TEACHING HUMAN TRAFFICKING TO 3RD YEAR MEDICAL STUDENTS

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**Purpose:** Human trafficking (HT) is the fastest growing organized crime globally, with over 20 million victims annually. HT victims experience numerous medical and psychological issues, for which they are likely to interact with health care providers. In fact, 88% of HT survivors report seeking healthcare while being trafficked, yet less than 10% of physicians have been trained to identify HT. Because of the prevalence of HT and likelihood of victims to seek medical care, it is imperative that all physicians learn about identification, communication, and referral to safety. Many medical, nursing, and social organizations encourage members to receive training in HT. Despite these calls to action, there remains no formal requirement on HT in US medical education.

**Methods:** Our institution is one of two US medical schools using a novel HT educational program to provide an experiential learning activity to third year medical students. Students participate in a standardized patient (SP) case scenario, with a reticent teen who epitomizes many red flags for HT. Students are asked to write up the case in the Step 2 CS style. Immediately following the case, students complete a pre-survey identifying baseline knowledge, skills, and attitude toward HT. They then complete an online eLearning module about HT, after which they complete a post-survey. After IRB exemption, we used descriptive statistics to compare the results of the pre- to post-survey to quantify improvements in knowledge, skills, and attitudes toward HT.

**Results:** Pre-surveys were completed by 69 third year medical students last academic year. On pre-survey, when asked about differential diagnosis, only 10% of students correctly identified the case as human trafficking, with the largest group of responders (46%) answering domestic violence, 17% child abuse, and 6% prostitution. The majority of students (74%) stated that they did not have sufficient HT training. Of the 72 students who completed the post-survey, 79% reported now having adequate HT training and 57% now feeling confident with their ability to identify a HT victim. The differential diagnosis on the 113 student submitted write-ups of the SP case included HT (11%), rape/trauma/abuse (10%), and domestic violence (7%). The physical exams on case write-ups included relevant physical findings of cigarette burn (52%) and concerning tattoo (35%). Comments from the SP evaluations of students reported that many students seemed to suspect something but were unsure how to address their concerns, and many students did address safety and partnered with SPs.

**Conclusions:** Our novel educational intervention combining a standardized patient case scenario and eLearning module is effective in improving knowledge about and confidence in identification of HT among 3rd year medical students. Our pre-survey statistics are consistent with national data on identifying HT victims in clinical settings. Students in the 2nd half of the academic year were more likely to identify PE findings and include HT in differential diagnosis. By incorporating HT education into the medical school curriculum, we can ensure that every graduating physician, in every specialty, is trained to recognize HT and intervene on behalf of victims.

**Sources of Support:**
UNDERSTANDING ACCESS AND EQUITY: ASSOCIATIONS BETWEEN BARRIERS TO HEALTH CARE AND SOCIAL MARGINALISATION

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Purpose: The impact of technology on help-seeking and access to health care is not comprehensively understood. There is also a need to address inequities in health access for different groups of young people. The purpose of this study was to identify and measure the prevalence of a range of barriers to health care, their sociodemographic correlates and the associations between barriers and social marginalisation.

Methods: This was part 1 of a mixed-method study series; a cross-sectional survey of 12 – 24 year olds across New South Wales, Australia with oversampling of five subpopulations of marginalised young people: Indigenous, homeless, sexuality and/or gender diverse, refugee background, geographically rural or remote. The questionnaire collected demographic information, questions indicating social marginalisation, use of technology in help-seeking, barriers to health care, service utilisation in past six months, chronic health problems and measures of psychological distress. A youth consultant committee assisted questionnaire development and study promotion. The questionnaire was available online and hardcopy.

