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Contra Costa Regional Medical Center

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Vona Britz-Diener, MD
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Fernando Maldonado, MD
UCSF-San Francisco General Hospital

Rossan Chen, MD
UCSF-San Francisco General Hospital

Lealah Pollock, MD
UCSF-San Francisco General Hospital

Cristina Cuevas-Figueroa, MD
White Memorial Medical Center

Rohan Radhakrishna, MD
Contra Costa Regional Medical Center

Ann-Elizabeth Griego, MD
Sutter Medical Center of Santa Rosa

Celeste Reinking, MD
UC Davis Medical Center

To make a contribution to the
Jack Rodnick Memorial Fund
and help ensure our department’s continuing
support of research in family medicine, please visit
www.familymedicine.medschool.ucsf.edu/giving
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Redwoods in the Mt. Tamalpais Watershed
Courtesy of Jennifer Rienks, PhD

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Many thanks for your generous support.
JACK RODNICK MEMORIAL FUND

Dr. Jonathan (Jack) Rodnick served as Chair of the UCSF Department of Family and Community Medicine from 1989 to 2003 and was a vital and integral member of our faculty until his passing in January 2008. To honor his legacy as a leader and scholar in family medicine, our department has created the Jack Rodnick Memorial Fund. These funds will help support the Rodnick Colloquium on Innovations in Family and Community Medicine and allow the establishment of the Rodnick Research Grant Program.

Jack organized our department’s first colloquium many years ago as a forum to showcase our innovative work, enhance collaboration, and foster mentoring within our academic community. Today, the annual colloquium draws together members from all of our San Francisco campuses, as well as our affiliated residency programs in Santa Rosa, Fresno, and Salinas. It is attended by medical students, residents, fellows, and faculty: nurses, medical assistants, and clinic staff; department research assistants; and administrative staff. And each year, we leave the colloquium inspired by the amazing work being done and renewed in our commitment to a more humanistic and equitable healthcare system—the values Jack embodied in his life as a family doctor and an academic leader.

We will expand upon the mission of the colloquium through the creation of the Rodnick Research Grant Program. These grants will provide pilot funding for research projects by medical students, residents, fellows, and junior faculty. Such grants are instrumental in giving “rising stars” in family medicine a head start in their scholarly pursuits and positioning them to compete more successfully for larger research grants from funders such as the NIH and private foundations.

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 his legacy of giving.

For more information, please visit www.familymedicine.medschool.ucsf.edu/giving
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Laura Hill-Sakurai, MD
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Presentations are available for viewing by visiting the FCM department website and clicking on the Colloquium 2011 icon.

Anonymous survey gathered responses regarding self-perceived average time to completion and techniques that impede and maximize the efficiency of electronic charting. Using PDSA cycles in February and March of 2011, interventions will be tested to determine if residents can be taught techniques that improve electronic charting. Outcomes/Results: Initial data evaluated the electronic notes of 146 visits revealing that notes are typically written less than a week after a visit but at more than a month after visits 11% of the notes were still outstanding. PDSA interventions will be evaluated for effect on average time to note completion and for effect on residents’ attitudes towards the feasibility of using such techniques on a regular basis. Conclusions: Initial data indicate that residents desire formalized teaching about electronic note-writing. Such teaching aims to minimize resident frustration with electronic charting and maximize the efficiency of writing high quality notes to optimize patient care. Additional conclusions will be revealed at the project’s completion.
30. Are we making a difference? Model SFGH 2007-2010 match data on underserved and primary care residency choice

Context and Objective: The U.S. faces a primary care physician shortage, especially in underserved communities. Research has shown that students trained in underserved programs have more positive attitudes toward underserved patients and higher intentions of practicing in underserved communities. Model SFGH is a six-month track for third-year students interested in urban health. Students complete three semi-integrated clerkships in underserved settings, follow continuity patients, and work in community health. Our objective was to evaluate whether Model SFGH students match into primary care and/or underserved residencies at higher rates than non-participants.

Setting/Population: We evaluated all medical students graduating from UCSF.

Intervention/Study Design: Using match data from 2007-2010, we compared specialty and program choice of graduating students who completed Model SFGH (59) to graduating students who had not participated (600). We defined primary care as family medicine, internal medicine, or pediatrics. We also evaluated match results from 2004-2006, before Model SFGH.

Outcomes/Results: When compared to non-participants, Model SFGH students have higher rates of matching into primary care residencies (66% vs. 38%), family medicine (19% vs. 7%), and/or programs in underserved communities (37% vs. 18%). Compared to the three years before implementation of Model SFGH, this represents an increase in the rate of matching into primary care for the total graduating class (40% vs. 30%) and matching into family medicine (7% vs. 4%) but not an increase in underserved programs (19% vs. 20%).

Conclusions: Model SFGH students match more frequently into primary care, family medicine, and/or underserved residencies than non-participants. Since Model SFGH began, the total rate of UCSF graduates matching into primary care and family medicine has increased. However, the primary care impact is limited by the fact that a significant percent of medicine and pediatrics residents will ultimately specialize. Further research will track students who wanted to do Model SFGH but were not selected in the lottery.

31. Staying afloat in a sea of charts: establishing sustainable electronic note-writing practices for family medicine residents
EAGEN K

Context and Objective: The expansion of electronic medical records challenges primary care residents to establish sustainable electronic note-writing practices. Residents are in a unique situation acquiring the medical knowledge required to care for patients and simultaneously learning to manage the logistics of charting and administrative follow-up. At the UCSF/SFGH Family and Community Medicine (FCM) Residency program, residents identified electronic charting as a primary challenge that, at times, threatens timely and high quality patient care. The goal of this project was to evaluate the scope of this resident-perceived problem and investigate interventions that could help residents establish sustainable note-writing practices to carry into their future careers.

Setting/Population: Data regarding the note-writing practices of UCSF/SFGH residents was collected from outpatient primary care clinic visits at the Family Health Center. Second and third year residents on outpatient rotations composed the focus of objective data collection and subjective data of residents’ attitudes came from all three classes.

Intervention/Study Design: As part of a FOCUS/PDSA project, electronic clinic notes were retrospectively reviewed to quantify the average time to completion. An
## Community Engagement

**Regent’s Room, S1-21**

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### 29. DM, HTN, CAD: can a chronic care cohort help students move beyond acronyms and into a more meaningful role in patient care?

**VENER M, SOMAVILLA N, CHOMSKY-HIGGINS K, HOWELL B, GOMEZ N, WHEELER M**

**Context and Objective:** To care for an aging population, future physicians need skills to optimize chronic illness management. We designed an innovative curriculum to improve third-year students’ ability to provide chronic illness care. Students developed their own panel of chronically ill patients. They performed structured visits emphasizing understanding the patient’s goals, self-management, education, and prevention. Our objective was to evaluate whether our third-year chronic illness curriculum improved: 1) students’ understanding of chronic illness and management and/or 2) clinical outcomes for chronically ill patients. **Setting/Populations:** We assessed third-year Model SFGH students caring for outpatients in underserved outpatient clinics as part of FCM 110. **Intervention/Study Design:** Twenty-five students each followed at least patients for six months. Using student reports, we tracked patient metrics (blood pressure, glucose, etc.) and behavior changes (starting exercise, etc.). We also followed patient educational outcomes. We assessed the educational impact to medical students through Likert surveys and focus groups. **Outcomes/Results:** While the average patient did not show significant change in blood pressure, etc., selected patients demonstrated very impressive changes (e.g., 20-pound intentional weight loss). Both students and patients found these changes highly inspirational. Students also reported greater appreciation of: 1) the ups and downs of chronic illness management; 2) the importance of continuity; 3) the value and challenge of patient education and prevention; 4) the need not to stereotype patients; 5) the importance of follow up outside office visits; and 6) the value of hope. **Conclusions:** Although chronic care was not optimized for all participating patients, helping even one patient in their panel make substantial health gains had marked impact on students’ understanding of chronic illness and their belief that they could improve health outcomes their patients. Future efforts will focus on how to extend this curriculum to third-year students in other longitudinal and block rotations.
27. Piloting practice inquiry to promote clerkship medical students’ skill and comfort in addressing clinical uncertainty
PANCHAL A, HILL-SAKURAI L, SOMMERS L

