12TH ANNUAL
HEALTH SERVICES RESEARCH DAY

Program & Abstract Book

Tuesday, April 21, 2026

#HSRDay2026

EMORY UNIVERSITY SCHOOL OF MEDICINE

Health Services Research Center
Department of Medicine
and Department of Surgery

Georgia CTSA
Georgia Clinical & Translational Science Alliance

Table of Contents

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12TH ANNUAL HEALTH SERVICES RESEARCH DAY

Emory University, Rollins School of Public Health

Claudia Nance Rollins Building,
Rollins Auditorium

Tuesday, April 21, 2026
7:30AM-2:30PM

Time	Agenda Item / Topic	Speaker / Presenter
7:30 am	Registration and Breakfast	
8:00 – 8:05 am	Welcome & Opening Remarks	**Neal Dickert, MD, PhD** Thomas R. Williams Professor of Medicine Emory University School of Medicine, Co-Director, Emory Health Services Research Center Director, Network Capacity Core and Recruitment Center Georgia Clinical and Translational Science Alliance
SESSION I **Moderator: Ambar Kulshreshtha, MD, PhD**		
8:05 - 8:30 am	**Featured Talk:** Health Services Research, Comprehensive Dementia Care, and the Road to GUIDE	**Carolyn Clevenger, DNP, RN, GNP-BC, AGPCNP-BC, FAANP, FGSA, FAAN** Founding Dean and Professor, University of Georgia Founder, Integrated Memory Care (IMC) Visiting Professor, Nell Hodgson Woodruff School of Nursing, Emory University
8:30 – 8:50 am	**Session I Selected Abstracts**	
	High Out-of-Pocket Costs and Income-Related Differences in Discontinuation of Cardioprotective Diabetes Medications in Medicare	**Liz Mitchell** PhD Candidate Health Policy and Management Department Rollins School of Public Health T32 Fellow Emory University

	Outpatient Crisis Services Reduce Pediatric ED Visits for Suicidality	**Janet R. Cummings, PhD** Professor Department of Health Policy and Management Rollins School of Public Health Emory University
	Medicaid Expansion and Diagnosis Experiences of People with Frontotemporal Dementia	**Catherine E. A. Scipion, MD, MPH, MS** Postdoctoral Research Associate School of Public Health Georgia State University
	Removing Race from the ichoose Kidney Tool to Predict Treatment-specific Patient Mortality: A Validation Study	**Mele Mafi, MPHc** Student/Graduate Research Assistant Rollins School of Public Health Emory University
8:50 – 9:00 am	**Session I Selected Abstracts Q&A**	
9:00 – 9:45 am	Poster Session 1 Location: 2nd Floor Claudia Nance Rollins Building Breezeway	
9:45 – 9:50 am	Break	

SESSION II **Moderator: Stacey Fedewa, PhD, MPH**		
9:50 – 10:15 am	**Featured Talk:** The Evolving Science and Epidemiology of Diabetes: Implications for Health Services	**Mohammed K. Ali, MD, MSc, MBA** William H. Foege Professor Co-Director, Emory Global Diabetes Research Center Vice Chair, Department of Family and Preventive Medicine Emory University
10:15 – 10:35 am	**Session II Selected Abstracts**	
	Association of Sensory Impairments and Cognitive Difficulty Among U.S. Adults from 2020-2024 NHIS: Assessing the Role of Hearing Aids and Corrective Eyewear	**Alyssa Jesse-Hugo, MPHc** Student/Graduate Research Assistant Rollins School of Public Health Emory University
	Influence of Inpatient vs Outpatient Delivery of Transcranial Magnetic Stimulation Therapy for Treatment-resistant Depression with Reduction in Depression Symptoms	**Noah Marchuck, BS** Data Specialist Skyland Trail
	Access, Care Coordination and Patient Experiences on Long COVID: A Comparison of Care Delivery in Primary Care Settings and Long COVID Specialty Clinics	**Imani Elsey, MPH** Program Manager Atlanta Long COVID Collaborative School of Medicine Emory University
	The Effect of Limiting Short-interval Repeat Methicillin-resistant Staphylococcus Aureus Testing on the Rate of Inpatient Antibiotic Prescribing	**Eric Caliendo, MD** Assistant Professor Division of Hospital Medicine Emory University Hospital
10:35 – 10:45 am	**Session II Selected Abstracts Q&A**	

KEYNOTE PRESENTATION
Moderator: Neal Dickert, MD, PhD

10:45 am – 11:45 am	**Keynote Presentation:** Behavioral Economics to Improve Care for Seriously Ill Patients	**Scott D. Halpern, MD, PhD** John M. Eisenberg Professor of Medicine, Epidemiology, and Medical Ethics & Health Policy, University of Pennsylvania Founding Director, Palliative and Advanced Illness Research (PAIR) Center
11:45 am – 12:15 pm	**Networking Lunch:** Please join other Health Services researchers and leaders for a networking lunch in the Rollins Lobby *Boxed lunches and refreshments available*	
12:15 – 1:00 pm	**Poster Session 2** Location: 2nd Floor Claudia Nance Rollins Building Breezeway	

SESSION III
Moderator: Ryan Suk, PhD, MS

1:00 – 1:20 pm	**Session III Selected Abstracts**	
	Trends in Opioid Prescribing by Oncologists for Medicare Beneficiaries (2014-2022)	**Shaimaa Elshafie, BPharm, MSc, PhD** Postdoctoral Fellow Rollins School of Public Health Emory University
	Payment Pressure and the Growth of Prior Authorization Requirements in Medicare Advantage	**Eunhae Shin, PhD** Assistant Professor Department of Health Policy and Management University of Georgia
	Infertility Diagnosis and Care Pathways Navigation at Kaiser Permanente Georgia	**Roxan Andre, MPH** Research Project Manager III Kaiser Permanente Georgia Center for Research and Evaluation (CRE)
	Early Identification of Severe Maternal Morbidity from Baseline Pregnancy-Episode Features	**Mustapha Oloko-Oba, PhD** Postdoctoral Fellow Department of Medicine Morehouse School of Medicine
1:20 – 1:30 pm	**Session III Selected Abstracts Q&A**	

HEALTH SERVICES RESEARCH PANEL **Moderator: Jessica Harding, PhD**		
1:30 – 2:15 pm	**Panel Topic:** The Evolving Funding Landscape in Health Services Research	**Scott D. Halpern, MD, PhD** **Carolyn Clevenger, DNP, RN, GNP-BC, AGPCNP-BC, FAANP, FGSA, FAAN** **Karen Hacker, MD, MPH** Adjunct Professor Health Policy Fellow Rollins School of Public Health Emory University **Theresa Wicklin Gillespie, PhD, MA, FAAN** Looney Family Professor of Cancer Research Department of Hematology & Medical Oncology Department of Surgery Emory University School of Medicine Associate Director for Community Outreach and Engagement Director, Winship Center for Cancer Health Equity **Hui Shao, MD, PhD** Associate Professor Hubert Department of Global Health Department of Family and Preventive Medicine Rollins School of Public Health Emory University Director of the Emory AI Causal Lab
2:15 – 2:30 pm	Poster Award Announcements & Concluding Remarks	**Sarah H. Cross, PhD, MPH, MSW** Assistant Professor Department of Family and Preventive Medicine School of Medicine Emory University
2:30 pm	Conference concludes	

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Mixed Methods Program Lead, Emory Health Services Research Center

Zanthia Wiley, PhD, FIDSA, FAFMR
Professor of Medicine, Division of Infectious Diseases
Associate Vice Chair of Community and Engagement, Department of Medicine
Emory University School of Medicine

Huiwen Xu, PhD
Associate Professor
Director, Aging and Methods Laboratory Emory University School of Nursing

Resource Booths

Please take a moment to visit the information tables in the lobby to learn about the following:

Georgia Clinical and Translational Science Alliance (Georgia CTSA)	The Georgia Clinical & Translational Science Alliance seeks to accelerate clinical and translational education, research, and community engagement to impact health in Georgia and beyond. Georgia CTSA provides researchers with funding opportunities; clinical research units with specialized staff and resources; training and career development; and consultation in biostatistics, epidemiology, research design, regulatory processes, biomedical informatics, pediatric research, clinical trials, recruitment, and community engagement.	Andrew C. West, MBA, MHA Executive Center Administrator Karen Lindsley Manager, Coordinating Center and Regulatory Knowledge & Support
Georgia CTSA Clinical Research Centers (GCRCs)	Discover the Georgia CTSA Clinical Research Centers (GCRCs): Your dedicated partner for advancing clinical trials efficiently and effectively. One of our aims is to provide seamless support and resources to facilitate groundbreaking research initiatives. At GCRCs, we offer inpatient and outpatient research facilities staffed by expert professionals. From study initiation to study closeout, we handle the details so you can focus on breakthroughs. Our multi-site comprehensive services encompass nursing care, coordinator support, specialized laboratories, bionutrition expertise, and administrative assistance—all tailored to elevate your study's success. We pride ourselves on our transparent pay-as-you-go model, designed to reduce study costs and accelerate healthcare innovations. Let GCRCs be your bridge between scientific discovery and transformative healthcare solutions. Start your next trial with confidence—partner with us today.	GCRC@emory.edu Sherri Grady Senior Business Manager Turner Price Program Coordinator & New Protocols Liason

Keynote Speaker

Scott D. Halpern, MD, PhD
John M. Eisenberg, Professor of Medicine,
Epidemiology, and Medical Ethics &
Health Policy,
University of Pennsylvania
Founding Director, Palliative and Advanced
Illness Research (PAIR) Center

Scott D. Halpern, M.D., Ph.D. is the John M. Eisenberg, M.D. Professor of Medicine, Epidemiology, and Medical Ethics and Health Policy at the University of Pennsylvania, and a practicing critical care and palliative care physician. He is the founding Director of the Palliative and Advanced Illness Research (PAIR) Center, which seeks to improve the lives of all people affected by serious illness and remove the barriers to health equity that seriously ill patients commonly face. Within PAIR, he also directs the American Heart Association-funded BETTER Center (Behavioral Economics to Transform Trial Enrollment Representativeness) which tests ways to improve the diversity of enrollment in clinical trials, and Penn PORTAL (Patient-Oriented Research and Training to Accelerate Learning), 1 of 16 U.S. Centers of Excellence in learning health system science and training. He has received dozens of awards for scholarship in bioethics and health services research, and is most proud of his awards and accomplishments in mentoring, including having been the primary mentor for more than a dozen NIH K awardees. He is an elected member of the American Society of Clinical Investigation, the Association of American Physicians, the Hastings Center, and the National Academy of Medicine.

Featured Speakers and Panelists

*in order of appearance

Carolyn K Clevenger, DNP, GNP-BC, AGPCNP-BC, FAANP, FGSA, FAAN
Founding Dean and Professor, University of Georgia
Founder, Integrated Memory Care (IMC)
Visiting Professor, Nell Hodgson Woodruff School of Nursing, Emory University

Carolyn Clevenger, gerontological nurse practitioner, is Visiting Professor at the Nell Hodgson Woodruff School of Nursing at Emory University. As of January 2026, Clevenger was named Founding Dean of the new School of Nursing at the University of Georgia. She is a Fellow of the American Association of Nurse Practitioners, and the Gerontological Society of America, and the American Academy of Nursing. Her research focuses the geriatric nurse practitioner workforce, psychoeducation programs for dementia family caregivers, and new models of care.

Clevenger is the Founder of the Emory Integrated Memory Care practice. The IMC is a nurse-led primary care practice for people living with dementia with both a clinic location and in select senior living communities. The IMC model of care has been recognized as a Patient-Centered Medical Home, an Age Friendly Health System, a Best Practice exemplar for patient- and family-centered care, a Best Program for Caregiving, a Guiding an Improved Dementia Experience (GUIDE) practice, and an Edge Runner.

Dr. Clevenger has led or collaborated on a variety of psychoeducation programs for dementia family caregivers including Savvy and Tele-Savvy Caregiver, Caregiving during Crisis, Caregiving While Black, Caregiver as Navigator, Caregiver Bootcamp, and most recently two implementation studies to test the use of digital cognitive assessments and blood-based biomarker testing for Alzheimer's disease.

Mohammed K. Ali, MD, MSc, MBA
William H. Foege Professor Professor
Co-Director, Emory Global Diabetes Research Center
Vice Chair, Department of Family and Preventative Medicine, Emory University

Mohammed K. Ali, MD, MSc, MBA, serves as the William H. Foege Distinguished Professor of Global Health and a professor of epidemiology at Emory University's Rollins School of Public Health, co-director of the Emory Global Diabetes Research Center, and Vice Chair of Research in the Department of Family and Preventive Medicine at Emory's School of Medicine. He is also a primary care physician at Emory University.

Ali earned his medical degree at the University of Cape Town, South Africa, master's degrees in cardiovascular medicine and global public health from the University of Oxford, United Kingdom as a Rhodes Scholar, and an MBA and family medicine board certification from Emory.

Dr. Ali's work focuses on the epidemiology and quality of care as they relate to diabetes and cardiovascular health. With expertise in implementation science, he has led projects that evaluate practices, programs, and policies that promote better detection, prevention, and management of chronic conditions. He served as a scientific advisor to the CDC's Division of Diabetes Translation from 2010-2025 and has led or contributed to key reports for the World Health Organization, World Bank, International Diabetes Federation, and National Academy of Medicine. In recognition of his contributions to global health and chronic disease prevention, he was elected to the National Academy of Medicine in 2025.

Featured Speakers and Panelists

*in order of appearance

Karen Hacker, MD, MPH
Adjunct Professor
Health Policy Fellow, Department of Health Policy and Management
Rollins School of Public Health, Emory University

Karen Hacker, MD, MPH, is the former Director of the National Center for Chronic Disease Prevention and Health Promotion at the CDC (2019 to 2025) where she oversaw a budget of $1.4B and a staff of 1000. Dr. Hacker has over two decades of leadership experience in the public sector serving at the city, county and federal levels. Her expertise spans public health, policy, healthcare, and research. Prior to CDC, she was the Director of the Allegheny County Health Department in PA. Dr. Hacker uniquely bridges critical community needs with national health policy and is recognized for her practical, solutions-focused approach to complex challenges. She is also widely published with over 100 peer-reviewed articles and an expert in community-based participatory research. Dr. Hacker has a Bachelor of Arts (BA) from Yale University, a medical degree (MD) from Northwestern University School of Medicine, and a Master of Public Health (MPH from Boston University School of Public Health. She is currently an Adjunct Professor at the Emory, Rollins School of Public Health and Morehouse School of Medicine.

Theresa W. Gillespie, PhD, MA, FAAN
Looney Family Professor of Cancer Research
Department of Hematology and Medical Oncology and Department of Surgery
Emory University School of Medicine
Associate Director for Community Outreach and Engagement
Director, Winship Center for Cancer Health Equity Research
Winship Cancer Institute

Theresa W. Gillespie is the Looney Family Professor of Cancer Research in the Department of Hematology and Medical Oncology and Department of Surgery in the Emory University School of Medicine. She also serves as Associate Center Director for Community Outreach and Engagement in the Winship Cancer Institute, and as Director of the Winship Center for Cancer Health Equity Research. Dr. Gillespie's research involves multiple cancer types, encompassing clinical, health services, and population-based investigations, all with cross-cutting themes of cancer disparities, including rural health. She developed and led the clinical trials programs at Winship Cancer Institute, conducting prospective therapeutic and cancer control studies. Dr. Gillespie subsequently served for 10 years as the Director of Health Services Research at the Atlanta Veterans Affairs Medical. She has a long history of research funding involving health disparities and outcomes, including from the NIH/NCI, AHRQ, DoD, CDC, PCORI, Movember Foundation, Gates, and Avon. Her recent NIH-funded studies include development and evaluation of curricula and interventions to promote a more diverse STEM and biomedical workforce in the future; and a trial to determine factors contributing to worse cancer outcomes among people living with HIV. Dr. Gillespie has extensive mentorship experience supervising students, residents, fellows, and early-stage investigators, and has served in multiple senior leadership positions within the Winship Cancer Institute, across the state of Georgia, and nationally.

Featured Speakers and Panelists

*in order of appearance

Hui Shao, MD, PhD
Associate Professor
Hubert Department of Global Health
Department of Family and Preventive Medicine
Rollins School of Public Health, Emory University
Director of the Emory AI Causal Lab

Dr. Hui Shao is an Associate Professor at Emory University's Rollins School of Public Health, with joint appointments in the Departments of Global Health and Family and Preventive Medicine. A physician-scientist by training, Dr. Shao is nationally recognized for his pioneering work at the intersection of precision medicine, health economics, and machine learning. He leads several NIH- and CDC-funded projects that develop AI-driven simulation models to inform value-based coverage, pricing, and health policy—particularly in diabetes and multimorbidity.

Dr. Shao has authored over 160 peer-reviewed publications, including lead or senior-author papers in JAMA, Diabetes Care, and Lancet Diabetes. He is the principal architect of two of the most widely used diabetes economic simulation models in the field: BRAVO and the CDC-RTI Diabetes Model, both of which are foundational tools for evaluating the long-term impact of therapeutic and policy interventions.

A dedicated educator and mentor, Dr. Shao has taught hundreds of students across PharmD, MPH, and PhD programs and has mentored over 30 trainees and early-career professionals worldwide. He serves as Course Director for the simulation modeling curriculum in the CDC's Steven M. Teutsch Prevention Effectiveness Fellowship and leads the Global Health Data Science concentration at Emory.

Internationally, Dr. Shao is Director of Academics for the China Health Policy and Management Society, where he organizes global symposia with over 2,000 participants. He is a standing member of NIH's HSQE Study Section, a frequent grand rounds speaker, and an editorial reviewer for leading journals in diabetes, health economics, and informatics.

8:30 – 8:50 am

#1

High Out-of-Pocket Costs and Income-Related Differences in Discontinuation of Cardioprotective Diabetes Medications in Medicare

Mitchell E, Ali MK, Dieci M, Graetz I, Patel S, Patrick S, Yarbrough CR, Li P, Shao H

GLP-1 receptor agonists (GLP-1RAs) and SGLT2 inhibitors (SGLT2is) can improve health outcomes for people with type 2 diabetes (T2D), but high out-of-pocket (OOP) costs contribute to socioeconomic disparities in their uptake in Medicare. We examined the associations of OOP costs and nonadherence and discontinuation across income levels among unsubsidized Part D enrollees aged ≥65 with T2D using 2015-23 Medicare Current Beneficiary Survey and claims data (n=10,677).

We examined GLP-1RA and SGLT2i nonadherence (PDC < 80%) and discontinuation (≥30-day gap between fills) in relation to income and OOP cost burden per 30-day supply. Logistic regression models incorporated nonlinear income functions and income-OOP interactions, adjusting for sociodemographic, insurance, year, and clinical characteristics.

Mean OOP per 30-day supply was $194 for GLP-1RAs and $119 for SGLT2is. Nonadherence and discontinuation were observed in 64.3% and 26% of GLP-1RA users and 59.3% and 16.5% of SGLT2i users, respectively. Counterfactual OOP reductions were associated with larger absolute decreases in discontinuation at lower incomes, while income-related differences in nonadherence were modest and imprecise. At the median income, lowering OOP from the 90th to the 10th percentile was associated with reductions in discontinuation of 16.2 (SE 6.8) percentage points for GLP-1RAs (from 59.8% to 43.6%) and 26.5 (SE 6.7) percentage points for SGLT2is (from 48.2% to 21.8%).

Higher OOP costs were strongly associated with increased discontinuation of GLP-1RAs and SGLT2is among unsubsidized Medicare beneficiaries with T2D. Interventions to lower drug prices may improve continuity of guideline-recommended medications and reduce income-related disparities in care.

#2

Outpatient Crisis Services Reduce Pediatric ED Visits for Suicidality

Cummings JR, Copeland WE, Braykov N, McCutchan PK, Henderson HM, Hudziak JJ, Livingston-Burns B, Jing X, Ramos C, Constantino JN

Objectives: Pediatric emergency department (ED) visits for suicidality have increased substantially, while effective interventions and outpatient follow-up remain limited. This study evaluated whether an acute outpatient crisis service model reduced subsequent ED revisits among youth presenting with suicidal thoughts and/or behaviors.

Methods: We conducted a retrospective cohort study within a large children's health system including 2,998 youth who presented to the ED with suicidality between October 1, 2023, and August 31, 2025. Participants were either referred to: (1) outpatient crisis services offering evidence-based psychotherapy based on the Collaborative Assessment and Management of Suicidality framework and/or psychiatric medication management (i.e., treatment group), or (2) community services (i.e., treatment as usual). Referral was based primarily on service availability, and propensity score modeling balanced demographic characteristics, index visit features, and prior mental health treatment. The primary outcome was a mental health–related ED revisit within 90or 180 days.

