

Community Engagement & Primary Care Convocation

April 14, 2026

Presented by:

The NYC Research and Improvement Networking Group & The Einstein ICTR's Community Collaborative Core

NYC RING

ICTR Institute for Clinical and Translational Research AT EINSTEIN AND MONTEFIORE
Building Bridges in the Bronx and Beyond

EINSTEIN Albert Einstein College of Medicine

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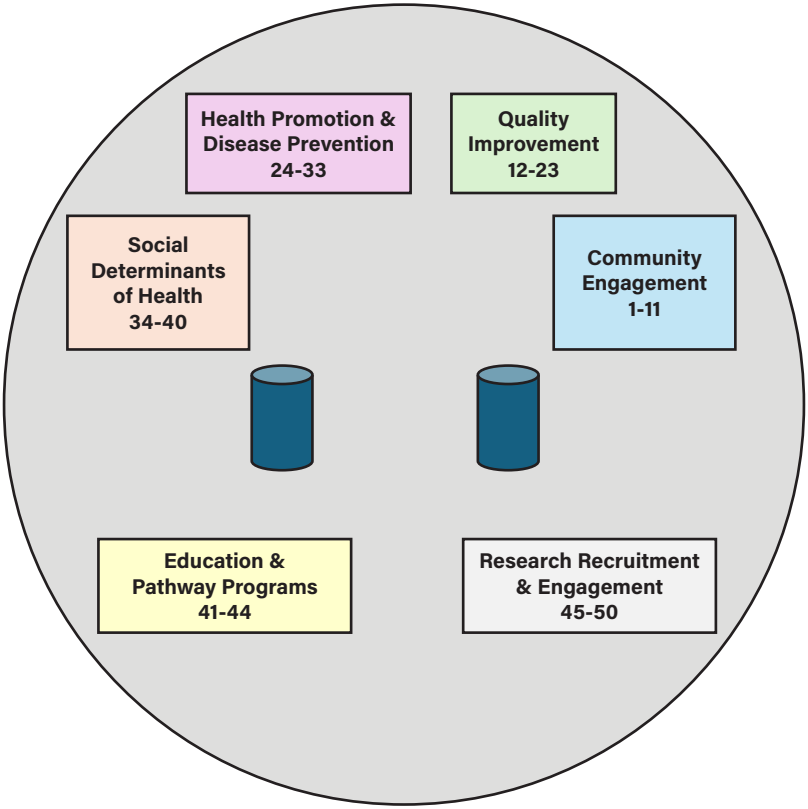
Department of Family and Social Medicine

Office of Research and Sponsored Programs

The Paul Meissner Memorial Fund

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Welcome Message

Welcome to the **2026 Community Engagement and Primary Care Convocation**, which we are very excited to present together with the ICTR's Community Collaborative Core. At its essence, NYC RING is about working together with primary care patients, practitioners and communities to address important health issues, and our annual Convocation of Practices is a great example of that. Many important research studies have gotten their start from conversations around a poster at the NYC RING Convocation.

This year our keynote will be presented by Dr. Maida Galvez, a true leader in the field of pediatric environmental health whose work exemplifies how community-engaged research and advocacy can be wielded to improve children's health. We are also excited to present a number of innovative workshops in community health as well as an amazing variety of research and quality improvement initiatives that will be showcased in our poster sessions. We hope you'll spend some time today in conversation with old colleagues and making new connections as we all work to build a future for healthcare delivery based on a shared vision of health equity.

Thank you so much for joining us today,

Andrew Telzak MD MSc
Assistant Professor, Family and Social Medicine and Pediatrics
NYC RING Associate Director

Jonathan Ross, MD MS
Associate Professor, General Internal Medicine
NYC RING Director

About NYC RING

THE NYC RESEARCH & IMPROVEMENT NETWORKING GROUP is a Practice-Based Research Network (PBRN) supported by the Department of Family and Social Medicine and the Institute for Clinical and Translational Research at the Albert Einstein College of Medicine. Founded in 2003, NYC RING is built on the premise that **actively involving primary care practices in all phases of the research process** will increase the relevance of the questions, enhance protocol implementation, and significantly improve the translation of results into primary care practice to impact health equity.

By **building relationships, sharing resources, and engaging our community**, NYC RING aims to provide researchers and practices with the tools they need to effectively investigate clinical questions that will have a real impact on the health of individuals, families and communities here in the Bronx.

OUR MISSION is to define and strengthen the knowledge base that informs and improves primary care practice by:

- Defining and pursuing a research agenda focused on the specific health, disease, and health services issues of communities historically excluded from research to advance health equity
- Identifying and addressing research and quality improvement questions important to primary care providers, patients, families, and their communities
- Providing a resource for translational research in primary care and community health.

OUR TEAM



Jonathan Ross, MD MS
Director



Andrew Telzak, MD MSc
Associate Director



Hernidia Guerra, BA
Network Coordinator

Learn more about NYC RING, our current and past projects, and how to collaborate with us, by email or on our website:
nycring@einsteinmed.edu
www.einsteinmed.edu/centers/ictr/nycring

ICTR's Community Collaborative Core

Welcome to all from the Community Collaborative Core (CCC)! We are delighted this year to partner with NYC RING to present the 2026 Primary Care and Community Engagement Convocation. As a core component of the Harold and Muriel Block Institute of Clinical and Translational Science (ICTR) at Albert Einstein, the CCC promotes meaningful community engagement across all stages of clinical and translational research. We work closely with faculty members alongside maintaining close partnerships with community stakeholders. Among many services we promote to increase community engagement, we provide individual consultation services for faculty members with questions on their community engagement initiatives.

We strongly believe this Convocation will bring together faculty, staff, and communities in service of this major goal. We are excited to see what learning opportunities, networking, and ongoing and future collaborations come out of this Convocation!

About the Community Collaborative Core (CCC)

The overall aim of the Community Collaborative Core (CCC) is to improve health by transforming our Learning Health System (LHS) into a Learning Health Care Community (LHCC) that integrates community voice into research collaborations. Our goals work towards enhancing community engagement and improving health for all by:

- Accelerating Clinical and Translational Science research to address the significant burden of conditions that disproportionately affect populations in the Bronx.
- Promoting participation of representative populations in Clinical and Translational Research to ensure that community-academic partnerships are fully collaborative.
- Building capacity for sustainable community and stakeholder engagement in all aspects of Clinical and Translational research.
- Developing and maintaining a skilled, multi-disciplinary and diverse translational workforce to support and lead high-quality Clinical and Translational Research.

OUR TEAM



Hector R. Perez, MD, MS
Director



Damara Gutnick, MD
Associate Director



Heather Archer-Dyer, MPH, CHES
Co-Lead, Community Engagement Collaborative



Anisha Balaji, MPH
Program Coordinator

Learn more about the Community Collaborative Core, our goals, resources, services and opportunities for collaboration by email or at our website:
Anisha.Balaji@einsteinmed.edu
https://einsteinmed.edu/centers/ictr/community-engagement-core/

Special Thank You to Our Sponsors

The Community Engagement and Primary Care Convocation has been made possible through the support and collaboration of our event sponsors:

Department of Family and Social Medicine (DFSM)

Institute for Clinical and Translational Research at Einstein and Montefiore (ICTR)

Office of Research and Sponsored Programs

Montefiore Care Management Organization (CMO)

Your participation and partnership is greatly appreciated. Thank you for supporting practice-based research in our communities!

Thank You to the Community-Based Organizations & Partners in Attendance

Anti-Racism Community Collaborative in Healthcare Confronts structural racism in healthcare through community engagement in the Bronx, integrating patient voices, and promoting equitable care. **https://www.aamc.org/about-us/excellence-academic-medicine/population-health/next-award**	**African Services Committee** A multi-service human rights organization dedicated to assisting immigrants, refugees, and asylees from across the African Diaspora. **https://africanservices.org/**	**Bronx Regional Health Information Organization** Harnesses the power of information technology to improve care coordination and transform healthcare delivery across the Bronx. **https://bronxrhio.org/**
CRAVE! Engages communities through interactive theater to spark dialogue on cancer, chronic disease, and equity in clinical research participation. **https://beitenterprises.com/programs/crave-workshop.html**	**Health People** Empowers and trains residents in communities impacted by chronic disease, HIV/AIDS, and social determinants of health to become leaders in prevention and community health education. **https://healthpeople.org/**	**Mount Vernon Power** Brings together diverse men from the Bronx and Westchester NY area to engage in volunteerism, developing youth programming, and promoting health and wellness.
New Testament Temple Church of God Faith-based organization serving the Bronx community through spiritual guidance, outreach, and support services. **https://www.facebook.com/nttcogbronx/**	**The Bronx Health Link** Amplifies the voices of Bronx residents and community-based organizations while equipping them with tools to advance health equity. **https://www.bronxhealthlink.org/**	**The Fortune Society** Supports justice-involved individuals with resources and services to help them successfully reintegrate into their communities. **https://fortunesociety.org/**
Good Neighbors Community Outreach Agency Supports programming to help community residents improve their lives, support their families, secure their homes, and stabilize their community. **https://gncdcny.org/**	**WHEDco** Supports women in building and growing successful home-based childcare businesses across New York City, while improving the quality of childcare available to families. **https://whedco.org/**	**United Church of Jesus Christ** Works to create a welcoming environment for all while fostering community connection and positive impact across the Bronx. **https://unitedchurchbx.org**

Agenda

Registration & Networking		2:30 – 3:00
Symposia		3:00 - 5:00
Session A	**A1: Research in Action: Examples of Community-Academic Partnerships** This session will feature presentations from community–academic research teams highlighting real-world examples of community-engaged research. Speakers will describe how partnerships were formed, how community voices shaped the work, and key lessons learned from implementation. Emphasis will be placed on practical insights and the impact of collaboration on research relevance and outcomes.	3:00- 3:50
	A2: Community-Engaged Research in Practice This panel discussion brings together researchers and community partners to discuss the realities of conducting community-engaged research across diverse settings. Panelists will reflect on building trust, sharing power, navigating challenges, and sustaining meaningful partnerships. The discussion will offer actionable guidance for investigators, trainees, clinicians, and community members interested in advancing equitable, community-centered research.	4:00 - 4:50
Session B	**B1: Building Trust Together: Co-Designing a Learning Health Care Community in the Bronx** Join us for an interactive workshop on building trust through community engagement. Together, we will explore best practices in trust-building, discuss the Bronx Community Health Needs Assessment data, and examine how a Learning Health Care Community can strengthen partnerships between communities, health systems, and researchers. Participants will help shape guiding principles for community-engaged research at Montefiore-Einstein, and learn about opportunities to get involved through service learning, pathway programming, and other engagement activities.	3:00- 3:50
	B2: Community in Action: Partner Perspectives and Projects Shaping a Learning Health Care Community This interactive workshop will showcase how Montefiore-Einstein and community partners are working together to improve health and advance research that matters to the Bronx. Featuring highlights from NYC CONNECT, BRAID, The Bronx Health Link, and ARCCH, as well as a panel of community partners, the session will explore how shared learning and collaboration can strengthen a Learning Health Care Community. Participants will also learn how to join the Montefiore-Einstein network and stay involved in future community engagement opportunities.	4:00 - 4:50
Session C	**C: Establishing Primary Care Priorities** This one-hour session will bring together primary care physicians, nurses, and administrators from MMG clinics throughout the Bronx. Participants will share frontline perspectives on real-world primary care challenges and identify the most important topics to address, guiding new research that is relevant to patients, clinicians, and communities.	4:00 - 4:50

Agenda

Keynote Address		5:00 – 6:15
Welcome	**Jonathan Ross MD, MS** *NYC RING Director* **Andrew Telzak MD, MSc** *NYC RING Associate Director* **Yaron Tomer, MD** *The Marilyn and Stanley M. Katz Dean,* *Albert Einstein College of Medicine*	
Introduction to Keynote Speaker	**Hector R. Perez MD, MS** *Director, Community Collaborative Core* **Damara Gutnick MD** *Associate Director, Community Collaborative Core*	
Keynote Address *"Building Bridges and Working Together: Research at the Intersection of Primary Care and Community Engagement"* Q&A	**Maida Galvez MD, MPH** *Professor at Icahn School of Medicine at Mt. Sinai* *Director, New York State Children's Environmental Health Center (NYSCHECK)* *Director of Community Engagement, Mount Sinai Center for Health Across the Lifespan (HEALS)* *Director of Community Engagement, Clinical Translational Science Award (CTSA) Program at Mount Sinai Conduit*	
Closing Remarks	Heather Archer-Dyer MPH, CHES *Director of Community Outreach,* *Dept of Family and Social Medicine*	
Poster Session		6:15 – 7:30

Keynote Bio



Dr. Maida Galvez is a pediatrician whose clinical, research, and advocacy work is dedicated to promoting healthy environments for all children. She is Professor in the Departments of Environmental Medicine and Pediatrics at the Icahn School of Medicine at Mount Sinai where she is Director of the New York State Children's Environmental Health Center (NYSCHECK)—the first in the nation state-wide, publicly funded model for children's environmental health clinical services in the United States. NYSCHECK sites are located across New York State, including in Albany, Buffalo, Long Island, New York City, Rochester, Syracuse, and Westchester. Mount Sinai serves as the coordinating center. Since 2006, she has also served as Director of the Region 2 Pediatric Environmental Health Specialty Unit (PEHSU), a US Environmental Protection Agency and Centers for Disease Control (CDC) program that provides environmental health services to communities in New Jersey, New York, Puerto Rico, and the US Virgin Islands. In her work as Director of Community Engagement for both the NIEHS funded Mount Sinai Center for Health Across the Lifespan (HEALS) and NIH funded Clinical Translational Science Award (CTSA) Program at Mount Sinai Conduits, Dr. Galvez works to center community in all stages of research and translate emerging research into programs and policies that prevent and reduce environmental exposures for children, their families, and their communities.

