

future family physicians
family medicine matches 2015

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The Rodnick Colloquium

Innovations in Family & Community Medicine

Golden Gate Club, San Francisco

May 28, 2015

JACK RODNICK MEMORIAL FUND

Dr. Jonathan (Jack) Rodnick served as Chair of the UCSF Department of Family & Community Medicine from 1989 to 2003 and was a vital member of our faculty until his passing in January 2008. To honor his legacy as a leader and scholar, our department has created the **Jack Rodnick Memorial Fund**. These funds support the Rodnick Colloquium on Innovations in Family & Community Medicine and Rodnick Research Grant Program, providing pilot funding for research projects by medical students, residents, fellows, and junior faculty. Such grants are instrumental in giving these “rising stars” a head start in their scholarly pursuits and positioning them to compete more successfully for larger research grants.

We would like to take this opportunity to thank the past year’s donors for their generous contributions.

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Jack dedicated his life to improving medical education and patient care through intellectual inquiry and innovation. With the Rodnick Colloquium and Rodnick Research Grant Program, we invite you to join us in celebrating and continuing Jack’s legacy.

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Two-thirds gave ratings of 6 out of 10 or more for their likelihood of using the pilot community resource guide. Features of this guide that patients liked included the amount of information available, specific resources that were listed, the “all-in-one” organization, and the ability to review the resources in person with someone knowledgeable about the guide. **CONCLUSIONS:** This sample of postpartum women demonstrated needs for both basic and parenting-related services, reflecting the range of challenges in this low-income population. Our results will help inform efforts to connect postpartum women to community resources tailored to their specific needs.

practice improvement projects. The use of practice coaches has allowed for working with practices to identify and deliver support strategies to overcome these early challenges.

HARRISON B, WOJCICKI J. Pushcart vendors at SF elementary schools: friend or foe?

CONTEXT & OBJECTIVE: The SFUSD works to enforce healthy environments for students. City ordinances prohibit mobile food vendors from coming within 750 feet of middle and high schools, due to concerns that their unhealthy foodstuffs threaten school programs. Currently, there are no regulations that restrict vendors near elementary schools. In August 2014, the Food and Fitness Advisory Committee recommended, “pushcarts should not target elementary school students for sales.” The objective of this pilot project was to assess vendors’ impact at elementary schools. **SETTING/POPULATION:** We focused on five public elementary schools in the SF Mission District. Most students represent a high-need population with limited access to resources for nutrition, low income (68.3 – 95.8% students qualify for free/reduced meals), and high disease burden (below Healthy Fitness Zone goals). **INTERVENTION/STUDY DESIGN:** We investigated community needs through primary and secondary sources. By doing a windshield tour near the schools at dismissal time (when vendors congregate), I tracked sales and interviewed key stakeholders including principals, school nurses, security, parents, and vendors. I also collected public information about demographics and ordinances from SFUSD and Department of Public Works. **OUTCOMES/RESULTS:** The number of vendors present at school dismissal ranged from one to seven. Food prices were approximately \$0.75-1.50. The most popular item was ice cream. Other high-selling items were chicharrones (fried pork rinds), corn with mayonnaise, fruit, and churros. Vendors did not provide nutritional information, none had permits, and schools are not profitable sites for them. Most school administrators want regulation as the pushcarts hamper schools’ nutritional programs and pose safety threats when students sneak out to purchase food. Some parents find vendors bothersome. Other parents believe vendors are entitled to this source of income, and that schools should not regulate students outside school. **CONCLUSIONS:** Vendors’ presence at elementary schools provokes questions beyond nutrition, including safety and community concerns. A future direction is to evaluate vendors’ barriers to provide nutritional snacks (shelf time, costs, etc.), as “healthy” pushcarts might provide a solution to appease all stakeholders and promote collaboration between local business and schools to promote healthy options for families.

KO J, HANDLEY M, CHAN C. Engaging diverse postpartum women to improve referral to community resources.

CONTEXT & OBJECTIVE: Low-income women face barriers in accessing adequate health resources to meet guidelines for postpartum care. We worked with the San Francisco Department of Public Health to engage low-income postpartum women to develop a resource referral strategy for connecting low-income postpartum women to existing language-appropriate, low-cost community resources in San Francisco. **SETTING/POPULATION:** In partnership with the San Francisco Department of Public Health, we surveyed postpartum patients at the San Francisco General Hospital Birth Center. **INTERVENTION/STUDY DESIGN:** As part of a quality improvement project, we examined the gap between postpartum resources recommended by national guidelines with postpartum patients’ preferences for resources. Using our assessment of national guidelines, we developed and administered a postpartum survey to 52 patients at the San Francisco General Hospital Birth Center to learn about their community resource needs and preferred methods for receiving resource information. Participants were then referred to a pilot community resource guide and asked to rate their likelihood of using this guide. **OUTCOMES/RESULTS:** 58% of participants spoke Spanish. At least 70% wanted information on resources for medical care for their babies, medical care for themselves, breast pumps, or childcare. Half wanted to learn about classes on parenting and child development, help with finding housing or shelter, discounted bus passes, legal aid, and food assistance programs. A third wanted information on whom to contact if they had signs of postpartum blues or depression. Hard-copy pamphlets were the preferred format for receiving information, followed by websites and text messages, but 20% reported no Internet access.

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- 5 Event Schedule
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- 13 Abstracts—*Concurrent Talks*
- 25 Abstracts—*Poster Presentations*
- 49 Abstracts—*Works Not Presented*

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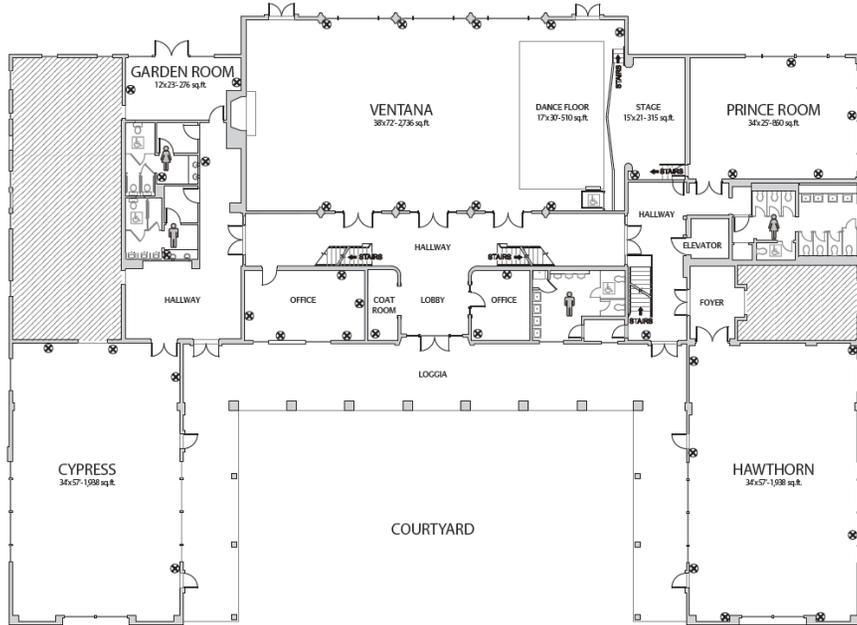
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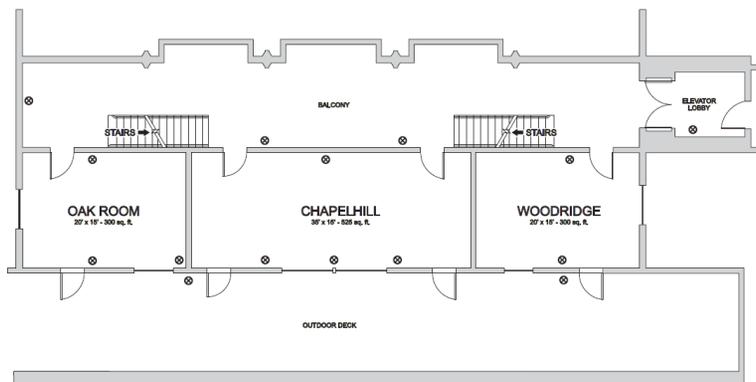
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First Floor



Mezzanine



ABSTRACTS: *Works Not Presented*

BRAVEMAN P, HECK K, RINKI C, MARCHI K, CURTIS M. Childhood hardships are associated with many indicators of maternal/infant health and well-being.

CONTEXT & OBJECTIVE: Adversity in childhood has been linked with poor health in adulthood, but little research has examined impacts during pregnancy or postpartum. **SETTING/POPULATION:** We used data from 13,354 US-born women in California’s 2011-2013 Maternal Infant Health Assessment, a statewide-representative survey of postpartum women. **INTERVENTION/STUDY DESIGN:** We examined relationships between several childhood hardships (parental separation/divorce, incarceration, or alcohol/drug problem; foster care; trouble meeting basic needs; hunger; housing insecurity) and 31 indicators of health or well-being (including maternal/infant health-related behaviors, receipt of medical care, maternal health status, birth outcomes, socioeconomic resources and stressors during pregnancy). We examined the prevalence of each indicator in relation to the number of childhood hardships, unadjusted and adjusted for potential confounders. **OUTCOMES/RESULTS:** Half of US-born women experienced at least 1 childhood hardship and 28% experienced 2 or more. After adjustment, experiencing 2 or more childhood hardships was significantly associated with poorer outcomes in 20 of 31 indicators. For 17 of the indicators, there was an apparent gradient effect, with magnitude of risk increasing as the number of childhood hardships increased. Adjusted prevalence ratios varied, but in 14 indicators there was a doubling (or more) of risk for women with 4 or more childhood hardships compared to none. **CONCLUSIONS:** The pervasive and strong relationship of California women’s childhood hardships to so many adverse health-related indicators around the time of pregnancy is striking. These associations, particularly given the dose-response patterns observed for many outcomes, add to a growing literature suggesting that policies to improve health in adulthood may require improving conditions during childhood.

FISHER L, HESSLER D, POTTER M, WADE M, BOWYER V, DICKINSON P. Implementation of a self-management support program in primary care: initial lessons learned.

CONTEXT & OBJECTIVE: Self-management Support (SMS) is a core component of both the Patient-Centered Medical Home and the Chronic Care Model, and focuses on the central role of patients in managing their illness by engaging with and adopting healthy behaviors that promote optimal clinical outcomes. However, effective SMS can be challenging for primary care practices to implement. Few SMS tools are available to help primary care clinicians identify, monitor, and intervene on unhealthy lifestyle behaviors and problematic psychosocial factors for patients with type 2 diabetes (T2DM). Connection to Health is a project designed to assist practices to implement and sustain SMS over time. **SETTING/POPULATION:** 36 primary care practices in the greater Bay Area and Colorado are participating. Practices are diverse (CHCs, IPAs) and include small to medium sized practices. **INTERVENTION/STUDY DESIGN:** The Connection to Health SMS system (CTH) is a comprehensive and evidence-based SMS program for T2DM in primary care. It utilizes interactive behavior change technology for patient SMS assessment and includes practical tools to aid clinical teams and patients with behavioral goal setting and monitoring through targeted conversations between patients and health care teams. In this cluster randomized trial, practices are randomized to receive: (1) SMS education, (2) the Connection to Health web-based system (CTH), or (3) CTH with practice coaching. A formal mixed-methods evaluation of CTH effectiveness and the impact of practice coaching to enhance implementation is ongoing using the RE-AIM framework to guide analyses. **OUTCOMES/RESULTS:** Early lessons learned will be presented. Common themes include: recruitment and engagement of individual practices without sole reliance on top-down system processes; the need for program flexibility to allow practices to adapt CTH tools to their needs and the needs of the practice population; identifying and addressing IT system barriers and medical record integration; and the roles of practice leadership and staff, with strong involvement from both a practice champion and an administrative team member being critical. **CONCLUSIONS:** The early implementation phases of the project encountered barriers common among

my. **INTERVENTION/STUDY DESIGN:** We conducted interviews with high school Wellness Center staff and organized one focus group with students. The interviews and the focus group were subsequently summarized for major themes and concepts. **OUTCOMES/RESULTS:** Based on the data gathered from the interviews of high school wellness staff and student focus group, the most significant barrier is the lack of awareness of the TYAC and services offered. Students also discussed the desire for drop-in care, short wait times, and cleanliness in their ideal clinic. In addition, the school wellness staff reported confusion and frustration with multiple components of the referral process (e.g. insurance status, clinic call center responses, same-day access). **CONCLUSIONS:** The barriers identified by the wellness staff and students are actionable. Through engagement in this project, the TYAC has started to foster relationships with local high schools and increase collaboration. In addition, to facilitate more robust teen referrals, TYAC leadership is exploring new approaches to clinic operations, including staff development, revised call center protocols and clinic refurbishing.

EVENT SCHEDULE

11:00 – 11:30	Registration and Lunch	<i>Lobby & Courtyard</i>
11:30 – 11:45	Welcome and Introduction *Please pick up provided lunch ahead of time	<i>Ventana Room</i>
11:45 – 12:45	Plenary Panel Discussion “Diversity in Family Medicine: Starting a Conversation about Bias, Discrimination and Inclusion” <i>Maddie Deutsch, MD</i> <i>Director of Clinical Services</i> <i>UCSF Center of Excellence for Transgender Health</i> <i>Jeff Haney, MD</i> <i>Program Director</i> <i>Santa Rosa Family Medicine Residency</i> <i>Lamercie Saint-Hilaire, MD</i> <i>PGY2 Resident</i> <i>UCSF-SFGH Family and Community Medicine</i> <i>Roberto A. Vargas, MPH</i> <i>Navigator, Community Engagement and Health Policy Program</i> <i>UCSF Clinical & Translational Science Institute (CTSI)</i> <i>Teresa Villela, MD</i> <i>Chief of Service</i> <i>UCSF-SFGH Family and Community Medicine</i>	<i>Ventana Room</i>
1:00 – 2:15	Concurrent Breakout Session #1 <i>Prince, Hawthorn, & Cypress Rooms</i> *See concurrent talk listing for specific room assignments	
2:30 – 3:40	Poster Viewing Session *See poster listing for more specific room/area assignments	
3:55 – 5:10	Concurrent Breakout Session #2 <i>Prince, Hawthorn, & Cypress Rooms</i> *See concurrent talk listing for specific room assignments	
5:10 – 5:25	Break	
5:25 – 5:45	Keynote Address “Reflections on Diversity, Unity, and Difficult Conversations” <i>FCM Department Chair, Kevin Grumbach, MD</i>	<i>Ventana Room</i>
6:00 – 6:45	Wine and Cheese Reception	<i>Lobby & Ventana Room</i>

CONCURRENT TALKS: *Session 1*

THE UNDERSERVED & SOCIAL DETERMINANTS

PRINCE ROOM

Moderator: Leah Schweid Romito, MD

Social risk and child health in the early childhood longitudinal study birth cohort

Jessica Chow, MPH

Abstract: p. 14

A needs assessment of California Children's Services: how well are we serving children with special health care needs?

Jennifer Rienks, PhD

Abstract: p. 22

Building a regional hospital partnership to address social determinants of health in clinical settings: lessons from the Bay Area Regional Help Desk Consortium

Aby Burns, MDc, MSW

Abstract: p. 14

Investments in social determinants of health by Medicaid Managed Care Organizations

Laura Gottlieb, MD, MPH

Abstract: p. 18

PIPELINE & WORKFORCE DEVELOPMENT

HAWTHORN ROOM

Moderator: Fred Adler, MD

Social determinants of health: challenging community disparities through training in community based research and mentorships

Eric Sanford, MD

Abstract: p. 22

Mentoring diverse students and promoting primary care through the Future Faces of Family Medicine program

Francheska Gurule, MD; Mariah Hansen, PsyD; Shawn Ruiz; and Morgan Theis, MD

Abstract: p. 18

Addressing health workforce disparities by connecting San Francisco General Hospital and Mission youth through the Summer Urban Health and Leadership Academy

Manuel Tapia, MD, MPH

Abstract: p. 23

Community collaborations: developing healthy lifestyle curricula with Mission District youth-serving organizations

Marianna Kong, MD and Alexa Lindley, MD

Abstract: p. 20

EDUCATION & TRAINING

CYPRESS ROOM

Moderator: Ron Labuguen, MD

Leading the way toward inter-professional leadership development

Jeremy Fish, MD

Abstract: p. 16

Students add value: turning reflections into curricular action

Erika Schillinger, MD

Abstract: p. 13

Patient-provider continuity in residency teaching practices: rising to the challenge

Kate Dubé

Abstract: p. 15

Crowdsourcing curricular change

Renee Betancourt, MD; Ivel Morales, MD; and Lealah Pollock, MD, MS

Abstract: p. 12

following a series of optional in-service trainings. **OUTCOMES/RESULTS:** The educational intervention for our HIV Concentration Pathway providers was useful and did increase providers' comfort with prescribing PrEP. The pocket card has already been well received at nearby community health centers, and we expect that it will increase provider comfort with PrEP prescription at our clinic. Our goal is to increase uptake of PrEP for HIV prevention at the Family Health Center and in the broader San Francisco community. **CONCLUSIONS:** Primary care providers are generally interested in HIV prevention and theoretically support prescription of PrEP, but often lack comfort with prescribing HIV medications. A pocket card with the basics of PrEP prescription, along with brief provider education, should help to increase provider comfort with and provision of PrEP.

WOLF J, GARDNER H, SABA G, DEVORE D, LIN M, ADLER S, BODENHEIMER T, GRUMBACH K, THOM D. The role of a patient and stakeholder advisory board in a study of patient decision making.

CONTEXT & OBJECTIVE: The use of research study advisory boards that include patients and other non-investigator 'stakeholders' is being aggressively promoted by PCORI and supported by other advocacy groups. We report our experience with an advisory board for a study of patient decision making. **SETTING/POPULATION:** San Francisco Department of Public Health and Community Consortium clinics. Patients who had ever received health coaching, health coaches, primary care clinicians, and patient friends/family members. Advisory board composed of representative from these groups plus clinician-administrators and a national expert. **INTERVENTION/STUDY DESIGN:** The advisory board met 6 times between February 2013 and September 2014. The approximate composition at each meeting was 5 patients, 2 health coaches and 1 trainer, 4 clinician-administrators, a national expert, and the study team. **OUTCOMES/RESULTS:** Each meeting had different goals, challenges, and ways to meet the challenges. For example, the major goals of the first meeting were to educate the members about the study, to create a positive working atmosphere in which everyone could participate, and to get ideas on recruitment and how to focus the study. The second meeting included an evaluation and feedback on the structured interview questions. The third meeting included an opportunity for participants to code passages from the data, and the fourth focused on dissemination strategies. We also held a meeting with patients only to do additional coding of passages. The primary challenges were to get everyone to participate and to use the meeting time efficiently. Solutions included using ice-breakers, a combination of large group and small group breakouts; a 'card sort' activity to rank the relative importance of specific health coach behavior, identified from the study, to patient decision making; and post-it notes to allow everyone to identify themes in selected transcribed passages. The meetings had several positive impacts on the study that will be described. **CONCLUSIONS:** Advisory boards composed of patients and other stakeholders provided useful support for our study. We used several techniques to maximize participation. In future studies we hope to assemble an advisory board earlier and provide more opportunities for patients to participate in the research process between advisory board meetings.

WOLFE-MODUPE F, WOLDEYESUS T, CHHITH V, LEE I, UY-SMITH E. Linking locally: Exploring the barriers to referrals to the Family Health Center (FHC) Teen and Young Adult Clinic from local high schools.

CONTEXT & OBJECTIVE: The Family Health Center's Teen and Young Adult Clinic (TYAC) provides reproductive, mental health, and primary care services for youth between the ages of 12-25 years. It is open Mondays from 1-8pm and sees patients by appointment or drop-in. The TYAC has experienced periods of limited use by its target demographic, particularly amongst high school-aged teenagers. This project attempts to explore the reasons behind low patient volume and identify barriers for teenagers accessing care. **SETTING/POPULATION:** To strategically encourage more teens in our catchment area to engage with TYAC services and better address their health service needs, we focused on three local high schools: John O'Connell, Mission High School, and International Studies Acade-

income. The AMA Code of Medical Ethics states “A physician shall promote access to medical care for all people” and “Each physician has an obligation to share in providing care to the indigent.” **OUTCOMES/RESULTS:** A minimum standard of public service activities should be defined and required by all U.S. medical specialties in order to maintain Board Certification and/or professional society membership. **CONCLUSIONS:** Public service activities should be tracked and reported, like Continuing Medical Education hours.