Results: Of 2,998 qualifying ED visits, 763 youth (25%) were referred to crisis services. In intent-to-treat analyses, the treatment group had a significantly lower likelihood of ED revisits at 90 days (8% vs 12%; odds ratio [OR], 0.54; 95% CI, 0.45–0.65) and 180 days (11% vs 16%; OR, 0.64; 95%CI, 0.55–0.75). Treatment effects were strongest among youth determined as requiring inpatient care (OR: 0.30, 95%CI 0.23, 0.39) and among females (0.61, 95%CI 0.48, 0.77).

Conclusions: Acute outpatient crisis services were associated with reduced ED revisits among youth with suicidality. Identifying subgroups most likely to benefit may help optimize intervention impact.

#3

Medicaid Expansion and Diagnosis Experiences of People with Frontotemporal Dementia

Scipion CEA, Nielsen KE, Manchester MA, Arias JJ

Background: Timely and accurate diagnosis of frontotemporal dementia (FTD) is essential for patient and caregiver well-being, yet access to diagnostic care may be constrained by limitations in insurance coverage. The impact of health reform on diagnostic experiences among individuals with FTD is unclear. We examined whether residing in Medicaid-expanded states under the Patient Protection and Affordable Care Act (ACA) is associated with misdiagnosis prior to FTD diagnosis.

Methods: Retrospective analysis of the Association for Frontotemporal Degeneration Insights Survey used self-reported data from 1049 caregivers. Misdiagnosis was defined as one or more incorrect diagnoses prior to FTD diagnosis. Individuals were grouped by state Medicaid expansion status at diagnosis (expanded, not expanded, inconclusive status). Multivariate logistic regression assessed the association between Medicaid expansion and misdiagnosis. Sensitivity analyses (1) excluded the inconclusive group and (2) classified it as expanded.

Results: Overall, 527 (50.2%) individuals experienced misdiagnosis prior to FTD diagnosis. Misdiagnosis prevalence by Medicaid expansion status was 45.5% in expanded states, 55.1% in non-expanded states, and 47.5% in inconclusive states. After adjusting for race/ethnicity, marital status, and FTD symptoms, individuals residing in Medicaid-expanded states were significantly less likely to experience misdiagnosis than those in non-expanded states (OR=0.55; 95%CI: 0.33–0.91). Sensitivity analyses supported these findings.

Conclusion: Medicaid expansion under ACA was associated with 45% lower odds of misdiagnosis among individuals with FTD. State-level health policies may shape FTD care pathways, warranting further study to address diagnostic disparities.

#4

Removing Race from the ichoose Kidney Tool To Predict Treatment-Specific Patient Mortality: A Validation Study

Mafi M, Hu C, Pastan S, Di M, Patzer RE, Harding JL

Background: In 2016, iChoose kidney was developed to improve communication between providers and patients with kidney failure about their relative survival on dialysis vs. transplant. The original algorithm included race as a mortality predictor. Following the 2021 removal of race from eGFR calculations, citing racist origins of its inclusion, we update and validate the iChoose Kidney tool to reflect these new standards.

Methods: We identified all adults (aged ≥18 years) from the United States Renal Data System initiating dialysis or transplant between 2014 and 2019, with follow-up through Dec 2022. Mortality risk (3-year) was determined from logistic regression models adjusted by sex, age, history of cardiovascular disease, hypertension, diabetes, dialysis vintage (transplant patients only) and low albumin (<3.5 g/dL). We compared the discriminative ability of models with and without race using c-statistics.

Results: Among 697,281 dialysis and 56,190 transplant patients, mean age was 64 and 51 years, 27% and 17% were Black, and 49% and 28% had type 2 diabetes as the primary cause of their kidney failure, respectively. Mortality occurred in 40% of dialysis and 3% of transplant patients. In equations including race, c-statistics were 0.709 (0.707, 0.710) and 0.717 (0.706, 0.729) for dialysis and transplant patients respectively. When excluding race, c-statistics were 0.696 (0.695, 0.697) for dialysis and 0.717 (0.705, 0.728) for transplant patients.

Conclusions: When removing race as a predictor, the iChoose Kidney algorithm performs similarly to when race is included. These findings are in line with new eGFR calculations and confirm race should not be included as a clinical predictor.

10:15 – 10:35 am

#1

Association of Sensory Impairments and Cognitive Difficulty Among U.S. Adults from 2020-2024 NHIS: Assessing the Role of Hearing Aids and Corrective Eyewear

Hugo AJ, Xie E, Kulshrestha A

Sensory impairments, including vision and hearing loss, are increasingly recognized as significant risk factors for cognitive decline in older adults. This study examined associations between sensory impairments and cognitive difficulties among U.S adults and evaluated whether use of sensory aids, hearing aids and corrective eyewear, modifies these associations. We analyzed cross-sectional data from the 2020-2024 National Health Interview Survey including adults aged ≥45 years without self-reported dementia and complete data on key exposures and outcomes. Hearing, vision, and cognitive difficulties were self-reported and dichotomized; dual sensory impairment (DSI) was defined as concurrent hearing and vision difficulty. Survey-weighted Poisson regression models estimated associations, with interaction terms testing modification by sensory device use.

The analytic sample (n = 94,66, weighted, n= 136,121,908 individuals), included 13% with hearing impairment only, 15% vision impairment only, and 7% with DSI. Compared with adults without sensory impairment, those with DSI were older (Mage= 68 years, SD = 11), more often female (51%), and Non-Hispanic White (76%). Sensory impairments were associated with cognitive difficulty strongest for DSI (PR = 2.69 [95% CI; 2.60, 2.79]), followed by hearing-only (1.90 [1.82, 1.97]), and vision-only (2.03 [1.96, 2.11]). Adjusted models showed hearing aid use reduced the prevalence of cognitive difficulty across all impairment groups (p < 0.0001). Use of both sensory devices were associated with lower cognitive difficulty across all groups (p < 0.0001).

Findings highlight strong associations between sensory impairment and cognitive difficulty and suggest that optimizing sensory aid use may help preserve cognitive function in older adults.

#2

Influence of Inpatient vs Outpatient Delivery of Transcranial Magnetic Stimulation Therapy for Treatment-Resistant Depression with Reduction in Depression Symptoms

Marchuck N, DeMoss RF, Turner WC, Chen M, Hunter B, Rothbaum AO, van Rooij S

Transcranial magnetic stimulation (TMS) is an efficacious, non-invasive neuromodulation therapy for treatment resistant depression (TRD). Despite TMS becoming increasingly available, the effect of inpatient versus outpatient delivery (setting) on outcomes remains unclear. The current study examined the influence of setting on depression response. Patients 18 to 65 years old (N=138) completed 30-36 sessions of TMS at a non-profit, non-emergent psychiatric facility. Outpatients (n=67) were referred for TMS by treating psychiatrists, and inpatients (n=71) were referred by program psychiatrists to supplement standard treatment. The Montgomery–Åsberg Depression Rating Scale (MADRS) measured depression pre- and post-TMS. Repeated measures general linear models assessed interactions between depression symptoms pre- and post-TMS and setting, adjusting for age, sex, and TMS protocol. Post-hoc independent samples t-tests analyzed reduction in MADRS scores by setting. Remission (MADRS scores ≤9) and clinical response (≥50% reduction from baseline) were computed. Remission and clinical response rates across groups were 52% and 78%, respectively. MADRS scores decreased significantly following TMS (F(1,133) = 26.92, p < .001). There was a significant interaction with setting (F(1,133) = 6.40, p =.013), with outpatients seeing significantly greater reduction in symptoms (M = -22.04, SD = 1.28) than inpatients (M = -17.37, SD = 1.25), t(136) = -2.64, p = .005. One explanation for the greater reduction in the outpatient group is the behavioral activation embedded in the treatment model: leaving home for and consistent social engagement during daily sessions. This routine social engagement may strengthen the effects of TMS and contribute to outpatients' greater reduction in symptoms.

#3

Access, Care Coordination and Patient Experiences on Long COVID: A Comparison of Care Delivery in Primary Care Settings and Long COVID Specialty Clinics

Elsey I, Walker TA, Harris S, Kohler J, McDonnel T, Brown B, Han JE, Truong A, Weber MB

Background: Electronic health record data indicate substantial underdiagnosis of Long COVID (<0.1% vs. a CDC-estimated prevalence of 7%). Patients also report fragmented care, including clinician skepticism and ineffective referrals to subspeciality physicians. To address this, we established Long COVID clinics (LCCs) offering patient-centered specialty care. This study examines patient perspectives on this model compared with primary care.

Methods: Six virtual focus groups (December 2024–April 2025) were conducted with 6–8 adults receiving care at LCCs at Grady Memorial Hospital and Emory University Midtown Hospital. Discussions examined prior care experiences, access, coordination, and health impacts. Transcripts were thematically analyzed in MAXQDA using multidisciplinary consensus-based coding approach.

Results: Participants reported major barriers to care before LCC referral, often finding clinics through personal networks or independent research. Many described negative, fragmented care outside LCCs, including limited provider knowledge, denial of Long COVID, and emotional and financial strain. In contrast, LCC care was viewed positively, with improved mental health and hope, personalized specialty care, and coordinated, patient-centered teams.

Conclusions: Many adults with Long COVID experienced stigma, delayed diagnosis, and inadequate care prior to LCC referral, contributing to mental strain and delayed improvement. Participants emphasized the value of specialty clinics for their health and well-being. Future research should focus on strengthening primary care diagnosis, management, and referrals through targeted training interventions to expedite diagnosis and linkage with specialty care clinics when feasible.

#4

The Effect of Limiting Short-Interval Repeat Methicillin-Resistant Staphylococcus Aureus Testing on the Rate of Inpatient Antibiotic Prescribing

Dunn RC, Caliendo ET, Witt LS, Wilber EP

Several studies have demonstrated that repeating polymerase chain reaction (PCR) testing for methicillin-resistant Staphylococcus aureus (MRSA) from nares swab within 2 weeks rarely reveals a different result. In an effort to limit unnecessary testing, our institution implemented a restriction on repeat MRSA PCR nares testing within 2 weeks which reduced the median weekly rate of short-interval repeat testing from 13 (pre-intervention) to 2 (post-intervention).

We aimed to determine whether inpatient prescribing of anti-MRSA agents changed after this diagnostic testing restriction. Through interrupted time series analysis using a quasi-Poisson regression model, we analyzed the patterns of anti-MRSA prescribing.

We found no clinically significant difference in the rate of anti-MRSA prescribing per 1000 patient days before and after the intervention; the point estimate of change was 5.74% (95% CI -0.89% to 12.74%). This was further demonstrated in subgroup analyses with similar findings based on care setting (i.e. general medical-surgical ward versus intensive care unit).

The rate of anti-MRSA therapy did not increase based on lack of repeat MRSA testing, showing that appropriate limitations on diagnostic testing can result in more efficient patient care without leading to overtreatment.

1:00 – 1:20 pm

#1

Trends in Opioid Prescribing by Oncologists for Medicare Beneficiaries (2014-2022)

Elshafie S, Villa Zapata L

Background: Opioid overprescribing has contributed to substantial morbidity, mortality, and healthcare costs in the United States. Regulatory efforts, including revisions to the opioid Risk Evaluation and Mitigation Strategy (REMS) in 2018, have targeted evidence-based prescribing practices. This study examined national trends in opioid prescribing by oncologists for Medicare Part D beneficiaries from 2014 to 2022 and assessed changes following the 2018 REMS update.

Methods: This cross-sectional study used data from the 2014-2022 Medicare Part D Prescriber Public Use Files. Opioid prescribing patterns were characterized by opioid type, oncologist subspecialty, geographic region, and rural-urban practice location. Interrupted time series analysis evaluated changes in prescribing trends before and after the 2018 REMS modifications.

Results: The analysis included 25,371 oncologists; the majority were male (66%) and specialized in hematology-oncology (47%). Oncologists issued over 9.4 million opioid prescriptions from 2014-2022, with long-acting opioids representing 18% of claims. Hematology-oncology specialists contributed the majority of opioid prescriptions. Those in the South and in rural areas had higher prescribing rates and longer supply durations. Overall, opioid prescribing by oncologists declined steadily between 2014 and 2022, with a significant immediate reduction following the 2018 REMS update and a sustained downward trend thereafter.

Conclusions: Opioid prescribing by oncologists for Medicare beneficiaries declined substantially over time, with a notable discontinuity after the 2018 REMS revisions. Persistent regional and rural-urban differences underscore the need for targeted policies and provider education to support safe, equitable cancer pain management.

#2

Payment Pressure and the Growth of Prior Authorization Requirements in Medicare Advantage

Shin E, Jung D

Objective: To assess whether county-level payment reductions for Medicare Advantage (MA) plans led to more restrictive prior authorization (PA) policies.

Study Setting and Design: We exploited benchmark reductions introduced by the Affordable Care Act (ACA), which reset MA county benchmarks based on quartiles of historical Medicare spending. Counties with higher prior spending experienced larger cuts, phased in between 2012 and 2016 through blended pre- and post-ACA benchmarks. Using 2007–2019 MA Plan Benefit Package data, we constructed overall and service-specific measures of PA requirements. We estimated difference-in-differences models comparing top-quartile counties with other counties before and after ACA implementation.

Data Sources and Analytic Sample: Analyses included 2,639 counties with at least one health maintenance organization or local preferred provider organization MA plan and complete data.

Principal Findings: Top-quartile counties experienced average benchmark reductions of 16% after ACA implementation, compared with 3% in other counties. We found no evidence that plans in high-cut counties tightened PA requirements. Relative to other counties, top-quartile counties experienced nonsignificant declines in overall PA restrictiveness of 3 percentage points (pp; 95% CI, −6.3 to 0.3) during phase-in (2012–2016) and 4 pp (95% CI, −8.8 to 0.9) post-ACA (2017–2019). Event-study estimates suggest slower growth in PA adoption for outpatient diagnostic/laboratory services. Results were robust across alternative specifications.

Conclusions: ACA-induced benchmark reductions did not increase PA restrictiveness and, in some categories, were associated with slower PA growth. Payment pressure may temper, rather than intensify, utilization management.

#3

Infertility Diagnosis and Care Pathways Navigation at Kaiser Permanente Georgia

Andre R, Clarke L, Martinez M, Robinson B, Mcdonald B

Background: Integrated health systems without in-house infertility specialists may face unique challenges coordinating fertility care. The Infertility Diagnosis and Care Pathways project examines infertility care delivery within Kaiser Permanente Georgia (KPGA).

Methods: We are recruiting 20-35 female KPGA members ages 18-45 who sought fertility-related care from 2014-2024.Participants complete one 30-60-minute virtual semi-structured interview. Interviews explore experiences initiating fertility care, navigating diagnostic workups and referrals, understanding insurance coverage, and preferences for additional support. A rapid qualitative analysis of coded transcripts was conducted using Dedoose to identify relevant themes.

Results: To date,19 participants have been interviewed. Most participants are Black or African American (47%), heterosexual (94%), and have household incomes over $200,000 (36%). Emerging findings highlight three central challenges: (1) difficulty identifying clear next steps following diagnostic testing; (2) frustration navigating referral pathways and understanding available treatment options; and (3) uncertainty regarding insurance coverage, including out-of-pocket costs for advanced fertility services. Participants consistently expressed that wraparound support, spanning insurance education, care navigation, and mental health resources, would meaningfully improve their fertility journeys and reduce psychosocial stress associated with fragmented care.

Conclusions: Preliminary findings suggest opportunities to improve clarity, coordination, and continuity in fertility care delivery at KPGA. Ongoing analysis will inform recommendations for a potential infertility navigation program designed to support patients across diagnostic and referral pathways.

#4

Early Identification of Severe Maternal Morbidity from Baseline Pregnancy-Episode Features

Oloko-Oba M, Aslam A, Mtuanwi B, Graham N, Farrington JF, Jenae Farrington, Willis C, Brown K, Smith L, Kopp K, Idris MY

Background: Severe maternal morbidity (SMM) is a major contributor to preventable maternal mortality and high-cost obstetric care in the United States. Health systems lack scalable approaches to identify high-risk pregnancies early enough to target enhanced prenatal care and referral to appropriate levels of obstetric services.

Objective: To evaluate whether baseline electronic health record data can support early population-level risk stratification for SMM.

Methods: We conducted a retrospective cohort study of 50,080 pregnancy-related episodes in the All of Us Researcher Workbench. Predictors were restricted to information available early in pregnancy, including demographics and pre-existing clinical conditions (e.g., hypertensive disorders, diabetes, obesity, renal disease, asthma, sickle-cell trait). Predictive models were developed using an 80/20 stratified train–test split. Performance was assessed using AUROC and capacity-based triage by flagging the top 1%, 5%, and 10% of pregnancies by predicted risk.

Results: SMM prevalence was 1.07% (538/50,080). Discrimination was moderate (AUROC 0.73–0.74). Risk stratification produced substantial enrichment of SMM in the highest-risk groups. The top 10% of pregnancies by predicted risk captured 33.4% of SMM events, while the top 5% captured 26.1%. Precision in the top 10% risk group was 3.6%, representing more than a threefold increase over baseline risk.

Conclusion: Baseline EHR data can identify a small subgroup of pregnancies that account for a disproportionate share of SMM. Early EHR-based risk stratification could support targeted prenatal care management, referral to high-risk obstetric services, and resource allocation within maternal health programs.

Session One

#1

Depression, Anxiety and Stress Among Caregivers of Children with Chronic Kidney Disease and its Impact on Kidney Failure Treatment Decisions: A Cross-Sectional Survey Study

Schanith A, Urbanski M, Reed B, Huang H, Westbrook A, Garro R, Kennedy S, Greenbaum LA, and Wang C

Background: Caregivers of children with chronic kidney disease (CKD) make important kidney failure treatment decisions, including type of dialysis (hemodialysis or peritoneal dialysis) and type of kidney transplant (living vs. deceased). Little is known about the prevalence of depression, anxiety and stress in caregivers of children with chronic kidney disease (CKD) and its impact on kidney failure treatment decisions.

Methods: We administered a survey to caregivers (legal guardians) of children <18y with CKD III-V inclusive of dialysis at outpatient clinics to assess presence of depression, anxiety and stress among caregivers using the Depression Anxiety & Stress Scale [(DASS-21): depression ≥ 10, anxiety ≥ 8 , stress ≥15]. Enrollment 8/1/2025-4/1/2026. We will describe the distribution of parental demographic and socioeconomic and patient clinical factors by parental mental health status. Univariate logistic regression will be performed to examine associations between caregiver depression, anxiety and stress on kidney failure treatment preference, significance level set at alpha = 0.05.

Results: Currently, 41/44 (93%) caregivers approached consented to the study: 11/12 HD, 12/13 PD, 18/19 CKD, with 37 (90%) completing the survey (30 mothers, 7 fathers). Median age of child at time of survey was 8.7y (IQR 2.7, 13.1) with median duration of CKD of 3.1 years (IQR 2.0, 6.8). Based on the DASS-21 scores, 14 (37.8%) caregivers reported depression, 18 (48.6%) reported anxiety, and 19 (51.4%) reported stress.

Conclusions: Stress, anxiety, and depression are common in caregivers of children with CKD. We will determine if there is a need for caregiver mental health screening and if there are associations between caregiver mental health and kidney failure treatment decisions.

#2

Racial and Ethnic Differences in Undercounting Disability Related to Mental Health

Qu A, Druss BG, Wen H

The ACS Six Questions (ACS-6) and Washington Group Short Set on Functioning (WG-SS) are used in U.S. surveys to inform disability-related policy and resource allocation. However, these surveys undercount individuals with mental health-related disabilities, potentially due to not capturing many psychosocial domains that may cause impairment in serious mental illness (SMI). We used data from 2017-2019 and 2022-2024 of the National Survey on Drug Use and Health (NSDUH) to examine the overall, and racial/ethnic differences in, undercounting of mental health-related disabilities in ACS-6 and WG-SS scales. Mental-health related disability was defined as having a SMI, which NSDUH defines as a mental disorder resulting in substantial functional impairment.

Among those with SMI, we examined racial/ethnic differences in screening negative for disability by the ACS-6 and WG-SS scales (false negative), using logistic regressions controlling for age, sex, chronic comorbidities, self-rated health, and English proficiency. 8,171 and 10,544 adults had SMI with non-missing outcome and covariates in 2017-2019 and 2022-2024 NSDUH, respectively. The adjusted percentage of a false negative on the ACS-6 was 38.9% (CI: 37.3-40.5) among non-Hispanic White and was significantly higher among non-Hispanic Black (44.9%, CI: 39.9-49.8). The adjusted percentage of a false negative on the WG-SS was 12.2% (CI: 10.8-13.5) among non-Hispanic White and was significantly higher among non-Hispanic Black (16.9%, CI: 13.1-20.7) and non-Hispanic Asian (18.5%, CI: 12.4-24.6).

Both scales inadequately capture individuals with mental health-related disabilities, which can potentially lead to their deprioritization and insufficient resource allocation for this vulnerable population.

#3

Quantifying Intersectional Racial and Gender Disparities in Kidney Transplant Access in The US

Gompers A, Stanhope KK, Collin LJ, Harding JL

Background: Racial and gender disparities in kidney transplantation are well established, but the literature on joint (i.e., intersectional) disparities is limited and outdated. This study examines intersectional racial and gender disparities in kidney transplant access in the US.