Graphic Recording

Graphic recording is the art of illustrating key themes of a discussion in real time to help people see what's being said and make connections. Today we are joined remotely by Haley McDevitt from Illustrating Progress who will be visualizing our keynote and workshop presentations in real time. The completed illustration will be revealed at the end of today's keynote and will remain on display in the auditorium for the rest of the evening. When viewing the illustration, we encourage attendees to engage with the topics and ideas represented in the image through further reflection and discussion, observing any new or existing connections that emerge.

The illustration from this graphic recording will also be made available online following the event. Visit **www.einsteinmed.edu/centers/ictr/nycring**

COMMUNITY ENGAGEMENT

1. Co-Designed Strategies for Dissemination of Genetic Risk Information in the Bronx Garifuna Community

Sanjana Boyapalli, BA; Rachel Sklar, BA; Noah Jacobs, MMSC, Srilakshmi Raj, PhD; Nereyda Franco, PMH; Christa Farris; BS; Damara Gutnick, MD
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Genetic testing can inform preventative measures and guide therapeutics. However, use by diverse populations has been limited by mistrust and unequal representation in research. Our team identified founder populations with elevated genetic disease risks. Garifuna were found to possess elevated risk for Hypertrophic Cardiomyopathy (HCM). HCM increases risk of heart failure and sudden death, but early treatment is effective. Genetic testing messaging can increase healthcare engagement, mitigating adverse outcomes. This study aimed to ascertain Bronx Garifuna's perceptions of genomic medicine and develop a tailored messaging model based on co-created strategies. We leveraged BRAID, an evidence-based community engagement model, to facilitate dialogue between clinical experts and community members. We collaborated with a community leader to recruit 6 trusted messengers who participated in a series of 4 conversation circles. Participants co-created a video and flyers to share with their community. Qualitative analysis of session transcripts identified themes related to perceptions of genomic medicine and effective outreach. Analysis of pre/post surveys and a survey from a focus group reviewing the codesigned materials were conducted. While qualitative analyses (n=6) revealed participants' understanding of health burdens and openness to genetic testing, they also highlighted mistrust amongst the broader community. Participants were confident that sharing experiences of other founder populations and leveraging community networks would improve these perceptions. Analysis of surveys identified BRAID participants, faith leaders, doctors, and scientists as key messengers. Feedback on codesigned materials (n=11) demonstrated increased dialogue with peers and providers about HCM and genetic testing. Successful outreach will involve culturally rooted strategies that leverage existing networks. Participants' eagerness to serve as messengers reflects BRAID's ability to mobilize community leaders. Future work will engage Garifuna men and youth to ensure comprehensive outreach. Given the NIH's goal of precision medicine for all, the impact of our findings can extend to other founder communities.

2. COVID-19 Vaccine Concerns Among Patients with Hypertension: Insights from a Community Health Worker-Led Intervention, the Boost Your Health (Refuerza Tu Salud) Study

Jacqueline Cortez Lainez, MPH; Tameir Holder, MPH; Andrea Cassells, MPH; T.J Lin, MPH; Marielena Lara, MD; Lisa S. Meredith, PhD; Jonathan N. Tobin, PhD;
Contact: CDNResearch5@cdnetwork.org

Hypertension is a significant public health concern, affecting nearly half of U.S adults (45%) and disproportionately affects communities of color. Individuals with hypertension face higher risk for severe COVID-19 outcomes. Despite this elevated risk, uptake of COVID-19 vaccines remains low among those with hypertension and other chronic conditions. This study will examine reasons for COVID-19 vaccine hesitancy among participants with hypertension. Boost is a randomized controlled trial (RCT) evaluating whether a community health worker (CHW)-led intervention increases COVID-19 and influenza vaccination rates among adults with chronic diseases. Participants were recruited from four Federally Qualified Health Centers (FQHCs) in New York City that are part of Clinical Directors Network's (CDN) practice-based research network (PBRN), with two FQHCs rolled out per wave. CHWs were trained in motivational interviewing and four strategies to address barriers: education, patient navigation, storytelling, and encouragement. Participants discussed concerns with their CHW during touchpoints. CHW notes were analyzed from the first two of three enrollment waves to identify themes related to vaccine hesitancy. Themes were compared among two groups of participants: those with hypertension, and those with hypertension and other chronic conditions. The study enrolled 254 participants in the intervention during the first two waves. Of the 234 who spoke with a CHW, 60% had hypertension. Among those with hypertension, the most frequently expressed concerns regarding COVID-19 vaccines included fear of side effects, impact on blood pressure and cardiovascular health. Logistical barriers such as scheduling challenges and competing work responsibilities were documented. In contrast, participants without hypertension more often described broader safety concerns and expressed uncertainty about evolving public health guidance. Among adults with hypertension, COVID-19 vaccine hesitancy appears driven primarily by concerns about side effects and logistical barriers. Future analyses will compare patterns across other chronic disease groups to help CHWs tailor condition-specific messages.

3. Exploring Infant Feeding Practices and Experiences to Inform Breastfeeding Promotion Efforts in Bronx, NY

Mayssa Gregoire, BS; Alma Idehen, MS, Elisa Fisher, MPH,
Rebecca Williams, MD, David Lounsbury, PhD, Hal Strelnick, MD
Contact: Mgregoire@nyam.org

4. Researcher and Clinician Insights into a Community Engagement Model as a Quality Improvement Tool

Saba Saidi, BS; Sarah McNeilly, MD; Debra Williams, EdD; Damara Gutnick, MD
Contact: Saba.saidi@einsteinmed.edu

BRAID (Bridging Research, Accurate Information & Dialogue) is an evidence-based community-engagement model that creates safe spaces to bring trusted community messengers (BRAIDers) together with scientific experts (invited guests) for ongoing facilitated discussions about controversial health and science topics. Our past research surveyed BRAIDers and demonstrated that BRAID builds community members' trust in science. This study aimed to measure the impact of BRAID participation on study team members and invited scientific guests. An online survey was emailed to 34 BRAID participants, including facilitators, invited clinicians and scientific experts, and medical students. The survey assessed insights gained from BRAID participation and changes in attitudes surrounding healthcare inequities and community engagement behaviors. An optional post-survey 15-minute semi-structured interview provided space to elaborate on what respondents learned. 22 of 34 participants completed the survey (10 study team members, 12 invited guests). 91% of respondents reported that they "learned from the community." 73% reported feeling they were "making a difference" and 77% felt "the community trusted the information they shared." 82% agreed participation made them more aware of healthcare inequities in the Bronx. 100% of clinicians and future clinicians (n=10) reported that participating "helped them be a better physician/future physician", made them "better able to understand their patients' perspectives", and motivated them to listen better to what matters to their patients. Participating in a community engagement model like BRAID can empower clinicians to better understand their patients' perspectives and what matters to them. This has the potential to improve health outcomes. BRAID can facilitate an alignment of priorities between the healthcare system and the community it serves. Further, incorporating a community engagement model into medical school curriculum can prepare future physician workforces to deliver more person-centered care.

5. Building an Evaluation Framework to Assess the Impact of a National Center Advancing Community-Academic Collaboration in Diabetes Research

Aditi Luitel, MSPH; David Lounsbury, PhD; Stephanie Albert, PhD; Laura Wyatt, MPH; Arleen Brown, MD, PhD; Nadia Islam, PhD; Earle C Chambers, PhD, MPH
Contact: Aditi.luitel@einsteinmed.edu

The National Center for Engagement in Diabetes Research (CEDER) aims to strengthen community engagement to advance type 2 diabetes (T2D) research across diverse populations through research consultations and community engagement studios. CEDER is a national center jointly led by community and academic partners and supported by a partnership hub and steering committee representing diverse expertise and perspectives from urban and rural communities across the U.S. Partners guide development and implementation of CEDER's service model for research teams and community organizations. We describe CEDER's evaluation framework to assess service delivery and progress toward the Center's aims. Guided by CEDER's logic model outlining inputs, activities, outputs, outcomes, and anticipated impact, an Evaluation Workgroup (EWG) identified and prioritized metrics for a practical evaluation framework. Development was informed by review of community engagement models, program documents, and partnership hub discussions. Indicators were generated and refined iteratively, drawing on typologies such as 100 Metrics to Assess and Communicate the Value of Biomedical Research. The framework incorporates quantitative and qualitative data across 5 domains: Reach, Service, Partnerships, Practice, and Products. Reach and Service align with logic model outputs (e.g., consultations and studios), while the remaining domains reflect outcomes related to service quality. Evaluation questions were developed for each domain. Data sources include service request forms, post-services, and 6/12-month post-service surveys, and qualitative interviews. The framework provides a structured approach to assessing CEDER services, documenting contributions to community-engaged diabetes research, identifying opportunities to strengthen services, and supporting improvements in T2D research.

6. From Silos to Synergy: Designing a Three-Pillar Toolkit for Health System-Wide Community Engagement

Katherine Wang, BA; Liz Spurrell-Huss, MSW, MPH; Claudia Lechuga, MS; Sarah McNeilly, MD; Raisha Hernandez, MA; Jasmine Davila, AS; Damara Gutnick, MD
Contact: Katherine.wang@einsteinmed.edu

Community engagement (CE) is essential to advancing health equity and improving population health outcomes. However, CE efforts within large health systems are often fragmented and inconsistently documented, leading to inefficiencies and limited accountability. To address these challenges, Montefiore Einstein developed a Three-Pillar Community Engagement Toolkit inspired by national CE frameworks and co-designed with community organizations to streamline CE infrastructure, enhance transparency, and better support community partnerships. Pillar 1): The Linkage Request Process provides a streamlined pathway that connects internal members seeking research or program partnerships with community organizations aligned on shared goals. Pillar 2): The CE Tracker is a set of four interlinked databases (Organizations, Programs, Events, Contacts) built into redcap to document and visualize system-wide CE activities. Pillar 3): The 360 Community Feedback Tool is a structured mechanism for partners to evaluate engagement experiences in order to foster accountability and trust. Development of Pillars 1 and 2 engaged 36 departments and generated over 200 implementation recommendations, including requests to limit accessibility of private contact information and enable uploading of organization- and program-level annual reports. During pilot feedback, stakeholders unanimously recognized the toolkit's value for tracking community engagement activities and managing relationships. For Pillar 3, two internal teams have been engaged thus far, with a plan to engage four others on co-design. Community focus groups and individual community members will be surveyed to provide feedback on the tool before implementation. The co-design process revealed key success factors including early and continuous community involvement, clear governance structures, and metrics that capture both process and impact. The three-pillar model provides a scalable framework for integrating a system-wide CE support program and offers practical tools that can be adapted by other health systems seeking to align community partnerships with health equity goals.