VENER M, CHANG S, STERN N. Mo’ bro? Recruiting and retaining men in UCSF Family Medicine programs.

CONTEXT & OBJECTIVE: Nationally, students who are male or have higher post-graduation salary expectations are less likely to choose primary care (Macy Foundation). In 1974, 2438 men entered FM residency (92% total FM residents). By 2008, 4796 men matriculated (45%), and that percentage has persisted to today (AAFP). Despite this, UCSF falls below national averages. We sought to investigate why the percent of male students matching into FM and the percent of men in our residency fall below national norms and how to address this problem. **SETTING/POPULATION:** UCSF medical students, residents, and faculty from 2000 to present. **INTERVENTION/STUDY DESIGN:** We examined rosters of students attending primary care events and career mentoring during first and third year and compared to students ultimately matching in FM. We also analyzed the number of male UCSF-FM residents and faculty at UCSF and compared with national trends. We conducted a focus group of male residents and an open-ended online survey of male faculty. **OUTCOMES/RESULTS:** In first year, an average of 41 UCSF students are interested in FM (30% male). By third year, 31 are interested (27% male). Although the number of UCSF students matching in FM since 1996 and the percent men varies widely, the median is 3 men/year (mean=20%). UCSF-FM residency classes of 2000-2003 had 30% male residents; while classes of 2014-6, have 20%. This falls below the national average of 45% men. Of 72 UCSF-FM faculty, 21 are male (29%). Of these, 3 (14%) are 30-39 years; 1 is (5%) is 40-49 years; and 17 (19%) are over 50 years. A focus group of male residents and an online survey of male faculty will be completed in March. **CONCLUSIONS:** Numbers of male UCSF medical students considering and matching in FM continue to fall below the national norm, so do number of male residents. Nationally recognized factors such as salary and perceived prestige may play a role. However, the impact of lack of young role models cannot be ignored given the aging demographics of our faculty. Focus groups with male residents and students are planned to generate ideas about how to engage more young men in Family Medicine at UCSF.

WOLCHOK L, POLLOCK L, HAHN M, MITTAL P. PrEParing for HIV prevention in primary care.

CONTEXT & OBJECTIVE: A) Context and objective: Daily emtricitabine/tenofovir (Truvada®) is safe and effective for reducing the risk of HIV acquisition in sexually active men and women and injection drug users. One of the obstacles to the widespread use of pre-exposure prophylaxis (PrEP) is that HIV experts, who are familiar with antiretroviral agents and might be comfortable prescribing PrEP, often do not see HIV-negative patients. Primary care providers, especially those serving high risk populations, are well poised to prescribe PrEP. However, they may be reluctant to offer PrEP for prevention due to discomfort or lack of experience with Truvada and the necessary follow-up. Our project set out to assess feasibility of increasing PrEP prescription in an urban academic FQHC primary care setting and create resources for implementation. **SETTING/POPULATION:** We surveyed resident, attending, and advanced practitioner primary care providers at an urban academic FQHC. **INTERVENTION/STUDY DESIGN:** We started by surveying resident providers from the HIV Concentration Pathway (an HIV-specific educational track) to gauge experience and comfort with providing PrEP before and after an educational intervention. We then created a pocket card to guide providers in prescribing and counseling patients about PrEP. We have now initiated this same process with the wider community of primary care providers at the Family Health Center. Having completed the collection of pre-survey baseline data, we now plan to reassess provider experience and comfort with PrEP in a post-survey

CONCURRENT TALKS: *Session 2*

COMMUNITY ENGAGEMENT

PRINCE ROOM

Moderator: *Lisa Quinones, MD*

Community health centers with formal strategies to engage patients in practice improvement activities get more in return for their efforts

Rachel Willard-Grace, MPH

Abstract: p. 24

What do SF’s low-income communities of color think about education and policy approaches to sugary drinks?

Roberto A. Vargas, MPH

Abstract: p. 17

Bridging the gap: from the streets to a medical home

Mariah Hansen, PsyD; Amy Marietta, MD; and Monique Mendoza

Abstract: p. 19

50 shades of stigma: exploring the healthcare experiences of kink-oriented patients

Jess Waldura, MD, MAS

Abstract: p. 12

PRACTICE TRANSFORMATION & QUALITY IMPROVEMENT

HAWTHORN ROOM

Moderator: *Isabel Lee, MD*

Do individual and organizational capacities to address social determinants of health predict lower burnout in primary care providers?

J. Nwando Olayiwola, MD, MPH, FAAFP

Abstract: p. 12

How patients make decisions with health coaches and primary care clinicians

Dave Thom, MD, PhD

Abstract: p. 24

Practice transformation technical assistance for demonstration sites integrating HIV and primary care

Steve Bromer, MD

Abstract: p. 13

Team-based care in teaching clinics: what do high-functioning teams have in common?

Marianna Kong, MD

Abstract: p. 19

CLINICAL TOPICS

CYPRESS ROOM

Moderator: *Pana Lossy, MD*

Pre-exposure chemoprophylaxis for HIV prevention in transgender women

Madeline Deutsch, MD

Abstract: p. 15

Post-discharge care coordination from the safety net medical home: a health worker phone call intervention

Lydia Leung, MD

Abstract: p. 20

Mindfulness training for providers as a way to enhance patient-centered outcomes?

Larissa Duncan, PhD

Abstract: p. 16

A medical student-driven group diabetic visit

Sharon Stortz

Abstract: p. 23

POSTER PRESENTATIONS

ADDICTION MEDICINE

CYPRESS ROOM

Inpatient Buprenorphine: a needs assessment at San Francisco General Hospital

Sky Lee, MD and Emilia De Marchis, MD

Abstract: p. 40

Implementing a workflow to identify, treat and refer hospitalized patients with alcohol use disorder

Jimmy Feeney and Zachary Matthey

Abstract: p. 38

Expanding buprenorphine treatment and residency education in response to an opioid abuse and overdose epidemic in Contra Costa County

Ken Saffier, MD

Abstract: p. 47

ADVOCACY & LEADERSHIP

CYPRESS ROOM

Value-added medical education: engaging future doctors to transform health care delivery today

Steven Lin, MD

Abstract: p. 40

Improving primary care leadership: the longitudinal community health advocacy medical partnership (L-CHAMP)

Ian Nelligan, MD

Abstract: p. 42

STEP UP: An innovative cross-residency and interdisciplinary collaboration focused on training providers interested in urban underserved care

Angela Echiverri, MD, MPH

Abstract: p. 32

The MINT Program: unique opportunities for resident involvement and advocacy

M. Kathryn McClellan, MD

Abstract: p. 33

Education beyond clinical medicine: the creation of a collaborative curriculum

Leah Schweid Romito, MD and Lauren Wondolowski, MD

Abstract: p. 28

A modest proposal: mandatory reporting of physician public service hours

Marc Tunzi, MD

Abstract: p. 49

EDUCATION & TRAINING

CYPRESS ROOM

Mo' bro? Recruiting and retaining men in UCSF Family Medicine programs

Margo Vener, MD, MPH

Abstract: p. 50

Revamping a didactic curriculum: responding to resident feedback

Lealah Pollock, MD, MS; Renee Betancourt, MD; and Ivel Morales, MD

Abstract: p. 44

Bridges curriculum: a medical students' experience as a health coach on the complex care management team at the family health center

Donald Richards and Lydia Leung, MD

Abstract: p. 45

Development and implementation of a competency-based ambulatory care assessment for Family Medicine residents

John Silva, MD

Abstract: p. 48

Pediatric curriculum innovations – the experiences of a new residency program

A. Elizabeth Iten, MD, MS

Abstract: p. 39

Rates of unanswered questions and behaviors felt to be not appropriate were considered proxies for reliability and validity. The data also allowed an assessment of efficiency of use of the assessment tool. Prompted comments also allowed feedback and thus evaluation of this effort. **OUTCOMES/RESULTS:** Resident performance evaluation is much layered. This tool was designed to formatively assess developing resident knowledge and process in the clinic setting. The experience with the design and roll-out of this tool made it clear that certain competencies are more easily assessed by direct observation, with precepting, e.g. Patient Care, Medical Knowledge. Other competencies do not lend themselves well to direct observation. In particular, rather consistently Practice-Based Learning for Improvement, System-based Practice was challenging to evaluate. **CONCLUSIONS:** Direct observation of resident physician can objectively and efficiently be measured in the ambulatory clinic setting by faculty. The information can be added to other observations to round out a summative evaluation, and guide curriculum design. The competencies of PBLI and SBP will need additional tools to fully support assessment in clinic.

SILVA J. Implementation of a resident clinic-based quality assurance program using the AAFP METRIC tool, two year experience.

CONTEXT & OBJECTIVE: As part of an effort to prepare our residents for Board Certification and to develop a needed "culture of quality" that a modern practice requires, the Natividad Medical Center Family Medicine Residency Program (NMCfMR) has undertaken various office-wide Quality Assurance/Process Improvement projects. This abstract summarizes the implementation experience of the AAFP METRIC DM Module during the PGY-2 year of residency training. This process began in May of 2013 and is in its second year presently. **SETTING/POPULATION:** This project is taking place in the NMCfMR's main continuity clinic in Salinas, CA. The clinic is a Federally Qualified Health Center look-alike and serves the ethnically diverse safety-net population of Northeast Salinas. The foci of the improvements are on the practices of the PGY-2 residents. These residents are in clinic twice weekly, and carry panels of approximately 200 continuity patients. **INTERVENTION/STUDY DESIGN:** The intervention is to use the AAFP METRIC diabetes curriculum in a longitudinal manner over the course of twelve months; to quantitatively study their practices; propose an intervention; and work with their clinic support staffs to improve their selected process area. The teams will essentially be undertaking an improvement trial using the Plan-Do-Study-Act (PDSA) tool, part of the Model for Improvement. **OUTCOMES/RESULTS:** The PGY-2 class of 2013 noted diabetes care outcome improvements in nine of eleven of the typical diabetes quality measures by way of implementation of the group project: DM Flowsheet use. Additionally, foundation was laid for improved interdisciplinary practice with their support staffs. The class of 2014-2015 is presently striving to improve care by implementing a series of patient-centered, low literacy HGBA1C educational tools. **CONCLUSIONS:** The group implementation of this longitudinal curriculum has offered the benefit of preparing the graduating class of 2015 residents to complete ABFM's MC-IV requirement. Additionally, this project, now in its second year, is founding a new, emerging "culture of quality" that is a requirement of a modern primary care practice.

TUNZI M. A modest proposal: mandatory reporting of physician public service hours.

CONTEXT & OBJECTIVE: Studies suggest that there are not enough physicians in the U.S. to care for individuals who are now eligible for health insurance via the Patient Protection and Affordable Care Act. **SETTING/POPULATION:** Private offices are busy and are worried about exchange program reimbursement rates. Safety-net clinics are already at capacity. Waiting times for newly-covered patients are months long in some geographic areas. Individuals who continue not to have coverage – including both undocumented residents and U.S. citizens working without employer-based insurance who would rather risk a fine (\$695 per person) than purchase coverage – are likely to find primary care access unavailable. **INTERVENTION/STUDY DESIGN:** With the foundation of the American Medical Association in 1847, physicians became society's first organized professionals: highly-trained individuals with a 'social contract' to provide high-quality, evidence-based service to their communities, in exchange for the privilege of establishing their own license and peer review standards and maintaining status and

come data at both 12 and 24 months. The proportion of coached patients with control of at least one condition uncontrolled at enrollment dropped only slightly from 47.5% at 12 to 45.5%, at 24 months, supporting an overall maintenance of the coaching effect. In the usual care group, the proportion of patients achieving the primary outcome increased from 10.4% at 12 months to 34.7% at 24 months among patients who received health coaching and from 45.5% to 46.8% among patients who did not receive health coaching. **Conclusions:** One year after a health coaching study was completed, there was minimal loss of benefit for clinical outcomes in the coached group, while the original usual care group improved primarily for poorly controlled patients who received coaching. These results support that improved clinical outcomes persist one year after the completion of the health coaching intervention.

SHARMA A, WILLARD-GRACE R, WILLIS A, ZIEVE O, DUBÉ K, PARKER C, POTTER M. “I see the facilitator as a conductor and we are the musicians”: lessons learned from a qualitative study of high-functioning patient advisory councils.

Context and Objective: Patient advisory councils (PACs) are a promising way for primary care clinics to achieve patient engagement on the clinic organizational level. However, there is scant research on how patient advisory councils run within a clinic site. This study aimed to understand how PACs are structured at community health centers, common successes and challenges with PACs, and their perceived impact at a clinic. These findings will have insight into key ingredients for facilitating effective PACs. **Setting/Populations:** Clinics were selected using reputational sampling within the state of California that were identified by key stakeholders as having high functioning PACs. Each clinic nominated one staff member and one patient advisory council member to be interviewed. **Intervention/Study Design:** Semi-structured, one-on-one interviews were conducted at study sites or by phone by using an interview guide. Interviews were dual-coded using modified grounded theory methods in Atlas.ti, deriving common themes pertinent to best practices for running advisory councils. **Outcomes/Results:** 15 interviews were conducted with patients and staff from eight clinics. Key drivers for effective PACs included carefully identifying and orienting PAC members, providing good facilitation to harness strong personalities toward a common purpose, and developing a mechanism to ensure accountability for reporting back outcomes. Interviewees identified a variety of impacts of the PAC that ranged from tangible improvements to the waiting area to a culture shift among staff. **Conclusions:** Patient advisory councils show great potential for promoting patient-centered practice improvements in primary care practice. Best practices include deliberate approaches to patient recruitment and careful attention to the development of sustainable group processes. There is a common interest in developing a common set of strategies to assist practices in creating and sustaining effective patient advisory councils.

SILVA J. Development and implementation of a competency-based ambulatory care assessment for Family Medicine residents.

CONTEXT & OBJECTIVE: Beginning with the evaluation of a resident in remediation in spring 2013, it became clear that a more objective manner of performance evaluation was needed to effectively assess progress. At the same time, the ACGME was introducing Milestones based assessment to Family Medicine residency programs. The objective of this study was to develop a valid, reliable, and efficient tool to formatively evaluate resident clinic performance according to the six competencies. **SETTING/POPULATION:** The assessment tool was employed in the Natividad Medical Center Family Medicine Residency (NMCfMR) continuity clinic. The author was advised by faculty of the Northern California Faculty Development Fellowship. **INTERVENTION/STUDY DESIGN:** The tool was developed based on a review of the FM Milestones Competency document. An effort was made to define directly observable behaviors that faculty could document as present, absent, or not applicable, over the course of a series of patient encounters. The data demonstrating presence, absence, or non-applicability of a certain observable behavior was evaluated to determine validity, reliability of the survey questions.

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ing sexual health was directly related to clinicians' willingness to initiate the topic and to an overall feeling of trust and familiarity within the relationship. **CONCLUSIONS:** Family medicine clinicians receive a fair amount of cultural competence training and are attuned to perceiving cultural differences between themselves and their patients. Although this has obvious benefits, it may lead to some reluctance to discuss sexuality. In contrast, patients see clinicians as authority figures whose racial/cultural identity is of minor significance compared with the general emotional tone of the relationship. Clinicians should be encouraged to bring up the topic of sexual health in both racially/culturally concordant and discordant relationships.

SAFFIER K, RODELO L, MERJAVY S, MARTINEZ C, RADHAKRISHNA R. Expanding buprenorphine treatment and residency education in response to an opioid abuse and overdose epidemic in Contra Costa County.

CONTEXT & OBJECTIVE: There is a U.S. public health opioid overdose emergency that claimed over 16,000 lives in 2013. Every week in 2014, nearly 2 people died of overdoses in Contra Costa County and the majority involved opioids. Since 2000, federal legislation (DATA 2000) allows DEA waived physicians to prescribe buprenorphine, a partial opioid agonist that can eliminate opioid craving and can be offered in out-patient settings. However, a recent study showed that only 3% of family physicians and general internists had taken the 8 hour course that qualifies them to prescribe this potentially life-saving medication. The challenge for residency programs is to develop educational and clinical opportunities to train a new generation of doctors and their faculty to prescribe buprenorphine, an evidence-based medication assisted treatment (MAT). **SETTING/POPULATION:** Contra Costa Regional Medical Center and Health Centers' family medicine residents, faculty and primary care physicians. **INTERVENTION/STUDY DESIGN:** Beginning with 1 family physician specializing in addiction medicine, meeting the needs of patients with opioid use disorders expanded to include residents, faculty and more recently other Divisions in the Contra Costa Health Services (CCHS). We identified and continue to overcome obstacles in an ongoing process of expanding services and resident and faculty education. **OUTCOMES/RESULTS:** We now have 3 buprenorphine treatment clinics with group visits, periodic DEA approved waiver trainings, and collaboration with other CCHS Divisions that promote medication assisted treatment that includes local substance abuse social model treatment programs. We will share how we have implemented these services, their role in resident education as well as the growth of our population of treated patients. **CONCLUSIONS:** By providing buprenorphine treatment for opioid addiction, we are educating residents, faculty, residency leadership and administration to expand opioid addiction services in response to our local public health emergency of an epidemic of opioid abuse and overdose deaths. Life-saving MAT with buprenorphine is invaluable to engage patients, residents and faculty, demonstrating how opioid use disorders can be successfully treated. Our program is one model for integrating primary care and buprenorphine treatment for opioid addiction.

SHARMA A, WILLARD-GRACE R, HESSLER D, BODENHEIMER T, THOM D. What happens after health coaching? Observational study 1 year after a randomized controlled trial.

Context and Objectives: Health coaching is a useful strategy for chronic disease self-management in the primary care safety net setting, but little is known whether benefits persist after health coaching is completed. We conducted an observational study of participants in the Health Coaching in Primary Care (HCPC) Study, 1 year after its conclusion to evaluate whether improved control of cardiovascular risk factors persists. **Methods:** This was a pragmatic follow-up to a 12-month randomized controlled trial (RCT) comparing health coaching to usual care for patients with uncontrolled diabetes, hypertension or hyperlipidemia. At the 12-month mark, all patients in the usual care arm under poor control were offered access to a targeted, limited health coaching; the health coaching arm did not receive further coaching. The primary outcome was being at goal for at least one of the measures (A1C, SBP or LDL) above goal at enrollment. Chi-square test and paired t-test were used to compare dichotomous and continuous measures, respectively. **Results:** 310 of 441 participants (70.3%) provided out-

and Baby ROS showed promise in enhancing the role of the MA in clinical data gathering and improving team-based care. Neither intervention added significant time to rooming processes.

ROUSE IÑIGUEZ J, POTTER M, GRUMBACH K. Establishing a hypertension data collaborative.

CONTEXT & OBJECTIVE: The goal of this project is to initiate a process to develop a regional health information network for safety net clinical practice settings in the San Francisco Bay Area, supported by CTSI through SFBayCRN, in active collaboration with UCSF Academic Research Systems and with leaders and medical informatics experts from several of the Bay Area's largest community health center consortia. The work focuses on data sharing related to hypertension, a topic of mutual interest to UCSF researchers and community health center leaders. Through this SFBayCRN Hypertension Data Collaborative, we are developing agreements for sharing de-identified patient data, develop a common data dictionary, test approaches to integrate clinical data from different electronic health records systems, and develop a searchable clinical data repository for quality improvement and practice-based research activities. On a broader level, this project demonstrates the potential feasibility and utility of a health information network to support regional translational science and quality improvement initiatives in the safety net. **SETTING/POPULATION:** This project takes place in safety net clinical practice settings, UCSF clinics, and in research teams which convene regularly. **INTERVENTION/STUDY DESIGN:** Established agreements and processes for de-identified data sharing between UCSF and at least three SFBayCRN-affiliated community health center consortia, established a data dictionary for key clinical variables, including patient demographics and other metrics relevant to hypertension and its management, and developed a searchable clinical data repository for de-identified data that can accept and integrate de-identified data related to hypertension from the three most commonly used electronic health records systems (Epic, eClinicalworks, and NextGen) by SFBayCRN affiliated community health center consortia. **OUTCOMES/RESULTS:** As a feasibility study this project's primary outcome would be to see whether or not this type of data collaborative would be mutually beneficial for UCSF and FQHCs in the Bay Area. **CONCLUSIONS:** PBRNs can become the foundation for "learning healthcare systems," enabling the development and testing of new and improved processes of care that are embedded within electronic health records systems themselves. Electronically connected PBRNs have become, therefore, an increasingly critical piece of the clinical and translational research process.