Context and Objective: Primary care physicians are characterized as being comfortable working in clinical situations that involve significant uncertainty. Third-year medical students, transitioning from a classroom environment where there are “right answers,” can be challenged by the ambiguity that arises in daily practice. Helping medical students feel less uncomfortable and more skilled working with uncertainty should be a key goal of Family Medicine clerkships. Practice Inquiry (PI), a set of small-group, practice-based learning and improvement methods, has successfully helped practicing doctors, mid-level providers, and family medicine residents feel more confident addressing situations of clinical uncertainty. Setting/Populations: The Parnassus Integrated Student Clinical Experience (PISCES) is a longitudinal clerkship program at UCSF for a subset of third-year medical students, in which students manage a small patient panel. In September 2010, we began piloting PI as a modality to help students in the PISCES program address the case-based uncertainty they identify in their patient panels. Intervention/Study Design: Sixteen students have been participating in four, 90-minute PI seminars where they present a case in which they face clinical uncertainty. Guided by faculty, the group: 1) explores unique facets of patient, clinician, and healthcare delivery context that could be contributing to the uncertainties; 2) applies clinical ‘evidence’ to their cases; 3) plans strategies for improved patient/family communication; and 4) builds a cohesive, trusting group of colleagues with whom they can share their uncertainties. Students will complete a pre/post questionnaire about their comfort with clinical uncertainty and self-efficacy in engaging in the PI process. In addition we will collect students’ qualitative comments on their participation and suggestions to enhance PI’s effectiveness in this setting. Outcomes/Results: At the time of the FCM Colloquium, we will present the questionnaire data and a summary of the qualitative data. Conclusions: While the generalizability of our evaluation will be limited by the lack of a control group, the small number of PI sessions, and the unusual integrated curriculum of these students, we feel this presentation will stimulate interest in modalities to promote student comfort and positive engagement with clinical uncertainty.

28. Residency SBIRT training in the community: residents as trainers to carry the message
SANFORD E, SASSON N, TIRADO S, TUNZI M, HARRISON S

Context and Objective: Substance abuse, like all chronic diseases, harms to varying degrees. Family Medicine training has focused on those who are substance “dependent,” with severe addictions. By identifying those earlier in this disease at “risky levels,” prevention and harm reduction through Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been proven effective. Although patient adherence to therapy and relapse rates are similar for addiction and other chronic diseases, such as hypertension and diabetes, residents develop lower confidence, less personal satisfaction, and negative attitudes towards substance abusing patients over their training. This is equivalent to caring for stroke patients in the ICU and determining that hypertension management is ineffective. By developing training for SBIRT beyond the hospital, residents can focus on “at-risk” patients, engaging in prevention and rehabilitation which improves knowledge, personal satisfaction and changes resident attitudes. Residents do not just learn SBIRT techniques; they are taught to train others.

Medical Education

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ABSTRACTS
Plenary Presentations

REDEEM: An RCT to reduce disease distress and improve diabetes management: first results
FISHER L, HESSLER D

Context and Objective: Diabetes distress among primary care patients with type 2 diabetes is a highly prevalent, persistent condition that has been consistently associated with poor glycemic control, diet, physical activity, and medication adherence. The goal of the REDEEM trial was to test a set of interventions to reduce distress and enhance disease management in a high distress patient sample. We asked if a time-efficient and inexpensive, web-based behavioral management program would significantly reduce distress and improve outcomes, or would it be necessary to add a more expensive, personalized, emotion-focused intervention to improve outcomes, compared to controls? Setting/Populations: 392 patients with type 2 diabetes and significant levels of diabetes distress were recruited from diabetes registries at several Bay Area IPAs. They were aged 21-75, spoke and read English, were not clinically depressed, had no severe functional deficits, and had T2DM for at least one year. Intervention/Study Design: This 12 month RCT randomized patients into one of three study arms, following baseline behavioral, emotional, and biological assessment: Computer-Assisted Self-Management (CASM)—a web-based disease management, tracking and goal-setting system with action planning, resources and behavioral tracking; Computer-Assisted Problem Solving (CAPS) – CASM, plus diabetes-related problem solving therapy; Leap Ahead (LA) – general health risk education that serves as an attention control. Following baseline intervention, all patients received four live follow-up live phone calls during the next 12 weeks to expand and support their respective interventions. All patients were reassessed on primary outcomes at 16 weeks. A live intervention booster session to extend the impact of CASM, CAPS, or LA occurred at 20 weeks, followed by four phone calls over the remaining seven months of the trial to support and maintain the intervention. Outcomes/Results: Primary outcomes were change in diabetes distress, diet, physical activity, and medication adherence. Secondary outcomes included change in HbA1c, lipids, and BP. Four-month assessment data for the entire sample will be available on March 1. We propose presenting our four-month findings regarding change in both primary and secondary variables as a function of the interventions. In particular, we will focus on how changes in diabetes distress—the target of the intervention—co- varied with changes in the primary and secondary outcomes differentially in each of the three groups. Conclusions: To be determined, based on the new findings.

26. Preparing for teaching health center residency programs: migrant and farm worker fourth-year transition elective
PADILLA A

Context and Objective: The Migrant and Farm worker elective engages participants in a pathway highlighting primary healthcare in community health centers while learning about systems based practice. Such pathways will be critical to transition fourth-year students into teaching health centers. Academic Medicine’s November 2010 journal highlights the challenge of “Taking back Year 4.” Wally and Merando further suggest that goals for the fourth year should be clarified. The Affordable Care Act will promote teaching health centers (THC) which are expected to develop in the Central Valley. This elective was designed to facilitate a student’s transition to a rural THC and its unique systems-based practice to encourage advance practice skills. Setting/Populations: Fourth-year medical students from LCME accredited medical schools working with rural and farm worker populations in the Central Valley at a THC. Intervention/Study Design: The four-week elective includes clinical care responsibilities three days a week and two days of field work activities highlighting systems-based practice themes to allow demonstration of an awareness of and responsiveness to the larger context and system of healthcare. Fieldwork activities include orientation to reflective learning and allow for reflective analysis of student learning goals. Outcomes/Results: Participants are evaluated utilizing UCSF’s standard clinical evaluation form. Four reflective summaries are required from fieldwork learning goals. Qualitative methods will be used to explore the range of participant learning themes. Themes will be analyzed to enhance future participant learning and faculty development. Conclusions: This educational research design elective is unique in its goals to recruit fourth-year medical students interested in matching to THC residency programs. Future study will analyze comfort and efficacy of clinical work in a THC between residents who participated in this transition elective and those who did not.

Elation or dismay? Attitudes of California healthcare stakeholders on the Affordable Care Act Medicaid expansion
KIEBER-EMMONS A, BODENHEIMER T

Context and Objective: In California, the new healthcare reform bill and Medicaid expansion will allow approximately three million Californians to become newly insured, at an estimated cost of up to $3 billion/year in the years to come. This study was designed to examine the thoughts, attitudes and concerns of the major California project focuses on learners in UCSF’s four health professional schools—medicine, nursing, pharmacy, and dentistry. Intervention/Study Design: The aims of this ongoing project are to: 1) map the existing integrative medicine content in UCSF’s health professional schools; 2) develop guidelines, based on a national Delphi survey of integrative medicine experts, for an interprofessional curriculum of core integrative medicine content; 3) design and implement components of a multidisciplinary integrative medicine curriculum in a simulated clinical setting; and 4) evaluate the implemented integrative medicine curriculum components and their impact on learners. Outcomes/Results: The results of the curriculum-mapping component of this multi-year project indicate uneven dissemination and poor coordination of existing integrative medicine curricula across the health professional schools. There is currently little agreement on the ideal core competencies for medical, nursing, pharmacy, and dental students or on the ways in which integrative medicine should be included in the (interprofessional) training of these future healthcare practitioners. Conclusions: Using integrative medicine principles to educate and engage interprofessional learners enables individuals to work together more effectively; share problem-solving and decision-making tasks; and integrate disparate knowledge structures into a single action plan. Both integrative medicine education and interprofessional education seek to bring diverse professionals together in collaborative teams—and the synergy of these principles and strategies—has the potential to improve patient-centered and team-based care.

Outcomes/Results: The results of the curriculum-mapping component of this multi-year project indicate uneven dissemination and poor coordination of existing integrative medicine curricula across the health professional schools. There is currently little agreement on the ideal core competencies for medical, nursing, pharmacy, and dental students or on the ways in which integrative medicine should be included in the (interprofessional) training of these future healthcare practitioners. Conclusions: Using integrative medicine principles to educate and engage interprofessional learners enables individuals to work together more effectively; share problem-solving and decision-making tasks; and integrate disparate knowledge structures into a single action plan. Both integrative medicine education and interprofessional education seek to bring diverse professionals together in collaborative teams—and the synergy of these principles and strategies—has the potential to improve patient-centered and team-based care.
parents. **Intervention/Study Design:** Family Medicine residents performed a needs assessment initially with TAPP and determined that there is a lack of support and resources for expectant young fathers. Residents then collaborated with TAPP to develop and implement a six-week curriculum, which TAPP will pilot starting on March 3, 2011. **Outcomes/Results:** The modules include: stress management; pregnancy education; empowerment; parenting and family relationships; labor and delivery preparation; early childhood education. **Conclusions:** We plan to perform a qualitative assessment after the completion of the pilot. In addition, as part of the COPC process, we will evaluate our relationship with our community partner.

