RIG Poster #1

Approaching Health Promotion Through the Lens of Lifestyle Medicine

Residency Program: UPMC McKeesport Family Medicine
Lead Resident: Carlie Hoffman, DO

Background: Our family medicine residency is a community-based program, which provides care to an underserved, urban population. A significant percentage of our patient population is insured under Medicare or Medicaid. Many of our patients also have multiple chronic diseases and co-morbidities, low health literacy, and experience barriers in medicine due to social determinants of health. Lifestyle Medicine is an evidence-based discipline in which comprehensive lifestyle modifications are used to prevent, treat, and reverse the progression of chronic lifestyle-related diseases.

Objective: Our grant project aims to address several chronic disease risk factors impacting our health center patients by facilitating access to community services and promoting healthy lifestyles. This will consist of four resident-led projects that address specific pillars of Lifestyle Medicine: nutrition, stress, exercise, and substance abuse.

Methods/Approach: For each identified pillar, funds will be allocated for facilitating a community partnership and incentivizing healthy living by (1) providing blood pressure cuffs for aiding in hypertension management and educational resources about DASH diet, (2) organizing youth art classes for stress relief, (3) providing fitness trackers to promote daily exercise, and (4) creating a resource cart to facilitate self-reflection during MOUD activities. This QI project will be reviewed by the institutional quality review council.

Outcomes Measured: Project 1 (nutrition): - Follow-up of patients with uncontrolled hypertension - Adherence to DASH diet with access to educational materials Project 2 (stress): - GAD-7 and PHQ9 scores pre- and post-event Project 3 (exercise): - Participation in exercise classes - Fitness tracker vitals data/utilization Project 4 (substance abuse): - Patient-reported impact of the activities - Creation of a curriculum for MOUD sessions based on participant feedback and usage of materials

Conclusion: Lifestyle Medicine is a multi-faceted approach to preventing, treating and reversing the progression of chronic lifestyle-related diseases. Through four resident-led projects, we aim to incorporate healthy lifestyle modifications in the everyday lives of our patients who face significant socioeconomic challenges. These projects are designed in partnership with local organizations and provide education, resources, and incentives to our family health center population. Both qualitative and quantitative outcomes will allow for assessment of our interventions and lay the foundation for continuing these efforts long-term.

RIG Poster #2

Culinary Medicine

Residency Program: Penn State Health St. Joseph's
Lead Resident: Sara Kaskowitz, DO

This community is a food desert with high poverty rates and incidence of obesity and associated co-morbidities. The goal of this project is to teach local residents healthy, low-cost, food options and preparations. Discussions with patients at our clinic has revealed that most community residents are unaware of the impact that healthy eating has upon their medical conditions and would be receptive to teaching in this area.

Our objective is to increase healthy food awareness and access to healthy food options through community partners. This will be accomplished through the creation of culinary medicine classes for residents. Research will be conducted on plant-based diets appropriate to the local community and the creation of appropriate recipes.Community members will be invited to these classes which we expect to run from March through July 2023. We expect to serve 120 people (15 per class). Participants will be obtained through a combination of mailings sent to clinic patients, partnering with local high schools and other community partners, and Facebook advertising. During these classes, residents will be taught the best approaches to plant-based cooking using the Lifestyle Medicine Culinary Medicine cookbook. Participants will work with professionals and resident and attending physicians in creating their meals with this approach. Classes will be recorded, as well as live-streamed. This will allow participants to share their work with family members and friends who are unable to attend the sessions in person. The recordings will also serve as an archive for participants and others to refer to upon completion of the class. All participants will also be provided with recipes and contact information for healthy, plant-based food sources in the local community. Prior to the start of the class, surveys will be administered to participants to assess healthy food awareness and behaviors. Participants will then be contacted 30 days post-class to assess healthy food awareness.

RIG Poster #3

Food For Life Farmacy

Residency Program: UPMC Altoona Family Physicians
Lead Resident: Kyle Trabocco, MD

One of the top health issues impacting our community is obesity, with approximately 32% of Blair County's rural underserved population considered obese. Furthermore, the heart disease mortality rate in Blair County is currently outpacing the average for Pennsylvania statewide. Food is listed as one of the inciting factors, with concerns for poor diet, food insecurity and access to healthy food being specific avenues for intervention.