RUBIN A, WALDURA JF. Impact of race and culture on discussions of sexuality for midlife women in primary care: differences in the perspectives of patients and clinicians.

CONTEXT & OBJECTIVE: Sexual health is a key contributing factor to women's overall health. Yet, almost half of women in the U.S. are dealing with sexual concerns and up to 15% are significantly distressed by these. Previous research has identified male provider gender as a barrier to discussing sexuality for midlife women; however there is little information about the impact of the race or culture of the provider on these conversations. Our objective was to explore whether race or culture deters or encourages sexual health conversations between primary care clinicians and midlife women in a multi-cultural setting. **SETTING/POPULATION:** The study included female patients, 45-65 years old, and clinicians located at the Family Health Center at San Francisco General Hospital, a multi-cultural, safety-net primary care setting in San Francisco, California. **INTERVENTION/STUDY DESIGN:** We conducted in-depth interviews and focus groups with 50 patients and 25 clinicians. Subjects were asked to define their race and culture, and to comment on their experiences discussing sexual health with patients or providers of the same and different races/cultures. Data were coded and themes were identified using thematic analysis methodology. **OUTCOMES/RESULTS:** Providers generally reported feeling more comfortable discussing sexual health with patients of their own race/culture. Racial/cultural discordance led to provider anxiety about using the wrong language and to fears about making the patient uncomfortable. Patients, on the other hand, reported seeing clinicians as authority figures, and therefore as culturally discordant, even when they were racially concordant. As such, they tended to de-emphasize the importance of the race/culture of the clinician and reported that their comfort discuss-

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ABSTRACTS: *Concurrent Talks*

ARORA I, RANDALL A, SPROTT R, WALDURA J. 50 shades of stigma: exploring the healthcare experiences of kink-oriented patients.

CONTEXT & OBJECTIVE: The term "kink" describes sexual behaviors and identities encompassing bondage, discipline, domination/submission, sadism/masochism (collectively known as BDSM) and sexual fetishism. Our goal is to describe the healthcare experiences of kink-oriented patients, specifically examining experiences of stigma, anticipated stigma, and issues surrounding "coming out" to healthcare providers. **SETTING/POPULATION:** Kink-oriented San Francisco Bay Area residents **INTERVENTION/STUDY DESIGN:** We conducted in-depth interviews and focus groups of over 100 kink-oriented San Francisco Bay Area residents. Data were coded and themes were identified using thematic analysis methodology. **OUTCOMES/RESULTS:** One half of subjects reported direct experiences of stigma within the healthcare system, mostly in the form of micro-aggression. Almost all subjects reported anticipated stigma, with some avoiding healthcare altogether, for fear of being ridiculed or pathologized. Most subjects felt that kink sexuality had a significant impact on their health, and that it was important to be "out" to healthcare providers in order to receive appropriate care, however fewer than 50% reported being "out" to their current primary care provider. **CONCLUSIONS:** Kink sexual orientation appears to function as a "concealable stigmatized identity," much like LGBT. Kink-oriented individuals may be at risk for health disparities due to their sexual behaviors, their experiences of social disapproval, and their difficulty accessing culturally competent healthcare. Further research is needed to better understand the population and address its healthcare needs.

BETANCOURT R, MORALES I, POLLOCK L, SABA G, COFFA D. Crowdsourcing curricular change.

CONTEXT & OBJECTIVE: Background: Residency curricula should be dynamic and responsive to changes in residents' needs as well as regulatory requirements. At our urban Family Medicine residency, curricular changes have traditionally been generated through quarterly curriculum committee meetings with residents and faculty. This process is lengthy and tends to include only a handful of residents who are available to participate. During the current academic year, we have increased resident involvement in curricular change using an online platform to crowdsource suggestions to improve resident education. **INTERVENTION/STUDY DESIGN:** Methods: A private online community of residents and chief residents was created on Ideascale, a cloud-based innovation software. This tool allows residents to post ideas anonymously on how to improve the residency in a forum style. Residents can comment and vote for or against proposed ideas. The chief residents then present the most popular ideas in the forum to the residency leadership, who help evaluate changes from the standpoint of learning objectives and ACGME requirements. Ideas that garner sufficient excitement can then be implemented. **OUTCOMES/RESULTS:** Since the creation of this online forum in October of 2014, residents have posted 22 new ideas. There have been 40 comments and 115 combined votes. Of these, 16 ideas have been considered for implementation based on their popularity in the forum. At least four ideas have resulted in curricular change or a serious reconsideration of our current curriculum. As a result, we have expanded the intern core lectures from one to two hours per week to include more chronic care topics and supportive wellbeing activities. We have also considered restructuring our current system of 3 month blocks (3 months of inpatient rotations in a row and 3 months of outpatient rotations in a row) to a system of 2 month blocks. **CONCLUSIONS:** Conclusion: Crowdsourcing is an effective way to gather pioneering suggestions from residents to improve resident education. This method facilitates continuous improvement to curricula and is highly inclusive. Strengths of this approach include rapid brainstorming, anonymity, ability to gauge resident interest, real-time feedback about feasibility, and shared information. Limitations of this platform include potential for misrepresentation of interest in proposed ideas.

RICHARDS D, LEUNG L. Bridges curriculum: a medical students' experience as a health coach on the complex care management team at the family health center.

CONTEXT & OBJECTIVE: The Complex Care Management (CCM) Team at SFGH Family Health Center specifically works with patients who are high utilizers and incur high costs to the health system. The program identifies and enrolls individuals who have had more than 3 emergency room visits or hospitalizations in the past year. Via the Bridges Curriculum, a first-year medical student joined the CCM team for a summer and learned how to achieve better patient care and outcomes through a different model of care delivery. This workplace learning experience was a pilot project developed by the Bridges Curriculum and the CCM Team. Prior to joining the CCM team, the medical student completed health coach training. **SETTING/POPULATION:** The CCM team consists of a medical director, registered nurse, social worker, health worker and pharmacist. As part of the Bridges Curriculum, the medical student developed the multi-faceted role of a health coach and participated in the daily activities of direct patient care, working closely with the RN care manager. **INTERVENTION/STUDY DESIGN:** In an effort to gain exposure to direct patient interactions across multiple settings, the student participated as a health coach through outpatient, inpatient hospital, and home visits. Furthermore, the student consulted social service programs; completed telephone visits with patients; and tracked patients' progress on a database. The goal of the experience was to learn to partner with patients to achieve self-empowerment and disease self-management through a different model of care delivery. **OUTCOMES/RESULTS:** Depending on each patient's needs and severity of illness, the patients required different interventions and support. Being a health coach challenged and shifted the way the student approached medical school education. The student gained confidence in his ability to be a functional member of a health care team caring for the most vulnerable patients. Furthermore, this experience enriched the student's understanding of systems-based changes and the complexity and importance of implementing quality improvement project. **CONCLUSIONS:** Being a part of an inter-professional medical team that delivers care differently from the traditional model is a new and innovative way for first and second year medical students to engage in hands-on experience and supplement their medical education.

RODENHIUS A, BUI Q, HILL-SAKURAI L. The impact of enhanced chief complaint and review of systems templates on patient rooming: a quality improvement pilot.

CONTEXT & OBJECTIVE: To improve team-based care, we piloted two rooming processes designed to improve information gathered by the medical assistant (MA) at the time of rooming. These projects were meant to facilitate documentation of the visit in addition to providing better information about chief complaints and other symptoms to clinicians. This project examines the impact of the rooming processes on rooming times and summarizes feedback from participating MAs and clinicians. **SETTING/POPULATION:** This pilot project was completed at the UCSF Family Medical Center at Lakeshore in San Francisco. Two clinicians and two MAs piloted both the Enhanced Chief Complaint and the Baby ROS rooming procedures. **INTERVENTION/STUDY DESIGN:** The first, "Enhanced CC," consisted of structured templates within the EMR for common chief complaints which included more detailed questions about the condition which could then be copied into the provider's documentation. The second, "Baby ROS," was a shortened review of systems template, which could be quickly recorded in the EMR. Data on time spent by the rooming MA before and after implementing either procedure were recorded and the impact on time is presented. Feedback from participating MAs and clinicians were reviewed. **OUTCOMES/RESULTS:** Enhanced CC added about 1.4 minutes to rooming time. Clinicians found the templates to be accurate but sometimes not relevant to the visit. MAs reported that impact on rooming time was negligible but difficult to use with some patients. Baby ROS added 0.2 minutes to rooming time. Clinicians found the ROS information useful. MAs found the template easy and quick to use. Baby ROS provided less detailed information than Enhanced CC. **CONCLUSIONS:** Both Enhanced CC

nate these best practices for medical neighborhood integration to a broader national audience and create a useful, actionable resource for safety net primary care practices. **SETTING/POPULATION:** The CEPC partnered with the Center for Care Innovations (CCI), a leader in cultivating and spreading innovation in the safety net, to develop an online resource center for dissemination of best practices in care integration for safety net practices across the nation. **INTERVENTION/STUDY DESIGN:** CEPC identified high performing and innovative models of care integration and utilized a newly developed self-assessment integration tool, the Medical Neighborhood Care Integration Assessment (MNCI-A) to understand progress on an integration continuum and gauge the impact of the innovation. Innovators were then interviewed for deeper understanding of their innovation. CCI then used the CEPC's content to create an online platform for actionable and informative application by health centers nationally. **OUTCOMES/RESULTS:** An interactive resource center has been created to disseminate resources, build connections, and provide a platform for inter-agency learning and collaboration as Community Health Centers (CHCs) and other safety-net primary care providers tackle care integration challenges across the country. The resource center features innovator highlights, care coordination webinars, and a care integration assessment tool (MNCI-A) which provides instant feedback to CHCs. **CONCLUSIONS:** A vast number of Community Health Centers and safety-net providers across the country are being reached through the website, monthly updates, and bi-monthly live and recorded webinars. It provides an easily accessible platform for safety-net providers to learn and collaborate when searching for strategies to better integrate into the larger medical neighborhood and coordinate care for their patients and communities.

POLLOCK L, BETANCOURT R, MORALES I, STAFFORD M. Revamping a didactic curriculum: responding to resident feedback.

CONTEXT & OBJECTIVE: Didactic teaching is an important part of resident education. Balanced didactics should cover essential core topics as well as topics germane to active patient issues. In order to strengthen the didactic curriculum at our urban underserved family medicine inpatient service, we surveyed residents and implemented changes to address residents' needs. We will describe these changes and frame them within the context of the ACGME Family Medicine Milestone competencies. **SETTING/POPULATION:** This project focused on first year family medicine residents who receive didactic teaching as they rotate on the Family Medicine Inpatient Service at San Francisco General Hospital. **INTERVENTION/STUDY DESIGN:** We surveyed last year's intern class in June 2014 regarding their experience of inpatient didactics. We implemented changes to the curriculum based on these survey findings in July 2014. **OUTCOMES/RESULTS:** The survey results called for more lectures on core inpatient topics. Residents also expressed desire for more Morbidity and Mortality (M&M) conferences and "morning report style" presentations. Based on this feedback, we made four major changes. 1) Residents and faculty are collaborating to create or update teaching guides on core inpatient topics. These handouts compile recent literature, treatment guidelines and practice cases to help guide the lecturer during teaching sessions. 2) Attendings on service, who traditionally taught a topic of their choosing, are now given a choice of core topics to cover. 3) Every month, a chief resident does an M&M presentation. These presentations are reviews of actual cases, often interdepartmental and interdisciplinary, and at least one has led to a quality improvement initiative. 4) Morning admission rounds often include an interactive case presentation and discussion lead by a chief resident or attending in a morning report format. We are currently in the process of surveying residents regarding these changes and plan to further adapt the curriculum based on these results. **CONCLUSIONS:** These curricular revisions address domains within five of the six ACGME Family Medicine Milestones: patient care, medical knowledge, systems-based practice, practice-based learning and improvement, and communication. By being responsive to resident feedback, we have created a more robust inpatient didactic curriculum that addresses residents' educational needs as well as nationally recognized priorities for resident development.

BRAVERMAN G, SCHILLINGER E. Students add value: turning reflections into curricular action. CONTEXT & OBJECTIVE: Communication in healthcare has increasingly been recognized as a critical influencer of outcomes, and interpersonal communication has been deemed an AAMC core competency. While faculty assessment of trainees' communication has received considerable attention, there has been less scholarly focus on medical students' own perceptions of challenges. Using qualitative research methods, this study undertook a comprehensive characterization of the clerkship student perspective on communication difficulties in the outpatient setting. **SETTING/POPULATION:** Stanford University School of Medicine clerkship medical students participating in the family medicine clerkship. **INTERVENTION/STUDY DESIGN:** All students participating in the school's required family medicine clerkship received the mandatory prompt, "please describe a communication challenge or improvement opportunity." Responses were collected over seven years and analyzed through inductive modifications to a pre-existing communication framework (SEGUE). Following thematic analysis, we conducted focus groups with students on the family medicine rotation. Transcribed recordings were inductively and iteratively co-coded, and thematically analyzed. **OUTCOMES/RESULTS:** 799 written reflections were collected between 2007 and 2014. Analysis of 771 responses identified 10 major codes (SEGUE+). Inter-rater reliability testing of the SEGUE+ framework achieved a pooled Cohen's Kappa of 0.85. Dominant themes included challenges exchanging information with patients, managing emotional aspects of the patient encounter, and negotiating the terms of the encounter. We subsequently conducted three focus groups with a total of 15 students. Inter-rater reliability testing of the codebook yielded a Cohen's Kappa of 0.66. Analysis of the focus group transcripts revealed student concerns with navigating the healthcare team information hierarchy, modulating communication styles within an evaluative context, and balancing dual roles as learner and provider. **CONCLUSIONS:** Communication curricula focus on the content and process of the medical interview but insufficient time and energy may be devoted to psychodynamic factors, including those aspects of the encounter that are emotionally charged or conflicting. Triangulation between the written reflections and focus groups revealed a shift in focus from the patient to the hierarchy of medical training. This discrepancy may shed light on conversations outside the exam room that lack apparent patient-centeredness: when specifically prompted, students do in fact think deeply about their patients and their interactions with them.

BROMER S, COLVARIO S. Practice transformation technical assistance for demonstration sites integrating HIV and primary care.

CONTEXT & OBJECTIVE: System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings is a multi-site demonstration and evaluation of system-level changes in staffing structures to improve health outcomes along the HIV Care Continuum. It is funded through Health Resources and Services Administration (HRSA)'s Special Projects of National Significance (SPNS). **SETTING/POPULATION:** 15 demonstration sites across the country, in rural and urban areas. **INTERVENTION/STUDY DESIGN:** We provide technical assistance (TA) in practice transformation using the model of the 10 Building Blocks of High Performing Primary Care. We deliver this TA to sites through bi-annual in-person workshops, quarterly webinars, and regular virtual meetings with the project transformation teams at each site, comprised of medical and operations directors, quality improvement specialists, and frontline staff. **OUTCOMES/RESULTS:** In the first of four years of funding, we are finding that it is challenging for sites to plan how they want to transform. Guidance and support should be given to help sites define and document current state of clinical flow, training curricula and evaluation, and root cause analyses. Every medical practice has a different stage of readiness for transformation, as well as a different approach to integrating HIV and primary care. A "pre-implementation" checklist was developed, and webinars explaining practice coaching and specific tools for practice transformation were delivered. A practice coach, either from within the organization or externally, was recommended to implement practice transformative models, and plans are in place for TA to support practice coach collaboratives. **CONCLUSIONS:** Without practice coaching, sites are challenged to be able to document current state of clinical operations, develop PDSAs towards improved clinical operations, identify

measurable objectives, training competencies, workflows, roles and responsibilities, action steps, and evaluative measures.

BURNS A, LONG D, LAVES E, YAMASHITA B, ALTER H, NEWBERRY J, HSEIH D, GOTTLIEB L. Building a regional hospital partnership to address social determinants of health in clinical settings: lessons from the Bay Area Regional Help Desk Consortium.

CONTEXT & OBJECTIVE: Based on growing evidence showing the impact of social factors on health trajectories, many safety-net clinical settings are experimenting with ways to identify and improve patients' social circumstances. In the Bay Area, a diverse group of clinical and public health personnel established the Bay Area Regional Help Desk Consortium (BARHC) to develop and scale programs that provide standardized social needs screening and related clinic-based interventions. **SETTING/POPULATION:** BARHC is comprised of health care providers, social workers, public health advocates, lawyers, and students working to address social determinants of health in safety-net clinical settings across the Bay Area. BARHC supports programs at Highland General Hospital-Alameda Health System, UCSF Benioff Children's Hospital Oakland, San Francisco General Hospital, and Stanford Hospital and Clinics. **INTERVENTION/STUDY DESIGN:** BARHC launched in Summer 2012 as a series of informal meetings to brainstorm strategies for developing clinic-based programs to screen for and address the social, legal, and economic resource needs of vulnerable patients. Over six months, the informal group's enthusiasm for building resource intervention programs evolved into commitments across multiple safety-net institutions to meet monthly to collaborate on developing, piloting, evaluating, and scaling the cross-county effort. Partnership activities include shared volunteer recruitment, training, and continuing education, as well as collaborative technology development and funding efforts. **OUTCOMES/RESULTS:** BARHC evolved from an informal idea exchange between individual practitioners into a substantive consortium providing technical assistance and capacity-building for social needs interventions across four hospital sites. BARHC has trained 419 community volunteers to provide member programs with a diverse volunteer workforce. Together, BARHC clinical programs have screened over 3200 Bay Area families for social, legal, and economic resource needs. All sites are committed to rigorous evaluation and data are shared across sites as they become available to improve intervention models. **CONCLUSIONS:** BARHC enabled rapid program implementation and acceleration at all sites by providing a forum for emerging programs to share research and screening tools, develop and distribute county-based resource algorithms, and learn from one another's implementation and expansion challenges. Robust regional collaboration can increase efficiency and enhance scalability of clinical activities aimed at addressing social determinants of health.

CHOW J, GOTTLIEB L, PANTELL M, JONES-SMITH J, ADLER N. Social risk and child health in the early childhood longitudinal study birth cohort

CONTEXT & OBJECTIVE: Growing evidence suggests that exposures to multiple social risk factors in home, school and community environments may impact child health more than any single adverse exposure. However, existing studies on cumulative childhood adverse risk and child health often are constrained by the availability of longitudinal, comprehensive data on child and family circumstances. **SETTING/POPULATION:** Study analyses draw from a sample of over 10,000 child participants followed from infancy to kindergarten entry in the Early Childhood Longitudinal Study-Birth Cohort (ECLS-B) between 2001-2007. **INTERVENTION/STUDY DESIGN:** The primary outcome of interest is parent-reported overall child health status (CHS) assessed at multiple home visits. We dichotomized overall CHS as good/fair/poor versus excellent/very good. A cumulative social risk index was constructed by summing four independent dichotomized social risk factors (no education beyond high school, family income <185% FPL, not a 2-parent household, and public or no child health insurance) and classifying the cumulative risk index into 3 categories of no, low and high social risk. Bivariate and multivariate logistic regression analyses tested the odds of poor CHS at each time point. Across all time points, 20% of children were exposed to social adversity. One in five children categorized at baseline as "high social

sions on health systems, models of care, continuous quality improvement, health disparities, and leadership skills. **OUTCOMES/RESULTS:** L-CHAMP provides a unique combination of sustained community site placement, service-learning, and mentorship during preclerkship years. On average, students travel to their partner site once a week for approximately 2-3 hours. Projects that students are engaging in include creating educational handouts on prenatal care and developing a hepatitis B screening tool. **CONCLUSIONS:** Embedding medical students in multidisciplinary care teams helps to break down the silos of training, a primary recommendation of the Frenk report. With early exposure to serving as part of care teams, students who participate in L-CHAMP will be far better prepared to lead team-based care systems in the future. Future plans for data collection include soliciting student, physician mentor, and patient feedback on best practices for incorporating medical students in local community health centers.

OLAYIWOLA JN, RUBIN A, SLOMOFF T, WOLDEYESUS T, WILLARD-GRACE R. Perceived roles and drivers of E.H.R. vendors in optimizing primary care practice efficiency: a qualitative study.