24. **Strain/Counterstrain: expanding myofascial pain treatment modalities for allopathic-trained resident physicians**

**EDMUNDS M, PRECECHTLE E, MCKINNEY R**

**Context and Objective:** It is estimated that 54% of women and 45% of men suffer from myofascial pain with varying degrees of intensity and morbidity. Digitally tender points (DTPs) also known as trigger points, are an accepted way to assess superficial muscle pain used predominantly by physiotherapists and osteopathic physicians to guide treatment. **Strain/Counterstrain (SCS) technique reportedly relieves DTP pain through passive positioning of the body to inhibit the pain feedback mechanism. This then allows the muscle to regain its normal stretch reflex and range of motion. The purpose of our project was to allow trained interested residents in basic SCS techniques and assess the impact of the training on residents’ knowledge, self-efficacy, and satisfaction in treating myofascial pain.**

**Setting/Populations:** A new SCS clinic is being established in the Family Health Center to operate concurrently with the minor procedure clinic and be staffed by one or more attending physicians trained in SCS technique. Residents who are trained in SCS will perform a basic assessment of each patient and proposed trigger point treatment sites. The attending will confirm the treatment plan and the residents perform the treatments. Residents who are not formally trained in SCS technique will have the opportunity to rotate through the clinic to learn more about this treatment modality.**

**Intervention/Study Design:** The proposed SCS clinic is to operate concurrently with the minor procedure clinic, where prior to rotating in the SCS, residents will complete a survey to assess resident knowledge in SCS, interest in learning the technique, self-efficacy in treating myofascial pain, knowledge of the musculoskeletal system, and satisfaction with treatment of musculoskeletal pain. A similar survey will then be completed at the end of the academic year. **Outcomes/Results:** Results are pending. **Conclusions:** Based on resident interest and clinical experiences this year, more clinical time will be devoted to teaching and provider strain/counterstrain technique. Self-completed surveys of residents before and after exposure to the SCS clinic will be used to evaluate the impact of the clinic on knowledge, self-efficacy and satisfaction with treatment of musculoskeletal problems.

25. **Creating an interprofessional curriculum in integrative medicine**

**ADLER S, COULTER Y**

**Context and Objective:** An increasing number of academic health institutions are committed to integrative medicine principles, including partnership between patient and practitioner; collaborative, interprofessional healthcare; and promotion of health and the prevention of illness. The objective of this five-year project is to develop, implement, evaluate, and disseminate a multidisciplinary, interprofessional curriculum in integrative medicine. **Setting/Populations:** This curriculum and educational research

Healthcare stakeholders about the upcoming expansion of Medi-Cal (Medicaid) through the Affordable Care Act. **Setting/Populations:** 26 key informants, including consultants or members of the Dept of Healthcare Services, the Dept of Health and Human Services, the California Health and Human Services Agency, the California State Senate, the California State Assembly, the California Governor’s office, the California Academy of Family Physicians, the California Association of Public Hospitals, the California Hospital Association, the California Primary Care Association, the California Medical Association, the Center on Budget and Policy, and 4 county representatives. **Intervention/Study Design:** In-person and telephone interviews were conducted with 26 key informants regarding Medi-Cal expansion. The data were aggregated and common consensus themes identified for each category, in order to develop a report of what key informants in California think about the expansion. **Outcomes/Results:** General support for the expansion of Medi-Cal is felt by a large proportion of the informants; however the financing of a massive increase in Medi-Cal enrollees is of concern, with a variety of ideas given how to raise the funds. Many individuals also expressed concern about access to primary care, rate structures for primary care physicians, the interplay between public and private care and the necessary steps we must take to ensure access by 2014. **Conclusions:** While there is general support for the expansion of Medi-Cal, there is also much diversity of opinion about how to finance the expansion, how to ensure access to providers for new enrollees, and how the political landscape may color the implementation of the Affordable Care Act Medicaid expansion in the upcoming years.

**Impact on referral rates after adding Healthy Steps to curriculum**

**HUGHES S, HERRERA-MATA L**

**Context and Objective:** Children’s physical, emotional and intellectual development should be a priority at preventive care visits. As such, our family medicine residency training program implemented a change in a portion of the pediatric curriculum by incorporating aspects of Healthy Steps at certain well-child visits. **Healthy Steps** is a national program developed by a pediatric team from Boston University designed to enhance children’s development by fostering a close relationship between healthcare professionals and parents. Our objective was to determine the impact on developmental referral rates of adding Healthy Steps during well-child visits. **Setting/Populations:** Our setting was a rural California family medicine residency ambulatory care clinic. Children from newborn to five years of age receiving well-child care (primarily Medicaid insured) were included. **Intervention/Study Design:** Retrospective medical records review was done one year before the curriculum change and three years after implementation. Three comparison groups were created: well-child before, regular well-child after, and Healthy Steps well-child. Developmental referrals as documented in the chart and in a referral log were measured. **Outcomes/Results:** Chart review results for developmental referrals showed 0% (0/154) the year before the curriculum was implemented; 0.6% (1/159) in the regular well-child group after curriculum implementation and 5.4% (4/74) in the Healthy Steps group. Referral logs from the same time periods had developmental referral rates of 0.8% (10/1265) in well-child before, 1.1% (14/1251) in well-child after, and 9.9% (14/141) in Healthy Steps after curriculum implementation. In both sources the Healthy Steps group had significantly higher referral rates than the well-child group (p<0.05). For the well-child groups there was no statistical difference in referrals based on source or intervention. **Conclusions:** The Healthy Steps curriculum implementation had a positive impact in developmental
referral rates among those children who received the intervention. The regular well-child visits showed similar referral rates before and after the intervention.

**Measuring primary care providers’ trust in their patients on prescription opioids for chronic non-malignant pain**

**THOM DH, MOSKOWITZ D, GUZMAN D, WONG ST, WU A, PENKO J, MIASKOWSKI C, KUSHEL M**

**Context and Objective:** Mutual trust is an important aspect of the patient-physician relationship with consequences for both patient and physician. Previous measures have been limited to patient trust in the physician. We set out to validate a measure of physician trust in the patient and use it to investigate the role of physician trust in patients with a high prevalence of chronic pain, opioid use, and illicit drug use. **Setting/Populations:** A study of opioid use in chronic pain among HIV-infected indigent patients recruited from San Francisco and their 61 primary care providers. **Study Design:** We developed a measure of physician trust in the patient starting with items derived from physician focus groups. The final scale had 12 items, with a two-factor pattern, and high internal reliability (Cronbach’s α=.93). The scale was administered to 61 primary care clinicians (50 physicians and 11 nurse practitioners or physician assistants) with respect to a total of 169 patients as part of a larger study of chronic pain and opioid drug use. **Outcomes/Results:** Clinicians were more likely to order toxicology screening and refuse to provide opioids to patients in whom they had lower trust. Although reported lifetime and current illicit drug use as well as opioid analgesic misuse did not differ by patients’ race/ethnicity, physicians reported lower trust in patients of color than in white patients. In a multivariate model controlling for illicit drug use and other variables, clinician trust was 10% lower for patients of color compared to white, non-Hispanic patients (95% CI=4% to -16%, p<.01). **Conclusions:** This new measure of clinician trust in their patients will be useful in investigating the antecedents and consequences of mutual trust, and the relationship between mutual trust and processes of care, which can help improve the delivery of clinical care. In the current study of a socially marginalized cohort, we found that non-white patients were trusted less by their primary care providers, despite similar rates of illicit drug use and opioid analgesic misuse compared to white patients.

**Conclusions:** According to the results of one focus group, access to healthcare and medications were the primary healthcare-related concerns reported by Filipino patients living in SOMA.