Methods: We used the US Renal Data System to conduct a retrospective cohort study of all Black or White adults (≥18 years) initiating kidney replacement therapy (KRT; dialysis or transplantation) in the US from 2015−2019, with follow-up through 2021. We fit age-adjusted Cox proportional hazard models to assess racial and gender disparities in time from KRT initiation to waitlisting and time from waitlisting to receipt of a kidney transplant from a deceased donor (DDKT) or living donor (LDKT). We estimated hazard ratios (HR), relative excess risk due to interaction (RERI), and 95% confidence intervals (CI).

Results: Among 448,400 people (32% Black, 42% women), waitlisting was lowest in Black women compared with White men (HR 0.59 [95% CI: 0.58, 0.61]), with a RERI of 0.06 (95% CI: 0.04, 0.08) indicating that Black women had longer time to waitlisting than would be expected based on racial and gender disparities alone. Black adults had 17% (15, 19) lower access to DDKT and 74% (73, 76) lower access to LDKT than White patients, with no gender disparities. However, the RERIs indicated that Black women fare better than expected in both cases (−0.13 [−0.18, −0.08] and −0.07 [−0.11, −0.03], respectively).

Conclusions: The magnitude and direction of intersectional effects vary by transplant outcome, as racial and gender disparities may magnify or diminish each other. Future research and interventions specifically focused on alleviating barriers to waitlisting among Black women may be warranted.

#4

Evaluating Blood Pressure Checks and Postpartum Visits in Reducing Acute Care Use Among Hypertensive Women

Deshmukh A, Stanhope KK

Hypertension is a key driver of postpartum maternal morbidity and mortality. To combat this, ACOG has devised guidelines to promote timely postpartum care, specifically among hypertensive individuals, which include a blood pressure check and comprehensive postpartum appointment.

This study aims to identify how well these guidelines are being adhered to and if they prevent acute care use, such as emergency department (ED) visits and inpatient readmission in the late postpartum period (3-9 months postpartum).

We conducted a cohort study of all patients with a live or still birth with a hypertensive diagnosis from two Metro Atlanta health systems from 2016 to 2021. We fit logistic regression models to estimate the crude and adjusted odds ratio and 95% confidence intervals on 3 distinct exposures: timely blood pressure check (within 20 days postpartum), comprehensive postpartum visit (from 21 to 84 days postpartum), or both and 2 outcomes: readmissions and ED visits from 85 days to 365 days postpartum We adjusted for hypertension diagnosis, race and ethnicity, parity, insurance category, mode of delivery, number of prenatal visits, and comorbidities.Only 27% of patients with hypertension completed a blood pressure check and 38% completed a postpartum visit.

Completion of a blood pressure check was associated with lower odds of readmission (aOR: 0.617, 95% CI: 0.435, 0.874) but not associated with ED visits. Postpartum visits have no significant impact on readmission or ED visits. Our results show possible benefits of early care engagement for patients with hypertension, though attendance at postpartum blood pressure checks remains low overall.

#5

Attitudes Toward Eligibility of Solid Organ Transplant Candidates with Criminal Justice Involvement: A Cross-Sectional Survey of U.S. Transplant Providers

Fogel A, Ballamudi A, Blythe E, Hu C, Nonterah CW, Rogers JL, Ng Y, Calnon M, Chen G, Taffe J, Thiessen C, Urbanski M.

Little is known about transplant professionals' attitudes towards solid organ transplantation for patients involved in the criminal justice system (CJS). This study explored transplant professionals' opinions on transplant eligibility for this population. A cross-sectional survey was administered (Aug-Oct 2025) to transplant professionals via the American Society of Transplantation and Society for Transplant Social Workers' listservs. The survey assessed attitudes toward transplantation for patients who are currently incarcerated (i.e., prison or jail) and those involved with CJS but not incarcerated (e.g., probation, parole).

Among 165 respondents, most worked in kidney transplant (67%) and were social workers (59%); 23% had evaluated a transplant candidate who was currently incarcerated. Most respondents considered incarceration an absolute/relative contraindication to transplant (70%), with the most common concerns including lack of support post-transplant (59%), inability to pay for medications (55%), and logistical challenges (50%). 95% of respondents considered current CJS involvement without present incarceration a relative or non-contraindication to transplant. Over half of providers believed limiting access for those incarcerated (59%) and those with CJS involvement (55%) may worsen existing disparities in transplantation. Logistical and ethical concerns shaped providers' perceptions toward transplant access for patients involved with CJS.

Future research assessing transplant center processes and patient outcomes among this population is needed to create standardized eligibility guidance and reduce variability in clinical decision-making to promote equitable transplant access.

#6

African American Women's Lived Experiences with Obstetrics/Gynecology in Atlanta, GA

Blake, AM

African American women in Georgia die during the perinatal period at almost three times the rate of other ethnic groups. Adverse maternal outcomes demonstrate a disparity among African American women. This phenomenological qualitative study explores the lived experiences of African American women receiving obstetrical and gynecological (OB/GYN) services in Atlanta, Georgia. The study includes women who identify as African American, ages 18–45, receiving OB/GYN services in Georgia. No income limits were applied, allowing women across income levels to be included. Feagin's systemic racism theory, along with Greenwald and Krieger's implicit bias theory, provides a conceptual framework for data collection and analysis.

Participants were recruited using social media ads, postings, and meetings with community organizations. Semi-structured interviews via Zoom audio were conducted with 14 participants. Data was analyzed through the interpretative phenomenological analysis approach.

Results indicated that while some women felt heard by their doctors, who showed concern and provided them with beneficial resources, others experienced the impact of systemic racism and implicit bias. Their experiences reflected racism, multiple stressors, and perceptions of implicit bias from providers. This included financial challenges, not being heard by the provider, and the need for self-advocacy.

Study findings may promote social change by informing providers about prenatal and postpartum care service delivery in Georgia and may impact providers nationwide, resulting in maternal quality improvement and positive maternal health outcomes.

#7

An Assessment of Preventive Care Utilization and Results at a Student-Run Gynecology Clinic in Clarkston, GA

Nygren C, Rose C, Verma S, Richards J, Walke L, Crochet S, Goedken J

Introduction: The Harriet Tubman Women's Clinic (HTWC) is a student-run gynecology clinic serving underinsured patients in Clarkston, GA. In collaboration with Emory University Hospital, HTWC provides free Pap smears and sexually transmitted infection (STI) testing according to screening guidelines and patient requests. This study aims to assess utilization of these services and the frequency of abnormal results.

Methods: We analyzed 2025 clinic data, including patient demographics (preferred language, age), preventive and diagnostic gynecologic services (Pap smears, STI screening, procedures), and clinic staffing. Data were extracted from the electronic health record and an internally maintained, HIPAA-compliant log managed by medical student coordinators.

Results: In 2025, HTWC served 165 unique patients across 220 encounters at 33 clinics, staffed by 15 providers (11 MDs, 4 APPs) and 40 medical student volunteers. Patients were 56.8% English-speaking, with a median age of 38 (IQR 30–48). Screenings included 35 HIV tests (0% positive), 86 Pap smears (30% abnormal), and 85 vaginal infection screens (28% abnormal). STIs accounted for approximately one-third of vaginal infections: 3.9% gonorrhea, 15.4% Trichomonas, and 11.5% Chlamydia. Non-STIs, including bacterial vaginosis and yeast, comprised the remaining 19%.

Discussion: Preventive gynecologic screening at a student-run clinic for underinsured patients showed higher rates of abnormal Pap smears and similar STI positivity compared with previous studies. These findings demonstrate effective service utilization and highlight the role of student-run clinics in delivering safety-net preventive care when supported by appropriate follow-up systems.

#8

Trends in the Inactive Kidney Transplant Waitlist and Implications for Candidate Survival (2005-2023)

Hu C, Pastan S, Harding JL

Introduction: The kidney allocation system (KAS), introduced in December 2014, let candidates earn waiting time from dialysis start, not just listing date, reducing early listing for waiting advantage. In 2020, KAS250 removed donor service areas, replacing them with a 250 nautical mile radius around donor hospitals for kidney distribution. Whether these changes affected waitlist management and outcomes over time is unknown.

Methods: We identified adult first-time KT candidates from SRTR between 2005 and 2020, with follow-up through 2023. Candidates were categorized into four groups based on time-varying active status: always active, initially active then inactive, initially inactive then active, and always inactive. Primary outcomes were likelihood of 3-year transplant (living or deceased), death, and death before transplant.

Results: In 408,034 KT candidates, mean age was 52.7 (±13.0) years, 61.6% were men, 28.7% were Black and 32.3% had type 2 diabetes as the primary cause of their kidney failure. The proportion of always active candidates dropped from 57.3% in 2005 to 40.6% in 2020, while inactive-to-active rose from 10.8% to 18.7%. Active-to-inactive increased from 26.4% to 29.7%, and always inactive grew from 5.5% to 11.1%. The proportion of candidates receiving a transplant within 3 years increased over time in all groups, except always inactive candidates who had variable rates from 2005 to 2020. The proportion of candidates who died within 3 years of waitlisting decreased from 2005 to around 2015, then steadily increased in all four groups, similar to death prior to transplant.

Conclusions: Despite incentives to reduce initial patient lists inactive, they continue to make up a growing waitlist, negatively affecting transplant outcomes and mortality.

#9

Influence of Asthma on Racial and Ethnic Disparities In Mental Health Care Among Adolescents with Depression

Ramos C, Wen H, Cummings J

We investigated whether racial/ethnic disparities in mental health treatment differ by asthma status among adolescents with depression using

2022–2023 NSDUH data. Logistic regression models examined five mental health treatment indicators: medical care setting, prescription medication, telemental health, school-based services, and outpatient care.

The sample included 3,654 adolescents aged 12–17 with past-year depression (72.4% female; 12.1% with asthma). This sample was 59.9% White, 28.1% Hispanic, and 12.0% Black. Among adolescents without asthma, Black (marginal effect [M.E.] = −24.9; CI: −29.8, −19.9) and Hispanic (M.E. = −11.2; CI: −17.2, −5.2) were less likely to use prescription medication compared to White (predicted percentage [pp]= 35.1%). Black adolescents were less likely to use outpatient mental health services (M.E. = −22.4; CI: −29.9, −14.8) relative to White peers (pp = 53.0%). Among adolescents with asthma, disparities narrowed for Black and widened for Hispanic. Disparities for Black adolescents in medication use (M.E. = −9.1; CI: −30.8, 12.6) compared to their White peers (pp = 47.1%) narrowed and were no longer significant. Outpatient disparities (M.E. = −18.8; CI: −39.9, 2.29) compared with White peers (pp= 54.3%) also narrowed and were no longer significant. Disparities for Hispanic adolescents widened, and they remained less likely to receive prescription medication (M.E. = −19.6; CI: −37.7, −1.5) relative to their White peers (pp = 47.1%).

These findings may reflect heterogeneous barriers to mental health care. Integrating mental health screening into asthma management may improve detection and service use. However, culturally competent care and structural barriers to mental health must be addressed to reduce disparities for Hispanic adolescents.

#10

Trust, Mistrust, and Willingness to Participate in HPV Vaccination Research among U.S. Vietnamese Families: A Community-Engagement Qualitative Study

Tran D, Giang HA, Espinoza V, Nguyen N, Tran C, Vu M

Background: The U.S. Vietnamese community experiences disparities in HPV-related cancers, yet adolescent HPV vaccination remains suboptimal. Trust in healthcare systems and research institutions shapes preventive care and research participation. This formative qualitative study examines how trust, perceived risk, and participation expectations influence engagement in HPV vaccination research among U.S. Vietnamese families.

Methods: We conducted a formative qualitative analysis of 34 semi-structured interview transcripts to inform a larger HPV vaccination study targeting Vietnamese families. Participants included Vietnamese parents of adolescents, healthcare providers, and leaders from Vietnamese community organizations. Interviews explored HPV vaccination perceptions, attitudes toward research participation, and preferences for recruitment, consent, data collection, and digital modalities. Transcripts were analyzed using inductive thematic analysis to identify barriers and facilitators.

Result: Six analytical themes emerged: trust/trustworthiness, linguistic accommodation, communication engagement, contact frequency, content quality, and psychological experience. Participants reported high trust in clinicians and community-based organizations, alongside skepticism toward unfamiliar, especially government-affiliated, research entities. Concerns included data privacy, language barriers, and scams. Parents emphasized culturally and linguistically concordant communication, clear study purpose, and data use transparency.

Conclusion: Trust-building, transparency, and community partnership are essential for engaging U.S. Vietnamese families HPV vaccination research and for designing culturally responsive recruitment and data collection strategies to advance vaccination equity.

#11

Real World Utilization of Live-brpk (VOWST) among Patients with Recurrent Clostridioides difficile Infection: Single Center Experience

Siskin D, Sternthal J, Mehta N, Kraft CS, Wray L

Recurrent Clostridioides difficile infection (rCDI) is facilitated by the depletion of key bacterial taxa in the gut microbiome. Live-brpk is an oral therapy of encapsulated Firmicutes spores administered following antibiotics for Clostridioides difficile to prevent rCDI. Since live-brpk was FDA approved in 2023, there are few reports of the outcomes of this therapy outside of clinical trials, which excluded several high-risk groups, including immunocompromised patients.

We evaluated outcomes in adults referred for rCDI to the Infectious Diseases Clinic at Emory University. Patients were given a choice between live-brpk, live-jslm, and while available, fecal microbiota transplantation and bezlotoxumab. Patient demographic and clinical information was obtained through interview and chart review. Twenty-two individuals received live-brpk for the treatment of recurrent CDI; 55% were female with a median age of 69 years. 60% of patients had renal disease, 36% of patients were immunocompromised, including four patients with a history of solid organ transplantation, and one with recent stem cell transplantation. 45% of patients had greater than five lifetime episodes of CDI.

No patients had recurrence of CDI within eight weeks after receiving live-brpk. Five patients recurred within six months, one of these patients was immunocompromised. Three patients received a second dose of live-brpk and remained free from recurrence for at least eight weeks. No patients reported side effects requiring medical care. Among patients with high lifetime incidence of rCDI, following live-brpk >70% of patients did not have CDI recurrence six months after therapy. Immunocompromised patients were treated safely in this cohort and had a similar recurrence rate as non-immunocompromised patients.

#12

A Framework for Patient Access Management: Consensus from a Delphi Panel of US Health System Leaders.

Woodcock E, Profeta C

Background: Patient access management in the ambulatory setting is important for health systems as waits and delays lead to reduced health outcomes, inequity, and poor patient experience. Health systems may benefit from a framework that catalogs the determinants of access management in the ambulatory setting to deliver timely care to all patients.

Methods: The aim of this research is to define patient access and document the determinants of patient access management through a consensus from a two-stage Delphi panel of access leaders in US academic health systems and children's hospitals.

Results: The study demonstrates a patient-centered definition of patient access management focusing on the delivery of timely, simple, connected access to care. Twelve major determinants were identified for patient access management: executive leadership support, dedicated access leadership, system strategy prioritization, data collection and analysis, contact center management, capacity management, appointment availability, appointment accuracy, measurable and defined goals, simplification of system for patients, timely offering of care, and patient-clinician connection. The determinants were applied to a framework using the Donabedian model. Frameworks may improve validity and reliability in performance improvement activities.

Conclusions: Health systems may benefit from prescriptive strategies to identify, diagnose, resource, and address the determinants that constitute patient access management. Additional research is warranted to understand each determinant.

#13

Early Diagnosis, Lower Costs: The Impact of Georgia Memory Net

Anglin E, Moore MA, Jungerman JM, Bender AA, Perkins MM

The cost of care for individuals living with Alzheimer’s disease and related dementias (ADRD) places a substantial burden on families and caregivers and is often exacerbated by delayed diagnosis and limited access to, or knowledge of, supportive resources. Georgia Memory Net (GMN), a state-funded dementia care program, aims to promote earlier diagnosis of ADRD and connect patients with community-based resources. In 2022, staff at four GMN memory assessment clinics across Georgia evaluated 336 individuals for cognitive impairment, developed individualized care plans, and transitioned patients back to their primary care providers for ongoing management.

To evaluate whether GMN participation was associated with reduced healthcare costs in their first year of care with GMN, we analyzed Medicare claims data from the Centers for Medicare and Medicaid Services. A cohort of 108 GMN patients, along with a comparison group matched on age, gender, area of residence, and comorbidity burden, were identified and followed throughout 2022. We then tabulated total cost of care and Medicare expenditures across inpatient, emergency department (ED), and outpatient settings for both groups. Total costs for the comparison group were more than three times higher than costs associated with GMN patients ($2.3M vs $7.4).

Medicare expenditures were almost twice as high in the comparison group ($1.1M vs $2.1M). These findings suggest that GMN participation may be associated with reduced healthcare costs among individuals with ADRD. Future analyses will incorporate additional years of data and longitudinal follow-up to assess differences in downstream costs of care for these two cohorts.

#14

Health Shocks and Advance Care Planning Among U.S. Older Adults: Evidence from HRS 2012–2022

Yang H, Graetz I, Jiang C, Jiao B, Kavalieratos D, Wang N, Yabroff R, Hu X

Background: Advance care planning (ACP) allows individuals to document preferences for medical care, yet engagement among older adults remains limited. Health shocks, such as cancer diagnosis and major illnesses, may prompt ACP participation. This study examines associations between health shocks and subsequent ACP engagement and variation by sociodemographic characteristics.

Methods: We conducted a longitudinal cohort study using 2012–2022 Health and Retirement Study data among adults with no baseline ACP who completed ≥1 follow-up wave. The exposure was a new health shock (cancer diagnosis, stroke, heart disease, or hospitalization). The outcome was new ACP engagement. Generalized estimating equation models estimated adjusted odds ratios for associations between health shocks and ACP.

Results: Among 8,553 person-wave observations, median age was 74 years; 52.9% were women, 27.6% experienced a health shock. Health shocks were associated with higher odds of ACP engagement (OR = 1.41; p<0.001). Older age, female gender, and higher education were associated with greater ACP engagement. Non-Hispanic Black (OR = 0.73; p<0.001) and Hispanic (OR = 0.55; p<0.001) respondents had lower odds of ACP compared to non-Hispanic Whites. Living alone was associated with higher ACP engagement (OR = 1.29; p<0.001). Associations between health shocks and ACP were similar across subgroups, except those living alone showed larger effects (OR=1.76 vs. 1.31, p<0.001).

Conclusions: Health shocks were associated with new ACP engagement, yet sociodemographic disparities persisted. This highlights the importance of leveraging health shocks as clinical touchpoints for ACP discussions and the need for targeted solutions to ACP inequities.

#15

The Impact of Mandatory Bundled Payment on Prehabilitation Delivery for Lower Extremity Joint Replacement

Reiff JS, Marr J, Wolff JL, Mroz T, McGready J, Schrack J, Reider L

Objective: To determine the effect of bundled payment for inpatient lower extremity joint replacement (LEJR) on preoperative rehabilitation (“prehabilitation”) delivery.

Design: Difference-in-differences analysis comparing the proportion of hospitals delivering LEJR prehabilitation before and after implementation of the Comprehensive Care for Joint Replacement (CJR) mandatory bundled payment model in CJR treatment versus control areas in the United States.

Participants: 62,217 Medicare beneficiaries who received an incident elective inpatient LEJR between July 1, 2015 and December 31, 2017 and were continuously enrolled in Medicare fee-for-service 6 months preceding surgery at 945 hospitals (560 CJR control, 385 CJR treatment), identified in claims from a 20% random sample of Medicare beneficiaries

Intervention: CJR mandatory bundled payment model for LEJR

Main Outcome Measures: Proportion of hospitals delivering prehabilitation, defined as at least two patients receiving qualifying preoperative rehabilitation services in a given quarter

Results: The average quarterly proportion of hospitals delivering LEJR prehabilitation increased in both CJR treatment (from 8.94% to 14.62%) and control areas (from 10.19% to 12.72%). In adjusted difference-in-difference analyses, we observed a 3.46 (95% CI, 0.26 to 6.65) percentage point greater increase in the average proportion of hospitals delivering prehabilitation in CJR treatment areas relative to control areas after implementation.

Conclusion: Implementing mandatory bundled payment promoted an increase in LEJR prehabilitation delivery. Future research should explore the role prehabilitation may play in supporting quality outcomes while reducing episodic spending.

#16

Using Ethnographic Decision Tree Modeling As a Method for Understanding Maternal Substance Use Policy Implementation

Caton L, Krans E, Patrick S

Introduction: State punitive maternal substance-use policies—defining prenatal substance exposure as child abuse or mandating infant drug exposure reporting—deters maternal treatment engagement. Yet hospitals may interpret these mandates more selectively to reduce liability. The clinical decision-making processes underlying hospital–state discrepancies remain poorly understood.

Methods: We used ethnographic decision-tree modeling (EDTM) to examine variation in hospital implementation of substance-exposed infant reporting. Using semi-structured interviews—of 30 hospital administrators, clinicians, and state agency staff in Atlanta—we mapped decision pathways across organizational levels, identifying key decision nodes that shape how reports are filed.