Results: 1,416 young people completed the survey from 2016 – 2017, median age 18 years (IQR 4); 68.4% female, 28.7% male, 3.0% other. 426 were sexuality and/or gender diverse, 478 rural/remote, 169 Indigenous, 118 homeless and 75 of refugee background. 63.3% belonged to one or more marginalised groups. The number of chronic health conditions increased with increasing marginalisation (p<0.01), as did rates of very high levels of psychological distress (p<0.001). Young people were significantly more likely to have high or very high Kessler-10 scores if they belonged to at least one of the five marginalized groups (57.1% cf 43.4%; p <0.001). Spending time away from school or work due to illness or injury increased with increasing marginalisation (p<0.05), as did staying away due to care for someone else (p=0.001). Cost was the most prevalent barrier for all marginalised groups (26.7% to 56.1%), as well as for those belonging to no marginalised groups (45.0%). Confidentiality was only cited as a barrier by 15.2% of the whole sample, and varied from 12.7% to 19.5% between groups. Increasing marginalisation was associated with identifying fewer barriers. Cost (p<0.05), not having a Medicare card (p<0.05), opening hours (p<0.001), gender of the doctor (p<0.01) were less likely to be identified with increasing marginalisation. Those who belonged to more marginalised groups were more likely to have selected “nothing” would prevent or stop them from visiting a health service (p<0.01). However, these intersectionality groups were confounded by an association with both age and gender. Respondents belonging to an increasing number of marginalised groups were more likely to be younger (p<0.001) and male (p<0.001).
Conclusions: The cost of health care for young people is a significant barrier regardless of social marginalisation. The unexpected finding that number of barriers decreases with increased marginalisation could be due to life complexity and priorities, as well as ambivalence and disengagement relating to healthcare. Due to previous negative experiences, discrimination and stigma, barriers may be more associated with engagement rather than practical access. Qualitative data collected in the study series will help understand these findings.

Sources of Support: NSW Ministry of Health

53.

PEDIATRIC PRIMARY CARE PROVIDER KNOWLEDGE, ATTITUDES, AND SKILLS IN CARING FOR GENDER NON-CONFORMING YOUTH

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Purpose: Gender non-conforming (GNC) youth have specific healthcare needs. Pediatric primary care providers may be the first or only point of contact for these children in the healthcare system, and thus can play an essential role in their health and well-being. However, very little is known about pediatric primary care providers’ comfort and experience with caring for GNC youth. The objective of this study is to better understand pediatric primary care providers’ knowledge, attitudes, and skills in caring for gender non-conforming youth.

Methods: Between January and May 2017, we conducted a cross-sectional survey of 460 pediatric primary care providers employed in two pediatric hospital care networks and in the city health department clinics in a large metropolitan area. Participants from the hospital network practices were recruited via email invitation and those at the city health centers were recruited in-person. Surveys were administered electronically or on paper and included 18 items about knowledge, experience, and comfort providing care for gender non-conforming youth. Data were analyzed using descriptive statistics and Pearson chi square for bivariate analyses.

Results: Of the 161 respondents (35% response rate), 134 (83%) were physicians and 11% were nurse practitioners and been in practice for an average of 18.6 years (sd: 10.9, range: 1-44). The majority of respondents were female (83%) and 80% were white, 7% Asian, and 5% African American. In regards to knowledge, more than half (54%) of the participants did not know that there were professional guidelines to support puberty blocking medications for a child who identifies as transgender. Providers who reported having prior experience caring for LGBT youth reported feeling more comfortable knowing where to refer patients with questions about gender identity than providers with no experience (68.3% and 23.08%, respectively, p=0.002). A higher proportion of providers with personal experience knowing someone who identifies as transgender reported feeling more comfortable talking to patients about gender identity than those without personal experience (88.5% vs 48.8%, p=0.002). There were no differences in knowledge or comfort by provider primary insurance type, age, race, gender or years in
practice. The majority of participants (86.3%) either agreed or strongly agreed that they would be a better clinician if they had more training on supporting gender non-conforming youth.