**22. Sex, depression, and relationships: health class education seminars at Lincoln High School**

**WONG M, GOMEZ N, CHAN P**

**Context and Objective:** Adolescence is a pivotal time of development, change, and growth. Teens are faced with decisions that will mold their future health as adults. Therefore, adolescence is a great time for health education and intervention. Medical students are uniquely positioned to talk with teens because they are both equipped with a medical background and young enough to have recently departed from adolescence, themselves. As such, our goal was to design a series of medical student-taught health education seminars to address subjects that interested local San Francisco youth. **Setting/Populations:** We worked with approximately 150 teens of all grade levels at Lincoln High, a public San Francisco high school. **Intervention/Study Design:** To begin, we conducted a needs assessment, surveying the students for their health concerns and questions. Three topics were determined as areas for education: healthy relationships (over 30% had been verbally threatened); sexually transmitted infections (53% wanted to learn most about this topic); and mental health (one student wrote in the question, “What do I do with too much sad feeling everyday?”). We designed teen-oriented, interactive lesson plans for each of these three topics and taught the seminars during the students’ health classes. Activities included discussing relationships in the context of an Eminem song, role-playing, and Jeopardy teach backs. **Outcomes/Results:** At each seminar, students were given pre- and post-seminar surveys. While the quantitative data analysis from those surveys is pending, it will be available by the colloquium. Preliminary data based on the verbal feedback suggests that students appreciated the interactive seminar format. Participation rates were excellent, indicating that students were actively involved in the material. The medical students also had a positive experience. The opportunity to teach and interact with our community was a chance to practice and reinforce skills we have learned in medical school. Working with and teaching the teens also reminded us of the “big picture,” of why we came to medical school in the first place. **Conclusions:** Overall, high schools students face many challenges and stressors. In-school health seminars taught by local medical students appears to be a unique and effective way to provide education and intervention for teens at this crucial time, benefitting both the adolescent students and the medical student teachers.

**23. Community oriented primary care: a collaboration between family and community medicine residents and Teenage Pregnancy and Parenting Program**


**Context and Objective:** As part of the family and community medicine residency community oriented primary care (COPC) unit, the class of 2011 partnered with Teenage Pregnancy and Parenting Program (TAPP) to develop a “Preparing for Fatherhood” curriculum. The goal of the curriculum is to empower young fathers, ages 13-24. **Setting/Populations:** Community group providing support and education to teenage
20. Early lessons in the formation of a new patient advisory council in a community-based, academic family medicine clinic

BUI Q, TURNER E

**Context and Objective:** While patient advisory councils are becoming more common in large medical centers and community health centers, they are not often seen in small, private-practice model clinics. We describe the events and lessons learned in the formative months of a new patient advisory council at the UCSF Family Medicine Center at Lakeshore, a community-based, academic faculty practice. **Setting/Populations:** The Family Medicine Center at Lakeshore provides family medicine/primary care for all ages and serves an ethnically, socioeconomically, and educationally diverse community of patients. **Intervention/Study Design:** In 2010, patients were recruited through their physicians and through an electronic and print clinic newsletter to join a new patient advisory council. From this, a core council of four members met once monthly to establish the structure and bylaws of the council as well as to provide input on the patient experience at the Lakeshore practice. **Outcomes/Results:** The patient advisory council provided a positive forum for patient feedback and participation in the life of the clinic. Recruitment and retention of members proved difficult although patient participants felt the council worthwhile. **Conclusions:** The patient advisory council is a valuable resource for a clinic to hear and respond to constructive patient feedback. An expanded recruitment strategy and changes to meeting content and timing are expected to improve the stability of this new patient council.

21. Community health assessment of the South of Market Filipino population in San Francisco

TRAN M, NARVAEZ J, CARRILLO E, JARANILLA J, MACAPINLAC B, LABUGUEN R

**Context and Objective:** The South of Market (SOMA) district in San Francisco is home to a large number of low-income households and recently immigrated populations, of which the largest group are Filipino-Americans. Mabuhay Health Center (MHC) is a new student-run free clinic organized by UCSF professional students and volunteers providing monthly health services to the SOMA community. This study seeks to identify the healthcare needs and social service priorities of those served by MHC to improve the quality of MHC’s services. **Setting/Populations:** A total of eight participants were recruited from the Bayanihan Community Center, the Bayanihan House, and St. Patrick’s Catholic Church in the SOMA district. Of these participants, four have utilized MHC’s services in the past, three were new immigrants, four did not have health insurance, six lived in the SOMA district, and all were Filipino. Age ranged widely from teens to 80 years old. **Intervention/Study Design:** A qualitative study using a focus group with open discussion format and guiding questions was performed to characterize the most prominent healthcare issues of the SOMA community, barriers patients encounter in accessing healthcare, and resources that can improve the quality of their healthcare. **Outcomes/Results:** Participants reported that barriers to quality healthcare primarily included medication costs, lack of health insurance, difficulty arranging primary care appointments, and negative experiences with healthcare providers in the past. In terms of positive factors related to their health, participants reported they had access to fruits and vegetables and had a good understanding of their illnesses. In terms of MHC services, subjects identified several positive aspects: that services were free and that volunteers were friendly and accommodating to the Filipino SOMA community. Suggestions for improvement of MHC services included increasing the frequency of clinic sessions, subsidizing costs of medications, and having social workers on site.

**Community Engagement**

**Caminos a Salud**

LAING BY, CHEN E

**Context and Objective:** Patients with chronic conditions like diabetes make essential everyday decisions about medications, diet, and exercise. Primary care should link patients to health resources that support healthy decisions. For higher-income populations, patient-centered technology and information has exponentially expanded. For lower-income and limited-English proficient patients, the “digital divide” may increase already existing health disparities. As part of a larger UCSF Center for Excellence in Primary Care project, we partnered with a community organization, Caminos, to pilot a program linking nine Latino diabetic patients to computer literacy classes and online diabetes resources. **Setting/Populations:** At the SFGH Family Health Center there are approximately 400 Latinos with diabetes, most are women, monolingual, low-income, and have limited access to computers. **Conclusions:** A non-profit agency that strives to ensure that low-income Latina immigrant women in the community can reap the benefits of the digital technology. The agency’s areas of focus are economic self-sufficiency and job training but Caminos is also interested in health-related computer classes.

**Does school district compliance with state physical education policies matter for children’s fitness?**

SANCHEZ-VAZNAUGH E, SANCHEZ BN, ROSAS LG, BAEK J, EGERTER S

**Context and Objective:** In the United States over the past decade, concern about childhood obesity has prompted growing attention to policy interventions that support healthy eating and physical activity at the population level. Policies focused on physical education in schools have received particular focus as a means for improving physical activity levels, enhancing physical fitness, and contributing to obesity prevention.
Although compliance at the school and district levels is likely to be critical for the success of physical education policies in promoting these goals, few published studies have focused on this issue. Capitalizing on existing data from multiple sources, we investigated whether school district compliance with California physical education policies—which currently require that schools provide elementary students with at least 200 minutes of physical education every 10 days—was associated with physical fitness among fifth-grade public-school students. **Setting/Populations:** The study sample included 91,236 fifth-grade students in 1,275 schools in the 58 districts for which the California Department of Education (CDE) reported data on compliance with physical education requirements during the 2004-2006 academic years. **Intervention/Study Design:** In this cross-sectional study, we examined the associations between student-level physical fitness (from Fitnessgram data) and district-level compliance with state physical education requirements (from CDE data) for 2004-2006; additional data on other student, school and district characteristics were also considered. **Outcomes/Results:** Of the 58 districts with compliance data, 31 (53%) were in compliance with state physical education mandates; these districts represented 278 (22%) of schools and 16,571 (18%) of students in the overall study sample. Controlling for other student, school and district-level characteristics, students in policy-compliant districts were significantly more likely than students in noncompliant districts to meet or exceed physical fitness standards (adjusted OR=1.29; 95% CI, 1.03, 1.61). Similar associations between district-level compliance and physical fitness were seen for both boys and girls and across racial/ethnic groups, although statistically significant only for Hispanic and white children. **Conclusions:** Population-level approaches including policy mandates for physical education in schools are likely to contribute to improvements in children’s physical activity and fitness levels, but their success may depend on mechanisms to ensure compliance.

**Financial Fitness Clinic: a medical-financial partnership to reduce financial hardship and improve patient health**

BENNETT H, SCHICKEDANZ A, WHITTLE A, SHEA S

**Context and Objectives:** Despite widespread knowledge that economic disparities are determinants of health inequity, clinical strategies to address financial barriers to health are lacking. Medical legal partnerships provide a viable existing model for addressing such social needs in clinical settings. We are developing a medical-financial partnership—a Financial Fitness Clinic (FFC)—to provide low-income families in San Francisco workshops on financial literacy, individualized financial counseling, and streamlined access to money saving social services with the goal of economic empowerment and improved health. Medical financial partnerships can offer a novel and vital set of skills and resources to patients. This project will pilot and implement clinical tools for assessing and improving financial stressors among patients at high risk for economic barriers to health. It will also establish a FFC to promote patients’ financial stability through access to social services, money saving public resources, and personal financial planning consultations. **Setting/Populations:** Families and patients at an urban safety-net and academic affiliated family medicine and pediatric clinic, the UCSF-SFGH Family Health Center and Pediatric Clinic. **Intervention/Study Design:** Our team will: 1) review existing models; 2) identify key stakeholders and community partners; 3) develop and pilot screening tools; 4) train providers to use the screening tool to identify financial stress and connect patients to FFC; and 5) develop a monthly FFC where professional financial planners and community agencies will address patients’ financial needs.