Results: Provider-level models revealed substantial heterogeneity, with 12 decision nodes shaped by ethical considerations, institutional liability, and ambiguity in hospital policy. Clinicians described trade-offs between punitive adherence and perceived patient benefit. Hospital administrators demonstrated fewer (8) nodes centered on protocol and risk management, while state administrators reported more standardized rules (5), reflecting greater structural clarity at the state level. Across groups, moral reasoning, perceived legal risk, and definitions of “risk” based on substance test results emerged as central determinants. Validation testing in a subset (n=8) demonstrated high predictive accuracy (83%).

Conclusion: Variation in reporting decisions suggests insufficient clarity across state and hospital policies, contributing to heterogeneous reporting and substantial cognitive burden for clinicians. EDTM clarifies how institutional context and moral reasoning shape implementation under punitive policy environments.

#17

Hospitalist Knowledge Gaps Regarding Continuous Glucose Monitoring (CGM) Uses

Guevara-Bermudez LP, Hanna J, Kirkconnell Hall MA, Flores I, Shabbir H, Hwang P

Background: Continuous glucose monitoring (CGM) reduce the risks of hypoglycemia/hyperglycemia, glycemic variability, and improves quality of life. The American Diabetes Association recommends continuing personal CGM devices, when appropriate, alongside point of care glucose checks. Despite these recommendations, hospital systems lack protocols for inpatient CGM use and hospitalists infrequently prescribe CGM devices.

Methods: To educate hospitalists about CGM use, we provided 2 workshops in 2 settings: Atlanta Region Chapter of the Society of Hospital Medicine (SHM) meeting, and at the Southern Hospital Medicine Conference (SoHMc). Participants took a pre-session multiple-choice survey assessing their knowledge of CGMs. We performed a descriptive statistical analysis in Excel.

Description: 37 of 51 were somewhat or very familiar with the operation of CGM devices. Only 28 were somewhat/very comfortable interpreting the data. 4 respondents were very confident in identifying eligible patients. Only 1 person at the conference knew which clinical scenarios and medications could interfere with CGMs. 3 knew which devices need to be removed for imaging procedures. Most (40 of 51) were unsure or confirmed their hospital had no specific policy or protocol for CGM use. A small majority (57%) had recommended or prescribed a CGM for in the past. The proportions of hospitalists who had done so at the SHM chapter meeting was higher (67%) than at the SoHMc (33%). While nearly a quarter of the SHM Chapter members were very comfortable interpreting CGM data, none of the SoHMc workshop attendees were.

Conclusions: To align hospital practice with current clinical recommendations regarding CGM use requires focused clinician education and standardized institutional protocols.

#18

Telehealth Experiences and Outcomes in Oncology Care: Findings from a Pilot Survey Study

Elshafie S, Clemmons A, Krenz ZM, Bynum K, Zuber M, Villa Zapata L

Background: Telehealth may reduce barriers to care, yet real-world utilization and patient-reported outcomes remain poorly characterized. This study assessed telehealth utilization, patient experiences, and associated outcomes among cancer patients.

Methods: This cross-sectional pilot study included patients receiving care at Wellstar Georgia Cancer Center (November-December 2025). Surveys included demographics; telehealth use and barriers; selected Telehealth Usability Questionnaire items; medication adherence; treatment-related symptoms; and financial toxicity measured using the Comprehensive Score for Financial Toxicity (COST). Descriptive statistics summarized responses, and bivariate analyses evaluated differences in outcomes by telehealth use.

Results: Among 53 participants (median age 68 years; 50% female; 19% rural), 26% reported using telehealth. Most participants (74%) reported no barriers; lack of awareness of available options was the most common barrier (8%). Despite limited utilization, 62% perceived telehealth benefits in improving access or reducing travel burden, 60% reported satisfaction, 51% ease of use, and 23% perceived reliability. Medication adherence was high (85% fully adherent), and 49% reported at least one treatment-related side effect. Median COST score was 19, indicating moderate financial toxicity. Outcomes did not differ significantly by telehealth use, though telehealth users reported higher symptom burden (64% vs 44%).

Conclusions: Telehealth use among cancer patients was low despite favorable patient perceptions and minimal reported barriers. Findings highlight the potential role of telehealth in symptom monitoring and the need for larger studies to identify determinants of telehealth use and its patient-reported outcomes in oncology.

#19

Comparing Hospital Length of Stay for Patients with Catatonia Before and After the Intravenous Lorazepam Shortage

Sarkozy M, Gensler L, Robbins-Welty GA

Catatonia is a complex, potentially life-threatening psychomotor syndrome, characterized by a constellation of motor, behavioral, and autonomic symptoms. In the inpatient setting, the primary treatment for catatonia is intravenous (IV) lorazepam, which has shown high efficacy in symptom resolution. In April 2025, a national shortage of IV lorazepam was announced, leading to reported clinical challenges such as an increased reliance on alternative benzodiazepines and a greater need for oral lorazepam administration. However, to our knowledge, no studies have directly evaluated the impact of this shortage on hospital length of stay.

We utilized an electronic medical record tool (“SlicerDicer”) to identify all admissions of patients with catatonia (based on ICD-10 codes) to a combined medicine-psychiatry unit (MPU) between October 2023 and January 2026. 70 admissions were evaluated, divided into two cohorts: those admitted before (Group A: 49 admissions) and those admitted after April 2025 (Group B: 21 admissions). Mean age was 32.5 years in Group A and 47.2 years in Group B (p=0.003). The proportion of females was 53.0% in Group A and 66.7% in Group B (p=0.29). Medical comorbidities were assessed using the Charlson Comorbidity Index. The average length of stay in the MPU was significantly longer in group B compared to group A (13.0 days vs. 22.3 days in Groups A and B, respectively, p=0.040).

Our preliminary data suggest the national IV lorazepam shortage has had a tangible impact on the quality of care of hospitalized patients with catatonia, including prolonged hospitalizations. Further research is needed to elucidate the extent of the shortage’s effects on inpatient outcomes, as well as to study safe and effective treatment options beyond IV lorazepam.

#20

Exploring Patients Needs to inform AI Assisted Heart Failure Patient Education Tool

Shaik MA, Ergai A, Eghbalizarch M, Cho S

Heart failure (HF) remains one of the leading causes of hospitalization in the United States. Managing HF requires patients to understand complex medication regimens, dietary restrictions, symptom monitoring, and when to seek medical care. Although education is provided during hospitalization, many patients feel overwhelmed and struggle to retain information after discharge. As a result, preventable complications and 30-day readmissions remain common. At the same time, clinicians face time pressures, staffing shortages, and frequent interruptions that limit the effectiveness of inpatient education.

This study aims to better understand hospitalized HF patients’ educational needs to inform the design of an AI-assisted patient education tool. Using a human factors approach, we are conducting semi-structured interviews with patients, nurses, and physicians, along with structured observations of education and discharge interactions at a regional hospital in the southeastern United States. Participants are purposively sampled to capture variation in age, gender, health literacy, and socioeconomic background. Interviews explore patients' understanding of their diagnosis, medications, diet, and symptom monitoring, as well as their learning preferences. Observations document communication strategies, workflow constraints, and environmental factors that shape educational encounters.

Findings are expected to identify key information gaps and systemic barriers. These insights will guide the development of an adaptive AI-supported platform designed to reinforce education, improve care transitions, and support better self-management outcomes.

#21

Validation of an Ecological Momentary Assessment (EMA) Protocol to Reduce Recall Biases in Social Contact Data Collection

Pozzo NS, Kaplan DM, Scott T, Bruck M, Arconada Alvarez SJ, Ahmed SA

Background: Accurately measuring social contacts that may transmit diseases is crucial for effective public health interventions. Social contact data collection methods have been historically limited to retrospective self-report surveys. Participant recall bias and the time burden associated with completing this type of survey pose challenges.

Objective: To address these limitations, a cross-over study funded by a Center for Forecasting and Outbreak Analytics grant (CDC-RFA-FT-23-0069) aimed to validate an ecological momentary assessment (EMA) protocol for social contact tracing within the United States using Fabla. Fabla is a mixed-method EMA platform that combines quantitative momentary ratings with qualitative audio diary data collection.

Methods: Participants across the state of Georgia (n=106) were recruited into a study that included 4 days of data collection: 1x/day retrospective survey using a traditional social contact survey for 2 days and 10x/day Fabla EMA contact surveys for 2 days. A participant sub-set (n=20) was interviewed to identify responding differences between the traditional social contact survey and EMA.

Results: Participants completed an average of 1.5 out of 2 social contact surveys during the "traditional" data collection period and averaged 10.66 EMA surveys during the EMA period. Key barriers to completion include the number of daily assessments and a limited completion window. Key facilitators include an accessible app user interface and survey length.

Discussion: EMA-based social contact surveys may decrease instances of participant recall bias and result in increased accuracy of reporting. However, challenges include participant burden. Special attention should be paid to longer survey window durations and simplified wording.

#22

Machine-Learning Algorithm to Identify Carriers of the G6PD rs1050828 Variant in African American Men

Xue Q, Shao Y, Li P, Li Z, Phillips L, Shao, H

Introduction: The African-specific G6PD variant rs1050828-T results in G6PD deficiency, which lowers HbA1c independently of glycemia. risking diabetes underdiagnosis and undertreatment in African American (AA) individuals. We aimed to develop a machine-learning algorithm using routinely collected electronic health records to identify G6PD variant carriers among AA men.

Methods: We analyzed 5,981 AA men from the All of Us (AOU) Research Program (11% rs1050828 hemizygotes). Predictors included HbA1c, outpatient random plasma glucose, hemoglobin glycation index, demographics, other laboratory results, and antidiabetic medications and comorbidities recorded 2 years before AOU enrollment. A random-forest classifier was tuned via cross-validation on a 75% training set and evaluated on the held-out test set. External validation was performed in the UK Biobank (UKB).

Results: Among the 5,981 AA men analyzed, the saturated model (62 variables) demonstrated strong discrimination for identifying rs1050828 hemizygotes (AUC 0.89). A parsimonious model using the top 4 predictors—HbA1c, glucose, red cell distribution width, and age—retained high performance (AUC 0.87), offering a scalable clinical alternative. When translated into a 1–20 clinical risk score, the parsimonious model shown distinct risk stratification; a risk score threshold of ≥18 yielded robust prediction (Sensitivity 93%, Specificity 95%, PPV 68%, NPV 99%). External validation in the UKB showed higher discrimination (AUC 0.94); at the same threshold, performance remained strong (sensitivity 94%, specificity 99%; PPV 94%, NPV 99%).

Conclusion: This high-yield algorithm provides a scalable solution for targeted genotyping where universal screening is infeasible.

#23

Assessing Post-Exertional Malaise in Long COVID and ME/CFS: A Scoping Review

Wang R, Tsai W, Khambhati P, Slavin MD, Kazis L, Krishnan S

Post-exertional malaise (PEM) is a defining feature of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and is increasingly recognised in Long COVID. It involves a disproportionate, delayed, and prolonged worsening of multisystem symptoms following minimal physical, cognitive, or emotional exertion. Beyond fatigue, PEM commonly includes cognitive dysfunction, pain, sleep disturbance, autonomic symptoms, and flu-like features. Although now central to contemporary diagnostic criteria, earlier case definitions varied in how PEM was defined or required, contributing to heterogeneity in research and clinical identification.

PEM is associated with marked functional impairment, including reduced physical endurance, cognitive capacity, and social participation. Greater severity is linked to higher overall symptom burden, fatigue interference, and mood disturbance. However, delayed onset, variability in presentation, and the absence of objective biomarkers complicate assessment. Under-recognition may lead to inappropriate management and cumulative symptom worsening.

This scoping review maps the literature on PEM assessment in ME/CFS, CFS, and Long COVID. It evaluates the strengths and limitations of current methodologies and synthesises how PEM has been operationalised across studies. Using the International Classification of Functioning, Disability and Health framework, the review characterises the clinical presentation and functional impact of PEM. By identifying gaps and inconsistencies, it aims to inform the development of robust, multidimensional patient-reported outcome measures that capture the distinctive features of PEM.

#24

Disaggregation of Socio-demographics, Comorbidities, and Health Services Utilization Among Asian Immigrants in the United States.

Borate SN, O'Neal M, Tan CJ, Li N

Data on Asian American (AA) immigrants are predominantly grouped either as “Asians” or “Others”, preventing a better understanding of their differences. This study disaggregates first-generation AA immigrants' socio-demographics, comorbidities, and health services use, using the Understanding America Study (UAS) survey.

We conducted a cross-sectional analysis of UAS Health and Retirement Survey’s Wave 4 data. First-generation immigrants included either East Asians (EAs), Southeast Asians (SEAs), or South Asians (SAs). We calculated weighted descriptive statistics and conducted χ^2-test for subgroup differences. The weighted sample (510 participants) consisted of 44.0% EAs, 28.4% SEAs, and 27.6% SAs. A master’s degree or above was attained by >40% of SAs, followed by EAs (37.0%) and SEAs (15.2%) (p=0.008). Across the three groups (p=0.039), SAs had a relatively even income distribution across categories, while EAs and SEAs had more participants in the lower-income categories.

We found no significant differences across the subgroups in the prevalence of depression (10.9%), diabetes (15.6%), hypertension (28.3%), and hypercholesterolemia (22.6%). Across the subgroups (p=0.245), 50.4% had private health insurance, followed by public health insurance (23.8%) and no insurance (8.9%). Around 12% uninsured participants were SEA immigrants. Around 40% of the participants had 1-4 doctor visits in the past two years, followed by 5-19 visits (31.3%), and 0 visits (23.5%) with no statistically significant difference across subgroups (p=0.664). AA immigrant subgroups differed in socioeconomics, while comorbidities and healthcare utilization appeared similar.

Our findings support the disaggregation of AA immigrants when collecting and interpreting their data.

#25

Towards Zero Harm: A System-Wide Initiative to Improve Hospital Mortality

Millwee S, Quest T, Groff R, Hall MAK, Atoyebi P

Introduction: We sought to decrease misclassified observed mortality and increase accuracy of expected mortality (ratio of observed to expected deaths, given probability of death based on patient conditions documented in the chart). Inadequate documentation can falsely deflate this ratio, e.g., expected mortality is very different between a patient admitted for pneumonia, when Provider A documents “pneumonia,” vs. when Provider B more accurately documents “acute respiratory failure/aspiration pneumonia, obesity and hypertension.”

Methods: We leveraged our electronic health record (EHR) to capture common variables present on admission (POA) through use of a simple smartphrase that automatically populates variables that increase risk of mortality in admission notes to ensure that, if POA, they are documented. We then developed a dashboard to monitor the utilization of this smartphrase in admission notes, as well as tracking system-, hospital-, and provider-level mortality.

Results: The mortality index (observed deaths/expected deaths) as of September 1, 2024, was 0.86 (observed deaths=185, expected deaths=214.09). The overall mortality index decreased to a nadir of 0.5 in June 2025 (observed deaths=113; expected deaths=227.54); since initial implementation in April 2025, in all sites in all months, the observed deaths/expected deaths ratio has remained <1.

Discussion: Accurate documentation of conditions ensures that facilities and providers are correctly compensated for care provided and not penalized inappropriately for higher-than-expected deaths due to conditions POA but not documented. Smartphrase implementation is relatively simple and demonstrably effective in most EHRs, and impact on mortality index can be reliably monitored.

#26

Impact of Telehealth Use on Endocrine Therapy Adherence, Metastasis Incidence, and Healthcare Costs Among Women with Breast Cancer: A Claims-Based Cohort Study

Elshafie S, Villa Zapata L

Background: Opioid overprescribing has contributed to substantial morbidity, mortality, and healthcare costs in the United States. Regulatory efforts, including revisions to the opioid Risk Evaluation and Mitigation Strategy (REMS) in 2018, have targeted evidence-based prescribing practices. This study examined national trends in opioid prescribing by oncologists for Medicare Part D beneficiaries from 2014 to 2022 and assessed changes following the 2018 REMS update.

Methods: This cross-sectional study used data from the 2014-2022 Medicare Part D Prescriber Public Use Files. Opioid prescribing patterns were characterized by opioid type, oncologist subspecialty, geographic region, and rural-urban practice location. Interrupted time series analysis evaluated changes in prescribing trends before and after the 2018 REMS modifications.

Results: The analysis included 25,371 oncologists; the majority were male (66%) and specialized in hematology-oncology (47%). Oncologists issued over 9.4 million opioid prescriptions from 2014-2022, with long-acting opioids representing 18% of claims. Hematology-oncology specialists contributed the majority of opioid prescriptions. Those in the South and in rural areas had higher prescribing rates and longer supply durations. Overall, opioid prescribing by oncologists declined steadily between 2014 and 2022, with a significant immediate reduction following the 2018 REMS update and a sustained downward trend thereafter.

Conclusions: Opioid prescribing by oncologists for Medicare beneficiaries declined substantially over time, with a notable discontinuity after the 2018 REMS revisions. Persistent regional and rural-urban differences underscore the need for targeted policies and provider education to support safe, equitable cancer pain management.

#27

Community Led Development of Videos and Cookbooks to Address Infant Anemia in Refugee Communities

Alkozai M, Hau Dim E, Kapapa M, Moore T, Boden L, Goodson S, Videlefsky K, Rose E, Blake S, Young M, Rule A

Refugee children in Clarkston, Georgia, experience iron deficiency anemia at rates ten times higher than national averages. Data from a clinic serving refugee communities identified elevated iron-deficiency anemia prevalence among refugee children ages 12–24 months, prompting a deeper community assessment. Refugee Women's Network, Ethne Clinic, Emory University Rollins School of Public Health, and Department of Pediatrics formed a task force to launch a co-designed intervention.

Using a longitudinal, multi-community design, monthly focus groups were held with mothers from Congolese, Afghan, and Burmese communities (n=24). Sessions were co-facilitated by community members and academic partners at local sites. Each language group completed four sessions: 1) anemia and nutrition knowledge, 2) potluck with iron-rich foods, 3) cooking demonstration, and 4) filming in-language nutrition videos. Exit interviews assessed learning outcomes. Participants reported increased knowledge of anemia prevention, dietary strategies, and safe infant feeding. Mothers emphasized the value of hands-on learning and expressed a strong desire to share this information within their communities. In-language video content was identified as the most accessible and sustainable tool for peer education, especially across varying literacy levels. This initiative highlights the effectiveness of co-designed, experiential learning for refugee health education. Community-led programming enhances trust, cultural relevance, and relevance of materials. Replicating this model could extend nutrition education and improve pediatric health outcomes among refugee families nationwide. In the future, the project will assess the implementation and evaluation of resources in both clinical and community settings.

#28

Real-World Treatment Receipt of Medications for Opioid Use Disorder among Adolescents and Young Adults in U.S. Medicaid

Taj S, Rawal S

Background: Medications for opioid use disorder (MOUD)— buprenorphine, methadone, and naltrexone, are evidence-based treatments for opioid use disorder (OUD). However, real-world use among U.S. adolescents and young adults (AYA) remains poorly characterized, particularly within Medicaid, where policy and coverage differences may influence access.

Objectives:To describe annual receipt patterns of MOUD among Medicaid-insured AYA.

Methods: A retrospective descriptive cohort study using the Merative™ MarketScan® Multi-State Medicaid Database (2020–2023). AYA aged 12–25 years with OUD were identified using ICD-10 codes. The index date was the first OUD diagnosis within a calendar year, requiring ≥90 days of continuous Medicaid enrollment. MOUD receipt was identified using pharmacy and outpatient claims and categorized as buprenorphine only, naltrexone only, methadone only, multiple MOUD types, or no MOUD. Demographic characteristics were summarized overall and by treatment category.

Results: The cohort included 36,259 AYA with OUD. Overall, 36.6% received MOUD, while 63.4% received none. Buprenorphine was most common(26.9%), followed by naltrexone (5.7%), and multiple MOUD types (3.8%). Adolescents aged 12–17 years represented 2–8% of recipients, whereas young adults aged 18–25 years comprised 92–98%. Females accounted for 56% of buprenorphine receipt, 55% of naltrexone receipt, and 52% of no MOUD. White patients represented 70–73% of MOUD recipients compared with 61% of those receiving no MOUD.

Conclusions: MOUD receipt among Medicaid-insured AYA with OUD was low, with nearly two-thirds receiving no medication annually. Differences by age, sex, and race indicate uneven receipt of evidence-based care and highlight opportunities to reduce barriers and expand treatment access

#29

Experience of Birth Trauma and Attendance at the Postpartum Visit Among a Cohort of Women at Emory and Grady

Anderson S, Howard B, Young MR, Stafford J, Stanhope KK

Objective: The goal of this project is to estimate the effect of birth trauma on postpartum visit attendance.