7. Development of the Montefiore-Einstein Community Engagement Tracker

Hector Perez, MD, MS; Damara Gutnick, MD; Claudia Lechuga, MS; Anisha Balaji, MPH; Elizabeth Spurrell-Huss, LCSW, MPH
Contact: Hector.perez@einsteinmed.edu

The Albert Einstein College of Medicine's Institute for Clinical and Translational Research developed the Montefiore-Einstein Community Engagement Tracker with collaborators across the medical school and affiliated hospital. The tracker aims to connect researchers with community partners with shared priorities to build and sustain research partnerships. In the design process, we met with key collaborators to obtain feedback about the tracker. After implementing changes to accessibility of information, based on feedback, we now have 36 active users, and are tracking 28 community organizations. Next steps will include refining the tracker further and developing dashboards to better facilitate tracking.

8. Developing Culturally Tailored Psychoeducational Booklets to Facilitate Mental Health Conversations

Sana Azami, MD; Cameron Nienaber, MD; Alina Intisar, MD; Alan Roth, DO; Elizabeth Brondolo, PhD
Contact: Sazami@jhmc.org

Psychosocial barriers, including low mental health (MH) literacy and MH stigma, can limit MH service utilization across communities. However, there may be variations in the specific barriers members of each community face. We used a structured community-based approach to develop culturally tailored psychoeducational booklets for Black, Chinese, and Indo-Caribbean populations. First, we identified state-of-the-science messages about the social, cognitive, and affective barriers to mental health utilization. We validated these ideas using a large community advisory board composed of individuals from different cultural groups and including some individuals who had experienced mental health difficulties and employed mental health care. We generated an initial booklet containing these ideas and accompanying illustrations. Next, we recruited a series of smaller community advisory boards (n = 6-8 participants), creating one community advisory board for each cultural group. Members of these community advisory boards provided examples of their lived experiences associated with each topic in the booklet. Quotes and new illustrations based on the community advisory members' comments were added to the booklets. Topics focused on stress, including discrimination-related stress, MH and MH stigma. Each topic had a series of questions designed to help participants process their own thoughts and feelings about the issues and to support discussions with others, including mental health providers. We tested booklets using research panels and university samples. Quantitative findings reveal booklets increased patient activation, improved MH literacy, and reduced stigma (all ps < .03). Qualitative findings across booklets revealed culturally specific beliefs, barriers, and coping strategies influencing treatment-seeking behaviors. We are testing these booklets in community setting to determine the best ways to disseminate them broadly to change community attitudes towards mental health and mental health care and to improve patient motivation and ability to seek MH care as needed.

9. Community-Engaged Co-Design of an HIV Treatment and Prevention Intervention for People Returning from Incarceration

Jordy Rojas Antigua, BS; Amour Castillo, MPHIL; Dawun Smith, MPH; Fatoumata Kaba-Diakite, MPH; Lindsey Riback, MPH; Matthew Akiyama, MD, MSc; Micaela Linder, MPHIL
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Criminal legal system involved-individuals (CLSI) are disproportionately affected by HIV, but have disparate access to HIV treatment and prevention services. As an initial step toward designing the DEST2nation intervention (a Decentralized, Status-neutral, Stakeholder-engaged post-incarceration intervention for people with and at-risk for HIV), we identified barriers and facilitators to HIV-related care for CLSI from the perspectives of community members and staff from a reentry-focused community-based organization (CBO). Qualitative data were collected from Community Advisory Board (CAB) meetings with CLSI living with or at risk for HIV and stakeholder meetings with The Fortune Society, a large reentry-focused CBO in New York City. Meeting agendas were co-designed and co-facilitated by Fortune and Montefiore/Einstein researchers using community-based participatory research principles to ensure discussions reflected participant priorities and experiences with reentry and HIV-related care. Audio recordings were analyzed using a rapid qualitative analysis framework. Structured summary templates extracted key themes, illustrative quotes, and implications for intervention design. Analysis was conducted collaboratively through iterative discussions to refine interpretations and ensure findings remained grounded in participant perspectives. CAB members (n=10 CAB members, n=7 meetings) described how systemic instability, including disruptions to housing, employment, and insurance, create barriers to care during reentry. Staff (n=26 staff, n=2 meetings) noted how organizational policies, workforce shortages, and funding restrictions within nonprofit systems constrain their ability to meet participants' needs. Both groups emphasized that structural barriers are often misinterpreted by providers as individual failings, contributing to medical mistrust. Peer navigation was consistently identified as a critical strategy to bridge fragmented systems and support care engagement. CLSI and stakeholders identified peer navigation as a promising strategy to address multi-level barriers to HIV-related care. These insights informed the design of the Community Health Advocate (CHA) model, which emphasizes empathy, confidentiality, and sustained relational support to reduce structural barriers and rebuild trust in care.

10. A Client-centered Data Driven Approach to Achieving Birth Equity in the Bronx, NY

Alma Idehen, MS; Elisa Fisher, MPH, MSW; Mayssa Gregoire, BS;
Hal Strelnick, MD
Contact: Alma.idehen@einsteinmed.edu

The Bronx Healthy Start Partnership (BxHSP) began collaborating with The New York Academy of Medicine (NYAM) in 2019 to implement a data-driven approach to program planning, evaluation, improvement, and sustainability to drive progress towards improved maternal and child health in the Bronx. BxHSP aims to improve birth outcomes by employing Community Health Workers' to provide informational, psychosocial, and material support to new and expectant parents in the Bronx. NYAM's Center for Evaluation and Applied Research, was selected as an external evaluator. BxHSP and NYAM collaborate to plan and implement data collection activities aligned with program needs. NYAM collects and analyzes data and shares findings with program and community stakeholders for practical use. For instance, NYAM's environmental scan on root causes of infant mortality disparities in the Bronx, which included perspectives of program participants and community leaders, was used to develop an infant health equity plan to drive future investments in key community priorities. Collection and analysis of qualitative and quantitative data from program participants, program staff, community partners, public officials, and members of the broader community have informed the following insights and lessons: 1) focus data collection on programmatic priorities, questions, and needs 2) be both practical and flexible in the approach to data collection and analysis 3) recognize competing priorities of program participants and partners 4) avoid burdensome data collection activities and ensure participants are compensated for their time and expertise and 5) share findings from research activities widely, including with program participants, staff, and the broader community.

11. Co-designing a Community-Based Research Study in Co-op City

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Co-op City is a cooperative housing development in the Bronx, NY. It is the largest single residential development in the US with 50,000 residents. Recently, Co-op City residents have voiced concerns to their Assemblyman about potentially experiencing higher rates of certain cancers compared to the general public. In turn, the Assemblyman reached out to the Montefiore Office of Community Affairs where he was connected with the Montefiore Einstein Comprehensive Cancer Center (MECCC)'s Community Outreach and Engagement (COE) team. Through a series of virtual and in-person meetings at Co-op City and Einstein, Co-op City residents met with cancer epidemiology and COE experts to discuss their concerns. To start to explore the cancer burden in Co-op City, MECCC investigators compared the demographics, exposure to air pollutants, and top cancer sites by Co-op City (yes/no) among the 76,298 cancer patients treated at MECCC from 01/01/2004-12/31/2024. Patients living in Co-op City (n=2,990) more frequently identified as Black (63.0%, n=1,884), compared to the non-Co-op City patients (32.2%, n=23,598, $p<0.0001$). The mean age and BMI were higher in Co-op city patients (67.2±14.2, 29.2±6.8, respectively) compared to non-Co-op city patients (62.5±16.1, 28.6±7.0) ($p<0.0001$). Initial exploratory analyses suggest Co-op City residents experience higher outdoor air pollution levels and co-morbidities such as diabetes, hypertension, previous malignancy, renal disease, liver disease, COPD, CVD, and CHF compared to non-Co-op City residents. The top 10 cancer sites were similar across both groups; however, Co-op City had a higher proportion of breast (20.8%, n=621) and prostate cancer (12.3%, n=369) compared to non-Co-op City patients (16.5%, n=12,064 and 10.7%, n=7,818, respectively). Researchers have begun a series of discussions on these initial findings with Co-op City residents and will continue to work with the community to co-design a community-based study to robustly assess the prevalence of cancer-related risk factor among Co-op City residents.

QUALITY IMPROVEMENT

12. EHR-Based Patient Identification and Digital Outreach Increases Lung Cancer Screening in NYCRING Clinics: Early Outcomes of the MECCC Centralized Screening Unit

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Lung cancer screening (LCS) reduces lung cancer mortality; yet, < 9% of eligible individuals have been screened. We hypothesized that shifting workflow attributed to LCS (e.g., smoking history collection, eligibility determination) from usual care to a Centralized Screening Unit (CSU) would increase LCS uptake. To test this hypothesis, we conducted a stepped-wedge cluster randomized trial of 18 NYCRING primary care clinics phased-into the CSU intervention. Randomization was into three representative waves based on clinic size [small (<6,000), medium (6,000-20,000), large (>20,000)], teaching hospitals and FQHC's. Based on EHR-data, 74,801 patients were deemed to be "engaged" (e.g. having a primary care visit in last 2 years) and classified into three categories of LCS eligibility based on age, ever/never smoking, insurance status (to ensure follow-up care), and history of chest CT in past year - resulting in 64,029 not eligible, 8,128 potentially eligible, and 2,644 eligible. Outreach was conducted to eligible patients in a stepped-fashion (postcard, followed by text messages, followed by emails). To date, 258 patients have engaged with our trial, leading to 140 shared decision making orders, with 30 patients completing LCS (+2 pending). Across all waves, patient engagement was 0.7% with postcard, 4.5% with texts, and 3.0% with emails. Interestingly, engagement via digital campaigns was similar in the two waves including the postcard (texts=3.5%, emails=2.2%) vs. the one without (texts=4.7%, emails=2.8%), suggesting the increased cost/logistics associated with postcards may not improve engagement. This assertion was confirmed by the Community Advisory Board when discussing these results. Summary to date from our randomized clinical trial: EHR data can be used to identify patients eligible for LCS; digital outreach successfully engages eligible patients; postcards may not be cost-effective. Next, we will implement our outreach campaigns to capture missing eligibility data for the 8,128 "potentially LCS-eligible" patients in our trial.

13. Enhancing Hereditary Breast Cancer Risk Identification in an Urban Primary Care Teaching Clinic: A Quality Improvement Initiative

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Hereditary breast cancer (HBC) accounts for approximately 5-10% of breast cancer cases, yet risk identification in primary care remains inconsistent. Early recognition of elevated risk enables timely genetic counseling, enhanced screening, and preventive interventions. Integrating structured risk assessment tools into routine clinical workflow may improve detection and referral rates, particularly in diverse urban populations. This Quality Improvement (QI) initiative aimed to improve hereditary breast cancer risk screening, patient education, and referral for genetic counseling within a family medicine residency clinic. Using a Plan-Do-Study-Act (PDSA) framework, a baseline chart review was conducted, followed by two improvement cycles. The Gail Model was incorporated into routine visits for eligible patients aged 30-44 years. Outcomes measured included screening rates, positive screen identification, patient education, and referral patterns. Saint Joseph's Medical Center Family Health Center, an urban primary care teaching clinic serving a racially and ethnically diverse patient population in Yonkers, New York. Thirty female patients were included during intervention cycles. The patient population was 63% Hispanic, 17% Black, 10% White, and 10% Asian. Providers implemented structured risk assessment using the Gail Model and integrated CDC "Bring Your Brave" educational resources into counseling discussions. Positive screens prompted referrals for genetic counseling and testing. Baseline review demonstrated 0% documented HBC screening. Following implementation, screening rates increased to 100% during pilot cycles. Referral for genetic counseling was maintained at 88%, and use of educational resources improved across cycles. This project demonstrates that structured risk assessment tools can be successfully embedded into primary care workflow, improving early identification and management of hereditary breast cancer risk in underserved communities.