18. The FLU-FOBT program in the SFPDH community health network: lasting benefits of a community engaged, practice-based research project

JENKINS J, WALSH JME, YU TM, GILDENORIN G, GREEN LW, MCPHEE SJ, POTTER MB

**Context and Objective:** The FLU-FOBT Program has been studied in a randomized trial and shown to be an effective intervention to increase colorectal cancer screening in the SFPDH Community Health Network clinics. The purpose of this study was to explore the lasting benefits of participation in this research for the clinics that collaborated on this project. **Setting/Populations:** Castro-Mission Health Center; Curry Senior Center; Maxine Hall Health Center; Potrero Hill Health Center; Southeast Health Center; Tom Waddell Health Center. **Intervention/Study Design:** Pre-post surveys of clinic staff and debriefing interviews with medical directors and nurse managers. Data is currently being collected and analyzed. **Outcomes/Results:** We will present preliminary results from the surveys and debriefing interviews and show a video about the project that includes vignettes from clinic participants. **Conclusions:** There are several barriers to both research and lasting practice change in resource limited clinical settings. However, nearly all clinics adopted, implemented, and maintained certain elements of the intervention even after the study was completed. The nature of the research partnership contributed to the level of success achieved in each clinical site.

19. Qualitative insights to help develop a faith-based intervention to improve the completion of advance directives in Chinese and Vietnamese church communities

BUI Q, SUN A

**Context and Objective:** Limited evidence shows that Asian Americans have disparities in completing advance directives and in receiving appropriate EOL care. This study aims to develop a faith-based intervention in Chinese and Vietnamese Christian and Catholic churches to improve the completion of advance directives. We report on key informant interviews which are formative work for this study. **Setting/Populations:** Two Chinese Christian churches, one Vietnamese Christian, and one Vietnamese Catholic church have consented to participate in a pilot program to introduce and support the use of advance directives among their congregants. The three Christian churches are located in San Francisco, and the Vietnamese Catholic church is in San Jose, California. Religious services for all churches are bilingual in either Chinese/English or Vietnamese/English. **Intervention/Study Design:** Two key informants from each church, including pastors and church leaders, participated in an in-depth, semi-structured interview that addressed personal, spiritual, and cultural beliefs about advance directives and advance care planning. The key informants also provided strategies to introduce advance directives to their church members compatible with spiritual and cultural beliefs. Each 90-minute interview was audio-taped, transcribed, and translated into English. Qualitative analyses will be done in on the English transcriptions in order to compare and contrast Chinese and Vietnamese issues. Two coders independently coded transcripts into conceptual categories and themes. Emerging issues were written into memos and re-analyzed to discover new themes, categories, or hypotheses for future research. **Outcomes/Results:** This work is currently in progress. We present preliminary findings from the key informant interviews. **Conclusions:** Asian Americans have been shown to have low rates of advance directive completion. A faith-based intervention may be able to overcome spiritual and cultural barriers. Key informants can provide insights into culturally and spiritually-influenced beliefs about advance care planning as well as into church community values and resources.
on gender, language used to complete survey, age and whether they were born in the U.S. Fifty-five percent of respondents with hypertension want their doctors to be Hmong, while 40% don’t care what ethnicity the doctor is; 44% of respondents with a sexually transmitted disease want a Hmong doctor, while 42% don’t care about the doctor’s ethnicity. Eighty-six percent of participants had heard about HIV/AIDS; 90% who had heard were 30 years old or younger. Of those who knew about HIV/AIDS, 41% want a Hmong doctor, while 44% don’t care about the ethnicity of the doctor. Further multivariate results are pending. Conclusions: Despite the stigmatizing nature of HIV/AIDS, the fear of other fellow Hmong in the community knowing one’s HIV/AIDS status through their treating physicians does not appear to be an issue.

17. Disaster preparedness: a public health approach in Chinatown single-room occupancies


Context and Objective: Single room occupancy hotels (SROs) are homes to some of San Francisco’s most underserved communities. As a result of aging infrastructure, frequent usage of communal areas, and population density of SROs, infectious disease control and disaster preparedness represent two often overlooked public health issues. Setting/Populations: SRO Community Health Initiative Partnership (SRO-CHIP) was conceived in December 2009 after a UCSF Without Walls visit and tour of Chinatown’s SRO buildings. UCSF students were particularly alarmed by the confined living spaces, the communal bathrooms and kitchens shared by entire floors, unsafe stairways and hallways, and the lack of general sanitation. To address these vulnerabilities, UCSF interprofessional students created an academic-community partnership involving Chinatown Community Development Center, Chinatown Public Health Center, SRO Families United Collaborative, Department of Emergency Management, and students from UC Berkeley (UCB) and San Francisco Unified School District (SFUSD). Intervention/Study Design: Together, SRO-CHIP has developed an interactive, skill-based training curriculum that focuses on infectious disease control, basic first aid, and emergency survival skills. Disaster preparedness workshops are prepared by UCSF students and faculty mentor, with UCB undergraduates and SFUSD high school students interpreting and co-teaching. Workshop contents cover basic first aid, evacuation, fire prevention, waste disposal, water filtration and disinfection, safe water sources, oral rehydration solution, food safety, respiratory outbreak prevention, and disaster preparedness supplies. Outcomes/Results: SRO-CHIP has: 1) delivered four monthly workshops since November 2010 to over sixty Chinatown SRO residents; 2) enrolled 22 UCSF interprofessional students in an elective on health disparities within SRO populations; 3) engaged 24 students from UCB and SFUSD; and 4) produced a 2011 bilingual Chinese Disaster Preparedness Calendar, as a convenient reference and educational supplement to reinforce survival skills taught at each workshop. Conclusions: SRO-CHIP has demonstrated that a low-cost, academic-community partnership (ACP) can successfully train limited English proficient (LEP) Chinese SRO residents on important disaster preparedness topics with practical skills. In the future, SRO-CHIP aims to document the impact of this ACP model on knowledge retention, skill acquisition, workforce pipeline development, and adaptability of the curriculum to Spanish-speaking SRO families living in the Tenderloin and Mission neighborhoods.

economic issues through group didactics and one on one. Outcomes/Results: We will track: 1) number of FFCs held; 2) attendance at FFC; 3) number of providers trained to screen patients for financial hardship; 4) number of screenings administered; 5) number of referrals made to FFC; 6) determination screening rates by providers; 7) patient report of personal financial barriers to health; and 8) patient and provider pre- and post-FFC surveys. Conclusions: Medical financial partnerships represent a promising approach to address patient financial hardship. The FFC began on February 5th, 2011, and is growing and adapting each month with the suggestions and feedback of the FHC and GM staff, providers and our patients. We have partnered with SF Works and The Women’s Building.

How can health professionals intervene in gang violence?

WATSON L

Context and Objective: Salinas, California, is a community riddled with gang violence and youth that are involved in gangs. As healthcare professionals, there is a unique opportunity to interact with this at risk population in the clinic and Emergency Room setting. A method to permit health professionals to intervene was desired. Setting/Populations: Observational data was collected from community programs that were directly involved in youth that were involved in gangs or youth that were at risk of becoming involved in gangs. Surveys were done at Rancho Cielos, a program that offers youth between the ages of 15-19 academic classes, services in anger management, substance abuse, behavioral health, and 2nd Chance, an organization with youth between the ages of 12-18. 2nd Chance provided counseling services in conflict avoidance and offered youth already involved in gangs methods that would permit them to leave the gang and pursue a more productive and healthy lifestyle. Surveys of the perceived program in the community were conducted at the Laurel Family Practice clinic and Dorothy’s Kitchen, a homeless shelter. Intervention/Study Design: An observational study on the perceived problem of gang violence as well as suggested modes of intervention was collected from the lay community. Observation was made of various community leaders that were involved in the prevention and intervention in gang violence. These individuals were interviewed to determine suggestions for healthcare professionals to become involved in the process. Outcomes/Results: Based on data compiled from the community surveys, as well as experts in the field, a card of available community services and providers were compiled that could be made available to at-risk youth in the healthcare setting to facilitate discussion about gang activity in their community and that youth’s involvement in gangs rather they be a member or a victim of gang violence. Conclusions: It is possible for healthcare providers to conduct a brief intervention of youth that are suspected to be involved in gang related activities. Youth can then be referred to services that could assist them with either getting out of gangs or learning to be aware of and avoid gang-related violence.