**Conclusions:** In this study of pediatric primary care providers in a large urban area prior experience with gender non-conforming youth, whether personal or professional, was associated with increased comfort in providing care. There was also poor knowledge of existing guidelines and high levels of interest in additional training in this area. Our findings suggest an urgent need for targeted educational interventions addressing the care of gender non-conforming children and adolescents for practicing pediatricians.

**Sources of Support:** Community Access to Child Health (CATCH), American Academy of Pediatrics and Community Scholar in Residence (CSIR), University of Pennsylvania

54.

**AN INTERVENTION TO SUPPORT TEEN PARENTS OF HOSPITALIZED CHILDREN**
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**Purpose:** The children of adolescent parents present challenges for safe hospital discharge. Factors affecting safe discharge can be – power differentials between adolescent parents and providers, less experience in healthcare decision-making, and situations of high stress and emotion. We used research findings to create a navigator and video intervention to improve communication and collaboration between the adolescent parent and the medical team.

**Methods:** Program development: We conducted 40 interviews with adolescent parents, and had informal discussions with nursing, social work, medical, and chaplain staff. Analysis demonstrated that the difficulty with adolescent parents was not in decision-making competence, but rather in stigma, relationship building, communication, and difficulty accessing existing resources. These findings were presented to multidisciplinary health care teams at IU Health and the IU Parent and Youth Advisory Boards. The consistent recommendations across these groups were as follows: (1) rather than create new resources, consider a navigator as part of the intervention to help link with existing resources; (2) focus the intervention on communication and relationships; (3) educate both the health care team as well as the young parent; and (4) provide information in a youth-friendly medium. Setting: Large, Midwestern tertiary children’s hospital serving an ethnically, socioeconomically, and geographically (urban, suburban, and rural) diverse population. Funding: IU Health Values Integration of Religious and Spiritual Dimensions in Health Care.

**Results:** Results: Program description: A navigator with a health education background meets with the nursing team at their morning huddle. Young parents (14-21 years old) are identified, and the navigator introduces the program. This includes a series of web based, youth friendly video clips for young parents and their families: All Star Care Team, Communicate with the Healthcare Team, Know your Hospital Resources, and Support a Young Parent. The navigator offers these services to the young parent: attend morning rounds for support, provide a safe space to ask questions, and refer to needed resources.
Simultaneously, health care teams caring for children of young parents are asked to watch a short video describing adolescent decision-making and adolescent parent challenges. Movie clips: https://www.youtube.com/playlist?list=PLyw6c3UHrYT-YnFXTkJKCH0LMwDX-A-Vz https://www.youtube.com/playlist?list=PLyw6c3UHrYT8PbEij0kkJSnAuu6wVijQ9&spfreload=5

**Conclusions:** Next steps include a quasi-experimental, mixed-methods design to evaluate feasibility and acceptability. Quantitative measures will include demographics, child medical diagnoses, health literacy, and a validated consumer assessment of health care providers. Qualitative measures will elicit likes, dislikes, and ideas for improvement. Impact and innovation: Research findings led to the creation of an intervention to support adolescent parents based upon engagement and relationship building, not decision-making. The navigator intervention and video clips focus on building trust and respect, and include provider training to maintain an awareness of experiences of stigma and need for dignity of young parents.

**Sources of Support:**

55.

**PROVIDER ADHERENCE TO PREVENTATIVE REPRODUCTIVE HEALTHCARE GUIDELINES IN MEDICALLY COMPLEX AND DISABLED ADOLESCENTS AND YOUNG ADULTS: A CASE-CONTROL STUDY**

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**Purpose:** Adolescents and young adults (AYA) with complex medical conditions and disabilities represent an under-served population with regards to reproductive healthcare. Although research is lacking in adolescents, adult women with disabilities report that they feel less likely to receive contraceptive and sexually transmitted infection counseling and routine gynecologic care. Current reproductive healthcare guidelines from the United States Preventative Task Force, Centers for Disease Control and Prevention, and American College of Obstetricians and Gynecologists do not exclude patients from routine reproductive healthcare guidelines on the basis of disability alone. AYA with disabilities are not excluded from existing recommendations regarding menstrual, sexual, and pregnancy history documentation; gonorrhea, chlamydia, and human immunodeficiency virus (HIV) screening; and human papilloma virus (HPV) vaccine administration. The objective of this study was to examine provider adherence to routine reproductive healthcare guidelines in AYA with disabilities.