Altoona Family Physicians Residency program along with local community organizers hope to address this health disparity in conjunction with local community organizers through a wraparound food access and education initiative. Residents will identify patients in our practice and in the community who would benefit from improved access to and education about healthy eating options through "diet prescriptions". Prescriptions will provide access to a food pantry where participants can obtain the healthy, low-cost ingredients and recipes. Local community organizations including grocers and farms will help supply food, in addition to purchases we will make to keep the pantry stocked. However, our goal is not just to provide food but to improve food literacy. To achieve this goal, we also plan to include local nutritionists as well as physicians participating in our lifestyle medicine curriculum who will provide live food cooking demonstrations and specific low-cost recipes. We hope to conduct these events both in our facility as well as in local low-income housing complexes to include those with transportation limitations. Using pre- and post-intervention surveys, we hope to assess how metrics of healthy eating have changed after our intervention. Behaviorally, we will assess the extent participants use the prescriptions to obtain food, whether participants prepared the recipes, and to what extent involvement changed their knowledge and attitudes about whole foods. This project represents a collaboration between multiple stakeholders in the local community along with our residency program to address a key health disparity. We expect our intervention to give our participants access to the tools they need to improve their food habits, thereby promoting a healthier lifestyle with widespread potential to impact comorbidities associated with a poor diet.

RIG Poster #4

Go for the Greens

Residency Program: Einstein Medical Center Montgomery Family Medicine Residency Program
Lead Resident: Eva Vanegas, MD

Background: The prevalence of severe childhood obesity in the United States has continued to climb since the end of 20th century. In the United States, 1 in 5 children and adolescents between 2 and 19 years old are obese, and this number is disproportionately higher among the Hispanic and non-Hispanic black population. Most obese children will become obese adults. Montgomery Family Practice serves a large population of Latino or Hispanic (26.1%) and Black or African American (33.9%) patients in Norristown. Einstein Medical Center Montgomery's Family Medicine residency program, established four years ago, is dedicated to working with our community to promote healthy behaviors that will lead to better health outcomes. Since 2017, the Nicholas and Athena Karabots Medical Building has housed a produce garden that yields over 500 pounds of fresh fruits and vegetables that are distributed to our patients.

Objective: Our proposed program "Go for the Greens" for ages 6-to-13 year olds and their families will bolster our community relationships by teaching children about the nutritional quality of our food coupled with the fun of tending to our existing garden beds.

Methods/Approach: Our 3-month program will consist of 6 sessions and will be taught in Spanish and English. Each session will focus on specific learning goals, including how to tend to a garden, the nutritional content of foods, how to read nutritional labels, personal diet assessment and will culminate in a live cooking demonstration. Throughout these 3 months, patients will be able to watch the work they put into tending our community garden blossom into healthy produce.

Community Partners: Brandi Chawaga, Einstein Montgomery Community Liasion, The Garden Fresh Rx - community-based farming organization (established), Norristown Elementary and Middle Schools (not yet established) for ongoing educational partnership.

Results: We will conduct pre-program and post-program surveys to evaluate participants' (the children and their families) changes in knowledge, skills, and attitudes around nutrition.

Conclusion: "Go for the Greens" intends to reach across the food desert to not only provide families with produce but also educate patients on the importance of nutrition to help combat the prevalence of childhood obesity in our community.

RIG Poster #5

Laundry on Linden

Residency Program: St Lukes Family Medicine - Sacred Heart Campus
Lead Resident: Daniel Gilbey, MD

A unique opportunity to help the much-underserved population of Allentown, PA. Established four years ago by a Parish Nurse working at St Luke's University Hospital, the Laundromat is a weekly haven, a safe place, and an outlet for many in need within the heart of Allentown. The project is aimed at addressing the health inequality that exists in Allentown, with a primary purpose to offer free laundry, where the benefits extend far beyond just laundry! Each week, volunteers including St Luke's staff & students assist attendees with laundry cards, whilst ascertaining what support is needed, whether it be financial, spiritual, psychological, or medical.

During 90-minute laundry cycles, outreach services establish a relationship, provide support and expertise to those in need. Over 50 attendees present weekly, including many families. Of those attending, many experience homelessness and thus are without medical and dental care. Some are undocumented residents or victims of sex trafficking and drug abuse. Over 80% have no established primary care provider. Pastoral care is offered to all, regardless of faith or spiritual needs. Representatives from 'Valley Against Sex Trafficking' attend, as well as Certified Recovery Specialists from a local recovery center. A St. Luke's Internal Medicine Physician is present on alternate weeks, able to provide services on the mobile medical van. This provides a unique opportunity for representation from our local FQHC-look-alike residency training clinic.

Participating in such a project is a gem of an opportunity, offering our current and future Family Medicine Residents a true immersive experience to understand a community and deliver health education. We aim to reduce the healthcare inequality rates of uncontrolled and undiagnosed diabetes and hypertension burdening our community, with point-of-care testing and healthcare education. Through screening, our resident providers could meet those in need by addressing the social determinants of health. Our outcomes would include increasing access to Primary Care Providers in such an undeserved and 'in need' patient population. Our presence would allow us to offer follow-up appointments at our local teaching FQHC-look alike office, where access to further services are available and continuity of care may be developed to target such health care disparities.

