Methods: A questionnaire was created and distributed to 40 current Vietnamese patients in the resident clinic to determine their knowledge of HBV and their immunization status. Several health screening events were held in the community, and information for the clinic was provided for eligible individuals. Eligible individuals included those living in the county who were uninsured and without a primary doctor. The number of Vietnamese patients in the clinic was compared before and after intervention.

Results: Of those surveyed, 3 in 5 patients answered questions incorrectly regarding transmission of HBV. One in 3 patients did not know his/her immunization status. After the intervention, the Vietnamese population in the resident clinic increased by 33% in 6 months, from 81 patients to 121 patients.

Conclusion: Access to healthcare is a problem in our community. We learned that there was great interest in the Vietnamese community to learn more about HBV. We found the best way to educate the community was to coordinate with local leaders and participate in health screening events. By participating in community health events, we were able to increase awareness of a disease prevalent in the Vietnamese community and increase their access to healthcare. We hope to utilize the skills we learned from this project to improve access of care to other groups experiencing health disparities in our community.

PROJECT MANAGEMENT PLAN – Increasing Vietnamese Patients in the Resident Clinic

Vision Statement	Through this project, we look to increase access to healthcare in an underrepresented group by bringing awareness regarding screening, transmission, and treatment of a disease prevalent among this group. We seek to apply the strategies learned by this project to increase access to healthcare for other underrepresented groups in the community.
Team Objectives	The aim of this project was to increase the number of Vietnamese patients in the Internal Medicine Residency Continuity Clinic by 25% within a period of 6 months by raising awareness of hepatitis B virus (HBV).
Success Factors	The most successful part of our work was raising awareness about HBV by providing free educational events. We also were able to increase access to healthcare by providing information about our clinic for the uninsured.
Barriers	The largest barrier encountered was that many of the uninsured we encountered were not eligible for our clinic because of their citizenship status or their income was above the threshold. We worked to overcome this challenge by making these patients aware of another clinic in the community where they could receive primary care.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to establish relationships with community leaders!! They have experience with getting out into the community and having an impact.

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The Influence of Comprehensive Care Coordination on Patients With Chronic Medical Conditions and Special Healthcare Needs in a Community Pediatric Residency Program Continuity Clinic

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Background: The prevalence of chronic disease among American children has increased as a result of decreased mortality from once-fatal diseases. Pediatric healthcare providers must be prepared to tend to an increasing number

of children with special healthcare needs (CSHCN). Doctors in training are often not well versed in the care of CSHCN nor do they receive training in advocacy or care coordination, yet the patients they see in continuity clinic are likely to be underrepresented minorities who are uninsured or publicly insured and less likely to have access to care management. Our project goal was to study the influence of team-based comprehensive healthcare coordination on outcomes for children with complex healthcare needs in a pediatric resident continuity clinic.

Methods: We enrolled 27 patients. Interventions included a 1-hour initial visit, 40-minute follow-up visits with face-to-face time with all team members, telephone access directly to the social worker, and follow-up scheduling during office visits. A care coordination binder was provided to each patient, and monthly team meetings were held to discuss enrolled patients. The study period lasted 12 months. Data were collected for the time period 12 months prior to the initiation of the study. Data collected included completed and no-show visits for primary care and subspecialty appointments, hospitalizations and ED visits, continuity of care, use of care-coordination binders and medications, and results from parent satisfaction surveys that were administered every 3 months.

Results: Patient satisfaction and perceived quality of life showed no significant change between baseline and postsurvey. The no-show rate at the continuity clinic showed no significant difference overall, although patients with a CSHCN screener score of ≥ 4 were 5.3 times more likely to keep the appointment ($P = 0.01$). The number of missed appointments decreased from 26% to 24%. Continuity showed a significant increase, the number of hospitalizations decreased from 4 to 2, and the number of ED/urgent care visits decreased from 40 to 26.

Conclusion: Our project successfully decreased costs. We found that continuity with the PCP played a key role in developing relationships, connecting patients with critical resources, and instilling in residents a sense of confidence and self-efficacy. Future implementation and study will require recruiting a larger number of patients, investigating which subgroups benefit more from care management programs, and integrating our process across all resident panels to promote study generalizability, improve continuity and care team collaboration, and foster resident education and a desire to care for CSHCN in residents' future practices.