**Methods:** A retrospective, case-control study identified AYA, age 12 to 26, receiving routine well care (based on CPT codes) in a Complex Care Clinic from January 1, 2011 - December 31, 2016. The Complex Care Clinic provides lifelong primary care to medically-complex and disabled patients. Age- and sex-matched controls were selected from patients receiving routine well care during the same time interval at an internal medicine-pediatrics clinic in the same institution. 42 matched pairs were identified, and their medical records were reviewed for documentation of pregnancy, menstrual, and sexual histories; screening within the past year for gonorrhea, chlamydia, and HIV; and initiation and completion of HPV
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Poster Symposia III: "Putting out the Welcome Mat" - Addressing medical system barriers to adolescent healthcare

vaccine. Initiation and completion of meningococcal vaccines was collected as a comparison measure for HPV vaccination. Number (percent) of cases and controls receiving each specific reproductive healthcare recommendation was calculated. Chi-square tests were utilized to compare cases to controls.

Results: Mean age of cases and controls was 17.3 years ± 3.8 years and 40.4% was female. In general, adherence to sexual, menstrual, and pregnancy history recommendations was poor. Sexual history was documented in 22.5% of cases versus 73.8% of controls (p < 0.001). Among females, any documentation relating to menstruation was found in 16.7% of cases versus 41.2% of controls (p=0.11); menstrual regularity was recorded in 11.1% of cases versus 50.0% of controls (p=0.01); and pregnancy history was documented in 0.0% of cases versus 26.7% of controls (p=0.04). Among those 15 years of age and older, 7.1% of cases and 33.3% of controls had been screened for HIV (p= 0.03). While 92.3% of cases and 66.7% of controls started meningococcal vaccine series (p<0.01), 48.7% of cases and 59.5% of controls initiated HPV vaccine (p=0.33). Rates of HPV and meningococcal vaccine series completion did not differ between cases and controls. Absence of appropriate sexual history documentation precluded determination of adherence to gonorrhea and chlamydia screening guidelines.

Conclusions: Adherence to basic preventative reproductive healthcare guidelines was inadequate in both settings but worse among AYA with disabilities. Excellent rates of meningococcal vaccine administration in those with disabilities indicate that improved HPV vaccine coverage is possible. Reduction of this health disparity may require specific guidance regarding AYA with disabilities in current reproductive health recommendations.

Sources of Support: Unfunded.

56.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTHCARE ON CHICAGO’S SOUTH SIDE: ASSESSING THE GAPS
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Purpose: Recent years have seen gains in adolescent sexual and reproductive health (SRH) led by lower rates of adolescent pregnancy associated with later sexual debut and adoption of highly effective methods of contraception. However, these gains mask persistently high rates of adolescent pregnancies, HIV, and sexually transmitted infections (STIs) in communities facing the severest structural and systemic inequalities. One theory for understanding persistent disparities is that recent gains occurred in settings and for individuals most amenable to available interventions. There is an opportunity for further improvement by taking a human-centered approach in which gaps are identified and innovative strategies are developed in collaboration with affected communities.

Methods: To identify opportunities for intervention, key informant interviews were conducted with health care providers and educators serving a predominantly Black neighborhood on Chicago’s South Side. To select the neighborhood, SRH indicators were compared across Chicago’s community areas. The neighborhood exhibits rates of teen pregnancy, HIV, Chlamydia, and gonorrhea among the highest in Chicago. All health care and educational facilities serving adolescents in the neighborhood were
identified, and key staff from these organizations were invited to participate. Interviews focused on describing the status quo, identifying gaps in current services, describing the needs of local adolescents, and potential opportunities and barriers to fulfilling those needs. Interviews were transcribed verbatim and independently coded in Atlas.ti (version 7) by a two-person team, and salient themes were identified.