CONTEXT AND OBJECTIVE: Electronic Health Records (EHRs) are among the most touted mechanisms to improve primary care efficiency. Despite a burgeoning market, many primary care providers (PCPs) have expressed dissatisfaction with the use of EHRs. While concerns of PCPs are well represented in literature, there have been no studies investigating motivations behind EHR vendor development and to what extent optimization of primary care practice is a priority. The objective of this study is to better understand drivers behind EHR development, how EHR vendors perceive their role, and their strategies in maximizing the performance of primary care teams. **POPULATION:** Various key stakeholders within 6 EHR companies were interviewed. These included clinical informatics physicians, software developers, and senior leadership such as CEOs from EHR vendors working in the top ten U.S.-based EHR companies. **INTERVENTION/STUDY DESIGN:** In-depth interviews with EHR companies were conducted. Interviews were audio-recorded and transcribed. Data were coded and themes were identified using grounded theory methodology. **OUTCOMES/RESULTS:** Key drivers for EHR development included government regulation, feedback from customers, internal priorities, and a broader tech environment which drives end-user expectations about usability. EHR vendors have a variety of strategies for feedback that vary from public mechanisms to vendor testing groups. Because of competing demands, many user suggestions are lost within the prioritization process. EHR vendors perceive two major obstacles to innovation: regulatory requirements that take precedence over desired improvements and the long timeframe of development. Considering developments in EHRs, vendors applaud the movement away from paper-based programs and toward portable, interoperable systems that facilitate population management and predictive modeling. While optimizing primary care workflow was considered important by all vendors, this was not considered a primary driver of their development processes. **CONCLUSIONS:** While interviewees expressed empathy with frustrations and desires of end-users, they described customer feedback as one within a panoply of drivers. Many felt hindered addressing their ideal innovation strategies due to cumbersome product development processes and extensive governmental regulatory requirements. Primary care may most effectively influence optimization of EHRs by taking part in the development of regulatory requirements, taking part in existing opportunities for product feedback, and by offering their help as advisors to EHR vendors.

OLAYIWOLA JN, WILLARD-GRACE R, DUBÉ K, AULAKH V, RUBIN A. Disseminating best practices in care integration in the medical neighborhood.

CONTEXT & OBJECTIVE: Nearly half of adults with health issues report problems with the coordination of their care in the United States. Challenges with care coordination are magnified in the safety net and are increasingly complex. In 2014, a comprehensive literature review outlining strategies community health centers use to integrate into the medical neighborhood was completed by the Center for Excellence in Primary Care (CEPC) and focused on the domains of primary care: specialty care, diagnostic imaging, pharmacy care, oral health, and hospital care. The objective of this project was to disseminate

SSS-USA ladders ($p < 0.01$). Participants that ranked themselves lower in both SSS ladders also reported poorer child global health ($p < 0.01$). **CONCLUSIONS:** These findings suggest that caregiver reported SSS may be a useful target for impacting child health, and screening for SSS could prompt pediatric health care settings to intervene around unmet social needs to impact child health outcomes.

MIRSKY J, TIEU L, LYLES C, SARKAR U. Content and readability of patient-provider e-mails in a safety-net setting.

CONTEXT & OBJECTIVE: The wide implementation of the electronic health record raises questions regarding the safety and efficacy of secure electronic messaging (SEM) between patients and providers, especially among the 90 million Americans with basic or no literacy skills. Despite the prevalence of SEM in current practice, there is a surprising lack of knowledge about its use. Notably, most of the studies analyzing the content of SEM were conducted in the early 2000s among likely “early adopters” of this technology and did not include medically underserved populations. Moreover, there are no studies assessing whether providers are writing messages that meet national recommendations for 8th grade literacy levels. The objectives of this study are to qualitatively and quantitatively describe the content of e-mails exchanged between patients and providers in a safety-net primary care clinic and to assess the literacy level needed to comprehend these messages using a well-validated readability index. **SETTING/POPULATION:** Participants were English-speaking adult patients (or their caregivers) and their primary care providers in the publically funded San Francisco General Hospital general internal medicine clinic. **INTERVENTION/STUDY DESIGN:** We conducted a content analysis using inductive and deductive coding of e-mail exchanges ($n=31$). We compared patient and provider message “readability” using Flesch-Kincaid Grade Levels (FKGL), calculated the frequency of provider messages below an FKGL=8, and assessed the frequency of patient messages written >3 grade levels below provider messages. **OUTCOMES/RESULTS:** All e-mails were non-urgent. Patients included a medical update in 19% of all e-mails. Patients requested action in 77% of e-mails, and the most common requests overall were for action regarding medications or treatments (29%). Patient requests ($n=56$) were resolved in 84% of e-mail exchanges, resulting in 63 actions. There were no differences between patient and provider message FKGL ($p=0.46$), and 68% of provider messages were written below an FKGL=8. Nine of 31 (29%) patient e-mails were >3 grade levels lower than corresponding provider messages. **CONCLUSIONS:** Patients in safety-net clinics are capable of safely and effectively using electronic messaging for between-visit communication with providers. However, this medium is vulnerable to the well-characterized literacy divide between some patients and providers.

NELLIGAN I, BOGGIANO V, KO S, MCCLINTON-BROWN R, SCHILLINGER E. Improving primary care leadership: the longitudinal community health advocacy medical partnership (L-CHAMP).

CONTEXT & OBJECTIVE: Many primary care clinics in the U.S. are transitioning to team-based care models with the goal of becoming high-performing patient centered medical homes (PCMH). This transition to team-based care provides a unique opportunity to integrate medical students in care delivery in the primary care setting. Students trained in health coaching, panel management, medical scribing, and/or quality improvement can be valuable assets to community clinics. In turn, students benefit from early, multi-faceted clinical exposure. **SETTING/POPULATION:** The Stanford School of Medicine is in its second year of an elective course entitled Longitudinal Community Health Advocacy Medical Partnership (L-CHAMP). L-CHAMP pairs medical students at the Stanford School of Medicine with physicians who work at community health centers in the local community. A total of four community health centers are currently participating in the L-CHAMP program. **INTERVENTION/STUDY DESIGN:** L-CHAMP trains preclerkship medical students ($n=3$ during inaugural year; $n=9$ during current year) in health coaching and panel management, and places them at local community health centers in San Mateo and Santa Clara counties. At their sites, students work closely with a physician mentor and his/her team, while conducting health coaching and completing a quality improvement project. As part of their development, students also participate in monthly didactics and group discus-

“risk” changed social risk status during the remainder of the study period; 80% remained high-risk until the end of the study. Unadjusted odds of poor child health were 2-3 times greater in high social risk children compared to children with no social risk across the first 5 years (OR 1.62 at 9-months, 1.82 at 2-years, 3.51 at 4-years, 2.95 at 5-years; $p < 0.05$ for each). Social risks remained significant predictors of poor child health even after adjusting for common covariates such as age, race/ethnicity, sex, and number of children <18 years old in household. Results also show dose-response relationships between early life accumulated social risk and CHS at age 5. **CONCLUSIONS:** Using a longitudinal, nationally-representative birth cohort, we found that social risk-associated disparities in health begin early. Our findings are consistent with previous cross sectional findings and suggest potential clinical strategies for child health optimization could involve early recognition of psychosocial exposures.

DEUTSCH MB, GLIDDEN D, SEVELIUS J, KEATLEY J, GRANT D. Pre-exposure Chemoprophylaxis for HIV Prevention in Transgender Women.

CONTEXT & OBJECTIVE: Transgender women have been found to have rates of HIV as high as 20%, and even higher in some subgroups. HIV prevention interventions have had limited effect in this population, in part due to the focus on MSM rather than transgender women. **SETTING/POPULATION:** This is a subgroup analysis of transgender women within the iPrEx trial, an RCT followed by open label extension trial of tenofovir/emtricitabine for HIV pre-exposure chemoprophylaxis (PrEP). **INTERVENTION/STUDY DESIGN:** Transgender participants were evaluated for adherence and efficacy and compared to MSM controls. Outcome measures included drug level testing and rates of HIV seroconversion. **OUTCOMES/RESULTS:** By an intention-to-treat analysis, efficacy of PrEP in Transgender (T) or Woman (W) failed to reach significance (FTC/TDF: 3.54 v. Placebo: 3.57 HIV+ per 100 patient years[PY]) $p=.97$ and 2.06 v. 3.98 per 100 PY ($p=.001$) seen in NTW subjects (those not identifying as Transgender or Woman). A test for difference in efficacy of FTD/TDF failed to reach significance (3.54 vs. 2.06 seroconversions per 100 person-years, $p=.17$). Combining TW participants with those taking feminizing hormones (H) to the analysis showed a trend toward lower efficacy (FTC/TDF: 3.63 v. Placebo 3.29 per 100 PY, p for interaction=0.08). Of the 12 T/W/H subjects who seroconverted during the iPrEx trial, none had detectable TDF or FTC levels by intracellular ($N=9$) or plasma ($N=3$) analysis. TDF and FTC drug levels were measured at 8 weeks in a random sampling of 470 subjects in the intervention arm. No difference in prevalence of therapeutic drug levels was detected between T/W and NTW subjects. However, analysis of drug levels in a random sample of 303 subjects in the intervention arm measured at several points in time over the course of the intervention demonstrated that significantly fewer T than NTW subjects had drug levels always detected (13% vs 32%) while more were found to have inconsistent levels (61% vs 36%) ($p=.031$). **CONCLUSIONS:** Further study of HIV chemoprophylaxis in transgender women is needed to determine the factors which underlie observed differences in drug levels as compared to MSM. Successful PrEP interventions for transgender women will likely require that they be tailored to the needs of that community.

DUBÉ K, BODENHEIMER T, WILLARD-GRACE R, KONG M, SYER S, OLAYIWOLA JN, GUPTA R. Patient-provider continuity in residency teaching practices: Rising to the challenge.

CONTEXT & OBJECTIVE: Continuity of care is associated with improved preventive and chronic care, higher patient and clinician satisfaction, and lower costs. It is a strong component of the patient—clinician relationship and is key to the educational value of teaching clinics. Teaching clinics face significant challenges to maintaining continuity of care due to rotating residents and part-time faculty. **SETTING/POPULATION:** We conducted site visits at twenty primary care residency clinics across the country. The first ten site visits were selected as a convenience sample based on travel itineraries of study team members. In the second phase of the project, we asked national experts in graduate medical education to identify the highest performing academic teaching sites across the country. Those sites were contacted for screening interviews, and from these interviews, a subset of ten clinics were selected for site visits. **INTERVENTION/STUDY DESIGN:** Data was collected using a structured site

visit guide and semi-structured interviews with clinic leadership, providers, and clinic staff. Site visit reports were analyzed by two independent researchers through an iterative process. The research team reviewed these analyses to identify strategies for improving patient-PCP continuity. **OUTCOMES/RESULTS:** With regard to continuity of care, patients in high performing teaching practices are able to see their primary care provider 60- 80% of the time. Clinics can achieve this with a team-based model of care that includes a mid-level (NP or PA) team continuity anchor who is in clinic 5 days a week. In this model, the front desk uses a scheduling algorithm to schedule patients first with the PCP and second with the mid-level team member. Another effective strategy for achieving high continuity of care is to redesign the resident scheduling system. In this model, there are blocks of time during which residents are more often in clinic and therefore more often able to see their own patients or the patients of their resident practice partners who are away from clinic. **CONCLUSIONS:** Achieving high levels of continuity of care in residency practices requires team-based solutions. Redesign of clinic schedules so that residents are not absent from the clinic for long periods of time can also promote patient-provider continuity.

DUNCAN LG. Mindfulness training for providers as a way to enhance patient-centered outcomes?

CONTEXT & OBJECTIVE: The Centering model of group medical visits (GMVs) is an empowerment model in which the provider engages in facilitative leadership of group discussions on salient health-related topics of concern to the patients. Employing a “facilitative leadership style” is an essential element of the Centering model and one that differentiates it from other forms of GMVs that are didactic and provide health information in a top-down, provider-delivered fashion. Links between model adherence and patient outcomes were examined in a randomized controlled trial (RCT) of CenteringPregnancy group prenatal care (Novick, et al., 2013; AJOG). In that RCT, better fidelity to a facilitative (non-didactic) and participatory group leadership style (i.e., “process adherence”) was associated with better birth outcomes among participants. Fidelity to the recommended health education topics in CenteringPregnancy (i.e., “content adherence”) was also important, but predicted fewer positive outcomes. Reports from Centering faculty suggest that significant barriers to adopting this model of group care include resistance to moving out of a hierarchical model of care delivery in which the provider expects, and is often expected to, provide all of the healthcare knowledge transfer occurring in a medical visit (Rising, S., personal communication). A study of mindfulness training for family physicians (Krasner et al., 2009; JAMA) indicates providers who learn mindful communication skills are more compassionate with their patients and experience less burnout themselves. **SETTING/POPULATION:** We partnered with the national Centering Healthcare Institute, San Francisco General Hospital, and the Homeless Prenatal Program to study CenteringPregnancy with Mindfulness Skills. Study participants were pregnant women (N = 49) enrolled in English-language and Spanish-language CenteringPregnancy group prenatal care. **INTERVENTION/STUDY DESIGN:** We conducted a quasi-experimental study of CenteringPregnancy enhanced with mindfulness skills training. **OUTCOMES/RESULTS:** In this presentation we cover provider reports of implementation fidelity and patient perspectives on provider group leadership. **CONCLUSIONS:** We propose that by training providers in mindfulness—the awareness that arises through “paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 2003)—we can promote and support a more facilitative and empowerment-focused approach to patient-centered care. In turn, by improving the process of how care is delivered, we may predict better patient outcomes.

FISH J, MILLS W, HARRISON S, HANEY J. Leading the way toward inter-professional leadership development.

CONTEXT & OBJECTIVE: Many now believe that leadership and inter-professional teamwork are vital to creating effective system transformation such as shifting our fragmented, chaotic Residency Clinics into a Residency Patient-Centered Medical Home. Family Medicine has now officially taken on the

interdisciplinary teams. A fifth program, the Stanford Patient-Centered Longitudinal Integrated Clerkship Experience (SPLICE), where students do their first clinical year entirely in an interprofessional team-based health system, is under development. **OUTCOMES/RESULTS:** A comprehensive evaluation plan is currently in progress. Preliminary data indicate high levels of student satisfaction with the programs’ overall value, impact on core skills, and interest in primary care. More research is needed to assess the effectiveness and long-term impact of SHIELD. **CONCLUSIONS:** Students are eager to engage in care and take on responsibilities as part of the health care team. Harnessing their collective engagement and untapped capacity for patient care would be transformative.

MAHONEY M. Comparison of the design process of four medium-scale primary health care delivery models, using a 3.0 transformation framework.

CONTEXT & OBJECTIVE: The transformation of primary health care involves a shift away from health care systems that focus on producing medical care and towards the development of systems that optimize health of a population. Halfon et al published a 3.0 transformation framework for population health in Health Affairs in 2014 to “stimulate thinking and support the planning and development of the new roadmap for the next generation of the US health care system.” **SETTING/POPULATION:** The author has been involved in transforming four primary health care systems through University of California San Francisco and Stanford University: (1) The UCSF Correctional Medicine Consultation Network collaborated with the California Prison Health Care Services in the transformation of primary care in California’s 33 state prisons from 2006-2011. (2) In 2012, the Aga Khan University East Africa and UCSF developed the Integrated Primary Health Care Program, which is a public-private partnership between the Universities, government, and community in rural Kenya. (3) The Aga Khan University Hospital in Nairobi (AKUH) engaged in a strategy to rapidly expand their primary care services provided throughout the East African region. (4) Stanford Health Care is embarking on transforming its delivery of primary health care services through a yearlong design strategy called Primary Care 2.0. **INTERVENTION/STUDY DESIGN:** Using the 3.0 transformation framework, the author will compare the design approach of four different primary health care delivery models. **OUTCOMES/RESULTS:** A table outlining the objective, organization of services, care process, payment methodology, health information technology, quality of care, population health improvement, and opportunities for health professionals’ education in the learning health system of the four primary health care systems will be presented and comparisons will be made. **CONCLUSIONS:** A strategy is needed to align multiple stakeholders in health and social sectors and community to co-design a primary health care system that focuses on upstream social, behavioral, and environmental determinants of health.

MARTINEZ A, GOTTLIEB L, HESSLER D, ADLER NE. Understanding the influence of caregiver subjective social status on pediatric health outcomes.

CONTEXT & OBJECTIVE: Adverse social circumstances like hunger and food insecurity can have dramatic, negative impacts on the health of vulnerable children. Subjective social status (SSS), a self-rated measure of an individual’s stance in society, has been shown to be a good predictor of health in adults, independent of objective socioeconomic (SES) measures. An individual’s SSS may also have an effect on the health of their household dependents. This study explores how caregiver SSS relates to child global health and the presence of unmet social needs. **SETTING/POPULATION:** This study included 1963 caregivers of children receiving pediatric urgent care or primary care at San Francisco General Hospital (SFGH) or Children’s Hospital Oakland (CHO). **INTERVENTION/STUDY DESIGN:** This cross-sectional analysis is part of an 18-month randomized controlled clinical trial examining an intervention that attempts to address social determinants of health in pediatric settings. Participants provided objective SES measures (household income and education level), SSS measures using the MacArthur Scale of SSS, a global assessment of their child’s health, and were screened for fifteen other social needs, including food security and housing stability. **OUTCOMES/RESULTS:** Pearson correlations revealed that a higher number of unmet needs was associated with lower placement on the SSS-community and

RNs through PDSA cycles. **CONCLUSIONS:** Options counseling is a vital yet complex part of timely and effective reproductive health care. Creating standardized workflows and trainings can help decrease variability and support RNs in providing this important service to patients.

LEE SW, DE MARCHIS EH, COFFA D. Inpatient Buprenorphine: a needs assessment at San Francisco General Hospital.

CONTEXT & OBJECTIVE: Hospitalization provides a unique opportunity to counsel and treat patients with opioid use disorders who may be estranged from primary care. Although San Francisco General Hospital (SFGH) currently refers patients to the on-site methadone clinic, it lacks a protocol for buprenorphine induction (BI) for inpatients. Buprenorphine is a useful alternative with fewer side effects, easier access, and comparable effectiveness. To better understand the feasibility and need for inpatient BI, our quality improvement study aimed to: (1) identify eligible patients, (2) evaluate the benefit of establishing an inpatient BI program, and (3) outline resources required for a sustainable program. **SETTING/POPULATION:** Opiate users admitted to the Family Medicine Inpatient Service (FMIS) at SFGH from September–October 2014. **INTERVENTION/STUDY DESIGN:** A cross-sectional analysis of a preliminary inpatient needs assessment for BI. Inclusion criteria: opiate users admitted to FMIS, with subsequent screening by DSMV criteria for opiate use disorder. Exclusion criteria: chronic pain, cancer treatment or palliation, concurrent alcohol use disorder, current methadone therapy. **OUTCOMES/RESULTS:** Of the 238 patients on FMIS during the study period, 21 (8.8%) met criteria for opiate use disorder and three (1.2%) were eligible for BI. Of patients with opiate use disorder, 12 (57%) were on methadone maintenance, seven (33%) endorsed chronic pain. The mean number of hospital admissions and emergency department visits for the identified patients with opiate use disorders were 39% lower in patients on methadone maintenance versus individuals not in therapy. Extrapolating from the FMIS service, if 1.2% of the 7370 adult inpatients at SFGH were eligible for BI, 88 patients could qualify for BI each year. **CONCLUSIONS:** Our study identifies a subgroup of patients who could benefit from inpatient BI. Currently, a protocol is under development including coordinating linkage of patients with X-licensed primary care providers. Future steps include piloting BI on FMIS with eventual expansion to other services. Inpatient buprenorphine inductions not only provide an opportunity to engage often stigmatized and out-of-care patients with primary care, but may also decrease hospital costs by reducing admissions and ED visits.

LIN S, SCHILLINGER E. Value-added medical education: engaging future doctors to transform health care delivery today.