14. Enhancing Nutrition Education in a Clinic-Based Food Pantry to Address Food Insecurity and Chronic Disease in an Urban Primary Care Setting

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Food insecurity is strongly associated with increased risk of chronic conditions, including hypertension, diabetes, and cardiovascular disease. In 2023, 13.5% of U.S. households experienced food insecurity. At Saint Joseph's Medical Center Family Health Center, 17% of patients screened reported food insecurity, prompting the development of a clinic-based food pantry. While food distribution addressed immediate needs, patients often required additional support to use pantry items effectively in line with medical recommendations. This Quality Improvement initiative aimed to enhance nutritional literacy and chronic disease management among food-insecure patients by integrating culturally tailored, diet-specific recipe education into a primary care-based food pantry. Using a Plan-Do-Study-Act (PDSA) framework, providers identified commonly distributed pantry items and developed accessible, low-literacy recipe cards aligned with DASH, diabetic-friendly, and heart-healthy dietary guidelines. Recipes were adapted into six languages and tailored to reflect culturally relevant cuisines. Educational materials were distributed during pantry use and during clinical visits. Saint Joseph's Medical Center Family Health Center, an urban primary care teaching clinic serving a predominantly Hispanic and Medicaid-insured population in Yonkers, New York. Patients utilized the on-site food pantry, which served over 1,000 individuals between January and September 2024. Structured nutrition education was embedded into pantry distribution using visually formatted recipe cards aligned with available food items. Materials emphasized portion guidance, chronic disease-appropriate modifications, and culturally familiar ingredients. Preliminary implementation demonstrates the feasibility of integrating tailored nutrition education into the pantry workflow without increasing clinical burden. Patients reported increased confidence in preparing healthier meals using pantry items. Embedding nutrition education into food assistance programs may represent a scalable strategy to reduce diet-related chronic disease disparities in underserved communities.

15. Advancing Value-Based Breast Cancer Screening in a Safety-Net Health System: A Multimodal Approach to Improving Population Health and System Sustainability

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Evaluation of breast cancer screening (BCS) adherence in our large safety-net health system revealed wide variability and late-stage diagnosis rates that exceeded national benchmarks. A multidisciplinary taskforce (primary care, radiology, cancer center, and patient advocates) identified barriers, co-designed, and implemented a multi-pronged intervention to address screening uptake and adherence. Mixed-methods evaluation across 18 primary care sites revealed wide variability in BCS rates (60-82%); lack of systematic management of screening bottlenecks (ordering, scheduling, no-shows/cancellations); and unmet patient needs (transportation, screening hesitancy). We co-developed and implemented a phased intervention from March-December 2025 to address identified barriers through: (1) radiology navigator outreach to primary care patients at low-performing sites (March), (2) electronic medical record patient portal self-scheduling (July), (3) AI-assisted rescheduling after no-shows/cancellations (December), and (4) assessment and navigation of social needs and screening hesitancy (March). Outcomes measured were outreach, engagement, and screening completion. We performed multivariate regression to examine demographic predictors of screening. Of 57, 041 HEDIS-eligible patients, 15,971 (28%) were overdue at baseline (mean age 58y, 77% Hispanic or non-Hispanic Black, 74% Medicaid or Dual). Overall, the intervention resulted in 1,610 additional screens over 9 months, improving system-wide BCS rates from 72 to 76%. Of the additional screens, radiology navigator achieved 452 screens (29%), patient portal self-scheduling achieved 1,097 screens (70%), and AI-assisted outreach of no-show/cancelled achieved 61 screens (4%). Engagement and show rates varied: navigator outreach had the highest scheduling engagement (74%) but lower show rates (46%); patient portal self-scheduling showed moderate engagement (44%) with higher show rates (76%); and AI-assisted outreach had low engagement (4%) with moderate show rates (56%). Demographics did not predict screening outcomes. Screening hesitancy (37%) and transportation (10%) were the most common barriers, addressed through social and peer navigation, respectively. Revenue from additional screenings fully offset navigator costs. A coordinated, resource-efficient

screening outreach strategy combining digital tools, human navigation, and AI assistance-co-designed with patients and clinical stakeholders-improved BCS adherence, addressed unmet needs of underserved populations, and proved itself financially sustainable across a safety net health system. Future efforts will focus on further scaling of population health approaches to cancer screening programs.

16. Getting to Yes: Analyzing Barriers to Provider Response to Abnormal Cognitive Screening Among Older Adults in Primary Care

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The 5-Cog paradigm - a novel, culturally appropriate, 5-minute cognitive assessment tool paired with point-of-care clinical decision support - was developed to improve dementia care for historically minoritized groups. We recently (2019-2022) tested the 5-Cog in a randomized controlled trial (RCT) of 1200 patients aged 65 or older with cognitive concerns in a primary care clinic in the Bronx. The 5-Cog resulted in improved dementia care, a composite outcome of provider actions, within 90 days - but only in 43% of patients with an abnormal 5-Cog result. The present study examined whether patients with higher clinical complexity at the visit of 5-Cog administration were less likely to receive improved dementia care. This retrospective cohort study analyzed patients from the 5-Cog RCT who had an abnormal 5-Cog result. Ten patient complexity variables were collected through chart review. We used bivariate tests of association to examine the relationship between these variables and improved dementia care at 90 days. Statistical analysis was completed in SPSS. Of the 242 individuals (mean age 75, 70.2% female, 53.7% non-English speaking, 46.3% insured by Medicaid) with a positive 5-cog result, 106 (43%) received improved dementia care. Significant associations were found for higher mean number of diagnoses addressed (7.9 vs 6.7, P=0.008) and the administration of vaccine(s) during the 5-Cog visit (N= 33 vs 26, P=0.036). Other measures of visit complexity and overall patient complexity showed no significant association. Prior studies have shown that patients with higher complexity are less likely to receive recommended preventive care during time-limited visits. In dementia detection, this relationship may be more complex. Next,

we will examine provider-level and health system factors for impact on provider behaviors in dementia detection. The results of these analyses are critical to improve future implementation of dementia detection paradigms in primary care.

17. HPV Self-Collection Pilot to Improve Cervical Cancer Screening Rates Among Patients Experiencing Homelessness

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Cervical cancer is the third most common gynecologic cancer in the United States and is caused by persistent infection with human papillomavirus (HPV), which is present in 99.7% of cervical cancers. Recommended screening strategies include cervical cytology, primary HPV testing, and co-testing (HPV plus cytology). People experiencing homelessness face significant barriers to cervical cancer screening (CCS) due to challenges accessing healthcare; one study reported screening rates as low as 19%. Recent guidelines from the American Society for Colposcopy and Cervical Pathology (ASCCP) support self-collected HPV testing, which has shown promise in improving screening uptake among underserved populations. This six-week pilot program aimed to improve cervical cancer screening (CCS) rates by implementing HPV self-collection alongside targeted clinician training and support at an FQHC satellite clinic providing primary care within a women's shelter in Brooklyn, New York. Informal interviews were conducted with shelter-based clinicians to explore anticipated barriers to implementing HPV self-collection for CCS. Findings informed the development of an introductory training session reviewing patient counseling strategies, clinical workflow, and case-based scenarios. A provider toolkit was also created, including patient education materials in English and Spanish. HPV self-collection was then implemented during a six-week pilot at a shelter-based primary care clinic. During the six-week pilot, 62 self-collected HPV swabs were completed. Follow-up interviews with clinicians and support staff identified implementation challenges, including some ineligible patients being offered self-collection and difficulty following up with patients who had transferred out of the shelter. Feedback from these interviews led to development of an eligibility checklist and a more streamlined workflow for managing results. These initial findings suggest that HPV self-collection is a feasible and acceptable approach to improving CCS in shelter-based healthcare settings and may represent a promising strategy to address screening disparities among patients experiencing homelessness.

18. Improving Screening Rates for Universal Blood Lead Level Screening at Age 1 and 2 years at an Academic Primary Care Clinic

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Lead poisoning is a preventable harm with permanent health implications. Universal screening is essential as symptoms, if present, are usually non-specific. Children in the Bronx are especially vulnerable in older homes with peeling lead-based paint and leaded water pipes, and through exposure to imported foods, spices and toys. Medicaid mandates blood lead level testing at 1 and 2-years of age. Improving blood lead screening rates is an important element of providing equitable and timely care. To improve the blood lead level screening rates for established patients at a large urban academic outpatient clinic from 80% to 90% over a 12-month period. Caregiver surveys (n=25) indicated that the primary barrier to obtaining blood lead levels was child discomfort after vaccinations (64%), long wait time (12%), and lack of knowledge about blood lead testing (12%). Interventions to encourage catch-up blood lead testing at visits with fewer vaccinations were successful. Direct clinician reminders at catch-up visits improved the rate that clinicians ordered blood lead testing from 32% (21 out of 65 patients) to 73% (58 out of 79 patients) ($p<0.01$) in a similar 2-month time frame. Of patients with lab orders after intervention, 77% (45 out of 58 patients) had lead levels drawn, with one patient above the reference range of 3.5 μg/dl requiring intervention. At the end of our 12-month intervention period, 88% of established patients had two blood lead level screening tests, increased from 80% prior to intervention. Significant barriers exist to timely blood lead testing, the most predominant of which is a child's discomfort receiving vaccinations and phlebotomy. While we encourage caregivers to have children tested at the recommended 12- and 24-month visits, flexibility in scheduling and reminders for clinicians has been successful in capturing patients who missed routine testing at our primary care clinic.

19. Follow-Up and Bridge Care for Internalizing Concerns in Adolescent Primary Care

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Amongst adolescents who accept referrals to community mental health specialists at annual well adolescent visits in an urban pediatric clinic, 25 to 40% are not connected to care within 2-12 months of the referral. Only 3-5% of these adolescents have follow-up care with their PCPs within one month of their annual well visits. The purpose of this quality improvement initiative is to determine if there can be improved management of internalizing disorders (anxiety and depression) in adolescents (12-17 years) with the introduction of scheduled follow-up visits with their pediatric PCPs and documented care plans. A pretest-post-test design will be used to study the implementation of the project intervention. Implementation will be guided by the IHI Model for Improvement including Plan-Do-Study-Act cycles. Within 2 weeks of their annual well visits taking place in March 2026, a convenience sample of 12-17-year-olds with existing or new diagnoses of internalizing disorders, will return for a follow-up visit with their PCP. At the qualifying well visit, the PCP will document a care plan in the patient's EMR and provide them with a printed copy. This care plan will be updated at the scheduled follow-up visit. The primary outcome being measured will be the scheduling of follow-up visits with the PCP within 2 weeks of the qualifying well visit. The process measures will be documentation of the care plans at the well visit and at the follow-up visit. The implementation of the intervention will be conducted over 3 weeks in March 2026 and include the patient panels of 6 pediatric PCPs at the project practice. It is to be hoped that successful completion of this pilot project will demonstrate that with routinized follow-up, pediatric PCPs can routinely bridge gaps in mental health care for adolescents with internalizing diagnoses.

20. Real-World Implementation of Doxy-PEP in a Bronx Sexual Health Clinic

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In 2024, the CDC recommended doxycycline post-exposure prophylaxis (doxy-PEP) to prevent chlamydia (CT), gonorrhea (NG), and syphilis among gay, bisexual, and other men who have sex with men and transgender women with a bacterial sexually transmitted infection in the prior 12 months. Real-world data on doxy-PEP implementation in primary care and sexual health settings are limited. This study evaluated changes in CT and NG positivity following doxy-PEP implementation and assessed differences by CDC eligibility status. The retrospective cohort study with pre/post comparison and interrupted time series analysis to estimate changes in percent positivity over time. Pre/post periods were defined by staff training and program rollout at the Oval Center at Montefiore Medical Center, a large primary and sexual health clinic in the Bronx. The cohort included 4,322 and 3,180 unique patients in the pre- and post-implementation periods, respectively. Patients were grouped by CDC doxy-PEP eligibility using electronic medical record data. Clinic-wide doxy-PEP implementation began in October 2023. CT positivity declined post-implementation in both groups, with a greater reduction among CDC-eligible individuals (7.2% to 5.4%, $p<0.01$) compared to those not eligible (2.8% to 1.3%, $p<0.001$). Interrupted time series analysis demonstrated a monthly decrease of 0.36% in CT positivity among eligible individuals (95% CI 0.18-0.54, $p<0.001$) versus 0.17% among those excluded (95% CI 0.002-0.35, $p=0.05$). NG positivity showed smaller changes overall; post-implementation trends were not statistically significant among eligible individuals for percent positivity (8.7% to 7.6%, $p=0.08$) or monthly change ($p=0.14$), while modest declines were observed among those excluded (1.4% to 0.6%, $p<0.01$; −0.05% per month, 95% CI 0.004-0.11, $p=0.03$). Following doxy-PEP implementation in a Bronx clinic, CT positivity declined, particularly among CDC-eligible individuals. These findings support integration of doxy-PEP into routine primary and sexual health care services in urban communities and highlight the importance of equitable implementation.