Methods: We recruited 336 women during pregnancy to complete a web-based survey at 3 timepoints: during pregnancy, 12- and 24-weeks postpartum. During the 12-week survey, participants were asked if during labor, they believed either they or their baby were at risk of serious injury or death. Endorsing either of these questions is indicative of experiencing birth trauma. Using data from the electronic medical record, we linked participants' survey responses to their postpartum encounters. We created binary indicators of postpartum visit attendance, a primary or OBGYN outpatient visit in early (0-27 days), on time (28-84 days), and late (85-183 days) postpartum. We fit models using log binomial regression, adjusting for age, parity, delivery hospital, paid leave, hypertensive disorders of pregnancy, cesarean, and history of mental illness.

Results: 64 (19%) women endorsed birth trauma. In the unadjusted models, we found no difference in postpartum visit attendance for on time or late visits. For early visits, those with birth trauma were 1.93 (1.43, 2.55) times more likely to attend a postpartum visit than those without. In the adjusted model, this finding remained significant (RR:1.53, 95% CI:1.01, 2.26). For any visit during the first 6 months, those with birth trauma were found to be 0.24 (0.04, 0.92) times less likely to miss a postpartum visit, and 0.40 (0.14, 0.96) times less likely to miss an on-time visit.

Conclusions: Experiencing birth trauma was associated with increased postpartum care use in this sample, mainly during the early postpartum period which may be reflective of participants seeking care for issues that may have complicated the birth.

#30

Changes in Outpatient Mental Health Service Use Among Medicare Beneficiaries with Co-morbid Depression, Diabetes and Heart Disease After Cost-sharing Parity

Tetlow SM, Phillips VL

Depression (DEP) is associated with adverse health outcomes and high healthcare spending among Medicare beneficiaries with co-morbid

Diabetes Mellitus (DM) and/or coronary heart disease (CHD). The Medicare Improvements for Patients and Providers Act reduced cost-sharing for outpatient mental health services from 50% to 20%, creating parity with outpatient medical care in 2014.

Our objective was to assess parity effects by the presence of co-morbid DM and/or CHD among beneficiaries with DEP. We analyzed Medical Expenditure Panel Survey data using person-level sample weights from 2008-2019. We examined changes in service use, use among users, and expenditures. We used an interrupted time series design and specified Ordinary Least Squares, hurdle models using Logit and truncated Poisson, and two-part models using Probit and Generalized Linear Models.

The analytic sample included 2,701 Medicare beneficiaries aged ≥65 years with DEP, DM, and/or CHD, which corresponded to a nationally representative sample of 33,466,007 beneficiaries. Mean use increased significantly after parity from 0.186 visits per year (95% CI: 0.06, 0.31) among beneficiaries with DEP + DM to 0.804 visits per year (95% CI: 0.69, 0.92) among beneficiaries with DEP + BOTH. The latter group also experienced the largest increase in mean use among users after parity of 0.911 visits per year (95% CI: 0.16, 1.66).

Out-of-pocket expenditures did not increase significantly among any group. Parity was associated with increasing outpatient mental health service use without increasing beneficiary costs. The magnitude of change varied, with the largest increases experienced by beneficiaries with DEP and both DM and CHD. Beneficiaries with multiple conditions may be more sensitive to the price of mental health care.

#31

Association of Racialized Economic Segregation with Acuity and Severity at Initial Presentation among Children with Leukemia and Lymphoma

Falae T, Graetz I, Joski P, Lewis R, Jain T, Zhang L, Castellino S, Ji X

Background: Racialized economic segregation is linked to inferior adult cancer outcomes, but its impact on pediatric cancer outcomes is unclear. We examined the association of racialized economic segregation with severity and acuity at initial presentation among pediatric patients with leukemia and lymphoma.

Methods: We included 983 patients aged 1-20 years diagnosed with leukemia or lymphoma (2010-2018) and treated at Children's Healthcare of Atlanta. Segregation was measured by the Index of Concentration at the Extremes (ICE) and categorized into tertiles (tertile 1=most segregated areas; tertile 3=least segregated). Outcomes were 1) high acuity (intensive care unit [ICU] admission or ICU-level resource utilization within 72 hours, 2) high severity (leukemia: WBC ≥50,000 cells/µL or CNS involvement; Hodgkin lymphoma: stage III/IV; non-Hodgkin lymphoma: metastatic disease), and 3) high acuity and/or high severity. Multivariable logistic regressions estimated outcome differences across ICE tertiles.

Results: ICE tertile 1 had higher proportions of non-Hispanic Black patients (40.7% vs. 11.8%) and publicly insured patients (63.5% vs. 30.4%) than tertile 3 (p<0.001). Compared with tertile 3, tertile 1 was associated with higher likelihood of high acuity (25.7% vs. 15.9%; marginal effect [ME]=8.65 percentage points [ppt], 95% CI=2.51–14.78), high severity (33.2% vs. 23.0%; ME=9.21 ppt, 95% CI=2.63–15.78), and high acuity and/or high severity (46.0% vs 31.1%; ME=13.18 ppt, 95% CI=5.85–20.51).

Conclusions: Greater racialized economic segregation was associated with more acute and more severe presentation of pediatric leukemia and lymphoma, highlighting neighborhood structural conditions as upstream drivers of disparities in pediatric oncology.

#32

Promoting Voting and Civic Engagement Amongst Emory Medical Students

Durham T, Reimer C, Esposito F, Miller K, Rutledge R

Background: Students enter medical school with a drive to serve others and engage with the communities in which they will spend their critical years of training. However, the demands of the curriculum limits opportunities for civic engagement.

Methods: In 2024, two medical students, in coordination with Emory Votes, designed a pilot initiative to encourage voter registration in a targeted intervention offered at M1 orientation. In 2025, these now third year students trained two M2 students to continue this initiative at subsequent first year orientations.

Results: At the 2024 and 2025 medical student orientation, two M2 students guided interested M1s (>50 students in 2024, and >30 in 2025) to register to vote or update their registration, and informed them about opportunities to help register people in the Atlanta community and engage with local voting rights organizations. The pilot was well received, and the project leads worked with the Medical School admissions office to successfully enshrine the project as an official part of orientation.

Discussion: There is a strong and existing interest within the medical student body for advocacy surrounding voter registration, as well as enthusiasm to engage with their new community as they begin their medical training. Orientation provides an effective opportunity to establish connections between new students and local organizations along with encouraging civic engagement efforts.

Conclusions: The implementation of voter registration advocacy as a dedicated part of M1 orientation proved to be an effective method for promoting civic engagement in Atlanta. Training subsequent second-year medical students allows the project to remain consistent and sustainable.

#33

Palliative Care for Advanced Cancer under Privatized Medicare Market in the US and the Role of Provider Networks

Hu X, Jiang C, Kwon Y, Fang Q, Warren J, Han X, Yabroff R

Introduction: Despite guideline recommendation of early palliative care (PC) integration for patients with advanced cancer, its utilization remains low. Medicare is increasingly penetrated by private Medicare Advantage (MA) plans. But little is known about differences in PC between MA and Traditional Medicare (TM) and how restricted provider networks under MA contribute to these differences.

Methods: Using SEER-Medicare linkage, we identified Medicare beneficiaries aged≥66 years diagnosed with distant-stage breast, colorectal, lung, pancreatic, or prostate cancer in 2016-2021. The primary outcome was cumulative incidence of PC within 6-month of diagnosis. To assess the role of provider networks, we first assigned each patient a treating oncologist and then conducted 1:1 matching of MA and TM beneficiaries treated by the same oncologists. Multivariable Cox proportional hazards models estimated differences in PC receipt between TM and MA, before and after matching, adjusting for patient characteristics.

Results: Among 135,402 beneficiaries, 67.7% were enrolled in TM and 32.3% in MA; 7.3% were Hispanic, and 9.5% non-Hispanic Black. The 6-month cumulative incidence of PC was higher among MA than TM beneficiaries (13.3% vs. 9.3%), with an adjusted hazard ratio [aHR] of 1.39 (p<.001). PC use was particularly higher among patients in health maintenance organization plans (aHR=1.66, p<.001). After matching, 23,033 TM and 23,033 MA patients were included. Differences in PC were attenuated and statistically non-significant, with cumulative incidence of 11.0% and 10.4% among MA and TM, and an aHR of 1.05 (p=0.11).

Conclusions: PC billing was significantly higher among MA than TM beneficiaries, but these differences were substantially reduced after accounting for provider networks.

#34

Epidemiology of Pediatric Traumatic Brain Injury: Sex- and Mechanism-Specific Patterns from a Systematic Review

Bouchi Y, Wright J, Thomas S, Hayden B, Reisner A, El Hajj S, Kobeissy F, Tyndall J

Pediatric traumatic brain injury (pTBI) is a leading cause of morbidity and mortality in children, yet inconsistent reporting by sex, mechanism, and injury severity limits meaningful synthesis across studies. We conducted a systematic review of MEDLINE, Embase, and Scopus (1935–2022) identifying 652 U.S. studies comprising 134,025,377 pediatric participants to evaluate sex differences in etiology, severity, and outcomes across mechanisms of injury. Data were extracted into REDCap and stratified by sex, mechanism (sports, motor vehicle collisions [MVCs], falls, blunt/struck, other), injury severity, and outcomes using both study- and participant-weighted analyses. Sports-related TBIs represented 26.4% of studies but 72.4% of participants, reflecting large administrative datasets and predominantly mild injuries. In contrast, MVCs and falls accounted for fewer studies yet disproportionately contributed to moderate-to-severe injuries and mortality. Overall, 46.0% of participants were male, 28.7% female, and 25.3% had unspecified sex, with poorer sex reporting in non-sports mechanisms. Injury severity was unspecified in 58.1% of studies, and validated measures were infrequently reported (GCS 9.7%, ISS 10.4%).

Participant-weighted analyses confirmed that sports injuries were largely mild, whereas MVCs and falls carried greater severity. Overall mortality was 0.055% but approached 28% among severe TBI strata. Rehabilitation outcomes were reported in only 12.8% of studies. Although the literature is dominated numerically by mild sports injuries, severe and fatal pTBI cases are primarily driven by MVCs and falls, underscoring the need for standardized, sex-disaggregated, and mechanism-specific reporting to improve surveillance, care, and prevention strategies.

#35

The Impact of Mobile Community Screening on Free Clinic Engagement Among Uninsured Populations

Abuimweis Z, Lee S, Khan N, Abuimweis R, Hoque F, Chaudhry A

Uninsured individuals experience disproportionately high rates of uncontrolled cardiometabolic disease due to limited access to preventive care. Community outreach screening events may identify undiagnosed disease and serve as an entry point into longitudinal care, though follow-up rates remain poorly characterized.

We conducted a retrospective review of community outreach events organized by a volunteer-run, no-cost clinic over a 2-year period. Free blood pressure and point-of-care glucose screenings were offered at community events. Uninsured individuals meeting financial eligibility criteria were referred for clinic follow-up, and subsequent clinic engagement was assessed.

Across 16 outreach events, 556 individuals were screened. Blood pressure measurements were obtained in 496 participants, with 354 (71.4%) demonstrating elevated readings, including 204 (41.1%) with stage 1 hypertension, 137 (27.6%) with stage 2 hypertension, and 13 (2.6%) with stage 3 hypertension. Blood glucose screening was performed in 335 participants; 14 (4.2%) had values >200 mg/dL consistent with diabetes, and 51 (15.2%) had values of 140–199 mg/dL, for a total of 19.4% with impaired or diagnostic hyperglycemia. Of all individuals screened, 8 (1.4%) presented for clinic follow-up, with 4 establishing sustained care (≥3 visits). Common barriers included transportation challenges, work constraints, and inconsistent communication.

Community-based screening revealed a high burden of undiagnosed or uncontrolled hypertension and hyperglycemia among uninsured individuals. While outreach effectively identified at-risk patients, linkage to sustained care remained limited. Enhancing referral workflows and patient navigation may improve continuity of care and advance cardiovascular health equity.

#36

TAILORD Electronic Intervention to Improve Therapy in a Diverse Cohort of Patients with Heart Failure (TAILORD-HF) - A Study Design

Gillet AS, Speight CD, Dickert ND

Background: Evidence-based guideline directed medical therapy (GDMT) for patients with heart failure with reduced ejection fraction (HFrEF) is under-prescribed. Decision support tools have been studied to help bridge the gap between clinical evidence and real-world use for GDMT with mixed success. This paper describes a trial of modified GDMT checklist that is distributed to both patients and clinicians with the aim of evaluating its impact on GDMT intensification and identifying modifiable barriers and facilitators for its use.

Hypothesis: GDMT intensification will be increased by delivering an evidence-based checklist through the electronic medical record.

Design: TAILORD-HF is a trial conducted within one academic health system using a two-phase clinic-level parallel cluster randomized design. In Phase 1, patients in intervention clinics will receive the modified GDMT checklist via portal message. In Phase 2, clinicians in intervention clinics will also see an analogous GDMT list via EMR display. The primary outcome is intensification of GDMT. Clinicians and patients are interviewed to assess their experience with the checklist.

Discussion: TAILORD-HF will provide insights on the impact of a modified GDMT checklist on GDMT intensification in a real-world clinic population of patients with HFrEF. Additionally, the trial will provide novel information on patient and clinician perspectives regarding decision tools for GDMT intensification. Findings will enhance understanding of how to effectively deliver an EMR intervention for patients with HFrEF to address unmet needs around GDMT optimization, and in conjunction with other ongoing trials, deepen understanding of how to improve care of patients with heart failure.

Session Two

#1

Identifying Multimorbidity Patterns and Predictors of Healthcare Utilization Among Adults with Arthritis: A Machine Learning Approach

Namjoshi A, Zhang W

Background: Arthritis is a prominent cause of disability in the United States, frequently presenting with multiple comorbidities that influence healthcare utilization. Identifying patient characteristics that predict high resource use can inform targeted interventions.

Objective: To identify patterns of multimorbidity and social determinants among adults with rheumatoid arthritis (RA) and osteoarthritis (OA) using Classification and Regression Tree (CART) analysis and clustering techniques.

Methods: This cross-sectional study analyzed the NeLL electronic health record database including 72,611 adults (≥18 years) with RA or OA in 2019. Arthritis diagnoses were identified using validated ICD codes (Sears et al.). Charlson Comorbidity Index was calculated using the Quan algorithm. High utilizers were defined as top quartile of hospital encounters. CART analysis identified key predictors, and k-means clustering characterized patient subgroups. Predictors included demographics (age, sex, race, ethnicity, marital status), arthritis type, and comorbidity burden.

Results: The preliminary analysis identified mean age of 67.3 years and mean Charlson score of 1.1. CART analysis achieved 67.2% classification accuracy in identifying high utilizers. Charlson comorbidity score was a top predictor followed by arthritis type, RA status and age. Three patient clusters were identified: low risk (n= 53174, mean Charlson score = 0.5), high risk (n= 15547, mean Charlson score = 2.8), and moderate risk (n = 3890, mean Charlson score = 1.9) groups.

Conclusions: Understanding patterns of arthritis and their comorbidities, healthcare utilization patterns and the social determinants can guide strategies for equitable resource allocation for vulnerable populations.

#2

Multidisciplinary Perspectives on the Implementation Challenges and Strategies of an Eye-Tracking Device in an Integrated Primary Care Setting

Gonzalez Laca A, Kuhn J, Kim J, Ransom L, Menon N, Demetri B

EarliPoint has the potential to improve the efficiency of autism evaluations, alleviating waitlists, and facilitating earlier access to care.

Feedback from early adopters suggests that barriers interfere with the promise of EarliPoint. We anticipate identifying challenges that are affecting its implementation. This mixed methods study aims to harness methods from implementation science to identify, develop, and apply strategies to maximize the positive impact of EarliPoint within one early adopter site. We recruited participants clustered by role (e.g., caregivers, clinicians, care coordination staff). Participants engaged in a 4-hour focus group that consisted of: i) sociodemographic and professional background survey, ii) a group process mapping exercise to document the processes and challenges utilizing EarliPoint, iii) Failure Mode and Effects Analysis (FMEA) for each challenge, and iv) consensus building around solutions to the challenges. Challenges were determined as part of the FMEA exercise: participants assigned Severity (1=Insignificant, 5=Critical), Probability (1=Nearly Impossible, 5= Certain), and Detection (1=Certainly Detected, 5=Impossible) ratings for each challenge, and multiplied together to create a Risk Priority Number (RPN).

Preliminary findings from focus groups (n=8) indicated barriers and workflow challenges. Challenges included the lack of diversity among the characters depicted in the EarliPoint videos (m RPN rating=31.5), no current pathway to refer more complex cases to for specialty care (m RPN rating=24.8), and the limited assessment space for administration and storage (m RPN rating=21.3). Findings highlight the importance of refining processes when introducing new technology to maximize its impact for families, providers and systems.

#3

Intersectional Race and Sex Disparities in Provision of Kidney Transplant Information

Hugo AJ, Gompers A, Harding JL

Disparities in access to kidney transplantation exist by race, sex, and their intersection. This study examines intersectional racial and gender differences in the provision of transplant education, an early step in the transplant care continuum.

We identified all adults (aged 18-80) initiating dialysis between January 1, 2015, and September 30, 2018, from the United States Renal Data System. Patients preemptively transplanted, received a previous transplant, or missing information on key variables were excluded. Primary outcomes were being informed of a kidney transplant (yes/no) and, if not, whether this was due to psychological reasons (yes/no). Associations between sex, race, and each outcome were analyzed using crude odds ratios (ORs) and 95% confidence intervals (CIs).

Among 401,907 patients, 12% of White men, 12% of White women, 10% of Black men, 9% of Black women, 9% of Hispanic men, 9% of Hispanic women, 11% of other men, and 11% of women were not informed of transplantation. Compared with White men, White women had 7% higher odds of not being informed (OR: 1.07 [95% CI: 1.04, 1.10]), while Hispanic men had a 27% lower odds (0.73 [0.71, 0.76]), and other groups fell in between. Among those not informed, between 2% and 5% were classified as psychologically unfit across the same sex and race groups. Black men had a 26% higher odds of being deemed psychologically unfit than White men (1.26 [1.03–1.53]), with similar, but nonsignificant, estimates for Black women vs. White men (1.22 [0.99–1.50]).

Black men and women are more frequently deemed psychologically unfit compared with other racial groups. Efforts to improve equity in transplant education should consider both race and gender to address overlapping disparities early in the care continuum.

#4

Management of Early Pregnancy Loss in Outpatient versus Emergency Department Settings within an Academic Hospital System

Bagley A, Tillman CL, Flink-Bochacki R, Hailstorks T, Newton-Levinson A

Early pregnancy loss (EPL), defined as loss of an intrauterine pregnancy in the first trimester, occurs in 15% of pregnancies. Management options for missed abortion (prior to passage of pregnancy tissue) include expectant, medication, and procedural options. EPL-related visits account for 2.7% of all emergency department (ED) visits among reproductive-aged women. We compared treatment methods and timing between patients diagnosed with EPL in the ED versus outpatient settings. We conducted a retrospective cohort study within the Emory University hospital system from January 1 to December 31, 2024. Using Epic SlicerDicer, we randomly sampled 40 patients with a new EPL diagnosis for each month and included patients who were 18-50 years old with a first trimester missed abortion. We determined location of diagnosis (ED or outpatient OBGYN) and final treatment method. We defined time to treatment (TTT) as days from initial diagnosis to initiation of medication or procedural management, or to date of spontaneous passage for expectant management.

Of 480 patients sampled, 123 (25.6%) met inclusion criteria. Fifteen (12.2%) were diagnosed in the ED and 108 (87.8%) outpatient. Patients diagnosed in the ED most commonly received medication management (45.45%), while outpatients most frequently underwent procedural intervention in the operating room (54.28%). Median TTT was shorter for ED patients than outpatients at 1 day (IQR 0-7.5 days) [n=11] vs. 4 days (IQR 1-8 days) [n=72], p=0.32. While median time to treatment differed between ED and outpatient diagnoses, this was not statistically significant (p=0.32). Differences in timing and treatment method warrant further study to understand how diagnostic setting and system factors interact with patient preferences for EPL care.

#5

Differences in Heart Failure Patients With and Without Diabetes in the Home Healthcare Setting

Kang Y, Seeri A, Yoon E, Lee L, Henshaw L, Griggs SA

Introduction. Heart failure (HF) is a complex chronic disease often co-existing with other chronic diseases such as diabetes (DM), with comorbid DM prevalence ranging from 25% to 45%. Those with both conditions have a higher hospitalization rate and poorer prognosis. However, evidence on differences between patients with HF with and without comorbid DM in the home healthcare setting is limited.

Methods. This is a secondary data analysis of the Outcome Assessment Information Set dataset which contains standard home healthcare electronic records and is used to evaluate quality improvement and patient outcomes, including case-mix adjustment for factors affecting the outcomes. We employed descriptive statistics and score tests to confirm the proportional odds assumption for all variables with multiple levels, including demographic factors.

Results. Among 836 patients with HF, 372 had comorbid HF and DM. The median age was 79.5 years (IQR 70.2-85.9) with 56.8% female and 82.1% White. Patients with comorbid HF and DM had 1.44 times higher odds of a fall history compared to those without DM (OR=1.44, 95% CI: 1.06-1.94, P=0.02). Additionally, the odds of finding problems during drug review in patients with HF and comorbid DM were 1.32 times higher than those without DM (OR=1.32, 95% CI: 0.99-1.76, P=0.06, marginally significant).