CONTEXT & OBJECTIVE: Value-added medical education describes real world learning experiences that leverage the talents and commitments of early medical students to add value to the care of patients. Programs that merge robust experiential learning with the delivery of high quality patient centered primary care is not only desirable to produce 21st century physicians able to achieve better health outcomes for the American people, but necessary as an immediate solution to address the growing imbalance between population demands for medical care and our capacity to provide care. **SETTING/POPULATION:** Students at Stanford University School of Medicine. **INTERVENTION/STUDY DESIGN:** In 2014, we launched the Stanford Healthcare Innovations and Experiential Learning Directive (SHIELD) – an initiative that includes five value-added medical education pilots. All of these programs provide early integrated workplace learning for students by training and involving them in targeted patient care tasks. Programs include (1) the Longitudinal Community Health Advocacy Medical Partnership (L-CHAMP), where students are embedded in community health clinics as health coaches and quality improvement champions; (2) Patient Partners, where students facilitate care transitions for high-risk congestive heart failure patients by providing post-discharge telephone calls and home visits; (3) Clinical Observation and Medical Transcription (COMET) Fellowship, where pre-medical students serve as scribes in primary care clinics; (4) Interprofessional Management of Population Health with Advanced Computer Technology (IMPACT), where students perform population health outreach within

Triple AIM in our effort to assure America's Health. Kevin Grumbach has introduced the concept of the Quadruple AIM, adding to population health, patient's experience of care, and high value care the concept of a vibrant and joyful workforce (including family docs). We believe to achieve our Quadruple AIM in Residency Education we must start with building a strong, deep bench of Family Physician Leaders who fully embrace inter-professional teamwork, facilitative leadership, and leading us to the Promise Land of safe, high-value, effective care of all Americans regardless of payer. A true, vibrant Family Physician-led team care within a patient-centered village. Building our bench will take time, effort, and resources, yet begins with the very skills we embrace in our clinical and teaching roles – collaboration, teamwork, creativity in the face of complexity, and effort. Building on recent UCSF Primary Care Leadership Academy successes such as the Inter-Professional Primary Care Leadership conference recently held at Stanford, we will briefly present the Quadruple AIM concept and introduce a team-development framework based on Lencioni's "Overcoming the 5 Dysfunctions of Teamwork" which can be used to create a Greater Bay Area Family Medicine Inter-Professional Leadership & Teamwork Fellowship based within evolving GBAFMED (Greater Bay Area Family Medicine Educational Collaborative). **SETTING/POPULATION:** GBAFMED (Greater Bay Area Family Medicine Educational Collaborative) **INTERVENTION/STUDY DESIGN:** Developed Concept Proposal to create a GBAFMED Inter-Professional Leadership & Teamwork Fellowship. **OUTCOMES/RESULTS:** Expand our concept of leadership development toward inter-professional development, which will be more sustainable and effective in the long run. **CONCLUSIONS:** We need to expand and deepen our Family Medicine Leadership bench in order to meet the Quadruple AIM and achieve successful Residency transformation. In order to develop true teams at the bedside, we need to develop our leaders within the context of Inter-Professional Leadership & Teamwork. We propose creating a GBAFMED Inter-Professional Leadership & Teamwork Fellowship.

GOETTE C, CHICUATA B, FINE S, SCHMIDT L, VARGAS R. What do SF's low-income communities of color think about education and policy approaches to sugary drinks?

CONTEXT & OBJECTIVE: At UCSF, we have strong science around the impacts of sugary drinks and the evidence base for approaches that reduce consumption. There is a dearth of literature on related community-based perspectives, and we had yet to gather a comprehensive, low-income and communities of color perspective in SF on the subject. Effective approaches will be community relevant and evidence-based. We conducted focus groups and key informant interviews in partnership with organizational stakeholders to better understand perspectives from those communities most impacted by sugary drinks consumption and obesity-related disease in SF. **SETTING/POPULATION:** We partnered with the Shape Up San Francisco Coalition, the SF Department of Public Health, the American Heart Association, The Chicano Latino Indigena Health Equity Coalition, the API Health Parity Coalition, and the African American Community Health Equity Council to develop and conduct focus groups. Our focus group participants included: African Americans, Latinos, and Asian Pacific Islanders; residents of and service providers to the Mission, Tenderloin, and Bayview Hunters Point neighborhoods. We also targeted transitional-aged youth (18-25 years old) and parents. **INTERVENTION/STUDY DESIGN:** UCSF faculty and staff developed a series of focus group questions based primarily in presenting evidence-based approaches to reducing sugary drinks consumption and facilitated participant discussion in reaction to these. UCSF medical and nursing students helped facilitate. Study partners collaboratively analyzed findings and shared broadly for input into how to make findings useful locally. **OUTCOMES/RESULTS:** We learned which approaches community representatives support for education and policy interventions. Preliminary findings include a desire for more education and increased access to safe, clean drinking water in low-income communities in SF. **CONCLUSIONS:** We've engaged local stakeholders to share findings, helping to shape future education at the community level and increase access to drinking water. Most participants want more education on the subject. We learned that African American and Latino participants in particular wanted to learn more about soda industry marketing

tactics, in addition to health impacts. We also learned that participants want policy that is protective of children's health.

GOTTLIEB L, MANCHANDA R, ACKERMAN S, GARCIA K, WING H. Investments in social determinants of health by Medicaid Managed Care Organizations.

CONTEXT & OBJECTIVE: Increasing evidence suggests that social determinants, conditions in which people are born, grow, live, work and age, play a major role in disease onset and progression. Achievement of the health care Triple Aim will require that healthcare systems attend to these social adversities that increase morbidity and mortality. Some clinical innovations expand the traditional bounds of health care to address these "upstream" determinants. Understanding how these interventions have been adopted in the context of Medicaid Managed Care Organizations (MCOs), which serve a large proportion of patients with social and economic barriers to good health, is an important step towards implementing and scaling these interventions across healthcare settings. **INTERVENTION/STUDY DESIGN and SETTING/POPULATION:** To better understand how Medicaid MCOs initiate and implement interventions on social determinants of health (SDH), we conducted both a systematic review of the literature and key informant interviews with 26 Medicaid MCO leaders (Chief Medical Officers/Chief Executive Officers/Chief Innovation Officers) from across the United States. **OUTCOMES/RESULTS:** Results from the systematic review suggest that few data are available in the published literature about the extent to which these types of upstream interventions have been adopted by Medicaid MCOs, where they are likely to have early traction based both on capitated funding mechanisms and the low-income populations served. Key informant interview qualitative analyses demonstrate that Medicaid MCO leaders generally have a sophisticated understanding of SDH and their impacts on members' health; are interested in engaging with their leadership teams about the adoption of SDH interventions; do not routinely conduct social needs assessments with members or rigorous evaluations of interventions; and perceive substantial state influences on intervention adoption. **CONCLUSIONS:** Medicaid MCOs serve populations likely to benefit from clinical innovations on SDH, but little exists in the published literature about how MCOs adopt and sustain interventions in this arena. Many Medicaid MCOs currently experiment with social intervention models, but little standardization exists around reimbursement mechanisms, needs assessments or outcomes benchmarks. Addressing the challenges described by innovators in this field would increase implementation, sustainability and scaling of these interventions in the Medicaid MCO environment.

GURULE F, RUIZ S, HANSEN M, THEIS M, WU J, GRAY T, ROMERO R. Mentoring diverse students and promoting primary care through the Future Faces of Family Medicine program.

CONTEXT & OBJECTIVE: The purpose of our program, Future Faces of Family Medicine (FFFM), is to reach out to students of diverse populations in a local high school with hopes of providing mentorship; promoting careers in the health field, specifically primary care; and offering opportunities to learn a variety of medical skills. FFFM is a program which exists regionally to promote primary care among high school students. The Santa Rosa chapter has created a unique set of opportunities to reach this goal. **SETTING/POPULATION:** Our program is designed to work closely with 6-10 students from a local high school who have identified an interest in the health field. Each student is enrolled in a health track at school and can then apply to participate in FFFM. The students work with family medicine residents in a variety of settings including: primary care clinic, simulation labs, resident-led workshops, and classroom activities. **INTERVENTION/STUDY DESIGN:** We use a variety of educational methods to introduce students to the healthcare field. Each student is paired with two residents. Regular communication and mentorship is encouraged and various events (social and educational) are planned to allow for consistent contact. The students also shadow resident physicians in their continuity clinic to expose them to the intimate doctor-patient relationship. Various workshops are conducted, which focus on physical exam, communication, obstetrics, and suturing. The mentorship process allows students to be exposed to the everyday faces of family medicine and the process of becoming a doctor.

ITEN AE, FUNG-SAKITA S. Pediatric curriculum innovations – the experiences of a new residency program.

CONTEXT & OBJECTIVE: The Kaiser Permanente Napa-Solano Family Medicine Residency program had the unique opportunity of developing a new residency curriculum. Now that the curriculum has been implemented, it has gone through drastic revisions with the following objectives: 1) Build innovative experiences to strengthen resident comfort in pediatric medicine, and 2) Involve multiple specialties and disciplines to develop sense of ownership across an institution for the program. **SETTING/POPULATION:** The Pediatrics curriculum is of particular interest, as it is an area often identified by family medicine residency graduates as one of the weaker areas of their training. The process of evaluation and improvement of the Pediatric curriculum during this past year has incorporated direct feedback from the program's interns, and physicians and staff from both Family Medicine and Pediatrics. **INTERVENTION/STUDY DESIGN:** Written and verbal, one-on-one, and group-based feedback was requested from residents, attendings, and nursing staff. The feedback was pooled into categories that include rotation strengths, weaknesses, and suggestions for improvement. This data was then presented to the Pediatric Rotation Director with specific ideas for change and positive reinforcement on areas of strength. **OUTCOMES/RESULTS:** Changes suggested through feedback have been quickly integrated into the pediatric curriculum. It has resulted in a significant improvement and innovations of the curricular experience, particularly in regards to the 4-week Newborn rotation (identified by residents as the weakest component of the curriculum). Various staff now feel ownership of the curriculum; residents now have more ownership of the NICU patients, are actively called to deliveries for newborn assessment and/or resuscitation, participate in the ED Peds consults with the on-call Pediatrician, attend daily interdisciplinary rounds with OB and Anesthesia, and have an easily accessible reading list and online modules as resources for independent study. **CONCLUSIONS:** The Pediatrics Curriculum has undergone extensive review based on the experiences from the first resident class. A feedback process and curriculum design that integrates residents, faculty, and nursing staff has resulted in innovative changes that strengthen the learning experience for all residents. These unique experiences can be shared with other educators in family medicine, thereby strengthening pediatrics training within the Family Medicine specialty.

KONG M, LINDSAY R, TI A. Options counseling: developing training and standardized workflows in the Family Health Center.

CONTEXT & OBJECTIVE: Options counseling is an essential part of providing comprehensive primary care to female patients of child-bearing age. It also plays an important part in facilitating timely access to prenatal care and termination services. We sought to identify and address barriers and sources of variability in providing options counseling to patients at the Family Health Center (FHC) using the FOCUS-PDSA model of quality improvement. **SETTING/POPULATION:** The Family Health Center at San Francisco General Hospital provides full-service primary care to a multicultural and multilingual, urban underserved population in San Francisco. Registered nurses (RNs) at the FHC are usually the first-line clinic staff to provide basic options counseling to patients with positive pregnancy tests, thus we focused the project on improving and facilitating options counseling by RNs in the clinic. **INTERVENTION/STUDY DESIGN:** We performed a baseline needs assessment surrounding the process of options counseling by interviewing RNs, and sought additional baseline data by performing chart reviews of all patients within the prior months with positive pregnancy tests. We then worked with the RNs, clinic management, and faculty members to develop a standardized clinic workflow for basic options counseling and to create a training session for the RNs. We assessed the efficacy of our interventions using further interviews and chart review to compare with our baseline data. **OUTCOMES/RESULTS:** We identified common obstacles to options counseling by RNs, which included insufficient time and private space in which to counsel patients. Many RNs also identified a desire for more training in order to feel comfortable with options counseling, as well as for a standardized workflow across the clinic. Based on this, we drafted a preliminary workflow that we then assessed and adjusted with the clinic

teamlet staffing and colocation. Teamlet staffing is where one medical assistant works consistently with the same provider(s) and panel of patients. Co-location is where a provider and medical assistant sit next to each other during the workday. Four third-year medical students performed the project evaluation over six months. **SETTING/POPULATION:** Faculty practice with approximately 10,000 patient visits per year. **INTERVENTION/STUDY DESIGN:** Through restructuring schedules, our clinic changed on July 1, 2014 from 3 large teams to 7 "teamlets." Each teamlet consists of one MA working with 1-3 clinicians whose combined clinic load does not exceed 100%. Scheduled monthly meetings allow the teamlet to troubleshoot and maximize its effectiveness. A team of four medical students designed the project evaluation. It included an on-line survey, administered in July 2014 and January 2015, and semi-structured interviews. Survey data was analyzed with the unpaired t test. Interview data was analyzed with emergent thematic coding techniques. **OUTCOMES/RESULTS:** The survey response rate was 66%. Six months after implementation, there was increased satisfaction with the staffing model among providers ($p=0.002$) and staff ($p=0.004$). Teamwork was rated higher among providers ($p=0.01$) and staff ($p=0.04$). Staff perception of working at their highest ability increased but did not reach statistical significance. Qualitative data emphasized two areas not clearly addressed in the survey: increased communication and improved relationships with patients. Challenges included frustration with the physical layout of the clinic and difficulties with cross coverage when a teamlet member was not in clinic. **CONCLUSIONS:** This project supports previous evidence that teamlet staffing and co-location of nursing staff and clinicians can enhance teamwork and overall work satisfaction. It demonstrates that this model can be effectively applied in an academic clinic with many part-time clinicians. Finally, this project provides an effective model of medical student-driven quality improvement.

HUIZAR J, NADLER A, FEENEY J, MATTHAY Z, CLEMENT J, MARTIN M, SHAH SM. Implementing a workflow to identify, treat and refer hospitalized patients with alcohol use disorder.

CONTEXT & OBJECTIVE: Alcohol use disorder (AUD) is a significant cause of morbidity and mortality at San Francisco General Hospital (SFGH). The objectives of this intervention were to (1) develop and pilot a workflow to identify, counsel, and offer pharmacological and behavioral health treatment to all inpatients with AUD and (2) to determine the time and resources required to staff a dedicated position to sustain this workflow. **SETTING/POPULATION:** Our study population included inpatients at SFGH screening positive for at risk drinking. The project was led by medical students in collaboration with social workers, nurses, and behavioral health specialists. **INTERVENTION/STUDY DESIGN:** A single-question screening tool within the nurses' admission checklist was used to generate a daily list of inpatients with at-risk drinking. Medical records were reviewed to determine naltrexone eligibility. All patients were counseled and those interested in behavioral treatment were referred to a substance use counselor at discharge. Information about naltrexone was provided to eligible patients. A summary of this assessment was communicated to the primary medical team. **OUTCOMES/RESULTS:** During our two five-day pilots, 70 patients screened positive for at-risk drinking, and 57 (81%) were contacted. Upon further evaluation, 12 of these 57 did not have AUD. Of the 45 with AUD, 21 (47%) were interested in further treatment, and 14 of these were highly motivated and referred to a substance use counselor. Within one week, one patient had followed up with a counselor. Of the 10 patients interested and eligible for Naltrexone, 4 (40%) were prescribed the medication at discharge. Per patient, an average of 8.1 minutes was spent screening for naltrexone eligibility, 15.3 minutes counseling, and 5.6 minutes communicating with providers. Hospitalization provides a unique opportunity for interventions targeting alcohol use disorder, as patients are often more motivated for change at the time of an acute illness. Embedding a workflow to target AUD among patients within a hospital system is the necessary next step to address this command and devastating problem. Our findings support the feasibility of having a dedicated staff member identify, counsel, and offer treatment to inpatients with AUD.

OUTCOMES/RESULTS: Through this mentorship process, an interest in primary care is provoked. Each student was surveyed at the end of 2014 and all students agreed they felt capable of entering the field of medicine after participating in our program and 50 percent of the students were interested in family medicine. The students also commented that they "loved being with [their] mentor" and "the hands on experience was fun AND important." **CONCLUSIONS:** FFM is an exceptional way to connect with local students from diverse backgrounds, offer mentorship and create a pipeline for primary care. Our program is an effective means of doing so with half the students identifying an interest in family medicine upon completion.

HANSEN M, MARIETTA A, MENDOZA M, KING J. Bridging the gap: from the streets to a medical home.

CONTEXT & OBJECTIVE: At any given time, there are over 700 unaccompanied youth living on the streets in Sonoma County. Our project aimed to address the health needs of these youth as this marginalized population faces overwhelming barriers to accessing medical care. Through community partnerships, we improve health care access by bringing health services directly to where the youth are at. Our mobile clinic has provided much needed services to our youth, such as urgent care, family planning, and HIV/STD screening. Another goal is to improve our residency training in community health by creating a service learning opportunity that helps deepen resident understanding of community-based care. **SETTING/POPULATION:** Our target population was unaccompanied homeless youth in Sonoma County. These youth are recruited by our community partner, Social Advocates for youth (SAY), who have provided food, and shelter to youth for over 30 years. The mobile clinic operates on site at SAY's Teen Shelter. **INTERVENTION/STUDY DESIGN:** We have worked hard to establish an efficient and effective delivery of services at our clinic. We operate our mobile clinic twice per month for one half day. As part of our leadership curriculum, residents are assigned each clinic and have responsibility over all aspects of running the clinic from set-up to providing medical services to post-clinic inventory. With the help of SAY's outreach worker, we create a relaxed and welcoming environment for the youth. We sit outside together, chatting, eating, and working toward the development of trusting and positive relationships between our marginalized youth and our health care providers. **OUTCOMES/RESULTS:** We have begun to meet the health needs of our homeless youth in Sonoma County through many interventions including building a community partnership, performing providing medical care and improving access to insurance. Last year, 40 medical visits were provided to homeless youth with nearly half of those being for family planning. Results from a recent curriculum survey taken by residents identified the mobile van as one of the most successful activities. **CONCLUSIONS:** Through our efforts with the mobile clinic we have increased health care access to a gravely underserved population while providing valuable learning opportunities in community-based care to our residents.

KONG M, DUBÉ K, WILLARD-GRACE R, BODENHEIMER T, OLAYIWOLA JN, GUPTA R. Team-based care in teaching clinics: what do high-functioning teams have in common?

CONTEXT & OBJECTIVE: Well-designed team-based care is an essential building block of high-functioning primary care, but is faced with unique challenges in residency practices. We sought to understand how team-based care is implemented in teaching practices, where the presence of many part-time providers and inconsistent scheduling are common challenges. By identifying themes of successful team-based care in teaching clinics, the goal was to disseminate best practices in delivering collaborative and sustainable primary care in teaching practices. **SETTING/POPULATION:** We conducted site visits at fifteen primary care teaching clinics nationwide, which included teaching clinics in family medicine, internal medicine, and pediatric residencies. **INTERVENTION/STUDY DESIGN:** Site visits were completed using a structured site visit guide and semi-structured interviews with clinic leadership, providers, trainees, and staff. Two independent researchers coded and analyzed site visit reports using an iterative process, and the research team collaborated to identify major themes from

the visits. **OUTCOMES/RESULTS:** Five major themes were identified as important to successful team-based care in teaching clinics: small teamlets with providers and staff that consistently worked together; a culture of empowerment of all team members; expanded team member roles; effective co-location; and consistent team meetings and huddles for team/teamlet communication. **CONCLUSIONS:** Despite obstacles faced by teaching practices in providing team based care, such as irregular provider schedules and staffing ratios, high functioning teams in teaching clinics were able to deliver effective team-based primary care by prioritizing a core set of themes. Understanding these themes may help other teaching practices improve their delivery of team-based primary care as well.

KONG M, LINDLEY A, TAMAYO R, CORADO-VEGA I, MORALES I, POLLOCK L, CABRERA G, CARDOZA J, MARCIA C, MEDINA M, PIMENTEL T, TONEY D, WORTIS N. Community collaborations: developing healthy lifestyle curricula with Mission District youth-serving organizations. CONTEXT & OBJECTIVE: Engaging youth in learning about health and wellness can promote long-term healthy lifestyle attitudes and behaviors. This is particularly important in underserved communities that suffer a disproportionate burden of morbidity and mortality from preventable chronic diseases. Additionally, health education programs provide a forum for youth to establish positive relationships with health professionals, both as health care providers and as role models. The goal of this project was to collaborate with community youth-serving organizations to design an age-appropriate curriculum promoting healthy behaviors. **SETTING/POPULATION:** Family medicine residents at San Francisco General Hospital partnered with two established youth-serving organizations in San Francisco's Mission District – Mission Girls and Boys & Girls Clubs of San Francisco (BGCSF) Mission Clubhouse. The two organizations serve children and adolescents from the local, largely Latino immigrant community. **INTERVENTION/STUDY DESIGN:** Over a one year period, family medicine residents worked with Mission Girls staff, BGCSF Mission Clubhouse staff, and teen peer advocates to plan and pilot interactive, hands-on workshops on the topics of nutrition, positive body image, cyber-bullying, healthy relationships, support for LGBT youth, and reproductive health. We held focus groups with the youth to determine workshop conceptual content, and peer advocates designed workshop activities that would be engaging and culturally relevant for the target audience. Peer advocates led the multiple-station workshops at BGCSF Mission Clubhouse, and family medicine residents led the workshop at Mission Girls. **OUTCOMES/RESULTS:** With our community partners, we created and delivered five workshops, reaching 50 youth participants, ages 7-18. Feedback on the workshops was collected via informal exit interviews with workshop participants and from community organization staff members. We documented the workshops' content in a written curriculum, which is now being used at BGCSF Mission Clubhouse. BGCSF staff reported that the partnership increased academic success and interest in health careers among the peer advocates. **CONCLUSIONS:** Our project illustrates successful partnerships between resident physicians and community-based, youth-serving organizations to develop sustainable health education programming for children and adolescents in a local underserved community. This collaboration not only provided important information about healthy choices, but also engaged youth in peer education and increased their interest in health careers.