**Results:** Between March and July 2017, 16 interviews were conducted with providers from educational (n=5) and health facilities (n=9). First, informants characterized SRH services as haphazard. While programs for STI testing and sexual education existed, they were often temporary. Partnerships with organizations helped to provide services, but they were difficult to maintain over time, leading to serious gaps and interruptions in service provision. Second, informants said programs needed better alignment with youth’s rapidly changing social interactions. Smartphones and social media are prevalent in these adolescents’ lives, providing an opportunity for reaching them with SRH information. However, interventions are often not delivered via the platforms that youth in their communities use and are unable to compete for their limited attention. Third, in the absence of effective channels for SRH information, youth rely on one another, often sharing myths and misinformation and perpetuating a sense of stigma about SRH.

**Conclusions:** This study obtained clinicians’ and educators’ views on major gaps in SRH care for adolescents in their community. While on the surface it appears that youth have access to SRH care and information, a closer look reveals insufficiencies in infrastructure and consistency of partnerships. Further, available tools for reaching youth with SRH information are not aligned with how and what digital media youth use. These interviews reveal opportunities for redesigning current approaches to adolescent SRH with implications for reducing teen pregnancies and STI rates in hard hit communities.

**Sources of Support:** Funding for this project was provided by an anonymous foundational donor.

57.

"BETWEEN US"- AT THE CORNER OF PRIMARY CARE AND HEALTH EQUITY: SYSTEM-WIDE PRIMARY CARE INTERVENTION TO PROVIDE CONFIDENTIAL CARE TO THOSE WHO NEED IT THE MOST

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**Purpose:** Between Us is a system-wide intervention at the Hennepin County Medical Center (HCMC), a safety net healthcare network providing care for low-income, uninsured, and vulnerable populations in the Hennepin County in Minnesota. Between Us promotes confidential youth services and parent education (http://www.betweenushealth.com/). Funded through a Family Planning Special Project of the Minnesota Department of Health and a Title X Family Planning grant from the U.S. Department of Health and Human Services, Between Us has developed confidential clinical encounters in the electronic health record (EPIC) and funds sexual health services for adolescents and young adults, including clinical visits, laboratory testing, prescriptions, and procedures. Between Us began training professionals providing clinical care for adolescents and young adults at the HCMC in 2013 and begun funding sexual
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Poster Symposia III: "Putting out the Welcome Mat" - Addressing medical system barriers to adolescent healthcare

health services in 2014. This study reports the first evaluation of the Between Us intervention in the complete HCMC network and describes the population served, providers engaged with the program, and services delivered.

**Methods:** Patients receiving confidential services for Between Us were identified based on their Financial Guarantor. Socio-demographic and health data of these encounters were extracted from the electronic health record. Proportions, means and standard deviations were used to describe the population served, providers engaging with the program, and services delivered.

**Results:** Up to June 30th 2017, Between Us has funded 887 clinical encounters of 580 individual patients. While most patients have received services only once (n=376, 64.7%), others have received up to 8 different clinical encounters under the program. Patients served have been mostly female (n=482, 83.1%) from Latino/Hispanic (n=352, 60.7%) or Black/African-American (n=164, 28.3%) origin. The age of patients when receiving services ranged between 12 and 25, concentrating between 15 and 17 years old (n=613 encounters, 69.1%). Over the years, program uptake reached a plateau during the second year of implementation. During the 2014, only 69 encounters were provided. Then, in 2015 and 2016, 316 and 338 encounters were delivered respectively. Up to the end of the first semester of 2017, 164 encounters have been provided. Four HCMC clinics concentrate most services (n=743 encounters, 83.8%). 174 providers have used Between Us encounters. While most clinicians have delivered Between Us encounters fewer than 5 times (74.4%), two providers have used Between Us services for 62 and 88 times respectively (16.9% of total encounters). In most encounters, sexually transmitted infection screening was performed (n=549, 61.9%), identifying 77 new cases. In 225 encounters contraceptives were prescribed (25.4%), most commonly depot injections (n=95, 42.2%) and oral tablets (n=66, 29.3%). Intrauterine devices or subcutaneous implants were prescribed in only 31 encounters (13.8%).