Clinical Care

What do women want? Women’s experiences and preferences about contraceptive counseling: a qualitative study

LEVY K, STEINAUER J, KELLEY A, DEHLENDORF C

Context and Objective: With 50% of pregnancies in the United States being unintended, the role that healthcare providers play in how women choose contraception is of great importance. Little is known about how providers communicate with patients or about...
women value in their interactions with providers about contraception. This question is of particular interest in minority and low-income populations, who experience disproportionately high rates of unintended pregnancy. Setting/Populations: Women were recruited at five community clinics in the Bay Area by their provider after receiving contraceptive counseling. Recruitment by providers was carried out consecutively and stratified by race and ethnicity. To be eligible to participate, women had to be African-American, White, or Latina, over the age of 18, and English- or Spanish-speaking. Intervention/Study Design: We conducted 42 patient interviews addressing individuals’ experiences and preferences around contraceptive counseling. Patient recruitment was stopped when saturation was reached for the topics of interest. Consensus codes were reached by three researchers through an iterative process. Qualitative analysis of the semi-structured interviews was conducted using NVivo software and modified grounded theory. Outcomes/Results: Patients desired autonomy over the contraceptive decision, but also valued the opinions voiced by their providers. Patients who had experienced pressure to use a contraceptive method indicated that this made them less likely to use the method. The discussion of side effects associated with methods was highly valued by participants, who often felt that providers did not fully disclose this information. Overwhelmingly, patients expressed the desire for family planning providers to engage with them on a personal level when discussing this decision. Conclusions: Contraceptive counseling presents a unique challenge in health communication due to the socially complicated context of sexuality. The information from this study suggests that providers must be aware of the desire of patients for both comprehensive information provision and guidance in the decision making process, while being vigilant to avoid any appearance of pressure towards a specific method.

Treat to Target: a novel innovation in hypertension treatment
MARGOLIUS D, BENNETT H, PADILLA G, NGO V, THOM D, BODENHEIMER T

Context and Objective: Health coaching and home blood pressure monitoring have been found to be effective in improving blood pressure control compared to usual care. We investigated whether adding home titration to health coaching and home monitoring improved blood pressure control. Setting/Populations: Participants were low-income English-, Spanish-, Cantonese-, or Vietnamese-speaking patients who receive primary care at the Family Health Center. Participants were eligible if they had documented blood pressures greater than 145/90 mm Hg on two separate occasions in the past year. Intervention/Study Design: We conducted a randomized controlled trial that compared home blood pressure monitoring + health coaching (comparison) with home blood pressure monitoring + health coaching + home titration (intervention) over six months. Home titration involved adjusting medication based on home monitoring using an algorithm without the need for clinic visits. Outcomes/Results: A total of 237 patients were enrolled in the study (108 comparison group, 129 intervention group). Mean age was 60 years, 90% were racial or ethnic minorities, 50% were non-English-speaking, and 32% were diabetic. In the home titration arm, only 31 home medication titrations happened among 20 patients. We found no significant difference in reduction of systolic blood pressure between comparison and intervention groups (-19.4 vs. -23.0). In both arms combined, systolic blood pressure was lowered more in patients with baseline SBP of >160 vs. <160 (-30.9 vs. -16.3, p<0.0001) and for patients with 2+ or <2 baseline medications (-24.1 vs. -16.6, p<0.0001). Conclusions: This study demonstrates the feasibility of adding a home titration component to health coaching and home blood pressure monitoring for treating hypertension in an underserved population.

15. Developing a health communication tool for Vietnamese-speaking elders: results of the CLIP card pilot
VUONG V, ROMERO E, PHUNG K, COHEN J, BLAIR T

Context and Objective: Community members and healthcare providers identified language barriers as a clinical obstacle for Vietnamese-speaking elders. Utilizing community input, we sought to develop a tool for overcoming these barriers. Setting/Populations: A needs assessment was performed with Vietnamese-speaking patients and physicians at Lakeshore Family Health Center. In response to participant feedback, we broadened our focus and collaborated with Vietnamese-speaking elders at the Vietnamese Elderly Mutual Assistance Association (VEMAA) of San Francisco. Intervention/Study Design: Through a series of discussions with primary stakeholders, we developed a 5” x 7” card, the Clinical Language Illustrated Picto‐card, with basic clinical vocabulary, illustrative medical pictures, and everyday phrases in Vietnamese and English on one side and space for a medication list and problem list on the other. We presented this card to elders at VEMAA, with pre- and post-presentation surveys and brief post-presentation interviews, in order to assess elders’ attitudes toward the card. Outcomes/Results: In the pilot phase, 11 elders received cards. Surveys of this sample showed that while elders had primary care providers who spoke Vietnamese, elders nonetheless experienced language barriers outside of primary MD offices, including inability to communicate medication lists or basic health information to providers in urgent care or emergency situations. Overall, elders reported enhanced confidence in communicating symptoms and their list of medications to both urgent and primary care providers after receiving the card. Conclusions: This pilot found enthusiastic reception of a communication tool for non-English-speaking elders, particularly for interacting with providers other than their primary physicians. Given the inevitable need for urgent/emergent visits and primary care appointments with providers other than one’s own, the CLIP Card merits further piloting among non-English-speaking elders and their physicians. In addition, this project has demonstrated the feasibility of small-scale community collaboration across linguistic and cultural barriers.

16. Hmong, HIV, and their physicians
YANG H, VANG K, MORTIMER R, HUGHES S

Context and Objective: Traditionally, aside from leprosy, STDs including HIV/AIDS are thought to be the second most stigmatizing medical infections within the Hmong community. This study attempts to answer the question whether Hmong people prefer to seek treatment for HIV/AIDS from a Hmong healthcare provider. Setting/Populations: Adult Hmong attendees of the Fresno 2011 Hmong New Year Festival Celebration. Intervention/Study Design: Research personnel fluent in both English and Hmong asked passing individuals at the festival to complete a short survey and provided assistance if needed. Questions on the survey included age, zip code, country of birth, length of residency in the U.S., importance of whether the healthcare provider speaks Hmong, and preference of healthcare provider race for treatment of three medical conditions—hypertension, sexually transmitted diseases, and specifically HIV/AIDS. Outcomes/Results: Three hundred thirty Hmong people responded to our survey. The survey was completed in Hmong by 23% and in English by 77%. Males and females participated equally at 51% and 49% respectively. Forty-six percent of responders were 30 years old or younger; 63% were not born in the U.S.; 73% reside in California. It was very important that the responder’s doctor spoke Hmong in 57% of participants. There were significant differences (p<0.01) in importance of a doctor speaking Hmong based
clear understanding of the study purpose and its procedures. They also indicated that they would have a greater willingness to participate with encouragement from their primary care doctors and the clinic staff, when the research is being conducted by a well-known and trusted institution, and when they are appropriately compensated for the time and effort that would be required of them. Patients preferred being recruited in the language they feel most comfortable reading and speaking. **Conclusions:** Primary care clinicians and clinic staff have an important role to play in Chinese Americans’ participation in practice-based research studies. Unique issues to consider when recruiting Chinese Americans for practice-based research include endorsement of the project by the clinic staff, use of language- and culturally concordant research staff, a clear explanation of the expectations of the researchers with attention to potential barriers to participation, and clear communication about the potential relevance of the research to patients, their families, and the community.

14. To what extent do children with special healthcare needs covered by the California Children's Services Program have a medical home?

RIENKS J, GILLESPIE K, OLIVA G

**Context and Objective:** This research was conducted to determine the degree to which children with special healthcare needs covered by the California Children’s Services (CCS) Program have access to medical and care coordination services that are considered key aspects of having a medical home. **Setting/Populations:** Families with children enrolled in the CCS program. **Intervention/Study Design:** As part of a needs assessment for the CCS, families with children enrolled in the CCS program were encouraged to complete a survey either online or on paper regarding access to primary and specialty care, family-centered care, after-hours care and advice, and care coordination services. **Outcomes/Results:** A total of 409 people completed most of the survey questions and were included in the data analyses. Almost all respondents (95%) report that their children have primary care providers, and 34.1% report that their children’s primary care physicians are currently the most important doctors for their children, while 60% report that specialist physicians are the most important doctors for their children. Of those families reporting a need for primary care services, 18.8% report problems accessing primary care. Of those families reporting a need for specialty care, 30.4% report problems accessing care. When asked to rate specific types of access to physicians that are most important to their children, overall ratings were generally positive. However, others gave their physicians poor ratings for: being easy to contact by phone (7.8%), being available to give medical care or advice at night and on weekends (14.2%), being easy to reach in an emergency (14.1%), and communicating with their children’s other healthcare providers (7.1%). Help coordinating their children’s care is another area where ratings were also generally positive, but sizeable percentages report being somewhat dissatisfied (16.1%) and very dissatisfied (10.6%) with this help. **Conclusions:** Children with special healthcare needs are the most medically vulnerable children and a population that would benefit greatly from access to a true medical home. While the majority of families covered by CCS often have the kind of access to providers and services envisioned by medical home advocates, many families also experience significant problems which can result in increased costs and a lower quality of life.