LEUNG L, DAVIS E, ROSENTHAL A, BEAMAN J, CHEN E, HAMMER H, IMBERT E, JAMES C, OZA K, ROBERT A, SCHNEIDERMAN M, THOMAS L, WLODARCZYK S, MANCILLAS M, PINEDA I, SCOTT A. Post-discharge care coordination from the safety net medical home: a health worker phone call intervention.

CONTEXT & OBJECTIVE: There are 35.1 million discharges annually from US hospitals and approximately 18 percent of these results in readmission. Safety net hospitals have higher readmission rates attributable to serving patients with lower socioeconomic status and higher levels of comorbidities. With the new Medicare readmission penalty, hospitals have focused on improving patient transitions from inpatient to outpatient settings. **SETTING/POPULATION:** At San Francisco Health Network (SFHN), we implemented a primary care based post-discharge phone call by a health worker to im-

faculty) we incorporated two sessions to reinforce our professionalism through our connection to one another and to our patients. **INTERVENTION/STUDY DESIGN:** In the first session, residents and faculty each wrote a personalized Hippocratic oath (an exercise adapted from Rachel Remen's The Healer's Art Course). In the second session, participants completed a writing exercise that asked them to observe the world through the eyes of another person. Both sessions concluded with out-loud sharing of our writing within small and large groups. **OUTCOMES/RESULTS:** Forums in which residents and faculty reflect together on meaning in medical practice are critical for building a collaborative and supportive learning environment in our residency program. Particularly important are forums in which residents and faculty both are encouraged to allow themselves to be vulnerable by sharing stories and other creative expressions of their professional values and in turn, to experience a safe and judgmental acceptance from their colleagues. **CONCLUSIONS:** Professionalism can be reinforced through forums in which we understand our shared experiences and interests. Through our shared sense of purpose we reinforce our commitment to service. These forums promote the value of humility and shared decision-making in our doctor-patient relationships. These forums allow us to celebrate the thread of service which connects us to ourselves, our colleagues, our lineage as healers and to our patients.

HESSLER D, FISHER L, POLONSKY W, MASHARANI U, STRYCKER L, PETERS A, BLUMER I, BOWYER V, CRAVEN M. The surprisingly low prevalence of depression in adults with type 1 diabetes: A problem of misdiagnosis?

CONTEXT & OBJECTIVE: Studies of the prevalence of depression in adults with diabetes have yielded inconsistent findings, in part due to mixed type 1 and type 2 samples, variation in use of assessment scale cut-points, lack of formal diagnostic assessment for Major Depressive Disorder (MDD), and confusion between scales of depression and diabetes distress (DD). **SETTING/POPULATION:** 368 adults with type 1 diabetes living in California and Canada participated in the study (mean age = 43; 56% female; mean diabetes duration = 26.0 years; mean HbA1C = 7.59% [59.5 mmol/mol]). **INTERVENTION/STUDY DESIGN:** We compared depression prevalence using 4 cut-points on the Patient Health Questionnaire 8 (PHQ8), a gold standard psychiatric interview (Structured Clinical Interview for the DSM-SCID) to diagnose MDD, and a measure of DD (Diabetes Distress Scale-DDS). Our goals were to document differences in prevalence across measures and to identify rates of false positives when the PHQ8 was compared to the SCID. **OUTCOMES/RESULTS:** For PHQ8 score cut-points of >10, >12, >15, and by MDD algorithm, depression prevalence rates were 11.4%, 7.1%, 3.8% and 4.6%, respectively. Prevalence of current MDD based on the SCID was 3.5% and prevalence of clinically significant moderate DD was 42.1%. High rates of false positives occurred for all PHQ8 scoring criteria, when compared to a SCID diagnosis of MDD: >10 = 71.4%, >12 = 65.4%, >15 = 57.1%, DSM algorithm = 52.9%. Thus, between 52% and 70% of all patients who met criteria for depression on the PHQ8 were not clinically depressed. Also, between 93% and 96.2% of patients who met criteria on the PHQ8 and SCID reported at least moderate DD, suggesting considerable overlap between these two constructs (correlation between PHQ8 and DDS=.61). **CONCLUSIONS:** These findings question the use of the PHQ8 as a measure of depression with type 1 adults and suggest that the overall prevalence of MDD is no higher among type 1 adults than in the general population (CDC=4.1%). Results also suggest that the emotional distress assessed by the PHQ8 may be significantly linked with diabetes-specific distress.

HILL-SAKURAI L, BAUER L, CIPRES D, DONDERO T, PERKOVICH B, POYNTON C. Teamlet implementation: analysis of a new model of patient care at Lakeshore Clinic.

CONTEXT & OBJECTIVE: The Patient-Centered Medical Home model requires high quality teamwork and an environment in which all members of the medical team function at their highest abilities. It is challenging to transition a clinic from a traditional, top-down management style to this team-based care model. Specific challenges in an academic clinic include the large percentage of part-time clinicians and a management structure in which physicians work for the medical school and staff work for the medical center. This quality improvement project aimed to increase the sense of teamwork through

ments and lack of communication between clinicians at different sites. To facilitate same or next day appointments, a "LARC partnership" was formed, in which clinicians at referring clinics could call front desk staff at the insertion clinic, and using the term "LARC partnership", obtain prompt appointments for their patients. **OUTCOMES/RESULTS:** Since it began in November 2014, the LARC partnership has increased the number of patients at non-insertion clinics who have been successfully scheduled for a LARC insertion. Additionally, this partnership has built capacity for one non-insertion clinic to work towards becoming an insertion site, with support from the LARC partnership insertion clinic. **CONCLUSIONS:** Referral processes can increase access to LARCs as a cost-effective alternative to training at sites that do not currently perform insertions. This system also serves as a support network for IUD champion staff who want to offer IUD insertions on site. We plan to compare IUD uptake among participants in our current study to that among participants in previous contraceptive studies in these clinics, to assess the effectiveness of the LARC partnership.

GOLDHAMMER B, CORNELL H. Rebranding as a quality improvement strategy.

CONTEXT & OBJECTIVE: Since 1994, the Clinician Consultation Center (CCC) has provided more than 250,000 free, expert consultations to U.S.-based clinicians on HIV management and blood-borne pathogen exposures. As the CCC added new programs, understanding its scope of services under the current brand model became cumbersome. The CCC reintegrated its services under one umbrella with these objectives: 1) positioning the CCC as a leading online resource for consultation and information on blood-borne pathogen exposures; 2) balancing telephone and online access to the CCC; 3) introducing the CCC to a new primary care provider audience; 4) maintaining a focus on providing HIV management assistance; and 5) retaining flexibility for future growth. **SETTING/POPULATION:** The CCC is based in the DFCM at SFGH. The audience is clinicians nationally. **INTERVENTION/STUDY DESIGN:** The CCC enlisted its national Advisory Committee; key stakeholders (callers, funders, community partners); and the user experience, design, and branding firms Experience Lab and LeAnn Locher & Associates to help them understand clinicians' information and consultation needs through a strategic design process, including an extensive needs assessment, key informant interviews, surveys, and call and website data analyses. **OUTCOMES/RESULTS:** The project's value and purpose were confirmed. An umbrella name, logo, tagline, marketing materials, and Mission Statement were developed to cohesively communicate CCC's purpose and mission. Opportunities for new delivery channels for CCC services were identified. The CCC's name, "National HIV/AIDS Clinicians' Consultation Center," became "Clinician Consultation Center" to highlight its primary product: expert consultation, to provide better reach and visibility, and to establish a platform for emerging consultation needs. The website was redesigned, providing intuitive information architecture and clean design. Brand-reinforcing color-coding and iconography reinforced ease of navigation. New web-based tools such as online consultation, clinical guidances, and case discussion summaries were introduced, resulting in increased site usage. An editorial calendar was created to define and control the process of creating website content. **CONCLUSIONS:** Needs assessments, key informant interviews, and analyses by external branding firms resulted in a successful re-branding of this important clinical service. A cohesive message that clearly communicates the usefulness of the product along with supporting content can improve acceptance of clinical services.

HENNEBERG C, BOLY L. Discovering the shared meaning of personal service.

CONTEXT & OBJECTIVE: There is a need for forums that encourage residents and attending staff to build collaborative relationships. Creating these experiences is important in the hierarchical structure of medicine, in which residents traditionally view the attending staff as "experts". The risk of the "expert/learner" dichotomy is that physicians at all levels of training and experience may become disconnected from ourselves, our colleagues, and our shared sense of purpose. More disturbingly, a culture that posits a one-directional flow of knowledge disconnects us from those whom we serve – our patients. **SETTING/POPULATION:** At our annual residency retreat (including residents of all classes as well as

prove care coordination upon discharge from San Francisco General Hospital (SFGH), increase attendance of post-hospital discharge appointments within seven days, and decrease readmission. **INTERVENTION/STUDY DESIGN:** In late 2013, we piloted a post-discharge phone call at four primary care clinics. The health worker identified patients discharged from SFGH daily, made them a follow-up appointment, and called the patients. PDSA cycle #2 modified the script to include questions regarding medication issues and clinic access for worsening symptoms. PDSA cycle #3 focused on ensuring follow-up appointments within 7 days of discharge. Using telephonic survey results regarding patients' experiences with post-discharge follow-up calls, PDSA cycle #4 revised the script to include medication review and clarifying whether patients have sufficient medication until follow-up appointments, a screening for red flag signs, a teach back reviewing call content, and a description of the follow-up appointment's purpose. **OUTCOMES/RESULTS:** One year post-implementation, attendance of post-hospital discharge appointments within 7 days increased from 36% to 42% in General Medicine Clinic and from 33% to 52% in Family Health Center. There were no changes to two other pilot sites due to staffing issues. Overall, SFHN attendance of post-hospital discharge appointment has increased from 32% to 42%. The readmission rate remains unchanged. Only 0.05% of phone calls required nursing involvement. **CONCLUSIONS:** Post-discharge phone calls by health workers can improve post-hospital discharge appointment attendance in the safety net setting. Our low nurse involvement rate reflects that a health worker can do this intervention. The telephone call protocol implemented in this study could be used in other outpatient settings and serve as one method of improving patient safety and timely follow-up during transitions of care.

OLAYIWOLA JN, WILLARD-GRACE R, GRUMBACH K, DUBÉ K, GOTTLIEB L. Do individual and organizational capacities to address social determinants of health predict lower burnout in primary care providers?

CONTEXT & OBJECTIVE: Primary care providers, particularly in safety net settings, face the demands of providing medical care to chronically ill, complex patients while simultaneously addressing social determinants of health (SDH). We sought to understand relationships between providers' perceptions of their skills and clinic resources to address SDH with work experience outcomes. **SETTING/POPULATION:** The System Transformation Evaluation Project (STEP) is a survey of primary care providers (PCPs) and staff in 11 public, 1 not-for-profit, 6 university, and 3 VA health centers in San Francisco. The 2014-2015 STEP questionnaire has been completed in 12 of the 21 participating health centers; remaining sites will complete surveys in March 2015. **INTERVENTION/STUDY DESIGN:** The cross-sectional STEP survey examines multiple indicators of PCP work experience. Work experience outcomes include the Maslach Burnout Inventory burnout, including professional efficacy, emotional exhaustion, and cynicism, as well as a single-item measure of the "doability" of primary care. Predictor variables include provider confidence in asking about patients' social needs, the importance ascribed to addressing social needs, and providers' perception of their own skills and their clinic's resources to address SDH. Preliminary data were analyzed using descriptive statistics and correlations. The full dataset will be analyzed using multivariate modeling to examine predictors of the work experience outcomes. **OUTCOMES/RESULTS:** To date, most respondents (N=204) reported a high level of comfort asking about SDH (mean: 9.0 out of 10 points; SD: 1.3), and strongly agreed that it was important to address SDH (9.4; SD: 1.0). PCPs were less likely to agree that they had the skills (7.4; SD: 2.0) or that their clinic had the resources to address SDH (6.9; SD: 2.6). Higher confidence in skills to address SDH was associated with greater professional efficacy ($r=.20$; $p=.004$), lower emotional exhaustion ($r=-.28$; $p=.0001$), lower cynicism ($r=-.29$; $p<.0001$), and greater perceived "doability" of primary care ($r=.20$; $p=.005$). Greater perceived clinic resources to address SDH was likewise associated with greater professional efficacy ($r=.23$; $p=.001$), lower emotional exhaustion ($r=-.24$; $p=.0006$), lower cynicism ($r=-.29$; $p<.0001$), and greater perceived "doability" of primary care ($r=.32$; $p<.0001$). **CONCLUSIONS:** Building organizational capacity and strengthening PCP skills to address SDH in clinical settings may increase professional efficacy and lessen provider burnout.

RIENKS J, CLOPP L, LONG R, REMY L, OLIVA G, SILVEANU A. A needs assessment of California Children's Services: how well are we serving children with special health care needs?

CONTEXT & OBJECTIVE: The Family Health Outcomes Project at UCSF was contracted by the California Department of Health Care Services to conduct a needs assessment of the California Children's Services (CCS) program, which serves about 180,000 children with special health care needs (CSHCN) annually. **SETTING/POPULATION:** The needs assessment collected information from parents of children enrolled in CCS, county CCS administrators and medical consultants, advocacy organizations, and physicians who care for CCS children. **INTERVENTION/STUDY DESIGN:** To collect data on the program, 16 key informant interviews were conducted, six focus groups were held with 47 participants, and three surveys were developed and administered to families (N = 4065), CCS administrators and medical consultants (N = 82), and physicians (N = 130). **OUTCOMES/RESULTS:** Families expressed satisfaction with case management services, care coordination, and care at specialty care centers. Weaknesses identified by families include: lack of communication from the CCS program, delays in accessing specialists, lack of support for transportation, and variability in program implementation across counties. Local CCS administrators report a lack of CCS paneled physicians and other providers. Physician identified barriers to participating in CCS including low reimbursement rates, lack of resources for coordinating care, and challenges in working with Medi-Cal Managed Care plans. Other weaknesses include a lack of adequate data on program outcomes, and delays in accessing durable medical equipment, which can often result in longer hospital stays. Administrators and physicians indicated that the program should cover the whole child instead of just the child's eligible medical condition. All groups surveyed indicated that when a child ages out of CCS, there are significant challenges in finding adult providers. In the key informant interviews and focus groups, concern was expressed regarding the state not having enough capacity and infrastructure to administer adherence to the CCS standards and to update the standards based on advances in medicine. At the local level, concerns were voiced regarding case management capacity and the substantial variation in case manager ratios across counties. **CONCLUSIONS:** While families are generally satisfied with CCS, the program remains challenged by shortages of CCS-paneled physicians and medical equipment providers, complex paper work, and low reimbursement rates.

SANFORD E, TIRADO S, GONZALEZ J. Social determinants of health: challenging community disparities through training in community based research and mentorships.

CONTEXT & OBJECTIVE: Social Determinants of Health, such as employment status, housing conditions or educational levels, are the fundamental factors of when, why and how our patients get sick. As medicine progresses from fee-for-service to outcomes based models, Family and Community Medicine physicians are uniquely positioned to challenge the community disparities that affect their patients' health. It is imperative that residents are trained to engage in a continuous process of assessing the needs of the community they serve and learn to develop the most effective clinical and community based interventions to address the social determinants of health. **SETTING/POPULATION:** UCSF Natividad Family Medicine Residency has taken a career continuum approach of leveraging local high school and college students to collect community needs assessments. What issues do the people our residency, clinics, and hospital serve feel are most important? The study purposefully involves the community in its design and collection to gain trust and ownership of the process. **INTERVENTION/STUDY DESIGN:** Residents are assigned high school student from East Salinas who they mentor. In turn, the students serve as ambassadors to their community. UCSF medical students help analyze the collected data. Residents on the R2 Community Medicine Rotation interpret data, learn social asset mapping and collaborate to make change. As R3s, residents prepare and disseminate sustainable community based interventions based on results of the surveys and public health data available. **OUTCOMES/RESULTS:** By engaging with the community in collaboration with high school and university students, Residents gain better understanding of the importance of addressing their patients' particular social determinants of health. **CONCLUSIONS:** Collaboration with the local high school and university has enhanced resident wellbeing in terms of developing mentorship relationships in the community they serve, and emphasizing pride in their career accomplishments.

of women who used the tool than those who did not reported complete satisfaction with their method choice (29% vs. 12%; p=.06). **CONCLUSIONS:** The pilot test of our tool offers promising data about its effect on patient knowledge and satisfaction regarding contraceptive decision making. The potential value of the intervention has encouraged us to design a randomized control trial to test the effect of the tool on women's contraceptive continuation and contraceptive counseling experiences.

FLEISHER P, GRUMBACH K, LIU W, ROUSE IÑIGUEZ J, SCHMIDT L, VARGAS R. SFHIP Alcohol Policy and Nutrition Policy Research Study.

CONTEXT & OBJECTIVE: Long term research partnerships in San Francisco have yielded a variety of information on health disparities. Working closely with community partners, we were able to match UCSF expertise with disparities such as obesity, safety, and nutrition in community settings. Our partners wanted to address these disparities on both a behavioral level and a policy level. This study elicits community attitudes towards policy which would address health disparities related to nutrition, and consumption of alcohol. **SETTING/POPULATION:** Bayview/Hunters Point, Mission, Tenderloin with three different community agencies. **INTERVENTION/STUDY DESIGN:** The purpose of this project was to identify strategies to impact policies that affect off sale alcohol and its related harms as well as sugary drink consumption. The project team conducted 18 focus groups targeting vulnerable populations of diverse communities, collected 325 surveys on community-related health and safety problems and solutions and performed key informant interviews (ongoing) in collaboration with our key community partners. Six themes were identified for each of the policy areas. **OUTCOMES/RESULTS:** Two partnership working groups, one focusing on alcohol policy and another focusing on nutrition policy, made up of diverse organizations and neighborhoods residents to implement health promotion programs and policies to reduce health disparities related to unhealthy eating (sugary drink consumption) and alcohol use, respectively. We built consensus among diverse stakeholders and constituents on feasible and acceptable policy especially among disadvantaged populations. **CONCLUSIONS:** Now that we better understand how residents of low-income, alcohol outlet-dense neighborhoods identify their alcohol-related public health and safety problems and the information they need to know to address those problems in the policy arena, we can move forward together as a cohesive multi-sector partnership, taking the next steps toward accomplishing our public health and safety goals. Similarly, our community-based partners were lukewarm to regulatory and tax policies designed to reduce sugary drink consumption. This process of engaging individuals from affected communities in discussions about the harmful health effects of sugary beverages and the rationale for policy level interventions has resulted in low-income, minority communities in SF becoming more engaged and are more willing to partner to move local policy agendas that are relevant to their constituencies.

FOX E, REED R, FITZPATRICK J, EMMET D, JACKSON A, DEHLENDORF C. The LARC partnership: connecting providers to improve contraceptive access.

CONTEXT & OBJECTIVE: Women are increasingly choosing long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) and implants, for their birth control. Many clinics that provide family planning care do not have the resources, such as trained staff or materials, to perform IUD insertions on site. Timely referral processes to clinics that provide insertion may increase LARC access. We aimed to design and implement a LARC insertion referral process to link clinics that do not currently provide LARC insertion with clinics that do. **CONTEXT & OBJECTIVE: SETTING/POPULATION:** We partnered with two San Francisco clinics that provide family planning services, but not IUD insertion and/or implant insertion ("referring clinics"), and one San Francisco safety net clinic that provides both IUD and implant insertion ("insertion clinic"). **INTERVENTION/STUDY DESIGN:** During communication with family planning staff at partner clinics as part of the implementation of a randomized controlled trial, we identified the need for improved LARC insertion referral processes. We convened staff members from each site who identified as LARC champions for a collaborative meeting to discuss solutions. Identified barriers to successful referral were difficulty obtaining timely appoint-

promote the program. Lastly, we wrote a letter to the Dublin Prison Warden to raise awareness about prenatal issues among the MINT women and facilitate referrals to the FHC. **CONCLUSIONS:** Through the framework of the ACQILA curriculum, we collaboratively created products which will be used by MINT program staff and residents who choose to work on this project. This creates a foundation for a MINT curriculum and results in exciting opportunities to improve the care for these vulnerable yet resilient women.