21. Reducing Disparities in Maternal RSV Vaccination Among Predominantly Publicly Insured Pregnant Patients

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Respiratory syncytial virus (RSV) is a leading cause of infant hospitalization in the United States. In August 2023, the US FDA approved the first maternal RSV vaccine (Abrysvo) for administration at 32 0/7-36 6/7 weeks' gestation to protect infants during the first six months of life. Early uptake has been suboptimal, particularly among publicly insured populations. At Montefiore Medical Center, baseline maternal RSV vaccination during the 2024-2025 season was 38%, consistent with national rates. We implemented a quality improvement initiative entailing provider education, electronic health record templates, counseling smart phrases, eligibility tracking dashboards, leadership engagement, and pediatric coordination. The cohort included patients at 32 0/7-36 6/7 weeks' gestation receiving care between September 1, 2025 and January 31, 2026. Data were extracted from the Epic Clarity data warehouse and analyzed using PowerBI. The primary outcome was proportion of patients vaccinated. Among 1,699 eligible patients, 1,039 (61.2%) received RSVpreF vaccination, a 61% relative increase from baseline. Monthly uptake ranged from 50 to 70%. The cohort was predominantly Hispanic or Latino (49.6%), and predominantly publicly insured (70.8%). Uptake was similar across insurance groups: 60.6% publicly insured, 60.4% privately insured, and 79.7% self-insured. Vaccination rates by race/ethnicity were 61.4% among Hispanic or Latino, 61.6% among non-Hispanic Black, 68.6% among Asian or Pacific Islander, 56.7% among non-Hispanic White, 58.1% among Other, 50% among Multiracial, and 54.3% among patients with Unknown race/ethnicity. This initiative substantially increased maternal RSV vaccination and achieved equitable uptake across insurance groups in a predominantly publicly insured population, demonstrating that system-level interventions can mitigate disparities and improve infant protection.

22. Too Little, Too Late? Examination of the Quality and Timing of Goals of Care Discussions Between Physicians and Cancer Patients One Year Prior to Death at a Large Academic Medical Center

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Early goals of care (GOC) discussions are an integral part of providing care to patients with serious illness. Discussions that go beyond code status to include patients' understanding of their illness, prognosis, fears, and goals enhance patient-centered care. In practice, these discussions often occur late, are limited in scope, and are poorly documented. This study analyzes the quality and timing of GOC discussions between oncology patients and providers within our institution. We performed a retrospective chart review of the last 90 deaths on the oncology service at two hospitals. Patients were age 20 and older, had any type of cancer, and had a primary oncologist within our health system. We created a chart abstraction form to track demographics, dates of all GOC discussions within one year of death, who was present, and what topics were covered. All topics, including assessing understanding of prognosis, identifying values, and exploring wishes, were based on the Serious Illness Conversation Guide. 97% (n= 87) of patients had at least one GOC discussion in the year before death. 70% (n= 61) occurred within the last month of life during the terminal hospitalization. GOC discussions involved a palliative care attending in 76% (n=66) and an oncology attending in 67% (n=58). Determining code status occurred in 92% (n=80). Prognostic information was shared in 78% (n=68). Understanding patients' fears occurred in 21% (n=18). Only 16% (n=14) occurred in the outpatient setting. At least one GOC discussion was held with most cancer patients, but these discussions most often occurred days before death in the inpatient setting and focused on deciding code status. Despite evidence supporting the benefits of early, in-depth GOC conversations with patients in the late stages of illness, these interactions remain rare or are not being properly documented in the medical record at our institution.

23. Improving Osteoporosis Screening Using an Electronic Health Record Nudge

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Osteoporosis screening is recommended for women age 65 and older to facilitate diagnosis and treatment initiation. We assessed osteoporosis screening rates across an urban network of primary care practices serving a historically underserved population and found widely variable screening rates ranging from 50-80%. As part of a quality improvement initiative, we tested whether a nudge intervention involving pending orders for DXA screening in follow-up primary care encounters at one Federally Qualified Health Center would improve ordering and completion rates. Patients were eligible if they were at least 65 years old, had an upcoming appointment with their assigned PCP, and no record of prior screening was available. From August - October 2025, we identified and pended DXA orders in 160 follow-up primary care encounters for 144 unique established patients (who met screening criteria and for whom no record of screening was available). 106 of these appointments were attended (66%). 59 orders were signed during attended appointments (37% of all pended). Of those signed, 46 scans were scheduled (29% of all pended), and 22 screenings were completed (14% of all pended). Median weekly counts of screening DXA scan orders jumped from 1 to 6 after this intervention was implemented, with a special cause signal in our run chart. Average completed scan counts per month modestly increased from 7 to 10 scans. A nudge intervention utilizing pended orders increased ordering rates of osteoporosis screening among older women for whom it was indicated, with a more limited effect on screening completion rates. There is potential to scale this intervention to other clinical sites with implementation of EHR tools and development of population health workflows. Interlocking provider and patient focused interventions are necessary to drive large improvements in osteoporosis screening completion rates.

HEALTH PROMOTION & DISEASE PREVENTION

24. Increasing Postpartum Depression Screening During Pediatric Well-Child Visits in a Family Medicine Clinic

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Postpartum depression (PPD) is a prevalent mental health condition that can adversely affect maternal well-being, infant development, and family functioning. Despite national recommendations for routine screening, PPD often remains underdiagnosed in pediatric primary care settings due to time constraints, lack of standardized screening procedures, and limited provider awareness. This Quality Improvement (QI) project aimed to increase the rate of postpartum depression screening during 2-, 6-, and 9-month well-child visits by implementing a standardized workflow within a family medicine teaching clinic. Baseline screening rates were assessed prior to intervention. A standardized screening protocol was implemented, incorporating provider education, workflow modifications, and referral pathways for patients with positive screening results. Screening rates and provider adherence were monitored over nine months following implementation. Saint Joseph's Medical Center Family Health Center is a primary care teaching clinic serving a diverse, underserved patient population in Yonkers, New York. Mothers presenting for pediatric well-child visits for infants under 12 months of age were included. Pediatric healthcare providers, family medicine residents, and clinic support staff participated in implementing the screening protocol. The Edinburgh Postnatal Depression Scale (EPDS) was integrated into routine pediatric well-child visits at 2-, 6-, and 9-month intervals. Additional interventions included provider training and the development of referral pathways for mothers who screened positive on the EPDS (>10). Implementation of a standardized screening workflow increased the identification of postpartum depression in mothers attending pediatric well-child visits and improved access to behavioral health referral pathways. Integrating maternal mental health screening into routine pediatric care is a feasible strategy in primary care settings. It may improve early detection and intervention for postpartum depression, promoting improved outcomes for both mothers and infants.

25. Implementing Written Exposure Therapy (WET) for PTSD in Underserved Primary Care Settings: A Matrixed Multiple Case Study

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Access to evidence-based treatment for PTSD in underserved primary care settings needs improvement. Written Exposure Therapy (WET) is a promising evidence-based treatment because it is brief (six weekly sessions), easy for therapists to learn and deliver with high fidelity, and is well-tolerated by patients. However, understanding WET implementation in primary care is limited. We examined variation in the implementation of WET for PTSD in Federally Qualified Health Centers (FQHCs) within the context of collaborative care, a team-based and measurement-based health care delivery model. We used a multiple case study approach with data from the Building Experience for Treating Trauma and Enhancing Resilience (BETTER) study: a hybrid type 1 cluster RCT that randomized 12 FQHCs to collaborative care alone or collaborative care plus WET. Patients (n=722) were enrolled in three waves between 2022-2025. Guided by RE-AIM and CFIR, we analyzed data from the study's care management registry, surveys, and interviews to identify patterns in implementation success across the six WET sites. Patient WET completion rates were low-to-moderate across sites (range: 19-42%), with no differences by delivery mode (telehealth, in-person, hybrid). Median treatment duration was similar across five of six sites (range: 6.3-7.1 weeks), reflecting high fidelity to WET protocol timeframes. Across sites, patients who completed WET had clinically significant reductions in PTSD symptom severity from baseline to after the last session, as assessed during treatment with the PTSD Checklist for DSM-5 (PCL-5). Staff reported implementation barriers at the patient-level (e.g., unmet social needs), provider-level (e.g., discomfort delivering exposure-based therapy), and systems-level (e.g., limited resources, staffing capacity). Findings suggest that WET implementation success within FQHC collaborative care is contingent on patient engagement throughout the course of treatment. Effective strategies are needed to mitigate multi-level barriers to PTSD treatment among the primary care population.

26. Applying the ORBIT Model to Design a Patient-Facing Mobile App for Diabetes Prevention in Urban Primary Care: A Qualitative Study of Patient Perspectives

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Effective options exist to prevent type 2 diabetes, yet referral and uptake in primary care remain low, particularly among racial and ethnic minorities and people with low income who face structural barriers to lifestyle change. Health information technology, when designed for dissemination and sustainability, can bridge these gaps by delivering timely information, decision support, and navigation outside the clinical visit. However, few mobile health applications are designed for these populations or address their specific needs. We applied the Obesity-Related Behavioral Intervention Trials framework to guide early behavioral intervention development and customer discovery for a brief, scalable, patient-facing application for diabetes prevention in an urban primary care setting. Semi-structured customer discovery interviews were conducted with 24 adult, English-speaking primary care patients with electronic health record-documented prediabetes at an urban academic health system serving predominantly minority communities. All participants had a primary care visit within the past two years. Rapid qualitative analysis was conducted by three raters using a case-by-domain matrix; three interviews were double-coded to establish agreement, and remaining interviews were independently coded and synthesized into themes. Designing-for-dissemination and sustainability principles translated findings into app requirements. Activities corresponded to ORBIT Phase Ia (Define). Participants had a mean age of 58.8 years; 88% were women, 50% identified as African American or Black, and 42% as Hispanic or Latino. Six themes described what patients need to act: understanding the diagnosis, making informed treatment decisions, integrating lifestyle changes into daily life, finding motivation, staying on track with behavior change, and navigating prediabetes within health and financial constraints. Participants emphasized the need for clear information, respectful partnership, and small, self-chosen steps that fit real life. ORBIT-guided discovery in underserved communities produced actionable design targets for a patient-facing mobile health application and a blueprint for Phase Ib refinement, usability testing, and a feasibility trial.

27. Vaccine Access and Mpox Immunization Readiness Evaluation: A Cross-Sectional Study of High-Risk Populations in New York City

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Following the 2022 global outbreak of Clade IIb Mpox, the JYNNEOS vaccine was deployed in the United States for populations at increased risk, including men who have sex with men (MSM), people living with HIV (PLWH), and individuals using HIV pre-exposure prophylaxis (PrEP). Despite demonstrated vaccine effectiveness, vaccination uptake and series completion have been inconsistent. Ongoing international outbreaks of Clade I Mpox further highlight the importance of understanding barriers to vaccination among high-risk groups. We conducted a cross-sectional survey study over six months among MSM (both cis- and transgender men) who were either living with HIV or HIV-negative and receiving PrEP. Participants were recruited from two outpatient clinical sites in the Bronx, New York, and from the online New York City-based gay community platform, r/NYCgaybros. A seven-item survey assessed Mpox vaccination status, provider offer of vaccination, access experiences, and perceived barriers. Among 35 respondents, 27 (77.1%) reported receiving at least one dose of the Mpox vaccine, and 25 (71.4%) reported being offered vaccination by a healthcare provider. Vaccination uptake did not differ significantly by HIV versus PrEP status. Most vaccinated respondents obtained vaccination after one or two attempts, though a subset required multiple attempts. Participants who were offered the vaccine by a provider were significantly more likely to be vaccinated than those who were not offered vaccination. Among unvaccinated participants, the most reported barriers were uncertainty about eligibility, lack of interest, limited awareness of the vaccine, and logistical difficulty accessing vaccination. Mpox vaccination uptake was high among surveyed high-risk individuals; however, gaps in provider-initiated vaccination offers, clarity of eligibility criteria, and ease of access persisted. These findings underscore the importance of consistent clinician engagement, clear public health messaging, and streamlined access pathways to improve vaccination coverage and preparedness for future Mpox outbreaks.