Conclusions. This study demonstrates a higher risk of falls and in patients with HF and comorbid DM likely due to declines in sensory function from a common diabetes complication neuropathy and chronic hyperglycemia. Home healthcare clinicians should prioritize proactive fall risk assessments and tailored interventions for this high risk population from the initiation of care to ensure safer management of both HF and DM to improve patient outcomes.

#6

Ethnoracial Variation of Peer Recovery Support Services Utilization for SUD

Villongco C, Druss BG

Introduction: Minority individuals receive less substance treatment than White individuals(1). Peer recovery support services (PRSS) are services delivered by individuals in recovery with lived experience of substance use disorder (SUD) (2, 3). PRSS are effective at engaging underserved and hard to reach populations (4, 5). This study compared utilization rates of PRSS in Minority and White individuals.

Methods: This study sampled individuals aged ≥ 18 who met criteria for SUD based on the DSM-5 criteria, from the 2022-2023 National Survey of Drug Use and Health. Design-based analysis generated nationally representative and weighted estimates. Unadjusted percentages, confidence intervals, and multivariate logistical regression described past year PRSS based on race/ethnicity (White, Black, Hispanic, Asian American and Pacific Islander (AAPI), Native American/Alaskan Native, and Multiracial/ethnic individuals and PRSS (past year peer support specialist or recovery coach). Regression analyses controlled for sex, age, income, insurance, education level, and history of past year mental illness.

Results: Unadjusted rates of PRSS utilization ranged from 6.22% (95% CI = 0.00-13.88) in Native American/Alaskan Native individuals to 0.94% (95% CI = 0.00-2.17) in AAPI individuals with rates of 3.73% (3.19-4.26) in White participants. Adjusted analyses found Black (aOR = 0.58, 95% CI = 0.40-0.84, $p < 0.05$) and Hispanic (aOR = 0.51, 95% CI = 0.29-0.89, $p < 0.05$) individuals utilized PRSS services significantly less than White individuals.

Conclusions: Black and Hispanic individuals use PRSS less than White individuals. More research is needed to understand the unique needs of minority subpopulations for peer support services.

#7

Recorded Heights and Weights in the Critically Ill- an Exploratory Retrospective Analysis of Medical ICU Patients at Grady Memorial Hospital

Crosley, E, Arant C, Esper A

Background: Height and weight measurements are essential for inpatient care, particularly in the intensive care unit (ICU) where high-risk interventions utilize dosing and predicted body weights. Hospital policy typically mandates height and weight recording in the Emergency Department (ED) and ICU. However, entered data is often inconsistent. There is limited research on how healthcare systems collect anthropometric data, potential impact on patient outcomes, and opportunities to improve measurement reliability.

Objectives: The aim of this study was to (1) Understand practices for initial height and weight measurements in Grady Memorial Hospital (GMH) medical ICU patients (2) Evaluate measurement differences in the ED versus ICU (3) Determine patient factors associated with discrepancies.

Methods: This was an exploratory retrospective chart review of adult medical ICU admissions from January- February 2026 at GMH. Height and weight recorded values, timing, and measurement methods were analyzed from the ED and first 24 hours of ICU care.

Results: 112 patients were included- 70% male with a mean age of 62. Reasons for admission varied, the most common being sepsis (21%) and altered mentation (16%). 7% did not have a weight entered, and about half had weight recorded in only one location. The majority (60%) had no weight method recorded. 80% had a height, with values typically used from prior encounters. Obesity and intubation were associated with highly discrepant values (>10%) ($p<0.05$).

Conclusions: Recording of anthropometrics varies greatly during the initial phase of critical care. Certain patient and illness factors are associated with inaccuracies. Further research is needed to develop system-wide interventions.

#8

Development of a Centralized Department Website to Facilitate Information Sharing

Eyassu DG, Owen GS, Hardin KM, Mehta MP, Bouldin EI

Background: Department and residency information is frequently distributed across emails, shared documents, and informal communication. This leads to inefficiency and inconsistent access to clinical, educational, and administrative resources. This project aims to improve resident confidence in accessing clinical, educational, logistical, administrative resources through implementing an internal, centralized residency website.

Methods: A baseline survey was distributed to residents (n=17/22, 77.3%). Using a 5-point Likert scale (1 = not confident at all, 5 = completely confident), residents rated confidence across clinical (i.e. identifying landmark subspecialty papers), logistical, administrative, and research tasks. Based on identified gaps, a centralized website was developed to consolidate key information which is regularly updated and maintained. Post-intervention data collection is ongoing.

Results: Baseline mean confidence scores ranged from 1.5 to 4.6 across questions. Lowest confidence scores (1 or 2) were observed in identifying landmark subspecialty papers (n=16, 94.1%) and research opportunities (n=14, 82.4%). Questions on administrative/communication navigation demonstrated moderate confidence (mean 3.4) with greatest variability (range 2.7-4.6). After three months, there have been 13 unique views (59.1% of residents) and 339 total views to the website.

Conclusions: Prior to creating a centralized residency website, residents had variable and often low confidence in accessing critical resident resources. Implementation of a centralized digital hub is feasible and has been shown to be regularly utilized by residents. Ongoing evaluation of this resource will determine any measurable impact on resident confidence, efficiency, and performance.

#9

Machine Learning Typology of Longitudinal Palliative Care Use Among Patients with Non-Small Cell Lung Cancer

Yang H, Jiang C, Jiao B, Kavalieratos D, Hu X

Background: Palliative care (PC) improves quality of life among patients with advanced NSCLC. Despite guideline recommendations for early integration, PC use remains low and longitudinal patterns throughout the cancer trajectory are understudied.

Methods: Using SEER-Medicare linkage, we identified PC treatment status among decedents with distant-stage NSCLC (2016-2021) with ≥3-month survival and ≥1 PC visit. Hidden Markov Models inferred time-varying latent PC engagement states; hierarchical clustering identified distinct longitudinal utilization patterns. Multinomial logistic regressions examined differences in patient characteristics across clusters.

Results: Among 4,661 patients (50.9% female, 10.9% Non-Hispanic Black), we identified six PC trajectories: early initiators (months 1-3): early-continuous (n=774), early-moderate (n=1,147), early-low (n=501); intermediate initiators (beyond 3 months): intermediate-continuous (n=472), intermediate-low (n=770); and terminal-only PC (n=997). Early-continuous beneficiaries had highest MA enrollment (68.5%) and highest SES (30.1%). In adjusted analyses using early-continuous as reference, MA beneficiaries had lower odds of intermediate-continuous (OR 0.61), intermediate-low (OR 0.52), and terminal PC (OR 0.72). Highest SES quintile associated with lower odds of intermediate-low (OR 0.55) and terminal PC (OR 0.57). Females had higher odds of intermediate-low PC (OR 1.29).

Conclusions: MA enrollees and patients in higher SES neighborhoods were more likely to receive early-continuous PC, while females were more likely to initiate PC at intermediate timepoints after diagnosis. Future studies should examine how these patterns affect quality of end-of-life care and outcomes.

#10

Patient and Provider Perspectives on Contraceptive Counseling for Women with Sickle Cell Disease

Stevenson IC, Howards PP, Fasano R, Hailstorks TP, Thirkill M, Newton-Levinson A.

There is little research on the safety of hormonal contraception for people with Sickle Cell Disease (SCD). Evidence-based contraceptive guidance would help patients with SCD make informed decisions, but decisions are also shaped by factors beyond safety and effectiveness. The purpose of this study is to learn what factors affect patient decisions and guide clinicians in counseling.

We conducted a mixed-methods study to understand how women with SCD (n=139) think about contraception and what clinicians (n=7) consider when providing contraceptive contraception for patients with SCD. We surveyed SCD patients recruited from The Georgia Comprehensive Sickle Cell Center (2025-2026) about their opinions on contraception and their experiences with contraceptive counseling. We also conducted in-depth interviews with clinicians in Georgia who provided contraceptive counseling to patients with SCD, asking what they consider when counseling these patients.

Only 15% of participants reported being told that estrogen-containing birth control is unsafe for those with SCD, consistent with current guidance, whereas all clinicians reported emphasizing the risks of estrogen-containing birth control to patients with SCD. Although patients emphasizing trusting providers (81.6%) and medical websites (42.6%), around half of the clinicians thought patients trusted social media information sources. Most patients were not using contraception, but among those who were, male condoms, withdrawal, and progestin-only implants were most common. Clinicians suggested that their patients preferred Long-Acting Reversible Contraception options.

These results suggest potential communication gaps between clinicians and patients on contraceptive risk, information, and preferences.

#11

Exploring the Financial Value of Nurse Visits in Primary Care

Nikpour J, Annis A

While there is growing recognition of the importance of integrating registered nurses (RNs) into primary care, their collaboration with primary care providers (PCPs) remains inconsistent and poorly defined. Billing for nurse-only visits for low-acuity care, may support financial sustainability, yet little is known about their use or revenue. We examined the prevalence and revenue of nurse visits and identified patient panel and provider characteristics associated with billing. Using

Medicare Physician and Other Providers data, we constructed provider-level measures of nurse visit billing and reimbursement (CPT 99211) and estimated multivariable regression models adjusting for provider type, geography, panel demographics, & clinical characteristics.

Our sample included physicians (n=107,058), nurse practitioners (NPs) (n=112,478), and physician assistants (PAs) (n=52,132) in primary care, who received at least 50% of their Medicare reimbursement from primary care services. Fewer than 5% of PCPs billed nurse visits in 2023. Among billing providers, mean annual revenue was $1,646 (SD $5,866); the top 20% averaged $5,275 and the top 10% $8,011. Billing providers had larger panels (361.2 vs 201.4, p<.001) with lower mean risk scores (1.38 vs 1.19, p<.001). Adjusted analyses showed higher odds of billing among physicians vs. NPs (OR 3.4, CI 1.9–5.9) and PAs (OR 2.8, CI 1.4–5.3), and among micropolitan vs. metropolitan PCPs (OR 1.8, CI 1.1–2.9). Likelihood increased with panel size and patient age but decreased with higher risk and a greater percentage of non-White patients (all p<.001).

Greater uptake of nurse-led visits may require clearer billing guidance, RN role optimization, and reduced administrative burden, alongside evaluation of patient outcomes & financial value.

#12

Bridging Silos and Building Community: Reflecting on the Journey of the Southeastern Kidney Transplant Coalition Using the Community Based Participatory Research River of Life Tool

Taffe J, Blythe E, Pastan S, Fogel A, Urbanski M

Kidney transplant is the optimal treatment for patients with kidney failure; however, the rate of kidney transplant has historically been the lowest in the Southeastern U.S. In response, the Southeastern Kidney Transplant Coalition (SEKTC), an all-volunteer community partnership of stakeholders from Georgia, North Carolina and South Carolina, was founded in 2011 to address barriers in access to kidney transplant within the region.

The SEKTC includes patient partners, transplant and dialysis center clinicians, advocacy and regulatory agencies, and academic researchers. The SEKTC has collaborated on numerous projects and engaged in advocacy efforts. Most notably, they supported the development of a regional registry that captures novel data on the early steps towards transplant access. The SEKTC held their 14th annual meeting in October 2025, with the theme, “Stronger Together: Bridging Silos, Building Community.” Attendees engaged in a community-based participatory research exercise, the River of Life, which facilitated a collective reflection on the SEKTC’s history, current work, strengths, challenges, and long-term sustainability.

The exercise revealed themes celebrating the progress of the Coalition and outlined a plan for its future. Attendees emphasized the benefits and importance of data sharing and dissemination in current initiatives. Members also outlined aspirations of addressing social determinants of health and focusing more on patient perspectives/advocacy.

These reflections will be used to inform the future of the Coalition and further its mission of access and equity in kidney transplant. This presentation illustrates how the River of Life can be used as a tool to facilitate meaningful dialogue among stakeholders engaged in community research partnerships.

#13

Standardizing Discharge Instructions Among Head and Neck Patients Undergoing Transoral Robotic Surgery

Shah JP, Kinua AG, Fontenot AL, Daoud GE, Neptune NS

Background: High postoperative call and message burden among head and neck surgery patients overwhelms nursing staff. Many inquiries are preventable and relate to unclear pain expectations, diet concerns, drain and wound care questions, and inconsistent discharge instructions. This quality improvement project aimed to reduce postoperative encounters through standardized discharge communication for transoral robotic surgery (TORS) patients.

Methods: This single-institution study at Emory included TORS patients with a baseline cohort (n=40) measured from December 2024 through

September 2025. Encounters included MyChart messages, telephone calls, and nurse triage encounters within 14 days post-surgery. Root cause analysis identified inconsistent instructions, variable teach-back practices, and non-standardized workflows. Interventions implemented at week 42 included Standardized TORS Discharge Instructions via Epic dot phrase, structured teach-back methods, and workflow standardization for nurses and residents. The goal was to reduce average postoperative encounters by 25% within six months of implementation.

Results: In the baseline cohort (n=40), average encounters were 0.92 per patient. In the post-intervention cohort (n=10 to date, goal n=40), average encounters decreased to 0.80 per patient, representing a 13% reduction. Data collection is ongoing with chart review in 3-week intervals.

Conclusions: Standardized discharge instructions and teach-back methods show early promise in reducing postoperative encounters following TORS. Preliminary results demonstrate progress toward the 25% reduction goal. Future directions include expanding the post-intervention cohort, implementing patient satisfaction surveys, and continued refinement of discharge instructions.

#14

Impact of Active Learning and Interprofessional Didactics on Physician Assistant Students Perceived Confidence and Competence of SBIRT Implementation

Raiford JR, Skura Boutell J, Burrison-Scott L, Alfonso S, Goetz EJ, Owen A

Alcohol and substance use are primary risk factors for developing chronic disease; patients are often unaware that they have problematic use patterns. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is an evidence-based approach used to identify and treat substance use across healthcare settings.

This study aims to evaluate changes in PA students' perceived confidence and competence in substance use assessment and intervention using the SBIRT model. It is hypothesized that results will indicate a positive shift in these domains, prospectively leading to greater utilization and improved patient outcomes.

A mixed-methods quality improvement study was conducted via online survey with PA students participating in a 3-hour interprofessional didactic workshop designed to introduce, explain, and engage the SBIRT model using a pocket card to guide conversations about substance use, determine risk level, and offer Motivational Interviewing (MI)-based interventions.

The workshop consisted of lecture material and hands-on activities. Data was collected at three time points: pre-workshop (n=38), immediately post-workshop (n=37), and following participants' first clinical assessment (i.e., an Objective Structured Clinical Examination [OSCE]) one month later (n=49). Survey questions assessed changes in perceived confidence and competence, implementation practices, and barriers/facilitators to application of the SBIRT model in clinical practice.

Analytics will include Rapid Qualitative Analysis (RQA) of qualitative data and descriptive statistics for quantitative data. Results aim to inform future adaptations to workshop materials and implementation practices.

#15

Implementing Comprehensive, Evidence-Based Behavioral and Mental Health Services in a Childrens Healthcare System

Krause KH, Mays K, Daniel K, Jahan A, Livingston-Burns B, Cummings J, Constantino J

Objectives: To detail how a children's healthcare system used intervention mapping to provide comprehensive, evidence-based behavioral and mental health (BMH) care, developed an EHR informatics tool, known as a SmartBlock, that implements these objectives, and share key analyses that demonstrate early indicators of success.

Methods: We delineate objectives within the healthcare system to deliver BMH care and pair each objective to a mechanism that precisely identifies how the objective will be achieved. Each mechanism is a feature of the SmartBlock that is used by all BMH providers. We focus on patients receiving BMH care March-December 2025 (N=4,879). We present descriptive analyses of patient demographics and acquisition of 12 high-level services within the care plan, overall and stratified by insurance type.

Results: The first objective was to convert fragmented care to comprehensive care. The SmartBlock facilitates this goal by generating a clinician note from a form comprised of entirely discrete fields to outline a care plan in a standardized format across visits, patients, and providers. Within the healthcare system, the frequency of services recommended as part of patient care plans did not differ by insurance status (Medicaid vs. private) for 10 out of 12 services.

Conclusions: Methodically identifying distinct objectives for BMH care delivery, specifying mechanisms that would facilitate implementation, and evaluating success has enabled the implementation of a learning healthcare system. Descriptive analyses show that patient care plans have been assembled with parity when comparing patients who have Medicare compared to private insurance.

#16

Anal Cancer Stigma in People Living With HIV

Kawther A, Sarah B, Alicia M, Minh Ly N, Lisa F, Jolinta L

Background: Anal cancer incidence remains disproportionately high among people living with HIV (PLWH), yet screening and early detection are inadequate. This study explored how perceptions of anal cancer risk and symptoms, patient–provider communication, and care-seeking behaviors shape stigma and influence screening engagement among PLWH.

Methods: Semi-structured interviews were conducted with 14 PLWH receiving care at an urban academic infectious disease clinic in metropolitan Atlanta, Georgia. Data were analyzed using a hybrid deductive–inductive thematic approach with team-based coding.

Results: Participants were 35.7% female and 64.3% male, with a median age of 51.5 years (range: 25–69) and a median HIV duration of 13.5 years (range: 1–43). Most identified as Black or African American (93%), had completed high school (86%), and were employed (57%). Participants described embarrassment, social judgment, and blame related to HIV status, compounded by limited public discourse and inconsistent clinical guidance for anal cancer screening. Structural barriers—including time-limited visits, reliance on infectious disease providers for primary care, and absence of routine screening protocols—restricted anal cancer screening uptake. Trusting relationships with infectious disease physicians facilitated screening when recommendations were offered; however, discomfort and constrained communication reduced anal cancer risk awareness and uptake.

Conclusion: Stigma, knowledge gaps, and communication barriers may delay screening and perpetuate inequities across the cancer continuum. Interventions targeting patients and providers are needed to strengthen communication, increase screening uptake, and promote anal cancer prevention for PLWH.

#17

Modified Diuretics Guidelines for Heart Failure Patients Using a Large Language Model: Quality Improvement project

Henshaw L, Kang Y

Introduction. Despite advances in clinical care, maintaining effective heart failure (HF) self-management, including medication management, remains challenging. One reason may be the lack of HF guidelines developed specifically at the patient level. Current HF guidelines are difficult for patients to understand because they were developed for clinicians. The goal of this quality improvement project is to evaluate a modified version at a 6th-grade reading level of the diuretics section from the 2022 American College of Cardiology HF guideline.

Methods. We conducted a survey consisting of 15 questions evaluating the modified diuretics guidelines. To generate the modified version, we used a Large Language model through a simple instruction prompt without examples or predefined terms: "You will be given a section of a guideline for management of heart failure in markdown format. Convert the heart failure–related medication information into a 6th-grade reading level for patients."

Results. Among the 11 respondents, there were four registered nurses, one case manager, two respiratory therapists, one pharmacist, two social workers, and one physician assistant. Approximately 73% (n=8) reported being very confident or confident in caring for HF patients. Positive response rates (agree or strongly agree) ranged from 45% (n=5) to 81% (n=9). For example, 81% agreed that the modified version was quick to read and visually easy for HF patients. Only 45% agreed that HF patients would be able to explain diuretics after reading the modified version.

Conclusions. Although most respondents showed positive responses about the modified version, they questioned whether HF patients would be able to explain diuretics after reading it. Additional evaluation from the HF patients is warranted.

#18

Excess Burden of Hospitalizations in Adults with Diabetes by Race – a National US Cross-Sectional Study

Green M, Uppal T S, Tomic D, Ali M K, Salim A, Magliano D J, Harding J L

Background: People with diabetes are living longer due to improved treatment and survival, but whether this has diversified complications is unknown. We examined all causes of hospital admissions in people with and without diabetes by race, a known risk factor for diabetes-related complications.

Methods: Age-standardized risks of ICD-10-CM-defined inpatient hospitalizations were estimated from the 2019 National Inpatient Sample (numerator) and Behavioral Risk Factor Surveillance System Survey (denominator) and weighted to reflect the US population. Hospitalizations were considered diabetes-related if a diabetes code appeared as a comorbidity. Complications were grouped as traditional, emerging, and other based on existing literature. Using absolute risk differences (ARDs), we identified the 5 leading causes of excess hospitalizations in people with diabetes by complication type and race.

Results: Sepsis and cardiorenal conditions were leading traditional complications across all races with ARDs ranging from 262.2 to 1830.9 per 100,000 persons. For emerging complications, mental health disorders, procedure-related complications, and pneumonia were leading causes for most race groups with ARDs ranging from 97.2 to 346.8. For other complications, urinary disorders, fluid and electrolyte imbalances, and respiratory conditions were leading contributors across race groups. Hispanic adults were the only group with acute pancreatitis (ARD: 262.2) among their top causes. Black adults had similar causes of excess admissions but consistently experienced higher ARDs.

Conclusions: Excess hospitalizations associated with diabetes extend beyond traditional complications and vary by race, with implications for population-level planning, resource allocation, and clinical management.