Relatively few home medication titrations occurred and home-titration added little to the intervention of health coaching and home-blood pressure monitoring. However, the reduction in systolic blood pressure demonstrated in both arms was substantial and significant. Primary care practices can and should incorporate Treat to Target interventions into hypertension treatment strategies.

**The Healthy San Francisco chronic care redesign project: an innovative role for nurse practitioners**


**Context and Objective:** In 2007, San Francisco’s Department of Public Health launched Healthy San Francisco (HSF), the city’s program of “universal healthcare.” HSF provides uninsured adults with a primary care “medical home” and associated specialty, emergency, and acute care. Existing systems could not accommodate the anticipated increased demand for primary and specialty services for HSF enrollees, many of whom were medically complex patients with multiple chronic conditions. This necessitated the development of an innovative practice model. As a result, a cadre of specialty-trained nurse practitioners (NPs) was developed to be part of an integrated practice team in five areas: diabetes; asthma/COPD; heart failure; back pain; and as practice partners for physicians in training. **Objective:** To improve primary care/specialty care coordination and chronic illness care. **Setting/Populations:** Urban academic medical center. Patients encountering these practice teams are primarily referred from SFGH Family Health Center, General Medicine, or in some cases from the SF Community Health Network clinics. **Intervention/Study Design:** Each chronic illness integrated practice team has designed interventions and studied outcomes to meet the needs of its project. For example, the diabetes team instituted an insulin-initiation group medical visit and compared HA1C for patients in the group medical visit to those receiving usual care. **Outcomes/Results:** These unique NP roles improve the quality of patient care through a strengthened chronic care infrastructure. Access to specialty care is increased, and NPs enhance communication and improve coordination between specialty and primary care. Evaluation of patient care outcomes has a critical role in guiding this practice model. Outcome measures vary among chronic illness teams yet some include: referring provider satisfaction survey; patient survey; tracking echo data on LV dysfunction; documentation of patient self-care; and A1C change after intervention. **Conclusions:** Innovative NP roles in chronic care disease management in an urban academic medical center setting improve patient outcomes, primary care/specialty care coordination, and multidisciplinary communication.

**HIV-related stigma among clinical providers and its effect on access to care**

WARREN N, BERNSTEIN M, KEATLEY J

**Context and Objective:** Underserved, low-resource, low-prevalence communities in Federal Region 9 have long been challenged to provide HIV treatment and screening. Despite promotion of HIV testing and the existence of high-risk behaviors in these communities, providers in these communities have not embraced HIV screening and treatment. **Setting/Populations:** PAETC is a regional network of 15 local sites in a four-state region (AZ, CA, NV, HI), including the U.S. Pacific Jurisdictions. With Ryan White funding, PAETC provides training, education, capacity development, and clinical support activities to HIV clinical providers and other clinicians who manage high-risk populations including the needs of providers in rural underserved areas. **Intervention/Study Design:**
PAETC conducted focus groups with clinicians (both HIV and non-HIV) working in three diverse, low-resource settings: the California/Arizona border region with Mexico; California’s Central Valley; and the U.S. Pacific Jurisdictions. **Outcomes/Results:** Across three very different settings, focus group participants identified pervasive HIV-related stigma both within themselves and their fellow clinical providers. These providers reported high levels of stigma against people based on socio-demographic characteristics such as sexual orientation and substance use. However, these providers also reported a “new” stigma resulting from clinicians’ perception that HIV-infected patients will drain their already thin resources. Provider reluctance to HIV test was related to avoiding offering HIV care, or even linkage to care for fear of the perceived resource depletion. Focus group participants also described the devastating impact of budget cuts on patient care and emphasized how language, cultural and geographic barriers affected patient access. Participants speculated that HIV trainings, especially distance learning attached to a “live” provider who could provide ongoing mentorship, could aid providers to move past the perceived stigma(s). **Conclusions:** Discussions of “Test, Link, and Treat” should consider the seemingly intractable stigma among some clinicians, especially those in areas where other HIV clinical resources are not available and patients are unable to obtain screening or treatment locally. The dearth of resources includes lack of provider access to HIV education and training opportunities. PAETC will focus on providing increased opportunities for underserved low-resource settings in our region.

**Research**

The prognosis of acute low back pain in primary care in the U.S.: a two-year prospective cohort study  
MEHLING WE, GOPISetty V, BARTMESS E, ACREE M, PRESSMAN A, GOLDBERG H, HECHT FM, CAREY T, AVINS AL

**Context and Objective:** To assess the prognosis of patients presenting with acute low back pain (LBP) in a primary care setting in the U.S. **Summary of Background:** Practice guidelines for acute LBP based on return-to-work outcomes underestimate the development of chronic pain in the primary care setting. Due to differences in inclusion criteria, chronic pain definitions, and national health systems, prognostic cohort studies have reported a wide range of results limiting interpretation and generalization. Current data from carefully designed prognostic studies of acute LBP are lacking for the U.S. primary care system. **Methods:** Members of a large health service organization were enrolled after seeking medical care for acute LBP, with or without sciatica, of up to 30 days duration, with no prior episode in the past 12 months and no history of spine surgery. We conducted phone interviews at baseline, six months, and two years. Based on receiver operating characteristic analyses, a combination of global perceived recovery with pain intensity was used as primary outcome for chronic pain. Recurrence and multiple secondary outcomes were assessed to allow for comparison with other studies. **Outcomes/Results:** 605 patients had an average pain intensity of 5.6 (numeric rating scale 0-10) and disability of 15.8 (Roland Morris scale 0-24). Eight percent (8%) had declared sick leave between pain onset and baseline interview; 13% of 521 patients (86% follow-up) suffered from chronic pain at six months; and 19% of 443 patients at two years. At six months, 54% had experienced at least one LBP recurrence, and 47% in the subsequent 18 months. **Conclusion:** The prognosis of strictly defined acute LBP, with

**Populations:** PAETC is a regional network of 15 local sites in four states (AZ, CA, NV, HI) that includes the U.S. Pacific Jurisdictions that trains, educates, and strengthens the capacity of clinical providers to provide care for HIV-infected patients and screening for potentially infected patients. **Intervention/Study Design:** The needs assessment combined epidemiology, infrastructure assessment, and key informant interviews of HIV clinician and “systems level” (state/county) leaders. The design included quantitative measures from existing data sets such as OSHPD and HIVQUAL to achieve a more complete environmental scan of the state of HIV care, comorbidities, and case finding. **Outcomes/Results:** Findings from the needs assessment included: a substantial shift in the emerging epidemic in some localities; major cuts to basic services such as ADAP; major increases in Ryan White clients due to unemployment and subsequent loss of health insurance; clinics and ancillary services closing down; and patients presenting at diagnosis with AIDS. Reports from clinicians on their experiences with patients included: difficulty retaining patients in care (60%), especially patients with psychosocial issues (80%); difficulty with adherence (64%); resistance to HIV meds (24%); and treatment failure (12%). Systems-level key informants emphasized the need to support screening and testing programs to reduce late diagnosis. The use of existing data sets augmented our assessment of HIV screening, and our region’s outcomes on key clinical indicators. **Conclusions:** An increased focus on understanding epidemiology and infrastructure substantially shifted the focus of our region’s program planning. This was particularly dramatic in some areas where both the shifts in those testing HIV+ and the clinical and benefit infrastructure available to assist them had dramatically altered. Both the types of training and the method of providing support moved the organization toward long term longitudinal capacity building at a clinic and provider level.