28. Evaluating the Utility of the 5-Cog for Detecting Cognitive Impairment in a Hispanic Population

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Early identification of cognitive impairment in Hispanics/Latinos is essential for effective clinical intervention. It requires culturally/ linguistically appropriate tools particularly given access and language barriers in the United States. The 5-Cog is a brief cognitive measure composed of 3 tasks: 1) Picture-based Memory Impairment Screen, 2) Symbol Match, and 3) Motoric Cognitive Risk Assessment developed in the Bronx, NY, USA to screen for cognitive impairment. We explored the efficacy of the 5-Cog as compared with established cognitive measures in Spanish speakers. The 5-Cog study recruited Adults 65+ with cognitive concerns from a primary care practice (full methods elsewhere). This sub study looked at Spanish-speaking patients who completed the 5-Cog, Neuropsychological testing (NPT), and the MOCA-Blind (Max score: 22). Diagnosis of Subjective Cognitive Complaints (SCC), Mild Cognitive Impairment (MCI), and Dementia were independently derived from the NPT. Statistical analysis included fisher's exact test and t-tests comparing 5-Cog with those objective cognitive estimates. 130 individuals evaluated in Spanish (72% female, mean age 71.9 (SD=5.5), mean education of 10.1 (SD=4.5), 52% self-identified Dominican, 28% Puerto Rican) of whom 81 were diagnosed with SCC and 49 with MCI. 5-Cog Positivity (worse performance) was significantly associated with MCI (one-tailed, p=.03). The MoCA-Blind (N=129) was significantly lower in individuals with 5-Cog Positivity (11.1(SD 3.3) versus 13.9(SD 3.0), p<.001). In Hispanics with cognitive concerns in primary care, the 5-Cog was associated with performances on established cognitive measures suggesting that it can be a culturally and linguistically appropriate tool for identifying possible cognitive impairment in this population.

29. Program Evaluation of the BE BOLD Quit Smoking Program Serving an Ethnically Diverse Underserved Community Sample

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To explore effectiveness of a tobacco cessation program in the ethnically diverse, underserved community of Bronx, NY. Patients from a large academic medical center attended an 8-week tobacco cessation group-based program. Evaluations were completed and administered over the phone by trained BOLD psycho-oncology program interns and staff, in English and in Spanish. Mixed-methods univariate and thematic analyses identified patterns related to the effectiveness of the tobacco cessation program. Of 184 session attendees from 2022-2025, 66% were female; 59% over age 60; 44% Black, 36% Hispanic, smoking more than 10 cigarettes daily (40%), smoking for more than 45 years (40%). Those over age 60 (66%) were more likely to report being ready to quit smoking than those under 60 (34%), χ^2=7.6(3), p<0.05. Those most likely to participate in the tobacco cessation program were women (44% vs. 24%), and those over age 60 (42% vs 28%), χ^2=6.28(1), p<0.01, and χ^2=3.30(1), p<0.05, respectively. Based on 78 of 110 program evaluations, with qualitative responses intervention-specific areas for improvement included: streamlining subject matter (37%), modality of session (14%), quitting aids (11%) and engaging participants (11%). Qualitative suggestions for overall program improvement fell into four categories: subjects discussed in session (18%), time (18%), desiring more individualized support (16%) more information on quitting aids (10%). Overall, (N=110) thought the program helped to cut down on their smoking (58%) and to become more motivated to quit (52%). Overall, the program was useful in promoting harm reduction in that most attendees reported cutting down smoking and being more motivated to quit at the end of the program. Attendees also desired more individualized support and information on quitting aids. Future directions include investigating strategies to engage younger and male participants in smoking cessation programs among ethnically diverse populations in the Bronx.

30. Frailty and Use of Non-Pharmacologic Pain Management Approaches Among People Living with Opioid Use Disorder (OUD) and Chronic Back Pain

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People living with opioid use disorder (PLWOUD) experience high rates of chronic back pain and frailty. Non-pharmacologic pain management is effective for frailty and back pain. However, little is known about the use of such approaches among PLWOUD and chronic pain. We conducted cross-sectional analysis of screening data from a trial of PLWOUD with chronic (> 3 months) back pain and classified them as frail if they fell ≥ 3 times in the last year or use an assistive device. Non-pharmacologic pain management included any yoga, physical therapy (PT), martial arts, stationary bike, swimming, acupuncture, or massage in the prior two months. We examined differences between those who did and did not use these approaches using t-tests, chi square, or fisher exact tests. To examine the association of frailty and use of these approaches, we conducted logistic regression. Of 212 PLWOUD, 17 (8%) used at least one approach: PT (12), massage (3), stationary bike (2), acupuncture (1), and swimming (1). Mean age was 58 (SD 1.6), 113 (53%) were male, mean PEG score was 8 (SD 1.6), and 123 (58%) were frail. In bivariate analysis, those who used these approaches were more likely to be female (88% vs 43%, $p<0.01$) and take less methadone (82 mg vs 106 mg, $p=0.09$), and were less likely to use illicit opioids (6% vs 38%, $p<0.01$). In multivariate regression, frailty was associated with use of these approaches (aOR 8.1,95% CI 1.6-40.3). In this cohort of PLWOUD and chronic back pain, frailty was common. While use of non-pharmacologic pain management approaches was more likely among those who were frail, use was low overall. These findings identify a need to expand access to these approaches to frail and non-frail PLWOUD and chronic back pain.

31. "Art Saved Me": An Exploration of Self-Driven Repetitive Artmaking Practices on Pain and Mood States for Patients with Chronic Pain, Opioid Use Disorder, and Opioid Misuse

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While pharmacologic and behavioral interventions remain central to chronic pain (CP) and Opioid Use Disorder (OUD) treatment, there is urgent need for scalable, non-pharmacologic approaches patients can safely access to address pain, cravings, and co-occurring mental health symptoms. The objective of this exploratory mixed methods pilot was to assess the impact of self-guided repetitive artmaking on pain, depression, anxiety, and social connection. The study was a single-arm trial of an artmaking intervention delivered at an opioid treatment program (OTP) and participants' homes. Participants were 31 adults with CP and OUD or diagnosed opioid misuse. Pre and post surveys collected self-reported pain, depression, anxiety, social connectivity, and intoxication data at the in-person art workshop at the OTP and at home immediately before and after art kit use for up to four time points. Data was analyzed via means and paired t-test procedures and ANOVA. Seventeen participants shared qualitative feedback via focus group, which was analyzed using reflexive thematic analysis. Participants were primarily unemployed low-income Hispanic older adults. Analysis surfaced statistically significant reductions in pain from the workshop (6.4 to 5.6 out of 10, p=0.04), in sadness and anxiety from both in-person (sadness 1.5 to 1.0 p=0.01; anxiety 1.8 to 1.1, p=0.00) and at-home offerings (sadness 1.8 to 1.4, p=0.03 survey #1, 1.7 to 1.3, p=0.04 survey #2; anxiety 1.8 to 1.3, p=0.04 survey #2), and increases in social connectivity from both offerings (3.5 to 4.0, p=0.05 workshop, 3.1 to 3.6, p=0.01 survey #3). Participants described using art to distract from pain and support relaxation. This pilot indicates great promise in offering community- and home-based art practice for mitigating pain, negative mood states, and social disconnectedness in adults with CP and OUD or opioid misuse, providing people with at-home tools for when negative symptoms or cravings emerge.

32. Care Managers' Readiness and Motivation to Coordinate Care for Cancer Patients in the Medicaid Health Homes Program

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The Affordable Care Act established Health Homes to support comprehensive community care management for Medicaid recipients with multiple chronic conditions, including cancer. Care managers (CMs) are a primary source of support for highly vulnerable clients. Care managers work outside the cancer care system and may receive little preparation to support patients through multidisciplinary treatment. Care managers may also be affected by personal and family experiences with cancer. This study examined factors associated with care managers' perceived readiness and motivation to care for cancer patients. Care managers from 22 CBOs serving Medicaid clients in eight Hudson Valley counties were offered an online survey addressing their cancer-related work and personal experience. 103 (58.9%) of 175 respondents had worked with at least one cancer patient. Of those, 33.5% had prior training. Care managers reported greater challenges addressing the needs of cancer versus non-cancer patients in 15 areas of care coordination, behavioral health, and social determinants. Regarding coordination, care managers encountered oncologists' confusion about their role (56.4%), inability to access treatment information (57.4%), and inconsistent inclusion in case discussions (64.4%). CMs also had to frequently remind non-oncologists about clients' cancer treatment details (87.6%). Perceived readiness was associated with personal experience (r=.49*), training (r=.35*), and prior care for advanced cancer patients (r=.36*). Readiness was diminished by exclusion from oncology care (r=-.36*) and the need to remind non-oncologists (r=-.21*). Desire for more opportunities to work with CA patients was associated with personal experience (r=.21*), fewer years of employment (r=-.17*), and prior work addressing cancer patients' symptoms (r=.21*) or financial needs (r=.21*). Motivation was diminished by non-oncologists' uncertainty (r=-.30) and lack of recall (r=-.22*). [*p<.05]. Findings call attention to the vital support Health Home Care managers' provide to high-needs cancer patients. In addition to CM training, oncologists and non-oncologists require greater preparation to support CMs as a bridge across health care silos.

33. Initiating Group Prenatal Care in an Urban Setting

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SOCIAL DETERMINANTS OF HEALTH / SOCIAL CARE

34. From Detention to Care: Health Experiences of LGBTQ Immigrants Living With or at Risk of HIV

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Immigrants living with or at risk of HIV face major barriers to healthcare, including immigration status, language differences, and insurance access. Immigration detention can worsen health and disrupt engagement in care after release, particularly for already marginalized groups such as LGBTQ individuals and people with HIV. As migrant detention increases at the U.S. border, understanding how detention affects health and access to care after release is critical. This study examines how immigration detention influences health and healthcare engagement among LGBTQ immigrants living with or at high risk of HIV. Participants were recruited with support from a Community Advisory Board as part of a broader study on barriers to care for immigrants living with HIV. This study focused on participants who experienced immigration detention. Semi-structured interviews were conducted in participants' preferred language, covering immigration experiences, healthcare access during detention, and pathways to HIV and mental healthcare in the U.S. Researchers used inductive coding and thematic analysis to identify key themes. Nine LGBTQ immigrants who experienced detention were included. Eight were Spanish-speaking individuals from Latin America. One was English-speaking from the Caribbean. Detention experience impacted health in key ways: 1) negative mental and physical health effects of removal of personal agency and abuse and 2) inadequate and delayed medical care, often necessitating urgent connection to care once released. Conversely, community-based organizations played a critical role in mitigating harm and improving access to care. Immigration detention negatively impacted healthcare engagement and well-being among LGBTQ immigrants living with or at high risk of HIV. While detention created negative health effects of removal of agency and active abuse, and delayed access to care, community-based organizations often played a crucial protective role in many participants' lives. Continued support for these organizations is essential to ensure these individuals are effectively engaged in care.