#19

Assessing Racial Differences in Skin Cancer Outcomes, Presentation and Delays in Care

Burdyck M, Wei Y, Sur A, Idris H, Kamboj S, Aspey L

Skin cancer appears to be more prevalent in white populations than other racial groups. Notably, patients of color present at later stages and with more invasive disease at the time of diagnosis compared to white patients. The primary objective is to assess differences in risk factors, clinical presentation, and outcomes of skin cancer based on race and ethnicity.

A retrospective study was conducted from January 2015 to December 2017, at a dermatology clinic in a county hospital in Atlanta, GA involving 68 adult patients with a biopsy supporting a skin cancer diagnosis. Data were collected and analyzed on demographics, time to diagnosis, and tumor location categorized by risk level: Area H (high-risk), Area L (low-risk), Area M (medium-risk).

Our retrospective review of a diverse patient cohort at an urban county hospital suggests that patients of color may experience a delay in diagnosis and may develop skin cancers in higher risk areas compared to white patients.

These findings will aid in determining if people of color will need more targeted health services to improve their outcomes and reduce delays in care.

#20

Understanding Early Intervention Provider Self-Efficacy in a Parent-Mediated Intervention Before and After Training

Pu M, Myers S, Islam N, Valdivia Acosta M, Brane N, Guerra K, Greenfield E, Ulven Hopkins K, Pickard K

Background: Over half of autistic children receive services in Part C prior to age 3; thus, early intervention (EI) systems are an important safety net for children with social communication delays. While EI providers are an ideal workforce to deliver evidence-based practices (EBPs), limited research has explored the feasibility of learning EBPs or the factors influencing their implementation. This study evaluated provider self-efficacy in Project ImPACT, an EBP, pre- and post- training and examined provider- and system-level predictors of post-training self-efficacy.

Methods: Providers enrolled in Project ImPACT training between 2021-2026 as part of standard EI training. Prior to training, 101 providers reported demographics, EBP attitudes, stress and burnout, team cohesion, organizational readiness for change (ORC), and perceived Project ImPACT efficacy. Training included a 6-hour online tutorial followed by a 14-hour live workshop over four days. After training, 101 providers completed a self-efficacy survey. Paired t-tests examined changes in self-efficacy, and multiple linear regressions identified provider- and system-level predictors.

Results: Providers reported significantly higher self-efficacy from pre- (M=5.40, SD=2.83) to post-training (M=8.40, SD=1.22), t(100)=11.40, p<.001, d=1.13, 95% CI[2.48, 3.53]. The Supervision subscale of the ORC was significantly associated with post-training self-efficacy (R2=.20, F(2,78)=10.87, p<.01, β=.28).

Conclusions/Discussion: Training significantly increased EI provider self-efficacy in Project ImPACT. Findings highlight the importance of organizational readiness in supervision in supporting EBP uptake and emphasizes the need for system-level support alongside provider training.

#21

Multimodal Analysis of Patient–Nurse Interactions in Bedside vs. Virtual Nurse During Discharge Education

Prakash M, Gude L, Castro I, Bhagdikar R, Ergai A, Gaddis M, Hamilton L, Friday B, Thurman S

Patient–nurse interactions are central to high-quality healthcare delivery, shaping patient satisfaction, knowledge retention, emotional well-being, and self-management. As health systems increasingly adopt Virtual Nursing Care Models (VNCMs), understanding how these models influence patient engagement compared with traditional bedside care is essential. Prior research has often examined individual components of interaction, such as verbal communication or visual attention, in isolation, limiting insight into the full patient experience.

This study uses a multimodal framework integrating eye-tracking and prosodic vocal analysis to evaluate patient engagement and emotional response during standardized education sessions delivered by bedside and virtual nurses. Eye-tracking metrics assess visual attention and information processing, while acoustic features—including pitch, intensity, and variability—provide objective indicators of emotional response and interpersonal sensitivity. Together, these measures enable a comprehensive assessment of cognitive and affective engagement.

Preliminary findings suggest that virtual nursing can support attentional engagement comparable to bedside interactions, while differences in vocal prosody indicate variation in perceived emotional connection. Results highlight the importance of communication delivery—particularly vocal warmth and clarity—in shaping patient experience in digital care environments. By offering a holistic understanding of engagement across modalities, this study provides evidence to inform the design, training, and implementation of VNCMs, supporting more effective and patient-centered virtual care.

#22

Impact of Chemotherapy and Demographic Factors on Survival in Adult (21-64-Year-Old) with Acute Lymphoblastic Leukemia: A SEER Database 10-Year Cohort Study

Bhuiya NMMA, Villa-Zapata LA

Objectives: To assess the 10-year survival probability and the influence of chemotherapy, age, sex, and race on survival duration in adults with acute lymphoblastic leukemia (ALL).

Methods: This prospective cohort study employed adults (aged 21-64 years) with ALL SEER data from 2012-2021 combined with the U.S. Mortality dataset spanning 2000-2021. Age at diagnosis was classified into 20-29, 30-39, 40-49, and 50-59 categories. Race was categorized as White, Black, Asian/Pacific Islander, and American Indian/Alaska Native. All-cause mortality was the primary outcome. Kaplan-Meier survival analysis evaluated all-cause mortality over time and adjusted cox regression analysis calculated hazard ratios (HRs) with a log-rank p value=0.05 using SAS 9.4.

Results: Among 4,256 patients, 94.27% (4,012) received chemotherapy. Chemotherapy use varied by age and race. Younger patients had a higher likelihood of receiving chemotherapy, with the highest percentage observed in the 20-29 age group (95.17%). Overall, 60.77% of patients were censored, indicating a higher percentage survived beyond the observation period. Chemotherapy significantly reduced mortality risk (HR = 0.362, $p < 0.0001$). Older age (50-59 years:HR=2.024, $p<0.0001$) and Black race (HR=1.23, p=0.01) were associated with increased mortality, while Asian/Pacific Islanders demonstrating lower risk (HR=0.768, p=0.003). After adjusting for covariates, chemotherapy continued to reduce mortality risk significantly (aHR=0.38, $p < 0.001$). Increased mortality was observed for the 50-59 age group (aHR=1.97, $p < 0.001$), with Asian/Pacific Islanders exhibiting reduced risk (aHR=0.77, p=0.003).

Conclusion: The observed chemotherapy-induced outcomes underscore the importance of tailored and equitable interventions in ALL patients.

#23

Assessing the Implementation Potential of Consumer Health Wearables for SARS-CoV-2 (PASC) Symptom Management and Tracking

Pozzo NS, Kessler NR, Kaplan DM

Background: The multi-systemic symptoms associated with post-acute sequelae of SARS-CoV-2 (PASC) require patient-centered treatment approaches. Although consumer health wearable technologies have been recommended for tracking PASC pathophysiological changes, minimal research has investigated providers' perspectives. OBJECTIVE: Addressing this gap, a mixed methods study funded by the Georgia

Clinical and Translational Science Alliance investigated provider perspectives on acceptability, appropriateness, and feasibility of using consumer health wearable technologies for PASC symptom tracking.

Methods: Outpatient providers (n = 44) were recruited into an online survey. The survey included validated measures of acceptability (AIM), appropriateness (IAM) and feasibility (FIM) (Weiner et al., 2017). A subset (n = 21) participated in follow-up interviews; interviews assessed provider-level implementation barriers and facilitators. Interviews were coded in MAXQDA by two independent coders and underwent thematic analysis.

Results: Out of 5, participants provided a mean AIM rating of 3.99 (SD= 0.804), a mean IAM rating of 3.91 (SD= 0.828), and a mean FIM rating of 3.98 (SD= 0.759). Key barriers identified included: concerns about measurement inaccuracies, exacerbation of patient health anxiety, and device cost. Key facilitators identified included: promotion of patient autonomy and improved patient-provider communication.

Discussion: Although consumer health wearable technologies serve as tools for PASC symptom tracking, use recommendations should be context specific and clinically indicated. There is an urgent need for evidence-based and provider-supported protocols for implementing consumer health wearable technologies into wide scale clinical practice.

#24

Environmental, Cost, and Labor Savings from Implementation of an IV to PO Conversion Intervention in a Pediatric Healthcare System

Jaggi P, Berkowitz B

Antimicrobial Stewardship Programs promote appropriate antimicrobial use to combat rising resistance. Intravenous (IV) to enteral (PO) conversion strategies are associated with reduced length of stay and lower healthcare costs, labor, and environmental impact, but large-scale pediatric data remain limited. The Antimicrobial Stewardship Team and clinical pharmacy staff at Children's Healthcare of Atlanta implemented a pharmacy-directed IV-to-PO conversion initiative from December 14, 2024, through January 2026. We evaluated the social, environmental, and financial impact of this system-wide intervention.

We conducted a retrospective analysis of pharmacy dispensing data comparing a pre-intervention period (January–November 2024) with a post-intervention period (January–November 2025), with December 2024 as a wash-in phase. During the pre-intervention period, 4,715,978 doses were dispensed, 40.9% IV. Post-intervention, 4,704,343 doses were dispensed, 39.5% IV. This reduction corresponded to an estimated 55,261 IV doses avoided.

Assuming a conservative cost of $1 per IV dose, the intervention yielded at least $55,000 in direct drug cost savings. Pharmacy preparation time was estimated at 9 minutes per IV dose compared with oral administration; avoidance of 55,261 IV doses saved approximately 9,210 minutes of pharmacy labor. Environmental impact was estimated using the weight of a 10 mL prefilled normal saline syringe (9 g). Reduced IV use prevented approximately 1,706 kg of carbon emissions, equivalent to 145 bags of waste avoided or 4,342 vehicle miles.

Overall, this IV-to-PO conversion initiative demonstrated meaningful financial savings, reduced environmental burden, improved workflow efficiency, and supported patient safety within a large pediatric healthcare system.

#25

Excess Burden of Hospitalizations in Adults with Diabetes by Age – a National US Cross-Sectional Study

Patel R, Uppal TS, Tomic D, Ali MK, Salim A, Magliano DJ, Harding JL

Introduction: The burden of diabetes is underestimated when the full spectrum of related complications is not considered. We examined all cause-specific inpatient admissions among adults with versus without diabetes by age group.

Methods: Adults (≥18 years) with or without diabetes were identified using the 2019 Behavioral Risk Factor Surveillance Survey. Age-standardized risks of ICD-10-CM–defined cause-specific hospitalizations were obtained from the 2019 National Inpatient Sample. Hospitalizations were attributed to diabetes if diabetes was listed as a comorbidity. Complications were categorized as traditional, emerging, or other based on prior literature. Absolute risk differences (ARDs, per 100,000 adults with diabetes per year) were used to identify leading causes of diabetes-attributable hospitalizations and to compare patterns across age groups.

Results: Across all ages, leading traditional causes of diabetes-related admissions included sepsis and cardiorenal conditions, with ARDs ranging from 296.3–1570.9 (ages 18–44) to 681.9–2623.3 (≥75 years). Among emerging complications, cardiac device-related complications and pneumonia predominated (ARDs 125.6–312.4 in ages 18–44; 98.1–473.2 in ≥75 years). For other complications, fluid disorders and respiratory conditions (e.g., chronic obstructive pulmonary disease) were leading causes across age groups (ARDs 98.9–239.1 in ages 18–44; 229.0–482.5 in ≥75 years). Mental health disorder and urinary disorders were prominent only among 18-44 and 75+ year-olds, respectively.

Conclusions: Excess hospitalizations among adults with diabetes extend beyond traditional complications. Although patterns are broadly similar across age groups, key differences highlight the need for age-tailored diabetes management across the lifespan.

#26

Usability Testing of STEER-MBC (Support Tool for Enhancing Engagement, Empowerment, and Resilience for Patients with Metastatic Breast Cancer): A Qualitative Study

Jones RD, Bhatia R, Blake AM, Smith-Graziani D, Meisel JL, Wallner L, Hawley S, Jagsi R

Background: Patients with metastatic breast cancer (MBC) have complex medical and psychosocial needs. We developed a Support Tool for Enhancing Engagement, Empowerment, and Resilience for Patients with Metastatic Breast Cancer (STEER-MBC), an online tool to improve information access and emotional resilience. We conducted a qualitative evaluation following initial usability testing to inform iterative refinement.

Methods: Patients with MBC were recruited via purposeful selection and consented to participate in semi-structured interviews immediately following remotely observed usability testing. Interviews were audio-recorded, transcribed, and analyzed using framework analysis. A coding framework was developed via dual-coder method, applied, and refined through consensus.

Results: A total of eight patients were interviewed. Analysis produced two overarching themes on usability and potential benefits. The first theme detailed design aspects important to patients, such as color mirroring the MBC ribbon (aesthetics) and a centralized table of contents for information and activities (navigation). The second theme showed how the tool can strengthen empowerment and resilience. Patients described experiences coping with their health related to information sources, treatment or symptoms, and provider interactions. They discussed benefits of STEER-MBC tool use, such as better physician-patient communication, self-awareness of values concerning health decisions, improved emotional well-being, access to support services, and an avenue for community knowledge sharing.

Conclusions: STEER-MBC demonstrated preliminary usability and perceived informational and emotional value. These findings will guide iterative refinement and future evaluation in larger and more diverse populations.

#27

Social Desirability and Self-Reporting Bias when it comes to Social Distancing: A Demographic Comparative Analysis

Teimouri RT, Rahman OA

Accuracy of measurement when it comes to social distancy is necessary for evaluating responses. Self-reported behaviors can be influenced by social desirability, especially when behaviors are socially expected, there is concern that individuals may report inaccurately. This study examines the extent to which social desirability bias affects self-reported social distancing comparing genders and age. The dataset used in this analysis was originally collected by Ulrich Thy Jensen at Arizona State University.

The analysis draws on a between-subjects survey experiment of 1,059 U.S. adults recruited through Amazon Mechanical Turk. Respondents were randomly assigned to either direct questioning or the crosswise model, an indirect questioning technique designed to increase truthful reporting by protecting respondent anonymity while still allowing population-level estimates of sensitive behaviors. The dataset includes measures of self-reported social distancing, survey method assignment, and demographic characteristics such as gender and age group. These variables allow for comparison of reported compliance across groups and evaluation of differences between survey methods.

The objective of this study is to assess whether social desirability bias influences self-reported social distancing behavior and whether these patterns vary by gender and age. Statistical analysis is conducted in Python and includes regression models for associations between demographic characteristics and reported compliance, and two-way analysis of variance to evaluate effects between demographic factors (age and gender). These methods allow for the identification of systematic differences in reporting behavior and provide insight into the presence self report bias surveys.

#28

Combining Ambulatory Blood Pressure and Ecological Momentary Assessment to Examine Workplace Stress in Spiritual Health Clinicians

Salameh SE, Getz TE, Pozzo NS, Kaplan DM, Giordano NA, Mascaro JS

Introduction: Spiritual Health Clinicians (SHC) experience high rates of occupational stress and burnout, contributing to adverse health outcomes. Blood pressure (BP) provides an objective marker of autonomic stress reactivity. Combining ecological momentary assessment (EMA) with ambulatory blood pressure (ABP) monitoring allows for the examination of time-synchronized associations between workplace experiences and physiological responses. This study investigated associations between psychosocial workplace experiences and daytime BP patterns among SHCs.

Methods: SHCs completed baseline surveys assessing demographics, anxiety, depression, and burnout, etc. Participants wore an ABP monitor for three consecutive workdays during work hours. Participants received four-daily EMA prompts assessing workplace connectivity, team support, professional fulfillment, and incivility. Data analyses included descriptive statistics and linear mixed-effects models.

Results: Six participants completed 90.1% (±6.8) of BP readings and 84.1% (±10.2) of EMA prompts. Mean heart rate was 75.7 bpm (±8.1), systolic BP was 126.8 (±14.3), and diastolic BP was 75.4 (±6.6). Mean connectivity with colleagues was 6.3 (±0.7) on a 1–7 Likert scale, connectivity with patients 5.8 (±1.2), perceived team support 6.3 (±0.7), professional fulfillment 5.6 (±1.5), and burnout 1.9 (±1.1). Two participants reported incivility.

Conclusions: The collection of self-report and ABP data from SHCs during three workdays of monitoring was feasible. Linking momentary self-report of psychosocial indices to ABP reveals associations between stress reactivity and workplace experiences, highlighting the utility of EMA for understanding workplace stress and burnout among healthcare professionals.

#29

Changes in Pediatric Palliative Care Visit Content Following Addition of Mental Health Clinicians

Verma S, Lee K, Feifer D, Radbill LM, Korsah K, Brock KE

Introduction: Pediatric palliative care (PPC) focuses on managing physical, emotional, and spiritual distress in children with life-threatening conditions. However, most PPC teams do not include mental health clinicians (MHCs) like psychiatrists and psychologists. The effect of adding MHCs on PPC visit content is unknown.

Methods: This single-center retrospective study included PPC visits for children with cancer from 1/1/2023 - 6/30/2025. We assessed domains of care (Goals of Care, Symptom Management, Care Coordination) addressed by PPC clinicians during these visits. Visits were divided into 1-year pre- and post-addition of three MHCs, separated by a six-month washout period during MHC onboarding. Descriptive statistics summarized visit and patient characteristics, and frequencies of domains were compared using Pearson's Chi-Squared or Kruskal-Wallis tests.

Results: There were 4120 PPC visits with 332 patients (55% White, 46% female, and 20% Hispanic/Latino). The median number of domains addressed per visit was higher post-MHC (9.0 vs. 8.0; $p < 0.001$), with increases in the median number of Goals of Care, Symptom Management, and Care Coordination domains (all $p < 0.001$). Specific topics discussed more frequently post-MHC included hospice coordination (12% vs 6.9%, $p < 0.001$) and pain (78% vs 69%, $p < 0.001$). Depression was discussed less frequently post-MHC (8.7% vs 11%, $p < 0.021$).

Discussion: After MHC integration, PPC visits addressed more goals of care, symptom management, and care coordination topics. This change may reflect increased recognition and education about mental health challenges and redistribution of aspects of clinical care based on area of expertise, allowing non-MHC PPC clinicians to focus on other complex PPC topics.

#30

Improving Airway Resource Mobilization in the Emory University Hospital Midtown Emergency Room

Chauhan S, Rodas-Calderon A, Wright E, Patel S, Wang S, Iyiewuare H

Background: Otolaryngology–Head and Neck Surgery (ENT) residents are frequently consulted to manage emergent and complex airways in the Emergency Department (ED) at Emory University Hospital Midtown (EUHM). Timely identification and access to appropriate airway equipment are critical to patient safety. However, resident familiarity with ED-specific airway resources, including the difficult airway cart and its contents, is variable. At baseline, no standardized educational primer existed to orient ENT residents to ED airway equipment. A pre-intervention survey identified knowledge gaps, particularly in identifying ED airway cart contents and distinguishing ED-available supplies from operating room–only equipment.

Objective: To improve ENT resident knowledge of airway resources within the EUHM ED through a standardized educational intervention.

Methods: Baseline knowledge was assessed using a 12-question pre-lecture survey evaluating familiarity with ED airway equipment and resource locations. Residents then participated in a focused educational session reviewing ED airway cart contents and airway resource locations. A post-lecture survey assessed knowledge acquisition, with pre- and post-intervention performance compared using median survey scores.

Results: The baseline median survey score was 6/12. Following the intervention, the median score increased to 8/12. Frequently missed baseline concepts included identification of ED airway cart contents and recognition of operating room–only airway supplies.

Conclusion: Implementation of a standardized educational primer improved ENT resident familiarity with ED airway resources. Structured orientation to airway equipment may reduce delays in emergent airway management and enhance patient safety within the EUHM ED.

#31

Patterns of Psychotherapy and Antidepressant Use After Release of the U.S. Preventive Services Task Force Recommendation for Universal Adult Depression Screening

Tetlow, SM

Depression is one of the leading causes of disability, yet fewer than a third of adults with depression receive any treatment. In January 2016, the U.S. Preventive Services Task force (USPSTF) recommended screening all adults for depression with systems in place to ensure accurate diagnosis and effective treatment. My objective was to assess policy effects on psychotherapy and antidepressant use among U.S. adults. I analyzed Medical Expenditure Panel Survey data from 2008-2023 using person-level sample weights. I used an interrupted time series design to examine level and trend changes at and after the recommendation. I estimated two-part Logit and negative binomial models to examine the probability of use and use conditional on any use and calculated the average marginal effects (AME).

The analytic sample included 372,962 noninstitutionalized adults aged ≥18 years, which corresponded to a nationally representative sample of 244,316,623 adults. Probability of psychotherapy only use increased significantly at the recommendation (OR=1.18, 95% CI: 1.02, 1.37) and annually thereafter (OR=1.08; 95% CI: 1.04, 1.11). Probability of antidepressant only use decreased significantly at the recommendation (OR=0.88, 95% CI: 0.82, 0.94) and annually thereafter (OR=0.98, 95% CI: 0.96, 0.99). AMEs indicated small but significant increases in psychotherapy only visits and decreases in antidepressant only prescription fills after the recommendation. Probability of combination treatment (psychotherapy + antidepressants) did not change significantly. Clinical guidelines recommend use of psychotherapy and pharmacotherapy to effectively treat depression in adults. Healthcare organizations should ensure coordination of mental health care between prescribing and non-prescribing providers.