RIG Poster #6

Marion Center Playground Set to tackle Childhood obesity

Residency Program: Indiana Regional Medical Center Rural Family Medicine Residency Program
Lead Resident: Robin Rodriguez, MD

Within the United States, childhood obesity is an increasingly widespread epidemic with over 14 million children in the US alone being afflicted. This is approximately 19% of the pediatric population. In the state of Pennsylvania, the statistics do not differ much from the nationwide average with approximately 17% of Pennsylvanian school aged children being considered obese and another nearly 16% being at risk for being obese. Additionally, in an analysis conducted by the Center for Rural Pennsylvania, rural school aged children are at an even higher risk of being obese then their urban counterparts with a 3-point average increase respectively. Some of the key reasons determined to be responsible for this increase in rural childhood obesity dealt with lower educational levels in the adult population along with lower employment rates, and increased poverty status amongst rural families.

As primary care providers we play a key role in treatment and prevention of childhood obesity. Although there are some variables that we unfortunately cannot change; discussing and emphasizing the need for physical activity and good nutrition are factors we can certainly address. This is the reason why we would like to address physical activity in Marion Center Pennsylvania. With the addition of a playground set adjacent to our rural healthcare clinic, we feel we can provide a secure place for the rural pediatric population to be afforded the opportunity to have fun whilst providing for an increase in physical activity. To determine if this playground set would provide a benefit to the community, we plan on gaining parental consent from our pediatric population to extrapolate data in regards to BMI, weight, and physical activity pre and post installation of the playground equipment. We will also plan for this to be expanded to the entire community by reaching out to the surrounding school systems and gaining this data while providing the set for all community children. It is our desire to help stave off the excelleration of childhood obesity in the rural community we serve.

RIG Poster #7

New Kensington Community Food Access Shuttle System

Residency Program: UPMC St Margaret Family Medicine
Lead Resident: Benjamin Carnahan, MD

The UPMC St. Margaret New Kensington Family Health Center has been a part of the socioeconomically challenged City of New Kensington since 2001. The downtown city flats area has a large population of elderly, disabled, and people living with poverty, many of whom reside in structured housing projects and walk as their primary mode of transportation. As this city is in Westmoreland County, there are limited public transportation options and minimal public routes. For these citizens, there was a sole grocery store with fresh food within walking distance of the many senior high rises and family projects in this area. Unfortunately, in 2020 the local grocery store closed and no option for purchasing healthy food has taken its place. Through patient interactions, we have been alerted to the significant burden this closure has placed on the ability of the citizens to obtain healthy food options. Without transportation and public access to other grocery stores, citizens struggle to obtain necessary items.

Our project aims to bridge that divide, by providing a way for citizens to have direct access to a grocery store through a shuttle system. If we cannot bring a grocery store to them, we want to help bring them to the grocery store. Part one of this project is to survey the citizens to determine their grocery shopping habits in order to create a program to help improve access. The survey will be administered at several locations in the local community. Part two of the project is to provide a free shuttle that will transport residents from specified pick-up locations to the nearest grocery store. The store is planning on developing an easy ordering option for residents, and providing staff to help fill orders. Vouchers for healthy food options will also be provided. The shuttle van and driver would be provided by a local community agency three days per week for five hours per day. Patients will be able to call and schedule a trip, or groceries can be dropped off at predetermined locations. Our hope is to continue this program until a new grocery store within walking distance is established.

RIG Poster #8

Outreach to Life Turning Point Shelter

Residency Program: Abington Family Medicine
Lead Resident: Kai Inguito Galicano, MD

Background: Life Turning Point, established in 2019, is a safe haven for single-parent women and their children to take shelter for up to eighteen months. During their stay they pursue gainful employment, seek out permanent housing, and learn skills that they can apply to their lives outside the shelter. The Abington Family Medicine (AFM) residency program of Jefferson Health is committed to community outreach, and we have proudly partnered with Life Turning Point since the Fall of 2022.

Objective: Through this partnership, we strive to do more to help this vulnerable population to improve health education and access.

Methods/Approach: The residents of AFM would present at least two educational sessions to these mothers via small interactive group sessions, thus building an open environment for round robin discussions about social determinants of health for themselves and their children. We would start the session with provided nourishment, undergo the educational session, and then end with distribution of pamphlets for key points and explanations. While the mothers attend the information session, another group of residents will provide childcare.