**Conclusions:** The HCMC has successfully implemented a system-wide intervention to provide confidential care for adolescents and young adults. This evaluation highlights the impact of the Between Us program identifying new cases of sexually transmitted infections and preventing pregnancies. Efforts are still needed to expand the intervention to a larger number of clinics, providers, and patients, and promote the use of long-acting reversible contraceptives.

**Sources of Support:**

58.

EVALUATING ADOLESCENT HEALTH TRAINING IN GUATEMALA
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**Purpose:** Today’s generation of adolescents is the largest in history, creating a major challenge for low and middle-income countries faced with the necessity of addressing their health care. Our objectives were to (1) assess gaps in adolescent medicine competencies in Guatemala and (2) examine the extent
to which health care providers are trained, knowledgeable and feel comfortable with providing services to this growing population.

Methods: We conducted a national survey of active physicians who currently provide care to adolescents in Guatemala. The survey contained a total of 101 questions including yes/no, Likert scale, and check all that apply. The survey was pilot tested with 8 healthcare providers prior to being distributed. Emails with the survey link were sent via REDCap to members of the Colegio de Medicos y Cirujanos. Descriptive statistics were used to report training in 35 adolescent medicine topics, current screening practices, and availability of educational opportunities. We used chi-square tests to examine response differences by provider characteristics (specialty, age, trainee status, and geographic location).

Results: Four-hundred eight-four (90.6%) providers who opened our survey link consented to completing the questionnaire. Of these, 391 (80.1%) were currently caring for adolescents meeting inclusion criteria for our final sample. Ninety-five (24.3%) identified as pediatricians; 178 (45.5%) practiced in the capital city. Our sample was young with a median age of 31.0 years [(25th, 75th) quartiles = (29.0, 40.0) years; 3.1% missing]. Almost two thirds [250 (63.9%)] were currently in training. More than 50% of physicians felt that only 3 out of 35 core topics, specifically pregnancy, sexually transmitted diseases and HIV/AIDS, had been covered “well” or “very well” during medical school and residency training. Behavioral health (e.g. school performance, substance use, mood disorders) and communication-related topics (e.g. obtaining consent, maintaining confidentiality) were perceived as particularly poorly covered. Despite guidelines recommending screening for risk behaviors and confidential time during annual health visits, few providers asked “all” or the “majority” of the time about violence at home [62 (15.9%)], substance use [79 (20.2%)], depression [(65) 16.6% ], and sexual activity [23.0% (90)] with only 90 providers (23.0%) asking parents to leave the room for part of the visit. Although most providers [322 (82.4%)] felt comfortable discussing contraception with their adolescent patients, far fewer [164 (41.9%)] would provide a prescription. We found significant differences by specialty. Psychiatrists were significantly more likely to have parents leave the room (p<0.01) and screen for violence and depression; OB-GYNs screened more frequently for sexual activity (p<.01) and prescribed contraception (p<0.01) than others, while both pediatricians and OB-GYN physicians were more likely to discuss contraception (p<0.01). Over 90% of providers [358 (91.6%)] felt strongly about the need for additional training in Adolescent Medicine.

Conclusions: There are significant gaps in adolescent medicine training. The majority of providers are not screening for risk factors and behaviors strongly linked to morbidity and mortality. There is strong support for the creation of a credentialed fellowship program to address shortcomings in caring for this vulnerable population.

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