35. We Need to Address Both: Health-Related Social Needs and Pediatric Mental Health

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Health-Related Social Needs (HRSNs) are associated with worse overall well-being and mental health outcomes in adults. Pediatric HRSNs and mental health needs increased during the COVID-19 pandemic and persist today. Most pediatric studies are limited to distinct HRSNs and few studies have examined cumulative HRSNs and mental health screens. Post COVID-19 pandemic, there are no studies examining the association between HRSNs and mental health in children. We aimed to study the association between HRSNs and the Pediatric Symptom Checklist-17 (PSC-17) screens in school-aged children post COVID-19 pandemic. We conducted a retrospective analysis using electronic health record data from an urban primary care population. Pediatric patients with completed HRSNs and PSC-17 screens between May 5, 2023 and May 5, 2024 were included to represent a one-year period post COVID-19 pandemic. We limited observations to the first HRSNs and PSC-17 screens per patient. Bivariate (unadjusted) and multivariable (adjusted for age, sex, language, race/ethnicity, insurance) logistic regression were used to assess the association between categorical HRSNs (0, 1-2, >3) and positive PSC-17 screen (total score >15), using linear contrasts to compare the categorical HRSNs. In adjusted analysis of 15,388 patients, those with 1-2 HRSNs had 2.51 (95% CI: 2.17, 2.91) times greater odds and those with ≥3 HRSNs had 3.54 (95% CI: 2.81, 4.44) times greater odds of having a positive PSC-17 screen compared to patients with 0 HRSNs. In adjusted pairwise comparisons, patients with >3 HRSNs had 1.41 (95% CI: 1.09, 1.81) times greater odds of having a positive PSC-17 screen compared to those with 1-2 HRSNS. The association of HRSNs with pediatric mental health concerns emphasizes the need to consider how HRSNs impact delivery of mental health care. Next steps include developing interdisciplinary teams and referral networks that address both issues to optimize pediatric mental health care.

36. Advancing an Age-Friendly Health System: A Cross-Sector Partnership Bridging Health and Social Care

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Older adults in geriatrics and primary care settings frequently experience complex medical, behavioral health, and social needs that influence health outcomes, healthcare utilization, and quality of life. Addressing social determinants of health is central to advancing an Age-Friendly Health System and supporting aging in place. However, many health systems lack embedded capacity to systematically identify social needs and connect patients to community-based resources. Awareness of available aging services among clinical teams remains limited. This initiative addresses these gaps through a cross-sector partnership between JASA, a NYC aging services organization, and the Montefiore Health System, supported by the Geriatric Workforce Enhancement Program. A JASA social worker was embedded within Montefiore's Department of Geriatrics and Federally Qualified Health Centers (FQHCs), including the Williamsbridge FQHC. The social worker conducted proactive social needs screening, provided real-time psychosocial support, facilitated warm handoffs to community-based and public benefits resources, and served as an educational resource for clinicians and care teams. Program data were collected between September 1, 2025, and February 28, 2026. During the six-month period, 254 older adult patients received support through this model. Screening identified substantial unmet need, with more than 65% of patients connected to assistance or community-based services. Among those assisted, common needs included benefits and entitlements (45%), food insecurity (30%), support with activities of daily living (26%), housing concerns (18%), transportation (17%), behavioral health services (14%), and insurance coverage (10%). Closed-loop referrals strengthened care coordination, improved follow-up, and reinforced integration between healthcare and social service teams. Embedding aging services within primary care through a structured cross-sector partnership improves identification of social needs and strengthens integration of health and social care for older adults.

37. Patient Perspectives of Success: Community Health Worker Social Service Navigation

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In 2022, Montefiore Health System launched the Community Health Worker Institute to connect patients with unmet health-related social needs (HRSNs) to services through Community Health Workers (CHWs). CHWs are individuals from the community trained to support patients as liaisons between the health system and community resources. We sought to determine how patients defined successful resolution of unmet HRSNs by interviewing those assisted by CHWs. The study was conducted at Montefiore Health System in Bronx, NY. Semi-structured interview questions were informed by the four pathways of the Social Interventions Research and Evaluation Network (SIREN) Conceptual Model: 1) Social Services Connection, 2) Emotional Support/ Healing Relationships, 3) Health Services Connection, and 4) Tailored Clinical Care. Using purposeful convenience sampling, we recruited by phone/email English-speaking patients or caregivers. Interviews were conducted via Zoom by trained medical students between June-August 2025. Interviews were audio-recorded, transcribed, and analyzed using a rapid qualitative approach. 24 participants completed interviews, representing four patient groups: adult inpatient (n=8, 33.3%), adult outpatient (n=6, 25%), pediatric inpatient (n=5, 20.8%), and pediatric outpatient (n=5, 20.8%). Patients reported that CHWs provided expertise on resources navigation and emotional support demonstrated by: (1) CHWs advocated for patients by writing letters and contacting social service agencies; (2) challenges accessing resources were largely attributed to unavailability or ineligibility despite CHWs' support; (3) nearly half of patients felt emotional support provided by CHWs was equally or more important than social services; and (4) patients highlighted CHWs' role in coordinating care through appointments, medications, and insurance. This study demonstrates that while direct resource navigation is CHWs' primary role, patients perceive emotional support as equally essential for their needs to be met. Integrating emotional support components into CHW trainings, workflows, and evaluation models allows health systems to better align social care delivery with patient-centered definitions of success.

38. Addressing Health-Related Social Needs for Cancer Patients: An Implementation Assessment

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Health-related social needs (HRSNs) contribute to delayed diagnosis and treatment, poorer quality of life, and higher recurrence and mortality among cancer patients. Health systems increasingly recommend standardized HRSN screening and referral in oncology care, yet evidence is limited on effective implementation strategies for such interventions. We evaluated the implementation of a community health worker (CHW) referral and navigation intervention to address unmet HRSNs at a National Cancer Institute-designated comprehensive cancer center in Bronx County. We conducted a retrospective study of cancer patients utilizing data from HRSNs screenings, clinician CHW referral orders, and CHW navigation services between October 2023 and March 2025. Patients were identified as eligible for CHW assistance if they screened for and self-reported ≥1 unmet HRSN. Process and outcome measures were organized using the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) implementation framework and evaluated through descriptive statistics. Thirty cancer clinical practices adopted the HRSNs screening tool. Among 8,591 screened patients, 20.5% (n = 1,758) reported ≥1 unmet HRSN. Of those with unmet HRSNs, 43.4% were referred to CHWs by clinicians, with referral rates varying by practice (26-55%). Of referred patients, 64.5% (n=794) were assisted by CHWs, with the most common HRSNs identified as financial (50.3%), housing (48.7%), and food insecurities (45.5%). CHWs were successful in outreaching referred patients (95.5%) in a timely manner (Median: 3 days, IQR: 1-6 days), connecting patients to social services (98.9%), and resolving or improving HRSNs (97.6%). The median annual cost of implementation and maintenance was $345.58 per patient. Embedding CHW referral and navigation services within an NCI-designated comprehensive cancer center was feasible, timely, and effective in addressing unmet HRSNs in a safety-net cancer population. Further research is needed to optimize clinician screening and referral and evaluate the impact of CHW navigation on care delivery and clinical outcomes.

39. Assessing Race and Ethnicity Data in the Electronic Health Record to Advance Health Equity Research

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Accurate and complete race and ethnicity data within the electronic health record (EHR) is crucial to identifying health disparities and informing research on social determinants of health in clinical populations. However, healthcare systems often collect race and ethnicity data in irregular and insufficient ways, compromising the utility of such data for research. Revisions proposed by the U.S. Office of Management and Budget (OMB) include the option to select Hispanic ethnicity without requiring a separate race designation. Considering these proposed changes, it is critical to understand how EHR race and ethnicity data perform in practice and whether they accurately capture how patients self-identify. Our primary objectives are to (1) quantify missing and misclassified race and ethnicity information in the EHR, and (2) determine whether the current EHR categorization of race and ethnicity reflects our study population by comparing EHR data with self-reported data. We conducted a cross-sectional analysis linking EHR data from a large Bronx healthcare system with detailed self-reported data from the Jerome Ave Study, a mixed-methods study examining the effects of neighborhood land use rezoning on cardiovascular outcomes in mid-life and older adults (n=318). Current estimates reveal missing race data in 56.9% of the sample when relying on EHR-collected information. Ethnicity was recorded for 91.8% of our sample but only distinguished those identifying as Hispanic, or Latino. When Hispanic EHR ethnicity was operationalized as a race category, the proportion with missing race data decreased from 56.9% to 8.2%. Within this operationalized category, there were 14 distinct ethnic groups identified. Despite this decrease in missingness, the heterogeneity within broader racial and ethnic categories remains insufficiently characterized in the EHR. Current EHR data on race and ethnicity does not fully represent our patient population, leading to important gaps in the data used by researchers.

40. Addressing Systemic Racism in Healthcare Through Storytelling and Dialogue Between Providers and the Community

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Medical racism is a harmful reality that permeates all aspects of health care delivery. It results in poorer health outcomes and mistrust in the healthcare system. Medical institutions need to address these issues in order to provide equitable care, ideally with change guided by patients themselves. The goal of this project is to utilize storytelling and dialogue to build better connections between our institutions and the communities we care for. Antiracism principles and a storytelling framework guide our project. We work closely with the community-based organization to help reach community partners and participants. We conduct general and specific group conversations with various subsets of the community. Community members are encouraged to share their lived experiences with the healthcare system, while healthcare workers listen and engage with humility, helping to identify manifestations of racism and systemic inequities. These conversations have revealed the dehumanizing effects of racism in healthcare, especially among vulnerable populations. Participants have expressed that there has been a building of trust and empathy between healthcare providers and community members. After the community conversations, community members have shared they feel more confident in voicing their concerns. Healthcare workers have said they have learned to listen more, be proactive with involving patients, and try to better incorporate community resources and partners. The Community Conversations use storytelling and dialogue to highlight the lack of equitable care and the critical need to open avenues that ensure healthcare workers have access to community voices. Disseminating these stories with our colleagues has demonstrated the need to develop best practices for continued teaching. We hope to encourage trainees and educators to reflect and respond to patient stories in ways that honor trust and allow all of us to recognize that we have the power to affect meaningful change.

41. Elevating Resident Performance Through Patient Feedback: A Primary Care Quality Improvement Initiative

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Patient experience is a key indicator of quality in primary care. However, structured, real-time patient feedback is rarely integrated into resident evaluation within teaching clinics. Traditional evaluations rely primarily on faculty observation, thereby limiting the direct incorporation of patient voice into trainee development. This Quality Improvement (QI) initiative aimed to integrate structured patient feedback into resident evaluation to enhance communication, professionalism, and patient-centered care in a community-based primary care teaching clinic. Using a Plan-Do-Study-Act (PDSA) framework, anonymous patient feedback cards were distributed following outpatient visits over a one-month pilot cycle. Feedback focused on communication clarity, professionalism, respect, and overall visit experience. Data were collected and reviewed to assess feasibility, response distribution, and potential impact on resident development. Saint Joseph's Medical Center Family Health Center, a primary care teaching clinic serving a diverse patient population in Yonkers, New York. Thirty family medicine residents participated in the evaluation process. During the pilot month, 56 patient feedback cards were distributed. Nine residents received more than one patient review. Patients completed brief, structured review cards following clinical encounters. Responses were anonymous and incorporated into resident coaching discussions and semiannual evaluations. The pilot demonstrated the feasibility of implementing real-time patient feedback within the routine clinic workflow. Patient responses provided actionable insights into communication behaviors and patient experience domains not consistently captured by faculty evaluation alone. Integrating patient voice into resident assessment represents a scalable strategy to enhance patient-centered care, strengthen accountability, and promote quality improvement in primary care training programs.