PROJECT MANAGEMENT PLAN – The Influence of Comprehensive Care Coordination on Patients with Chronic Medical Conditions and Special Healthcare Needs in a Community Pediatric Residency Program Continuity Clinic

Vision Statement	Our vision is to educate, motivate, and empower vulnerable patients and young physicians by clarifying the roles of existing resources, streamlining communication among stakeholders, and utilizing a team-based strategy to deliver excellent care.
Team Objectives	Our objectives were as follows: • Study the influence of team-based comprehensive healthcare coordination on outcomes of children with complex healthcare needs in a pediatric resident continuity clinic at Heartland Community Health Clinic-Armstrong • Study the feasibility of providing comprehensive coordination in a resident's continuity practice and creating a framework of resources and strategies for sustainability • Understand the educational needs of pediatric residents in preparation for future practice
Success Factors	The most successful parts of our work were as follows: • The level of patient engagement that was achieved • The trust that patients put in the team (they kept in close contact and made extraordinary efforts to keep their appointments) • The small clinical *wins* (successful visits with subspecialists, approval for medications or durable medical equipment) • The increased understanding/fund of knowledge about nonmedical challenges, such as guardianship and disability enrollment • The significant increase of PCP continuity in a resident clinic • The decrease in no-shows for mental health visits • The decrease in ED/urgent care visits (average charge per ED visit was $2,244) We were inspired by the commitment of the parents of our patients and their ability to overcome barriers with our help and also the commitment of the residents to their patients despite busy work schedules.

Barriers	The largest barriers encountered were research issues: families often did not bring their binder to the office visit and some data were difficult to obtain/track (eg, medication compliance). Family issues such as instability of living situation, lack of transportation, and limited access to telephones were also barriers. Finally, researcher issues such as residents' schedules being affected by work duty hours and their panels having a limited number of spaces each clinic day were other barriers. We worked to overcome this challenge by increased access to care with direct social work contact and regularly scheduled appointments with the care team and by regularly reassessing patient needs with patient care team meetings.
Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative is to make sure resident continuity is the highest priority for children with special healthcare needs in the residency clinic setting, utilizing whatever resources the clinic has available to make this happen (schedulers, dedicated RN coordination, etc.). This continuity has improved the team's ability to build relationships and their ability to care for the patients. Also, follow strict protocols throughout the entire research process and meet regularly to discuss the protocol itself. More advice is as follows: • Pay attention to the enrollment process and exclusion criteria (adequate numbers, adequate enrollment period, scripted individual enrollment to include educating families about their commitment to the project and introducing families to the entire team to get them excited) • Choose data that are easily obtained and not dependent on patient behavior (eg, patient binders) and regularly review that the data are being documented properly, systematically, and in a timely fashion • Obtain funding to help patients and families overcome barriers such as transportation needs or telephone access

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Healthcare Disparities Knowledge, Attitudes, and Behaviors in Resident Physicians

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Background: Effective population health interventions must be grounded in the specific needs of the communities being served. Medical residents in community clinics have great potential to be the primary drivers of these interventions, as they have direct contact with a large number of community members on a regular basis. These residents may not have sufficient knowledge of population health issues to fulfill this role, partly because many residents are not native to the communities they serve. This project was designed to provide both an educational and a behavioral intervention to lay the educational foundations for the future development of targeted population health interventions.

Methods: Phase 1 of our 2-phase project involved a didactic session on health disparities, and phase 2 was a behavioral intervention in which residents were tasked with asking their clinic patients at least 3 resident-selected questions related to health disparities. Objective and subjective knowledge, importance, and learning along with behavioral changes were measured throughout the phases. Prior to the didactic session, residents completed the Learner's Needs Assessment Survey to measure their perceived and actual knowledge of underserved patient population topics. One month after the didactic session, the residents were resurveyed to measure changes in perception/knowledge and were asked to complete a self-assessment survey. Postintervention, the residents began asking the interview questions in their respective clinics and once again completed the Learner's Needs Assessment Survey to measure changes in perceived and actual knowledge of underserved patient population topics.

Results: After the first didactic intervention, 38%/27% of residents reported more subjective knowledge/subjective importance, respectively, while 68.7% reported knowing more about their patients and 55.6% said that the first