ESCANDÓN M. Quality improvement to recruit post-pregnancy adolescent women to primary care.

CONTEXT & OBJECTIVE: Despite recent reductions in the rate of adolescent pregnancy in the United States, persistent inequities remain between communities; low income individuals, Latinas, and African Americans are all more likely than other groups to become pregnant as teens and have rapid repeat pregnancies. Rapid repeat adolescent pregnancy carries serious health, educational, and economic consequences for adolescents and their children, which places a significant burden on individual teens and on society as a whole. While several programs have been shown to reduce rapid repeat teen pregnancy, it is unclear which parts of multi-faceted interventions are actually the most effective. Some research indicates involvement in coordinated primary care and improved access to effective contraception can help adolescents delay subsequent pregnancies. This quality improvement evaluation project was conducted as a MPH practicum project in maternal and child health. **SETTING/POPULATION:** This project was undertaken at Martha Eliot Health Center, a full-service outpatient adolescent medicine center affiliated with Boston Children's Hospital. Martha Eliot is located in Jamaica Plain, a historically marginalized neighborhood, and serves a predominantly underinsured, Latina patient population. All patients younger than 20 years old who presented to the clinic with newly diagnosed or previously established pregnancy in 2014 were included in the project. **INTERVENTION/STUDY DESIGN:** The study team developed a workflow quality improvement involving the adolescent clinic teamlet (provider, nurse, MA, family planning coordinator) to standardize counseling and follow-up with clients after diagnosis of pregnancy with the goal of recruiting clients to primary care. Chart reviews were performed to track completion follow-up appointments, well woman exam at 1 year, and client choice of contraception as markers of recruitment to primary care. **OUTCOMES/RESULTS:** Initial results indicate that recruitment of adolescent women post-termination was significantly increased compared to historical controls while this was not observed in adolescent women who are parenting. Analysis for completion of well visits and contraception is ongoing. **CONCLUSIONS:** Care coordination and patient centered clinical approaches are potentially effective in recruiting adolescent women to primary care post-termination. More robust interventions or a higher level of support might be necessary to recruit parenting adolescents to primary care.

FITZPATRICK J, ANDERSON N, KUPPERMANN M, STEINAUER J, WITTMAN A, DEHLENDORF C. Pilot study of "My Birth Control," a contraceptive counseling decision support tool.

CONTEXT & OBJECTIVE: While counseling can influence contraceptive use, the quality of contraceptive counseling varies. A decision support tool for contraception is a promising approach to facilitating patient-centered care. We developed a tablet-based decision support tool to help women choose the best method for them and conducted a pilot test to obtain preliminary data about its effectiveness. **SETTING/POPULATION:** Pilot testing was conducted at a safety-net clinic in the San Francisco Bay Area among women of reproductive age seeking a contraceptive method (n=84). **INTERVENTION/STUDY DESIGN:** Using bivariate and multivariate analyses, we compared contraceptive knowledge and satisfaction between women using the tool and women receiving usual care. **OUTCOMES/RESULTS:** Women who used the tool reported increased knowledge about all methods compared with those who received usual care (p=.09). This trend was driven by changes in knowledge about the IUDs and the contraceptive implant. A higher proportion of women who used the tool demonstrated increased knowledge compared with women in usual care (99% vs. 82%, p=.13). In addition, a higher proportion

STORTZ S, SANFORD J, LAFFEY J, KAHN I, GARCIA S, HILL-SAKURAI L, SMITH B. A medical student-driven group diabetic visit.

CONTEXT & OBJECTIVE: The effective management of diabetes requires sustained behavior and lifestyle changes. However, patients often lack the social support needed to assist them in making sustained changes. Group medical visits are an effective approach to increasing support and education for patients, and research has demonstrated the efficacy of group visits in improving diabetic outcomes such as the HgbA1c. To this date, utilizing medical students as group visit facilitators and health coaches has not been well-studied, but can likely provide patients with additional support mechanisms to make sustained behavior change. We piloted a medical student-driven group medical visit for diabetic patients at our clinic. **SETTING/POPULATION:** Our patient population consisted of patients established at our clinic with the diagnosis of Type 2 Diabetes. Patients were enrolled if they expressed interest in participating in group medical visits. Most patients conveyed a poor understanding of disease mechanisms and management at baseline. **INTERVENTION/STUDY DESIGN:** Medical students at our clinic conducted a needs assessment and identified the potential utility of a group diabetic visit. We recruited patients from the clinic's diabetic patient panel. Using 1st and 3rd year medical students as facilitators and health coaches, we conducted 3 pilot diabetes group visits. A validated tool was used to assess patient understanding of disease, and patients and medical students provided written feedback at the end of each visit. **OUTCOMES/RESULTS:** 11 patients have been involved in the group visits, 7 of whom have attended two or more sessions. At intake, patients expressed low levels of knowledge about diabetes management and low levels of confidence in their ability to manage their condition, despite being established diabetic patients. To date, all patients enrolled in the program have cited its usefulness in improving their understanding of diabetes and sense of support, and all have expressed the desire to attend future visits. Medical students have expressed satisfaction and educational benefit from group involvement. **CONCLUSIONS:** Student-driven group medical visits for diabetic patients can be effective in fostering support for patient behavior change, satisfaction, and understanding in diabetes management. They may also be an effective approach to involve medical students in quality improvement and health coaching.

TAPIA M, LUBEGA S, ECHIVERRI A, BRODE E, STEIN B, WILSON E. Addressing health workforce disparities by connecting San Francisco General Hospital and Mission youth through the Summer Urban Health and Leadership Academy.

CONTEXT & OBJECTIVE: Minority groups are severely underrepresented in the health professions. This disparity poses challenges to providing high-quality, culturally competent, patient-centered care to patients throughout the healthcare system, especially those from underserved communities. Our goal is to create a sustainable health professions pipeline for local under-represented minorities, starting with a Summer Urban Health and Leadership Academy (SUHLA). **SETTING/POPULATION:** SFGH FCM residents have partnered with John O'Connell High School, FACES for the Future, and Mission Boys and Girls Club to develop this program for high school and undergraduate students living in the Mission District. **INTERVENTION/STUDY DESIGN:** The SUHLA leadership team is developing curriculum and logistical plans for piloting a 3-week summer academy for 20 11th graders and 10 undergraduate students in 2015. SUHLA participants will learn key concepts of community health, social justice, advocacy, and social determinants of health through the lens of health and human rights, especially as it relates to the Mission District. Curriculum plans are informed by best practices from current successful pipeline programs and by focus groups conducted with local high school students. We are recruiting two medical students and two family nurse practitioner students to help lead the summer academy as SUHLA Fellows. Before the summer academy, they will get training in teaching skills, small group facilitation, program implementation/evaluation, and community assessment. The academy will culminate in the FHC community health fair, at which academy participants will host booths highlighting community health topics. Evaluations of curricula for both the fellows and academy will be conducted to ensure continued program improvement. **OUTCOMES/RESULTS:** Plans are under development and

on track to pilot SUHLA with 30 students in summer 2015. We have obtained grant funding for the program and created a dedicated faculty position within the UCSF FCM Department. **CONCLUSIONS:** We have begun to create a longitudinal program that aims to inspire youth from diverse backgrounds to invest in the health of their community; engage and empower Mission neighborhood youth through activities focused on mentorship and advocacy; strengthen and sustain relationships between SFGH and community partners; increase diversity in the health workforce pipeline; and grow leaders from within the residency and our neighboring communities.

THOM D, WOLF J, GARDNER H, DEVORE D, LIN M, ADLER S, BODENHEIMER T, GRUMBACH K, SABA G. How patients make decisions with health coaches and primary care clinicians.

CONTEXT & OBJECTIVE: We sought to understand and compare patient decision making with health coaches and decision making with clinicians. **SETTING/POPULATION:** English or Spanish speaking adult patients at safety net clinics who received health coaching, health coaches, clinicians and family members. **INTERVENTION/STUDY DESIGN:** We conducted 6 focus groups (3 in Spanish and 3 in English) with 25 patients and 5 friends/family members. Audio recordings were transcribed and analyzed in Atlas-ti using a modified ground theory to create a set of over 30 themes to describe the roles of patient, health coach, clinician and family/friends in patient decision making. We next completed structured, audio-taped interviews with 42 patients, 17 family members, 17 health coaches and 20 clinicians. Transcripts were coded using the themes generated by the focus group with some modifications to accommodate additional codes. Themes were summarized and the summaries used to create models of the roles of each of the 4 groups. In the current presentation we will report and compare patient decision making with health coaches and decision making with clinicians. **OUTCOMES/RESULTS:** Themes that appear to be unique to patient decision making with health coaches include the social equality of the health coach to the patient (being more like a peer, friend or family member than the clinician) and the shared culture, language and personal experiences of the health coach with the patient. As a result, many patients reported a greater willingness to reveal information compared to their health coach than their primary care provider. While health coaches and clinicians shared several common themes in supporting the patient's decision making (including education, motivation, personal support, and practical help with making and implementing health decisions), the specific actions in each of these categories differed substantially. In addition, the combination of the health coach and clinician working with the patient provided new opportunities for support that would likely have not been available to each working separately. **CONCLUSIONS:** Patient decision making with health coaches shares several aspects of decision making with clinicians, but also provides support in ways which are generally not available from clinicians due to time and role constraints.

WILLARD-GRACE R, SHARMA A, PARKER C, POTTER M. Community health centers with formal strategies to engage patients in practice improvement activities get more for in return for their efforts.

CONTEXT & OBJECTIVE: Despite increased calls for patient engagement in the redesign and improvement of primary care practices, little is known about whether and how primary care teams are actually doing it. This study sought to explore how community health centers (CHCs) are engaging patients as practice improvement partners and the perceived impacts of these activities on clinic-level strategies, policies, and programs. **SETTING/POPULATION:** We conducted a survey of CHC leaders in Arizona, California, Hawaii, and Nevada in July–August 2014. **INTERVENTION/STUDY DESIGN:** This cross-sectional, web-based survey examined current strategies, facilitators and barriers, and perceived impact of patient engagement on clinic-level strategies, policies, and programs. Data analysis included descriptive statistics and multivariate modeling. The study protocol was approved by the University of California San Francisco Committee on Human Research (14-13662). **OUTCOMES/RESULTS:** The response rate for the survey was 21% (97/470). The most common mechanisms for soliciting patient feedback were surveys (94%; 91/97) and suggestion boxes (57%; 55/97). On-going participation was

successes provide a platform for continued collaboration and opportunities to re-affirm SFGH's role as a national innovator in the field of urban underserved health.

EMMET D, ANDERSON N, FOX E, STEINAUER J, DEHLENDORF C. Pilot study of WhyIUD: an IUD user-led social communication intervention.

CONTEXT & OBJECTIVE: Low IUD uptake among contraceptive users (7.7% in the U.S.) may be explained in part by prevalent misinformation and concerns about IUDs spread through social communication channels. We sought to develop and pilot test an intervention that activates IUD users to disseminate evidence-based information and their personal experiences with IUDs to their peers, with the goal of accelerating and normalizing the acceptance of IUDs among contraceptive users. **SETTING/POPULATION:** We tested our intervention with women scheduled for an IUD insertion or post-insertion appointment at a safety-net family planning clinic in San Francisco, and their peers. **INTERVENTION/STUDY DESIGN:** Drawing on focus groups with IUD users and non-users, we developed WhyIUD, a multi-prong, low-cost, peer-led communication intervention. IUD users received WhyIUD pamphlets from providers in clinic. These pamphlets included evidence-based information about their IUD and encouraged IUD users to share this information and personal experiences with their peers. IUD users were also invited to visit and share a WhyIUD website and sign up for weekly WhyIUD text messages. We used surveys and interviews with IUD users (n=10) and their social contacts (n=32) to assess feasibility and acceptability of the intervention. We also conducted focus groups with clinic staff who implemented the intervention. **OUTCOMES/RESULTS:** IUD users felt comfortable talking about IUDs with an average of 5.4 social contacts. 59% of IUD-users' social contacts enrolled in the study, and 26% of these social contacts already had IUDs. Overall, participants liked the design and content of the intervention. Interviews suggested that the intervention had a positive effect on social communication. Engagement with the website and text messages was lower than desired. Clinic staff reported that implementing WhyIUD did not disrupt clinic flow. **CONCLUSIONS:** Harnessing social communication about IUDs promises to be a powerful strategy to influence social norms around IUDs. Based on initial pilot data, we have begun a second WhyIUD pilot at a family planning clinic in Sacramento, where IUD use among social contacts may be less prevalent and the intervention may have greater impact.

ENGLISH D, MCCLELLAN K, TIA A, MITTAL P, MASON K. The MINT Program: unique opportunities for resident involvement and advocacy.

CONTEXT & OBJECTIVE: In the MINT (Mothers and Infants Nurturing Together) program, incarcerated pregnant women come to the Family Health Center (FHC) during their third trimester to receive prenatal, obstetric, newborn, and postpartum care. A small group UCSF Family and Community Medicine residents are involved in their medical care. Through our Advocacy, Community Engagement, Quality Improvement and Leadership (ACQILA) curriculum, we explored ways to become more involved with this vulnerable population. **SETTING/POPULATION:** The women involved in the MINT program are incarcerated in federal prisons for non-violent crimes within a west coast catchment area. To be eligible for the program a woman's remaining sentence must be less than five years, and she must identify a family member who will take the infant upon her return to prison. They are furloughed from prison during the third trimester until three months postpartum. **INTERVENTION/STUDY DESIGN:** We conducted a literature review of publications related to health concerns of incarcerated women. We conducted site visits to the halfway house where the women are housed during the program, and held informal focus groups to elicit their interests, response to the program, and potential needs. Additionally, we worked with the Department of Federal Prisons to do a site visit and meet the physician and prenatal care team at Dublin Prison to increase awareness about the program. **OUTCOMES/RESULTS:** Major areas of need identified included women's awareness of MINT and gaps in knowledge about common prenatal and postpartum topics. We created and piloted teaching modules on breast feeding, contraception, circumcision, and newborn development. To advertise and advocate for the program, we designed a pamphlet about the program and networked with the prison's prenatal care team to

slots dedicated to scheduled appointments from 30-40% to over 90%. With this change, the number of visits available for walk-in visits decreased significantly, so appropriate utilization of the San Francisco Health Network/Community Clinic Consortium primary care clinics and the new UCC appointment system would be essential. The primary objective of my project was to determine the reasons why patients with existing access to primary care continued to walk-in for unscheduled visits. **SETTING/POPULATION:** My project involved the patients seeking care the SFGH UCC, and I worked with the Medical Director, Dr. Ronald Labuguen. **INTERVENTION/STUDY DESIGN:** I interviewed 96 English-speaking patients during the morning and afternoon sessions at the UCC on three consecutive Mondays during the months of November and December. **OUTCOMES/RESULTS:** Overall, utilization of the appointment system was far below the target goal. Only 25% of patients interviewed had scheduled appointments and the impact of the intended appointment scheduling is yet to be determined. Despite this under-utilization, patients with scheduled appointments generally found the process convenient, easy, and time-saving, and nearly all of the patients without access to primary care would prefer a direct phone line for appointment scheduling. The most interesting finding from my survey, however, was a significant need to support patients in the process of establishing care with primary care clinics and providers. Seventy-eight percent of patients reported having healthcare coverage with Medi-Cal, Healthy SF, or other source, but 45% of these patients reported that they had not established care with a primary care clinic or provider. **CONCLUSIONS:** Enrolling patients in healthcare coverage programs is not sufficient to reduce the number of UCC walk-in visits. A future UCC Quality improvement project should focus on finding ways to assist patients in the process of establishing care.

ECHIVERRI A, ROTHSTEIN J, JAIN S, KUO A, NGUYEN R, PETERSON A, THOMAS M, WHETSTONE S, WHITTLE A, WILSON E, WORTIS N, GOTTLIEB L. STEP UP: An innovative cross-residency and interdisciplinary collaboration focused on training providers interested in underserved care.

CONTEXT & OBJECTIVE: As a premier public hospital and academic institution, San Francisco General Hospital (SFGH) attracts trainees with an interest in caring for urban underserved populations. Organizational incentives and ACGME requirements strongly promote cross-hospital and interdisciplinary integration. The SFGH Training and Education Programs for Underserved Populations (STEP UP) formed as a joint effort across SFGH-based residency programs to define cross-program competencies, milestones, service learning opportunities, and certification requirements to improve training in urban underserved care. **SETTING/POPULATION:** The STEP UP Academic Taskforce includes faculty and trainees from Departments of Family & Community Medicine, Internal Medicine, Obstetrics/Gynecology, Pediatrics, and Psychiatry. The program is open to residents interested in expanding training opportunities in care of vulnerable populations. The STEP UP Community Advisory Board supports the program's mission around education, community engagement, advocacy and quality care delivery. **INTERVENTION/STUDY DESIGN:** In its first year, STEP UP has: a) defined cross-program competencies in care for vulnerable urban populations; b) identified existing curricula that help residents achieve competencies in care for these populations; c) established a program website and grand rounds schedule to share educational and service learning activities across the hospital and SFDPH system; and d) developed a Community Advisory Board to inform program efforts. Over the next year, the program will: a) develop innovative systems for coordinating cross-residency teaching experiences around vulnerable populations; b) establish live and asynchronous educational activities to fill gaps between articulated competencies and existing learning opportunities; and c) create a Certificate in Social Medicine for residents who meet all competencies and program requirements in leadership in care for vulnerable urban populations. **OUTCOMES/RESULTS:** STEP UP has been successful in creating a cross-program coalition of residents, faculty, and community members invested in advancing health professional training focused on underserved populations. Joint competencies and training curricula are being developed. We expect to confer the first Certificate in Social Medicine in 2016. **CONCLUSIONS:** STEP UP brings together academics, community members, hospital leaders and graduate medical learners to jointly develop graduate medical training goals and opportunities in underserved care. Early

pursued through advisory boards (69%; 67/97) or quality improvement committees (36%; 35/97). In multivariate modeling, having leadership support and a formal strategy for patient engagement were positively associated with patient influence on the clinic's strategic priorities. Having a formal strategy also positively predicted patient influence on policies and programs. Having time dedicated in team meetings to discuss patient feedback appeared to be an important mediator of these outcomes. Patient Centered Medical Home (PCMH) recognition, having dedicating funding for patient engagement, and the size of the practice did not predict the outcomes. **CONCLUSIONS:** Development of a formal strategy for patient engagement and establishing a standing agenda item on team agendas to discuss patient feedback may be practical ways to promote greater patient engagement in primary care transformation.

ABSTRACTS: *Posters*

BARROSO V, BIRNBERG J, CHRISTIANI A, ITEN E, NISSEN E, PAU C, WINDER G. Developing a novel community medicine curriculum through school based partnerships.

CONTEXT & OBJECTIVE: Family Medicine Residents at the Kaiser Permanente Napa-Solano Residency Program are assigned to a single Full Service Community School (FSCS) in the Vallejo City Unified School District (VCUSD) for the three years of residency training. VCUSD schools are comprised of an ethnically diverse, underserved population with a high proportion of students receiving free or subsidized lunch. Rates of school failure are historically high, approaching 50% by the time youth reach high school. By embedding family medicine residents in the public school system, residents learn community oriented approaches to public health interventions and at-risk youth acquire the opportunity for mentorship and schools benefit from the direct involvement of physicians in the wellness component of the FSCS model. **SETTING/POPULATION:** The project will be carried out at 6 Full Service Community Schools in the Vallejo City Unified School District – 3 middle schools and 3 high schools. Students age 12-19 who are enrolled in these schools are the target population for our health needs assessment. The work is carried out in collaboration with the school principals, teachers, and staff. **INTERVENTION/STUDY DESIGN:** A brief IRB-approved needs assessment will be distributed to all students (age 12-19) at six Vallejo Unified School District schools (3 middle schools and 3 high schools) during a homeroom class period with questions assessing student health priorities as well as health behaviors, attitudes, and risk exposure. The survey is projected for implementation in April 2015. **OUTCOMES/RESULTS:** Data will be collected and analyzed anonymously to determine top health priorities, risky behaviors, and health disparities in this urban, underserved youth population. The data will be evaluated in aggregate and by school site with comparisons to national norms and between one another, and assessed for opportunities for public health interventions. **CONCLUSIONS:** Results of this school-based multi-site needs assessment will inform the design and implementation of interventions to address identified needs. The needs assessment approach engenders a partnership between family residents and schools and promoting community buy-in. In addition, the project illustrates a hands-on curricular approach to teaching the skills necessary for community-based health interventions, increasingly recognized as a core competency for 21st century family physicians.