#32

Initiative to Equip Georgians to Engage in Voting at Grady Memorial Hospital

Durham T, Hackett L, Gurley S, Kirkconnell Hall MA, Rutledge R

Background: Studies show voting is a social determinant of health. Disenfranchised groups experience limited access to healthcare and may also experience barriers to voting, rendering their interests under-represented in policy. We describe a project where medical trainees implemented a nonpartisan initiative to equip community members at Grady Memorial Hospital, a large safety-net hospital, with resources to exercise their right to vote.

Methods: Volunteers were recruited via medical school and residency-wide emails and offered voter registration training. Once trained, team members set up a table in the hospital lobby and engaged with patients about previous voter participation, perceived and real barriers to voting, and determined voter eligibility. Those eligible and interested were offered the opportunity to register in real time. Volunteers also helped people make a plan to vote, providing dates of early voting, location of polling sites, and information on accessing transportation to polls.

Results: During the 2024 election cycle, 22 trainees and attendings engaged with approximately 250 individuals. While our initiative initially targeted patients, we also found significant interest and participation from visitors and several Grady employees.

Discussion: Several themes emerged in our work, notably misinformation and perceived difficulty about the voting process, as well as lack of knowledge about early voting opportunities and other items like automatic registration via driver's license renewal.

Conclusions: Providing a convenient space where people can check eligibility, register if needed, and construct a voting plan can mitigate barriers to voting and greatly boost civic engagement.

#33

Early Team Assessment for Emergency Department Patients

Fields VF, Franks N, Ross M

Background: Traditional emergency department care models where patients wait to receive care in a room or bed lead to delays in care. We aimed to determine if an early team assessment model is associated with improved patient throughput and quality measures.

Methods: This is a retrospective observational study of emergency department patients in a high volume urban academic hospital. Pre-intervention patients were seen by a nurse who initiated care with nurse protocols before receiving a bed to be seen by a provider (physician or advance practice provider). Post intervention patients were seen in triage by a nurse and provider who completed a full assessment and placed orders, then followed the patient throughout the visit. Outcomes included: time to provider, left without being seen, emergency department length of stay and likelihood to recommend. Data was abstracted from electronic reports. Adjusted outcomes were computed using interrupted time series generalized linear models.

Results: Over the study period there were 93,477 pre intervention and 53,650 post intervention patients. Groups were of similar age, gender, and acuity. Prior to implementation, average time to provider was 122 minutes and left without being seen rates were 7.8%. After implementation, time to provider significantly decreased to 40.9 minutes (adj. mean ratio=.41, 95%CI:.39-.43) and left without being seen rates significantly decreased to 2.8% (adj. odds ratio=0.49, 95%CI: .40-.60). Overall length of stay decreased from 491.4 minutes to 437.2 minutes (adj. mean ratio = 0.84 (95% CI: 0.82 - 0.86, p < .001). Likelihood to recommend scores increased from 48.48% to 56.68%.

Conclusion: The early team assessment model was associated with a significant improvement in throughput and quality measures.

#34

Outcomes of Care Coordination in a Student-Run Continuity of Care Clinic for Immigrant Populations

Monge VN, Prasad R, Pitaktong I, Ohamadike C, Farchi Behar D, Kahn J, Kumar R, Cohodes M, Zeidan A

Background: Department and residency information is frequently distributed across emails, shared documents, and informal communication. This leads to inefficiency and inconsistent access to clinical, educational, and administrative resources. This project aims to improve resident confidence in accessing clinical, educational, logistical, administrative resources through implementing an internal, centralized residency website.

Methods: A baseline survey was distributed to residents (n=17/22, 77.3%). Using a 5-point Likert scale (1 = not confident at all, 5 = completely confident), residents rated confidence across clinical (i.e. identifying landmark subspecialty papers), logistical, administrative, and research tasks. Based on identified gaps, a centralized website was developed to consolidate key information which is regularly updated and maintained. Post-intervention data collection is ongoing.

Results: Baseline mean confidence scores ranged from 1.5 to 4.6 across questions. Lowest confidence scores (1 or 2) were observed in identifying landmark subspecialty papers (n=16, 94.1%) and research opportunities (n=14, 82.4%). Questions on administrative/communication navigation demonstrated moderate confidence (mean 3.4) with greatest variability (range 2.7-4.6). After three months, there have been 13 unique views (59.1% of residents) and 339 total views to the website.

Conclusions: Prior to creating a centralized residency website, residents had variable and often low confidence in accessing critical resident resources. Implementation of a centralized digital hub is feasible and has been shown to be regularly utilized by residents. Ongoing evaluation of this resource will determine any measurable impact on resident confidence, efficiency, and performance.

#35

Community-Engaged Selection and Adaptation of a Family Healthy Weight Program in Fulton County, Georgia

Shahin, Z., Tables, LA, Section, E, Bicego, E, Driskell, T, Ampaw E, Kopchick L, Hoffman, L., Akintobi, and Rollins, L.

Background: Childhood obesity disproportionately affects Hispanic (26.2%) and non-Hispanic Black (24.8%) youth. Prevention programs support healthy behaviors and reduce chronic disease risk. Family Healthy Weight Programs (FHWPs) promote behavior change, yet Fulton County, Georgia faces barriers (limited healthy foods, safe activity spaces) limiting participation for families. Through CDC's REACH initiative, Morehouse School of Medicine is implementing an FHWP and examining how family and community partner engagement informed the selection and adaptation of of FHWP models, comparing MEND–Healthy Together with the Healthy Weight Clinic (HWC).

Methods: A community-based participatory landscape analysis included parent/child surveys, focus groups, and key informant interviews with community and clinical partners. Surveys captured behaviors, family history, and needs. Qualitative data were thematically analyzed for feasibility, acceptability, preferred format/scheduling, and barriers.

Results: Surveys showed strong family histories of overweight and hypertension, low fruit/vegetable intake, and limited physical activity. Barriers included time, transportation, competing responsibilities, and cost. Parents viewed MEND's twice-weekly 2-hour sessions as unrealistic; children valued MEND's exercise/skill-building, but families overall preferred HWC's monthly visits. Recommended adaptations included telehealth check-ins and fewer in-person weigh-ins; partners noted HWC's fit with staffing, space, and mission.

Conclusion: Community engagement supported selecting HWC and guided adaptations (flexible scheduling, hybrid delivery, family-centered content) to improve feasibility and acceptability in Fulton County.

#36

Exploration of Human-AI Teaming Concepts to Support Community Medical Emergency Response and Combat Casualty Care Management

Crooks CL, Khalfay A, Zhou V

Future large-scale combat operations expected to generate casualty volumes not seen since WWII, demand "medical multidomain operations" that integrate direct care with logistics, transport/bed capacity, telemedicine, clinical guidelines, decision support, and registry data across defense communication networks [1,2]. Similar challenges exist with community emergency management, including response to mass casualty events, emphasizing the need for translational research to explore decision optimization solutions in multiple contexts. Recent "casualty digital twin" proposals argue that meaningful medical command and control (C2) requires continuous passive data on casualty status, caregiver actions, resource availability, and operational context [3]. While artificial intelligence (AI) offers promising solutions, there are unresolved AI adoption barriers: validation of evolving systems, appropriate standards for austere/contested settings, liability for AI-guided procedures, and ethical dilemmas in triage [4]. Our research leverages open source gaming platforms and emergency response scenarios derived from a rigorous human systems engineering (HSE) process, to explore and evaluate human-AI teaming concepts for addressing challenges with: incomplete information, high uncertainty, high temporal demand, complex cognitive workflows, community resource coordination, collective situational awareness, critical task performance, and teaming dynamics. We demonstrate a promising human-centered design process where reinforcement learning and large language models are evaluated by domain experts from military C2, cybersecurity, HSE, and disaster medicine, to engineer customized decision optimization solutions that is critical to managing whole-community emergency response.

#37

Standardized BPMN 2.0 modeling of in-clinic and at-home self-sampling cervical cancer screening workflows in an FQHC

Suk R, Czerner M, Kheirandish M, CPCRN Methods Core, Calderon-Mora J

Introduction: Federally qualified health centers (FQHCs) are considering at-home HPV self-sampling to improve cervical cancer screening, but operational planning requires clear representations of delivery pathways to support stakeholder validation, explicit handoffs/role accountability, and further comparative evaluation and downstream operational analyses. We describe a structured-data-to-Business Process Model and Notation (BPMN) approach to map these workflows at an FQHC in El Paso, Texas.

Methods: Clinic staff and a research team completed a structured spreadsheet template capturing step descriptions, responsible roles, inputs/outputs, and approximate staff time. We translated the sheets into BPMN 2.0 collaboration diagrams with separate pools for Patient, Clinic (swimlanes for Front Desk, Medical Assistant, Provider), and external partners (Lab/Courier; Mail/Carrier for the at-home pathway). Sequence flows were used within pools, and message flows were used for cross-pool handoffs (e.g., specimen shipping, results return).

Results: The in-clinic workflow comprised 17 documented steps across three clinic roles, with a baseline of 70 minutes of total staff time per episode (Front Desk 15, Medical Assistant [MA] 39, Provider 16). The at-home self-sampling workflow comprised 6 documented steps primarily owned by MA (40 staff minutes) plus patient actions; the BPMN explicitly represented kit delivery, specimen transit, lab processing/results messaging, and an exception loop for lost-in-transit specimens with replacement kit reordering.

Discussion: Standardized BPMN models derived from structured site data produced shareable, role-explicit process maps for both screening modalities and a reusable BPMN XML foundation for subsequent simulation and budget impact analyses.

Poster Index by Presenting Author

Poster Session	Poster #	Name	Academic Affiliation	Abstract Title	Page #
1	35	Abuimweis, Z	Philadelphia College of Osteopathic Medicine	The Impact of Mobile Community Screening on Free Clinic Engagement Among Uninsured Populations	42
1	29	Anderson, S	Emory University	Experience of birth trauma and attendance at the postpartum visit among a cohort of women at Emory and Grady	38
1	13	Anglin, E	Emory University	Early Diagnosis, Lower Costs: The Impact of Georgia Memory Net	28
2	4	Bagley, A	Emory University	Management of Early Pregnancy Loss in Outpatient versus Emergency Department Settings within an Academic Hospital System	45
2	24	Berkowitz, B	Emory University	Environmental, Cost, and Labor Savings from Implementation of an IV to PO Conversion Intervention in a Pediatric Healthcare System	57
2	22	Bhuiya, NMMA	University of Georgia	Impact of Chemotherapy and Demographic Factors on Survival in Adult (21-64-Year-Old) with Acute Lymphoblastic Leukemia: A SEER Database 10-Year Cohort Study	56
1	6	Blake, AM	Emory University	African American Women's Lived Experiences with Obstetrics/Gynecology in Atlanta, GA	24
2	26	Blake, AM	Emory University	Usability Testing of STEER-MBC (Support Tool for Enhancing Engagement, Empowerment, and Resilience for Patients with Metastatic Breast Cancer): A Qualitative Study	58
1	24	Borate, SN	University of Georgia	Disaggregation of Socio-demographics, Comorbidities, and Health Services Utilization Among Asian Immigrants in the United States	35
1	34	Bouchi, Y	Morehouse School of Medicine	Epidemiology of Pediatric Traumatic Brain Injury: Sex- and Mechanism-Specific Patterns from a Systematic Review	41

2	19	Burdyck, M	Emory University	Assessing Racial Differences in Skin Cancer Outcomes, Presentation and Delays in Care	54
1	16	Caton, L	Emory University	Using Ethnographic Decision Tree Modeling as a Method for Understanding Maternal Substance Use Policy Implementation	30
2	30	Chauhan, S	Emory University	Improving Airway Resource Mobilization in the Emory University Hospital Midtown Emergency Room	61
2	36	Crooks, C	Georgia Institute of Technology and Emory University	Exploration of Human-AI Teaming Concepts to Support Community Medical Emergency Response and Combat Casualty Care Management	65
2	7	Crosley, E	Emory University	Recorded Heights and Weights in the Critically Ill- An Exploratory Retrospective Analysis of Medical ICU Patients at Grady Memorial Hospital	47
1	4	Deshmukh, A	Emory University	Evaluating Blood Pressure Checks and Postpartum Visits in Reducing Acute Care Use Among Hypertensive Women	22
1	32	Durham, T	Emory University	Promoting Voting and Civic Engagement Amongst Emory Medical Students	40
2	32	Durham, T	Emory University	Initiative to Equip Georgians to Engage in Voting at Grady Memorial Hospital	62
1	26	Elshafie, S	Emory- University of Georgia	Impact of Telehealth Use on Endocrine Therapy Adherence, Metastasis Incidence, and Healthcare Costs Among Women with Breast Cancer: A Claims-Based Cohort Study	36
2	8	Eyassu, DG	Emory University	Development of a Centralized Department Website to Facilitate Information Sharing	47
1	31	Falae, T	Emory University	Association of Racialized Economic Segregation with Acuity and Severity at Initial Presentation among Children with Leukemia and Lymphoma	39
2	33	Fields, V	Emory University	Early Team Assessment for Emergency Department Patients	63
1	5	Fogel, A	Emory University	Attitudes Toward Eligibility of Solid Organ Transplant Candidates with Criminal Justice Involvement: A Cross-Sectional Survey of U.S. Transplant Providers	23

1	36	Gillet, S	Emory University	TAILORD Electronic Intervention to Improve Therapy in a Diverse Cohort of Patients With Heart Failure (TAILORD-HF) - a Study Design	42
1	3	Gompers, A	Emory University	Quantifying Intersectional Racial and Gender Disparities in Kidney Transplant Access in the US	22
2	2	Gonzalez Laca, A	Emory University	Multidisciplinary Perspectives on the Implementation Challenges and Strategies of an Eye-Tracking Device in an Integrated Primary Care Setting	43
1	27	Goodson, S	Emory University	Community Led Development of Videos and Cookbooks to Address Infant Anemia in Refugee Communities	37
2	18	Green, M	Emory University	Excess Burden of Hospitalizations in Adults with Diabetes by Race – a National US Cross-Sectional Study	53
1	17	Guevara-Bermudez, LP	Emory University	Hospitalist Knowledge Gaps Regarding Continuous Glucose Monitoring (CGM) Uses	30
2	17	Henshaw, L	Emory University	Modified Diuretics Guidelines for Heart Failure Patients Using a Large Language Model: Quality Improvement Project	53
1	8	Hu, CC	Emory University	Trends in the Inactive Kidney Transplant Waitlist and Implications for Candidate Survival (2005-2023)	25
1	33	Hu, X	Emory University	Palliative Care for Advanced Cancer under Privatized Medicare Market in the US and the Role of Provider Networks	40
2	3	Hugo, AJ	Emory University	Intersectional Race and Sex Disparities in Provision of Kidney Transplant Information	44
2	16	Kawther, A	Emory University	Anal Cancer Stigma in People Living With HIV	52
2	15	Krause, K	Emory University	Implementing Comprehensive, Evidence-Based Behavioral and Mental Health Services in a Childrens Healthcare System	52
1	25	Millwee, S	Emory Healthcare	Towards Zero Harm: A System-Wide Initiative to Improve Hospital Mortality	35

2	34	Monge, V	Emory University	Outcomes of Care Coordination in a Student- Run Continuity of Care Clinic for Immigrant Populations	63
2	1	Namjoshi, A	Emory University	Identifying Multimorbidity Patterns and Predictors of Healthcare Utilization Among Adults with Arthritis: A Machine Learning Approach	43
2	11	Nikpour, J	Emory University	Exploring the Financial Value of Nurse Visits in Primary Care	49
1	7	Nygren, C	Emory University	An Assessment of Preventive Care Utilization and Results at a Student-Run Gynecology Clinic in Clarkston, GA	24
2	25	Patel, R	Emory University	Excess Burden of Hospitalizations in Adults with Diabetes by Age – a National US Cross-Sectional Study	58
1	21	Pozzo, NS	Emory University	Validation of an Ecological Momentary Assessment (EMA) Protocol to Reduce Recall Biases in Social Contact Data Collection	33
2	23	Pozzo, NS	Emory University	Assessing the Implementation Potential of Consumer Health Wearables for SARS-CoV-2 (PASC) Symptom Management and Tracking	56
2	21	Prakash, M	Kennesaw State University	Multimodal Analysis of Patient–Nurse Interactions in Bedside vs. Virtual Nurse During Discharge Education	55
1	12	Profeta, C	Emory University	A Framework for Patient Access Management: Consensus rrom a Delphi Panel of US Health System Leaders	27
2	20	Pu, M	Emory University	Understanding Early Intervention Provider Self-Efficacy in a Parent-Mediated Intervention Before and After Training	55
1	2	Qu, A	Emory University	Racial and Ethnic Differences in Undercounting Disability Related to Mental Health	21
2	14	Raiford, JR	Mercer University / Emory University	Impact of Active Learning and Interprofessional Didactics on Physician Assistant Students Perceived Confidence and Competence of SBIRT Implementation	51

1	9	Ramos, C	Emory University	Influence of Asthma on Racial and Ethnic Disparities in Mental Health Care Among Adolescents with Depression	25
1	15	Reiff, JS	Emory University	The Impact of Mandatory Bundled Payment on Prehabilitation Delivery for Lower Extremity Joint Replacement	29
2	28	Salameh, SE	Emory University	Combining Ambulatory Blood Pressure and Ecological Momentary Assessment to Examine Workplace Stress in Spiritual Health Clinicians	60
1	1	Schnaith, A	Emory University	Depression, Anxiety and Stress Among Caregivers of Children with Chronic Kidney Disease and its Impact on Kidney Failure Treatment Decisions: A Cross-Sectional Survey Study	21
2	5	Seeri, A	Emory University	Differences in Heart Failure Patients with and Without Diabetes in the Home Healthcare Setting	45
2	13	Shah, J	Emory University	Standardizing Discharge Instructions Among Head and Neck Patients Undergoing Transoral Robotic Surgery	50
2	35	Shahin, Z	Morehouse School of Medicine	Community-Engaged Selection and Adaptation of a Family Healthy Weight Program in Fulton County, Georgia	64
1	20	Shaik, MA	Kennesaw State University	Exploring Patients Needs to inform AI Assisted Heart Failure Patient Education Tool	32
1	11	Siskin, D	Emory University	Real World Utilization of Live-brpk (VOWST) Among Patients with Recurrent Clostridioides Difficile Infection: Single Center Experience	27
2	10	Stevenson, I	Emory University	Patient and Provider Perspectives on Contraceptive Counseling for Women with Sickle Cell Disease	48
1	19	Stielow, S	Emory University	Comparing Hospital Length of Stay for Patients with Catatonia Before and After the Intravenous Lorazepam Shortage	32
2	37	Suk, R	Emory University	Standardized BPMN 2.0 Modeling of in-Clinic and at-Home Self-Sampling Cervical Cancer Screening Workflows in an FQHC	65

2	12	Taffe, J	Emory University	Bridging Silos and Building Community: Reflecting on the Journey of the Southeastern Kidney Transplant Coalition Using the Community Based Participatory Research River of Life Tool	50
1	28	Taj, S	University of Georgia	Real-World Treatment Receipt of Medications for Opioid Use Disorder among Adolescents and Young Adults in U.S. Medicaid	37
2	27	Teimouri, RT	Emory University	Social Desirability and Self-Reporting Bias when it comes to Social Distancing: A Demographic Comparative Analysis	59
1	30	Tetlow, SM	Emory University	Changes in Outpatient Mental Health Service Use Among Medicare Beneficiaries with Co-morbid Depression, Diabetes and Heart Disease After Cost-sharing Parity	38
2	31	Tetlow, SM	Emory University	Patterns of Psychotherapy and Antidepressant Use After Release of the U.S. Preventive Services Task Force Recommendation for Universal Adult Depression Screening	62
1	10	Tran, D	Medical College of Georgia	Trust, Mistrust, and Willingness to Participate in HPV Vaccination Research among U.S. Vietnamese Families: A Community-Engagement Qualitative Study	26
2	29	Verma, S	Emory University	Changes in Pediatric Palliative Care Visit Content Following Addition of Mental Health Clinicians	60
1	18	Villa Zapata, L	University of Georgia	Telehealth Experiences and Outcomes in Oncology Care: Findings from a Pilot Survey Study	31
2	6	Villongco, C	Morehouse School of Medicine	Ethnoracial Variation of Peer Recovery Support Services Utilization for SUD	46
1	23	Wang, R	Emory University	Assessing Post-Exertional Malaise in Long COVID and ME/CFS: A Scoping Review	34
1	22	Xue, Q	Emory University	Machine-Learning Algorithm to Identify Carriers of the G6PD rs1050828 Variant in African American Men	34
1	14	Yang, H	Emory University	Health Shocks and Advance Care Planning Among U.S. Older Adults: Evidence from HRS 2012–2022	29

2	9	Yang, H	Emory University	Machine Learning Typology of Longitudinal Palliative Care Use Among Patients with Non-Small Cell Lung Cancer	48