42. Abstract withdrawn

43. Building a Bronx-to-Health Professions Pipeline: Pre-Biomedical Sciences Pathway Activities with Albert Einstein College of Medicine Office of Community Engagement and Outreach Partners

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The Bronx faces persistent inequities in educational opportunity and health outcomes, underscoring the need for sustained pathway programs that support entry into medicine, science, and the health professions. Albert Einstein College of Medicine has identified pathway development as part of its educational mission, and a recent institutional audit found 23 pathway programs spanning middle school through medical school and serving 563 learners in 2023-2024. Our work highlights four Office of Community Engagement and Outreach-managed pathway programs: the Einstein Enrichment Program (EEP), Emergency Medical Technician (EMT) program, Emergency Department Clinical Exposure and Mentoring Program (ED CEMP), and Medical Pathways Program (MPP). Together, these programs serve learners from middle school through post-baccalaureate stages through STEM enrichment, mentoring, research, clinical shadowing, certification training, service-learning, and medical school preparation. Historical EEP outcomes include 652 graduates, 100% high school graduation, 100% four-year college matriculation, and 76% STEM career participation among tracked alumni. Program activities are strengthened through Bronx HOPE and related collaborations, including Bronx Community Health Leaders, Fordham STEP/CSTEP, HCOE SUMP, City College post-baccalaureate pathways, and MonteHOP, supporting a coordinated regional pipeline. Bronx HOPE links Einstein, EEP, SUMP, Fordham STEP/CSTEP, and local high schools to strengthen and coordinate the educational pipeline. For 2025-2026, EEP included 40 continuing students and 100 accepted students; EMT received 149 applications and accepted 24; ED CEMP received 150 applications and accepted 75; and MPP received 451 applications and accepted 75. These programs represent a high-demand, Bronx-centered model for strengthening a diverse, community-responsive future health workforce educated to be health agents for growth in our community.

44. Addressing Housing Instability in Primary Care Practice: An Educational Intervention for Internal Medicine Residents

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Addressing housing instability can improve physical and mental health outcomes. Despite increasing identification of housing instability in clinical settings, a prior needs assessment among Primary Care Internal Medicine residents showed that knowledge gaps remain around the resources available, and the skills required to meet this crucial social need. Our aim is to develop and evaluate a curricular session to address the following topics: local affordable housing resources, existing legal rights for tenants, and policy solutions to improve housing access. Effective development and integration of this material into residency curriculum can support future physicians' ability to address housing instability. We interviewed community health workers in our large urban academic hospital system, met with housing-focused community-based organizations and lawyers, and investigated online community-facing material on housing rights to create a 90-minute hybrid lecture and case-based session on the aforementioned topics. The intervention was delivered to 8 residents in 2024 and 8 in 2025. We used pre-surveys administered at the start of the session and post-surveys six months after the session to evaluate changes in resident knowledge of and attitudes towards addressing housing insecurity. Likert score means were calculated for each question and compared across pre-and post-surveys. 16 residents completed the pre-survey and four completed both pre- and post-surveys. Prior to the intervention, while residents thought tackling housing insecurity was important (Likert score 4.7/5), they did not feel confident explaining affordable housing resources to patients (2.19/5). After receiving our curricular intervention, this confidence increased (2.5/5). This increase highlights the role of targeted curriculum on community resources and policy interventions to support residents' ability to address unmet social needs such as housing insecurity. Future directions include expanding implementation and further qualitative evaluation to better understand the most salient elements of the intervention.

45. Recruitment from Pediatric Primary Care Practices for a Multicenter Study of Children at Risk of Youth-onset Type 2 Diabetes: The DISCOVERY Study

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Youth-onset T2D (YO-T2D) has emerged as an important clinical and public health concern, with more aggressive progression than adult-onset disease. To address this need, NIDDK funded DISCOVERY - a multicenter cohort of 3,600 children across 15 sites - to develop prediction models informing targeted prevention. Herein, we describe the recruitment process at CHAM-Einstein. DISCOVERY enrolls children aged 8-15 at-risk for YO-T2D, (BMI ≥85th percentile, Tanner stage 2-4, HbA1c 5.5-6.4%). The protocol includes (1) screening visits to confirm eligibility; (2) baseline and annual visits comprising a 3-hour oral glucose tolerance test, HbA1c, continuous glucose monitoring (CGM), pubertal staging, anthropometrics, and biospecimen collection; and (3) mid-year visits with HbA1c, CGM, anthropometrics, sample collection, and updated medical history. Guided by a community advisory board, recruitment at CHAM-Einstein draws from primary care provider lists, outreach letters and calls to eligible families, and community health fairs. We identified 13,988 potentially eligible children based on age and BMI from 14 primary care practices. Since recruitment began (February 2025), we have sent 2,034 letters and called 1,718 families; 67% were reached. Of families reached, 38% scheduled a screening visit and 26% declined. Of 438 screening visits scheduled, 215 children were screened and 63 enrolled and completed the baseline exam. The primary barriers to enrollment are failure to meet inclusion criteria (HbA1c or pubertal stage) and visit no-shows or cancellations. Among those completing baseline visits, the majority were seen at their first scheduled appointment, and families expressed high satisfaction with participation. Strong provider engagement (e.g., mentioning and answering questions about the study) enhanced participant recruitment and enrollment. These preliminary findings highlight the feasibility of enrolling at-risk children from primary care practices into a rigorous, complex longitudinal study. We are developing a replicable model for practice-based recruitment in future pediatric studies.

46. Factors Associated with Participation in a Food-as-Medicine Program for Individuals with Diabetes or Prediabetes in Care in a Community Health Center Located in the South Bronx

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Diabetes affects 10% to 12% of all Americans. It is associated with cardiovascular disease, stroke, and chronic kidney disease, and is the 7th leading cause of death in the United States. Unfortunately, diabetes disproportionately affects low-income communities of color, where the prevalence rates are double that of better-resourced communities and the outcomes worse. In response, Montefiore Bronx Health Collective (BHC), a Federally Qualified Health Center located in the South Bronx, launched Fresh Takes! for patients in care at our health center with diabetes or prediabetes. Fresh Takes! aims to help reduce food insecurity and prevent the progression to overt diabetes in patients with prediabetes and to help patients with overt diabetes achieve better diabetic control. Across 4 cohorts of 70 to 80 individuals, participants receive bimonthly fresh food boxes from local farmers and nutritional education over the course of the six-month program. However, to be effective, patients must participate fully in the program. Other similar programs reported in the literature suggest that participation rates vary widely from 30% to 70%. Yet participation rates in our program are much higher. Of the 227 eligible individuals identified during recruitment for our first two cohorts, 95% signed up for an intake session and 71% enrolled in the program. Further, 95% of enrolled individuals picked up at least one food box. This presentation will describe the strategies used by BHC and its food partner to successfully engage and retain patients in the program care. We will expand our analysis to include participation in all study cohorts and account for other factors that may impact participation such as degree of food insecurity, number of diet-related health conditions, language, and longevity in our practice. This information can be used in designing and implementing programs that are acceptable to and well-utilized by the intended audience.

47. Overcoming Recruitment Barriers in Alzheimer's Disease Clinical Trials: Strategies and Lessons from the NICE-AD Study in the Bronx

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Recruitment for Alzheimer's disease (AD) research presents persistent challenges, particularly in achieving diverse and representative samples. Here we outline recruitment strategies used in the Neurostimulation for Cognitive Enhancement in Alzheimer's Disease (NICE-AD) clinical trial, which aimed to recruit 100 participants with mild to moderate AD in the Bronx and surrounding areas. Post-hoc analysis of recruitment strategies was employed to demonstrate the barriers encountered, techniques attempted, and lessons learned. Recruitment followed a multifaceted, adaptive approach designed to address barriers and reduce participant loss across the recruitment "leaky funnel." Weekly recruitment reviews and implementation of feasible strategy modifications were key to addressing identified barriers. Clinical referrals represented the largest proportion of participants (44.7%), followed by chart reviews (31.6%) which show the role of healthcare systems and provider engagement in research. Online referrals (14.5%), direct contact with the study team (7.6%), community outreach (.7%), and newspaper advertisements (.7%), showed variable effectiveness in recruitment. Community engagement, including tailored presentations, improved awareness and trust among potential participants and caregivers. Multifaceted recruitment strategies are essential for achieving enrollment goals for mild to moderate AD in diverse urban populations. These findings will aid future clinical researchers in optimizing recruitment strategies emphasizing the importance of clinical partnerships and systematic identification.

48. Engaging People with Lived Experience in the Earliest Stages of Research

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People with lived experience (PWLE) are rarely included in research development. The Integrative Management of Chronic Pain and OUD for Whole Recovery (IMPOWR) Research Center at Montefiore-Einstein (IMPOWR-ME) pilot grant program created a process for engaging PWLE in research development and selection. The IMPOWR-ME Community Leadership Board (CLB) includes PWLE with chronic pain and opioid use disorder who were engaged at several stages of the pilot grant program. First, the Board identified research topics of interest and import to them, which became research priorities in the request for applications. After applications were received, the CLB shared their perspectives on the strengths and weakness of each application. After compiling the Board review with internal and external faculty reviews, a selection committee including PWLE voted on proposals to select for funding. The CLB identified six priority areas for the RFA: engaging PWLE, stigma, whole person health, novel models of care, and innovative, innovative collaborations and partnerships, Standard NIH review criteria were expanded to include "diversity, equity, and inclusion." The standard criteria of "investigators" was revised to "research team" and the criteria "environment" was changed to "community engagement in research." The review process resulted in selection of six innovative projects led by early-stage investigators. By meaningfully engaging PWLE in the development and selection of pilot projects, we created a process and selected studies that reflect the needs of the community. This process also engages PWLE as partners in conducting research, instead of as subjects of research, which leverages the in-depth and invaluable expertise of PWLE and helps ensure that research is relevant and reflects the priorities of the community. Our process could be a model for other pilot programs in other communities.

49. Being Treated with Respect Drives Engagement in Physical Activity Interventions in Opioid Treatment Program

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Many individuals with opioid use disorder (OUD) also experience chronic pain. The Back Strengthening Onsite for General Wellness Study is testing yoga and physical therapy (PT) at opioid treatment programs (OTPs) for people with chronic pain. Prior studies have not examined determinants to engaging in yoga or PT at OTPs. We conducted semi-structured interviews purposively sampled to represent a spectrum of engagement in yoga or PT based on the number of sessions attended. The interview guide included questions about determinants for session attendance and interest in continuing yoga or PT after the study. This work represents preliminary data from analyses underway. We interviewed 8 participants from yoga and 6 from PT. Participants expressed that the main motivator for continued session attendance was how the interventionist treated them. Respectful treatment motivated people to return. One participant said, "I think it helped a lot because it is an encouragement...You can, you know, come here and you, you get treated right." Further, disrespectful treatment resulted in not wanting to return, with a participant stating, "Nobody wants to go to a place like that, right?" Participants also reported a desire to engage in yoga or PT after the study if the interventionist was respectful.Among people with OUD at and chronic pain, perceived respect is central to engagement in yoga or PT offered at OTPs. This likely reflects broader experiences of differential treatment by healthcare providers and suggests that treating people respectfully can impact their engagement in treatment. Future initiatives could include provider trainings in respectfully interacting with patients with OUD and chronic pain.

50. Strengthening Ties to Facilitate Diversity in Cancer Clinical Trials

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The norm in cancer research has been to consider diversity and inclusion at the end of the translational research pipeline through efforts specific to increase diversity in trial enrollment. This existing approach does not account for challenges of community mistrust of clinical researchers, experience and exposures when designing clinical trials (CT) targeting racial disparities in cancer, nor for barriers to investigator-initiated research. To address multifactorial difficulties requires inclusion of relevant stakeholders to identify resolution. We implemented networking events as part of the DISRUPT grant bringing together community members, researchers and pharma to discuss challenges of CT and diversity. We facilitated discussions among small groups including translational and basic scientists from 3 NCI-designated Cancer Centers and a city university, clinicians, patients, patient advocates, community and pharma representatives to obtain perspectives on: (Q1) What are the biggest challenges to develop CTs and enable collaboration and implementation? (Q2) What are ways to address these challenges and foster collaboration? Discussions were audio-taped, transcribed and notes summarized. We used qualitative content analysis to identity barriers (Q1) and strategies (Q2) to strengthen ties among scientists, clinicians, community, and pharma. 107 key stakeholders participated. Content analysis identified the following barriers to diversity and inclusion challenging the research enterprise to develop therapies for all: Knowledge, trust, finances, communications, social determinants of health, and structural barriers. Strategies addressing these barriers included: Participant engagement, infrastructure development, monitoring & evaluation, relationship building, and leadership development. Multiple stakeholders must be engaged to promote leadership that restructures the research enterprise and facilitates collaborations needed to develop or modify cancer CTs that can address disparities in cancer treatments. Scientists, clinicians, community, and pharma need opportunities for relationship building and sustained partnership.

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