BAUER L, BODENHEIMER T, OLAYIWOLA JN, SYER S. Empowering the nurse.

CONTEXT & OBJECTIVE: With the increase in demand for primary care, RNs are an untapped workforce to help improve access to care without increasing physician burnout. **SETTING/POPULATION:** "Empowering the Nurse" is a project sponsored by the California Health Care Foundation (CHCF) to highlight primary care practices in California that have expanded the RN role. **INTERVENTION/STUDY DESIGN:** The project team conducted structured phone interviews and site visits with 11 primary care practices that had expanded the RN role. The sites were asked to describe their RN innovations in detail, including barriers to success. **OUTCOMES/RESULTS:** We found four novel innovations to the RN role: 1) Chronic care management – RNs are successfully able to manage patients with chronic diseases such as diabetes and hypertension, in some cases titrating medication doses without involvement of physicians. 2) RNs as key team member – With the hiring of more RNs in ambulatory care, RNs are sharing responsibility for a team's panel of patients, including performing triage only for the team's patients. 3) Complex care management – Some RNs are focused on a small panel of complex patients, doing home visits and leading a complex care management team. 4) Ambulatory RN training and RN primary care residencies – the newly expanded RN roles require many skills not taught in traditional nursing schools. Clinics and nursing schools are realizing that for RNs to be effective in primary care, they need additional training, and curricula have been developed for such training. Barriers to expanding the RN role in primary care include: 1) RNs working in settings with poor patient access are overwhelmed by triage responsibilities and have no time for expanded roles. 2) Transforming RN roles requires clarification regarding scope of practice; many practices are confused on what RNs are and are

study demonstrates that offering same-day insertions for EC is feasible and highly acceptable to patients.

DEUTSCH MB, BRAUN H, GARCIA-GROSSMAN I, QUINONEZ-RIVERA A. Outcome and impact evaluation of a transgender health didactic student elective.

CONTEXT & OBJECTIVE: 50% of transgender patients report having to teach their provider about their own medical care. Only 1/3 of medical school curricula have content on gender transition. These training and knowledge gaps underlie health disparities faced by transgender people. Since 2010, a student-led elective course in transgender medicine has been offered at UCSF. We aimed to 1) Assess the impact of the class on student knowledge, attitudes, and beliefs about transgender medicine, and 2) Evaluate the course content to inform future educational activities. **SETTING/POPULATION:** Students taking the Transgender Health elective in Winter 2015 (FCM 160.04) **INTERVENTION/STUDY DESIGN:** pre-post quantitative survey/evaluation; each student is their own historical control. **OUTCOMES/RESULTS:** Data collection will complete on March 26, and will be analyzed by the time of the colloquium. **CONCLUSIONS:** Data collection will complete on March 26, and will be analyzed by the time of the colloquium.

DHIR N, PARK JY, VENTURINA A, LOPEZ J, IKAWA J. Impact of nutrition and physical activity interventions on knowledge and growth in sixth grade students.

CONTEXT & OBJECTIVE: Obesity is currently an epidemic in an increasingly younger population. In 2010, more than one third of children and adolescents were overweight or obese. The Centers for Disease Control (CDC) suggests that in the last 30 years, obesity has more than doubled in children and tripled in adolescents. Being overweight in adolescence is a stronger predictor of coronary artery disease than being overweight in adulthood. Healthy lifestyle habits can lower the risk of becoming obese and developing related diseases, and have led to successful weight loss in adolescents. The objective of this study was to investigate the impact of educational interventions on reported eating habits, physical activity, and growth. **SETTING/POPULATION:** The study took place in one 6th grade classroom at an elementary school located in a lower socioeconomic area of Fresno, California. **INTERVENTION/STUDY DESIGN:** A prospective study over the school year included three interventions. Each intervention involved a 20-minute lecture on nutrition and physical activity followed by 40 minutes of fun exercises. A pre-test was given to each student to assess baseline knowledge and behavior before the first instructional session. Each student's height and weight was measured to determine body mass index (BMI). Knowledge assessment was repeated and BMI was recalculated after each visit. **OUTCOMES/RESULTS:** Of the 31 students that were part of the initial session, 27 students were present during the final session. There were more male (59%) than female students. At baseline, 48% of the students were considered to have a healthy BMI based on current CDC age charts; the number increased to 56% (p = 0.68). The pre-test nutrition knowledge score was 13% and increased to 35% at follow-up (p = 0.13). Baseline exercise knowledge was 47% and increased to 83% (p = 0.01). There was a 26% decrease in servings of healthy foods students ate in the last 24 hours and a 44% decrease in unhealthy foods. **CONCLUSIONS:** The educational intervention significantly increased students' knowledge about exercise and showed a non-significant increase in healthy BMI. Getting students excited about learning how to be healthy can help motivate and engage students in eating healthy and modifying undesirable behavior.

DIZON M, LABUGUEN R. Assessing patient utilization of the SFGH Urgent Care appointment system.

CONTEXT & OBJECTIVE: In March 2014, the SFGH Urgent Care Center (UCC) created an appointment system to distribute patient demand over the course of the day to increase clinic efficiency and decrease wait times. Implementation of the system had been gradual, however, and the majority of patients seen in the UCC were walk-ins. In December 2014, the UCC increased the percentage of time

Craven M, Fisher L, Hessler D, Polonsky W, Masharani U, Peters A, Blumer I, Bowyer V. Anxiety disorders in adults with type 1 diabetes.

CONTEXT & OBJECTIVE: Few studies have examined the prevalence of anxiety disorders in adults with diabetes, with almost none focused on type 1 diabetes. **SETTING/POPULATION:** Given the potential impact of anxiety disorders on disease management and glycemic control, and the frequent comorbidity with depression, we assessed the prevalence of current and past year anxiety disorders and their associations with demographic and disease-related characteristics, Major Depressive Disorder (MDD) and Diabetes Distress (DD) in a diverse community sample of 368 adults from California and Canada with type 1 diabetes (T1D) [mean age = 43.1 (SD=15.1); 56% female; mean diabetes duration = 26.0 (SD=13.8); mean HbA1C = 7.59% (SD=1.2) [59.5 mmol/mol]]. **INTERVENTION/STUDY DESIGN:** The Structured Clinical Interview for the DSM (SCID) and the T1-Diabetes Distress Scale (T1-DDS) were utilized. **OUTCOMES/RESULTS:** Prevalence of SCID-diagnosed current and past year anxiety disorders, including all DSM-IV anxiety disorders, was low: 4.4% and 6.3%, respectively. Women more than men (8.8% vs.3.1%, $p=.03$) and those using an insulin pump vs. those using multiple daily injections (8.0% vs.2.6%, $p=.05$) were more likely to have an anxiety disorder. There was a positive association between the presence of an anxiety disorder and number of complications ($r=.11$, $p<.03$). There was a negative association between the presence of an anxiety disorder and number of hypoglycemic episodes ($r=-.10$, $p<.05$). Neither current nor past year anxiety disorder was related to HbA1c or time since diagnosis. Only 31.3% of those with an anxiety disorder also met criteria for MDD, but 81.3% of those with an anxiety disorder also had clinically elevated DD. Further, in multiple regression analyses current MDD ($\beta=.17$, $p<.01$) and current anxiety disorder ($\beta=.18$, $p<.01$) were each significant and independent predictors of DD. **CONCLUSIONS:** These findings suggest that among adults with T1D the prevalence of anxiety disorders is low. When they do occur, they are present more frequently in women than men, are linked to the number of long-term complications and less frequent hypoglycemia, and are significantly associated with DD independently of MDD.

Der Simonian K, Kerns, J. Implementation of counseling and insertion of same-day copper IUD as emergency contraception

CONTEXT & OBJECTIVE: Unintended pregnancies account for half the pregnancies in the United States and 36% of pregnancies worldwide. For women who have unprotected sex and wish to avoid pregnancy, emergency contraception (EC) is an effective option. The most commonly used method of EC is oral levonorgestrel (LNG), even though its effectiveness is far inferior to that of the copper intrauterine device (Cu-IUD). Beyond its superior efficacy as EC, the Cu-IUD offers up to 12 years of highly effective contraception and is one of the most cost-effective methods. Despite the proven superior efficacy of the Cu-IUD, barriers have prevented its uptake as a common form of EC. Clinic-level barriers include the expanded appointment time necessary for counseling and insertion, cost, routine two visits requirement for insertions, and the need for more providers trained in IUD insertions. **SETTING/POPULATION:** In 2012, Dr. Jennifer Kerns from department of Ob/GYN and Dr. Kohar Der Simonian, teamed up to implement Cu-IUD as EC in a University-affiliated family planning clinic specializing in reproductive health needs of underserved adolescents and young adults. **INTERVENTION/STUDY DESIGN:** All patients presenting for EC visits during a 6 mo. period of time were counseled about oral EC and Copper IUD. If patients chose the CU-IUD, they were roomed for a clinician visit including consent and immediate insertion. We utilized three different sets of data: discussions at two staff meetings and a log of clinic processes for all Cu-IUD as EC insertions. We used descriptive content analysis to analyze the notes from the two focus groups and the clinic coordinator's log. Two authors independently examined the data, identifying themes that emerged, and coding the data according to the themes. **OUTCOMES/RESULTS:** Three main themes emerged as barriers in implementing same-day copper IUD insertion for EC: 1) Implementation would disrupt clinic flow; 2) It would be difficult to counsel patients on the IUD's function as both EC and long-acting reversible contraception (LARC); 3) Concern that patients would not be receptive to the IUD or insertion process. **CONCLUSIONS:** Our

not able to do. 3) Expanding the RN role requires comprehensive training beyond what is traditionally taught in nursing school. **CONCLUSIONS:** Our presentation will feature concrete examples of these innovations and an explanation of relevant California RN scope of practice laws. Our take-home lesson: primary care practices have much to learn from innovative practices on how to expand the RN role to increase patient access.

Carroll D, Chodos A, Wong S. Evaluation of medication-related issues in a high-risk elderly population.

CONTEXT & OBJECTIVE: Older adults (≥ 65 y.o.) are at high risk for adverse drug events and polypharmacy due to age-related changes in liver and kidney function and multiple co-morbidities. We describe the occurrence of several types of medication-related issues detected during geriatrics outpatient consultation by a consultant geriatrics pharmacist or geriatrician at San Francisco General Hospital (SFGH). We examine the association of these medication-related issues with the training level of the primary care provider (PCP) who referred the patient. **SETTING/POPULATION:** Ninety-six patients 65+ years old were referred by their PCP to the Geriatrics Consult Clinic at SFGH between October 2012 and November 2013. The consult clinic is staffed by a geriatrics sub-specialist and pharmacist. Referrals to the clinic receive e-consults or in-person evaluation, and both receive medication recommendations if clinically appropriate. **INTERVENTION/STUDY DESIGN:** We performed a retrospective chart review and collected information on demographics, co-morbid conditions, medications, and medication-related issues, including: 1) potentially inappropriate medications according to Beers and START/STOPP criteria, 2) overtreatment, 3) no medical indication, 4) ineffective medication, 5) non-adherence, 6) drug-drug or drug-disease interactions, 7) side effects, 8) adverse drug effects and 9) other reasons. Prescription medication use and consultant recommendations were extracted from study participant's electronic medical records by one study investigator (AHC). **OUTCOMES/RESULTS:** Among patients who received a consult, 89% received a recommendation about medications. In 69%, recommendations were to stop a medication due to medication-related issues. The main reasons medications were stopped were: lack of an indication (24%); side effects (20%); over treatment (18%); and contraindication due to Beer's or the START/STOPP criteria (16%). Among patients referred by resident MDs, (N=66) recommendations were to stop a medication in 30% due to a lack of an indication and 18% for overtreatment; among those referred by nurse practitioners (N= 20), recommendations were to stop a medication in 25% for their inclusion in the Beers or START/STOPP criteria. **CONCLUSIONS:** This qualitative study is a starting point for understanding what medication-related issues are occurring in this high-risk older adult population seen in SFGH primary care. Further research could provide insight into tools that would help PCPs identify medication-related issues in their practice.

Chase J, Stafford M, Harris H. A new model: simulation-based procedure training & privileging for faculty physicians.

CONTEXT & OBJECTIVE: Previous studies have demonstrated that simulation-based practice improves technical competency in a number of medical specialties. To help faculty to improve technical competency and to maintain their procedure privileges, we designed a convenient, high yield, simulation-based procedure curriculum. UCSF Departments of Family Medicine and Internal Medicine obtained permission from SFGH Credentialing Committee to use supervised high-fidelity simulator-based procedures to fulfill SFGH credentialing requirements for five hospital medicine procedures (lumbar puncture, thoracentesis, paracentesis, internal jugular and femoral CVC insertion.) **SETTING/POPULATION:** Faculty providers in multiple departments at SF General Hospital. **INTERVENTION/STUDY DESIGN:** Grant funding was previously obtained to purchase high fidelity, ultrasound-compatible simulator models. Literature review was performed to design evidence-based procedure teaching diagrams for use in training/point of care and rubrics for competency testing. The authors are supervising ongoing workshops for technical practice and individual competency testing appointments. Faculty were surveyed before and after participation in workshops and competency testing.

UCSF Departments of Family Medicine and Internal Medicine at SFGH were queried to assess change in number of procedure credentialed providers before and after curriculum implementation. **OUTCOMES/RESULTS:** Qualitative outcome measures include providers' reported comfort and likelihood of practice of a given procedure before and after workshops (on a 5-point Likert scale). Quantitative measures includes number of simulator-based procedures performed for credentialing and the change in number of providers credentialed within Departments of Family Medicine and Internal Medicine. Early results are promising for individuals' assessments of competency and for increased numbers of credentialed providers. The curriculum (illustrated diagrams, testing rubrics) and the associated process (credentialing approval, workshop technique, model acquisition) were presented at UCSF Education Symposium, are posted for open-source use on UCSF Box (<https://ucsf.box.com/s/hckntf7kdwtu3s3kmmk6hno13hjz1g>), and are planned for presentation at 2015-2016 Society for Hospital Medicine national conference or for publication in the Journal of Hospital Medicine. The authors are available for implementation assistance via email or phone. **CONCLUSIONS:** We present this modular curriculum for faculty practice improvement and ease of credentialing in procedural medicine. Results appear likely to improve both providers' confidence in technical performance as well as number of credentialed providers.

CHUNG C, GJERDE C. Resident perceptions of shift change that decreased the number of hand-offs.

CONTEXT & OBJECTIVE: Studies have shown that the root cause of the majority of medical errors can be traced back to communication. Recently, in the interest of patient care and safety, the residents at the Natividad Medical Center family medicine residency proposed and implemented a change in shifts that decreased the number of handoffs from 3 to 2 per 24 hours and thus decreased the potential for communication based errors. The authors of this poster desired to evaluate specific subjective parameters regarding this change, including confidence in patient care, perceptions of efficiency and number of learning opportunities. **SETTING/POPULATION:** The setting and study population were the residents of the Natividad Medical Center family medicine residency program. **INTERVENTION/STUDY DESIGN:** Study design was a cross-sectional survey sent to every resident who had sufficient experience before and after the work hour change (two classes of 8 residents). **OUTCOMES/RESULTS:** Results showed that the majority of the residents felt that there was improved patient safety and efficiency with a decrease in the number of hand-offs but because of the change, some educational value was lost because admitting residents no longer presented the overnight admissions in front of attendings and instead used a less formal resident to resident hand-off. **CONCLUSIONS:** An inefficient and potentially unsafe schedule was identified and changed by residents with the programs' approval in an effort to decrease the number of hand-offs and to hopefully improve patient care. While objective data from the hospital regarding medical errors are out of the scope of this small study, the subjective data demonstrates that perception of patient care and efficiency has improved since the change was implemented.

COTTER E, MCNEIL S, ROMITO L, WONDOLOWSKI L. Education beyond clinical medicine: the creation of a collaborative curriculum.

CONTEXT & OBJECTIVE: As highlighted in the ACGME Milestone Project, residency faculty is responsible for imparting an enormous amount of knowledge beyond clinical medicine. To meet this objective, the Core Faculty at Contra Costa created and implemented a structured longitudinal curriculum that addresses leadership development and practice management. **SETTING/POPULATION:** At CCRMC, each residency class meets every four weeks: two hours for Balint-style support group and two hours for didactics. Our curriculum is organized around the monthly residency class meetings. **INTERVENTION/STUDY DESIGN:** Concurrently with the faculty, family medicine residents actively participated with planning to tailor this curriculum to specific interests and objectives. In the first year, residents are paired with an advisor, oriented to the Patient Centered Medical Home, introduced to MC-FP require-

ments, and loan repayment option. A process improvement specialist teaches Quality Improvement principles and integrates residents into system-wide QI projects. In the second year, residents participate in every-other-month Practice Inquiry to reconcile clinical uncertainty in challenging patient encounters while seeking non-judgmental guidance and peer support. Residents continue to meet with an advisor who encourages scholarly activity participation in QI projects, and addressing personal educational goals. In the third year, residents are mentored on job searches through setting personal and professional goals, writing effective CVs, and finding mentors. Budgeting and long-term financial planning is discussed, as well as preparation for the ABFM exam with reminders about CME and certification. **OUTCOMES/RESULTS:** Overall, 33 of 41 residents completed surveys for a total response rate of 80.5%. 92.3% of R1s, 64.2% of R2s, and 85.7% of R3s participated. Residents asked for more education on: Medical ethics, Cost conscious medical care (procedures, imaging, logistics), Insurance (Medi-Cal, MediCare, county health plan, other), and Family Medicine clinic orientation first year (including county health care system, insurance, patient centered medical home). **CONCLUSIONS:** Through focused planning, addressing core practice management skills and within the purview of ACGME Educational Milestones, we developed a resident-oriented curricula to improve satisfaction of medical training, combat burnout, and prepare residents to manage the various skills required to be a successful family medicine physician. Program improvement is an ongoing process to continually adapt this curriculum to meet new goals and objectives. We found that focused didactic learning is an effective way to meet Milestones related to Systems Based Practice, Practice Based Learning and Improvement, and Professionalism.

COTTER E, SAFFIER K. Bringing human rights home: facilitating clinical examinations for asylum seekers.

CONTEXT & OBJECTIVE: Family Medicine residents and physicians often express a passion for addressing human rights, global health, and community outreach in their clinical practice. Performing medical examinations for individuals seeking asylum from human rights abuses provides a means for providers to address many of these interests within the time constraints of busy clinical schedules. At Contra Costa Regional Medical Center, we are working toward the implementation of a process to enable our providers to use County facilities for these asylum examinations. **SETTING/POPULATION:** Physicians for Human Rights (PHR) and other organizations host trainings for providers to become skilled at performing medical and psychological examinations for asylum seekers. These trainings educate providers on U.S. asylum law and how to effectively document human rights abuses; this documentation can strengthen claims of persecution and be instrumental in the approval of an applicant's case. **INTERVENTION/STUDY DESIGN:** Two attending physicians and five family medicine residents from Contra Costa participated with PHR's Asylum Network training in October 2014. One resident and attending physician have since been working with Hospital and County Administration to address the logistics necessary to perform these exams at County facilities. **OUTCOMES/RESULTS:** From liaising with various County administrators and the Office of Risk Management, we have uncovered multiple barriers to obtaining approval for use of clinic space for pro-bono asylum exams. Despite the fact these examinations do not involve the provision of clinical care (thus there is no direct physician-patient relationship or medicolegal risk) and support staff are not required, we have discovered concerns by the County Administration and a desire for the creation of Waivers of Liability. We are actively working with the County Counsel to create such waivers in order to obtain approval for use of clinical space. **CONCLUSIONS:** Performing clinical and psychological examinations for applicants seeking asylum from human rights abuses is a rewarding and effective way to work toward improving human rights, address global health, and perform community outreach for many family medicine physicians. We hope to share our lessons learned on navigating the systems-level barriers to implementation – and hopeful success – of a process for physicians and residents to perform these asylum exams in our clinical facilities.