first community-based research center established by a Federally Qualified Health Center. We are dedicated to quality improvement and research in primary care for the underserved. We test promising innovations in primary care delivery and establish research priorities for Community Health Center, Inc. (CHCI).

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