Specifically, there will be a focus on topics such as hypertension, diabetes, use of the emergency department, readmissions, and the benefits of routine primary care visits. In addition, we aim to provide at least one health screening to address gaps in medical care and health literacy for the women and children here. We will supplement these education sessions and screenings with medical equipment, CPR training, and supplies. We understand that social situations like lack of transportation, food insecurity, and copays affect health outcomes, so these variables will be addressed. Lastly, plans include virtual check-ins between the physical sessions.

Results: With this longitudinal and interdisciplinary partnership of physicians, nurses, MAs, and social work, we will address gaps in medical care and social determinants of health through performing health screens and providing medical equipment.

Conclusion: This outreach intends to make a difference on health education and health outcomes on a vulnerable population. These mothers are raising the children of our future, so please consider the impact of this partnership.

RIG Poster #9

Sidewalk Doc Street Medicine Program

Residency Program: Lancaster General Health Family Medicine Residency
Lead Resident: Riley Ewen, DO

Lancaster General Hospital (LGH) is part of the Penn Medicine Lancaster General Health (LG Health) system. LGH is a not-for-profit facility with a mission to advance the health and well-being of the communities we serve. The LGH Family Medicine Residency is an integral part of community healthcare in Lancaster. Lancaster County has no public health department, therefore LGH and the family medicine residency demonstrate a strong commitment to addressing health equity and access to care for everyone in our community. For decades, we have looked beyond the walls of our hospitals and worked with community partners to address social determinants of health.

With the Pennsylvania Academy of Family Physicians Resident Community Health Impact Project Grant, we seek to enhance our commitment to community health improvement by taking primary care services to a new level in Lancaster County. The Sidewalk Doc Street Medicine program at LGH began providing care in early 2022. The program identifies and engages unsheltered individuals who are hesitant to pursue traditional medical care to prevent adverse health outcomes and improve overall health. Operating as a partnership between the LGH Family Medicine Residency Program and LGH's Community Health Department, the Sidewalk Doc program also collaborates with a network of trusted community partners who already provide comprehensive services to the target population across the spectrum of social needs. The Sidewalk Doc street team consists of medical residents (supported by faculty), a nurse from a partner organization serving this population, and an outreach worker who round twice monthly at two locations identified as "hot spots" or gathering areas for individuals experiencing homelessness. To date, clinical encounters have included basic physical exams, acute care services, minor procedures (including podiatric services), and prescribed pharmaceutical therapies (including leave behind naloxone).

This award will allow us to expand diagnostic services to include Point of Care Ultrasound and other testing, and provide additional training for providers involved. The ultimate goal is improving health and well-being by providing equitable access to person-centered medical care. The Sidewalk Doc team uses a trauma informed approach to work with each patient to reduce and remove barriers to care.

RIG Poster #10

Street Medicine

Residency Program: St Luke's Rural Family Medicine Residency
Lead Resident: Kathleen Bannerman, MD

The Ringtown Rural Health Center team provides weekly walk-in primary care services to clients of Servants to All and Schuylkill HOPE Center for Victims of Domestic Violence. Homelessness is usually thought of as an inner-city problem, but in 2021, 11.4% of the population of Schuylkill County was living with severe housing problems. 13.1% of Schuylkill County lives below the poverty line, with 15.5% of Schuylkill County's children living in poverty. Most parts of Schuylkill County are medically underserved.

Servants to All's clients are uninsured or have Medicare or Medicaid, negatively affecting access to care. They often use the emergency room or urgent care centers for primary care services or forgo them altogether. Most unsheltered individuals lack the devices required to conduct telemedicine visits. Many of the clients of the Schuylkill HOPE Center for Victims of Domestic Violence are uninsured or have Medicare or Medicaid and have limited access to primary care. They may have fled their abusive environment without insurance cards, personal identification, or medications. Confidentiality and security are paramount concerns for these patients. This is such a concern that some clients will not provide their cell phone numbers to conduct virtual appointments.

Objective: Our goal is to supply our community partners with telemedicine carts in order to provide reliable, HIPAA-compliant, and secure connections to our Rural Health Clinic in Ringtown. Dedicated telemedicine carts would increase access to care for these vulnerable patients.

Methods/Results: Our community partners have substantial primary care and mental health needs that can be addressed through telemedicine. Telemedicine encounters, types of visits, and diagnoses will be tracked over time. Conclusion: Patients with housing insecurity and/or who are domestic violence victims frequently have unmet primary care and/or mental health needs. Telemedicine will increase access to care for our community partners. A dedicated telemedicine cart located with these community partners is an ideal way to provide HIPAA-compliant and secure care to vulnerable patients in need.