13. Chinese American patients’ views about practice-based research participation: concerns and incentives  
YU T, TSOH J, POTTER M

**Context and Objective:** Ethnic minorities are underrepresented in practice-based research studies. The purpose of this national multisite study was to determine best practices for recruitment and retention of diverse ethnic groups into practice-based research studies in primary care. Here we present the results of focus groups conducted by the San Francisco Bay Area Collaborative Research Network (SF Bay CRN) with members of the Chinese American community. **Setting/Populations:** Participants were recruited through posters placed in primary clinics at UCSF, San Francisco General Hospital, one community clinic, and two private practices in San Francisco. Participants were required to be over the age of 18, self-identify as Chinese or Chinese Americans, and have had at least one primary care visit within the last two years. **Intervention/Study Design:** The study involved five practice-based research networks (PBRNs), each PBRN focused on a different ethnic group (Chinese Americans, Arab Americans, Navajo Nation, African Americans, and Latinos). The UCSF site conducted five focus groups of 47 Chinese Americans in Cantonese, Mandarin, and English. Common themes were generated based on focus group transcripts. **Outcomes/Results:** Participants expressed common concerns about research participation, which included loss of privacy, risks involved particularly with medications or non-routine clinical procedures, time commitments, and their role and ability to provide a level of participation and information that would be “helpful” or “needed” by the researchers. Participants indicated that they were most likely to participate in research projects that were personally relevant or important to their family or community and when they had a
AG, albumin and globulin measurements were all normally distributed, while ammonia level was not. Ammonia level ranged from 21 to 653 μmol/L and AG ranged from 1 to 19 mmol/L in our dataset. Spearman correlation of AG and ammonia was 0.012; p = 0.9191; 95% CI (-0.230 to 0.253). Pearson correlation of AG and Albumin was 0.344; p = 0.0035; 95% CI (0.119 to 0.536). Pearson correlation of AG and globulin was -0.086; p = 0.4767; 95% CI (-0.315 to 0.152). Conclusions: There was no correlation between the ammonia level and AG measurement. The positive correlation between albumin and AG confirms previous findings in the literature. The lack of correlation observed between the ammonia level and AG measurement results from the quantity of ammonia. Ammonia is measured at μmol/L, however, AG is measured at mmol/L. Although, ammonia level does affect the amount of cations in serum, due to its small quantity, it does not significantly alter the measurement of AG.

11. Qualitative evaluation of “HAPPEN,” an HIV prevention program for women partners of incarcerated and recently released men
BIEN M, MAHONEY M, WOODSON T

Context and Objective: High rates of incarceration in the African American community exacerbate a woman’s risk of HIV by decreasing the numbers of available sexual and marriage partners, shattering existing sexual relationships and family lives, and changing norms related to sex and monogamy. The Health Access Program for Prevention, Empowerment, and Networking for Women (HAPPEN) was established in September of 2009 to address the HIV prevention needs of women partnered with incarcerated or recently released men. Setting/Populations: HAPPEN is an adaptation of the evidence-based HIV prevention intervention Health Options Means Empowerment (HOME) project for women visitors of the San Quentin State Prison. HAPPEN is a three-year grant of the DHHS Office on Women’s Health that provides health education, HIV testing, and linkage to healthcare and social services in San Francisco, using a peer education model. Recruitment and program activities occur at four project sites—Epiphany Center, San Quentin State Prison, Glide Memorial Women’s Center, and the SF Jail Women’s Re-entry Center. Intervention/Study Design: To evaluate the effectiveness of our HIV prevention program among women partners of incarcerated and recently released men, we offered a short interview at one month after completion of the three-session program. Participants are interviewed about their satisfaction with the program using an informal discussion format. Outcomes/Results: Interviews are currently underway. After five interviews, we have noticed the major theme of empowerment. As we explore this theme further we hope to find how empowerment is linked to both perception and reduction of risk as it relates to HIV. Conclusions: An in-depth understanding of the experience of HAPPEN participants can inform future program development, as well as elucidate underlying themes that need further discussion to be integrated into prevention strategies in this community.

12. PAETC: mining existing data sources and interviewing key informants to construct a more effective needs assessment
WARREN N, BERNSTEIN M

Context and Objective: PAETC’s previous needs assessments had consisted primarily of a convenience sample survey compiling provider impressions of HIV care and its challenges. Drastic state and local budget cuts and related infrastructural shifts demanded a more comprehensive assessment of how these developments affected the ability of HIV institutions and clinicians to provide HIV care and screening. Setting/
and unmet healthcare needs. Telephone survey participants in both 2008 (after hospital closure) and 2003 (before hospital closure) were compared using multiple logistic regression models on imputed data sets weighted for non-response and adjusted for self-reported measures of demographic and clinical characteristics to examine the odds of reporting delays in care. **Outcomes/Results:** Of 708 study participants (response rate 63%), 48% were ages 50-64 years, 59% were female, 26% conducted the survey in Spanish, and 28% had household income below the federal poverty level. Compared to older residents, those ages 50-64 years were less likely to receive preventive care and had higher rates of delays in getting care and difficulty receiving needed medical care. After adjusting for covariates which were both known to influence access to care, greater delays in care were reported: adjusted odds ratios (AOR) 1.70 (95% CI 1.01, 2.87) for delays in care; 1.88 (95% CI 1.06, 3.13) for problems receiving needed medical care; and 2.62 (95% CI 1.46, 4.67) for seeing a specialist. **Conclusions:** We observed high rates of unmet need for primary and specialty care and greater delays after hospital closure, particularly among those ages 50-64 years, compared to older persons. As healthcare reform unfolds, monitoring changes in access to care that may result from new policies will be important, particularly for racial/ethnic minority and low-income populations.

<table>
<thead>
<tr>
<th>Age-related differences in rates of preventive care and delays in care</th>
<th>Relative Risk (95% CI)*</th>
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<tbody>
<tr>
<td>Overall</td>
<td>Ages 50-64 yrs vs. ≥65 yrs [Ref]</td>
</tr>
<tr>
<td>Flu shot in past year</td>
<td>47%</td>
</tr>
<tr>
<td>Colonoscopy in less than 10 years</td>
<td>41%</td>
</tr>
<tr>
<td>Mammogram in past 2 yrs [women]</td>
<td>16%</td>
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<tr>
<td>Reported any delay in care</td>
<td>16%</td>
</tr>
<tr>
<td>Problem receiving needed care</td>
<td>50%</td>
</tr>
<tr>
<td>Problem seeing a specialist</td>
<td>45%</td>
</tr>
</tbody>
</table>

*Weighted for zip-code level poverty, age, and race
*Adjusted for age, gender, race, income, insurance, and chronic conditions

**Women’s experiences with counseling for early pregnancy failure management: a qualitative study**

WALLACE R, DILAURA A, DEHLENDORF C

**Context:** Early pregnancy failure (EPF) is a common occurrence. Four options are established as safe and effective treatments for EPF: 1) aspiration in the operating room; 2) aspiration in the office; 3) medical management with misoprostol; and 4) expectant management. Trial data reveals that patients have strong preferences for EPF management and report higher satisfaction when treated according to these preferences. Honoring this preference-sensitive decision with a patient-centered approach to counseling is important, particularly for this intimate and often emotional experience. However, there is currently no research examining what women value for counseling and whether shared decision-making or another framework is most appropriate for EPF management options counseling. **Objectives:** 1) to describe patient experiences with, expectations of and values regarding EPF counseling, including how patients wish to arrive at a management decision and what role they want the provider to assume in this process; and 2) to identify opportunities for further study or potential is significantly higher than in the U.S. population. This high prevalence, coupled with the impact of food insecurity on chronic disease self-management and healthcare utilization, suggests that safety net hospitals are an important target of food insecurity interventions.

**9. Primary Care Progress at UCSF: a chapter, an organization, a movement**

BENNETT H, BRODE E, CHODOS A, GLEASON N, LAING Y, NEUHAUSEN K, SCHICKERANDZ

**Context and Objective:** Across the U.S., primary care medicine is in a state of crisis. Fewer trainees choose to pursue careers in primary care due to the demanding work schedule and poor reimbursement, while the need for high-quality primary care is increasingly clear. The field of primary care medicine must adapt in order to overcome these challenges. **Primary Care Progress at UCSF** aims to form a community of healthcare professionals and trainees dedicated to revitalizing primary care delivery and education through collaboration, innovation, and advocacy. **Setting/Populations:** Primary Care Progress is a group of UCSF medical students and residents from Family and Community Medicine, Pediatrics, and Internal Medicine who are working together and collaborating with faculty and community primary care providers to learn about, strengthen, and share primary care innovations. The organization has chapters in Boston, Providence, Washington DC, and San Francisco, and is spreading across the country as other local chapters form. **Intervention/Study Design:** Through campus and community **Primary Care Progress** events and lectures, a virtual home on the **Primary Care Progress** website, and partnerships between students, residents, and innovative primary care doctors in the community, we will build interest in primary care and create more providers with a change-minded approach. **Outcomes/Results:** 1) The creation of a local primary care community at UCSF, and a network with the larger national primary care community, through Primary Care Progress; 2) the creation and dissemination of innovations in primary care; 3) the creation of primary care curricula and opportunities for hands-on experience in medical school and residency; and 4) the creation of an inspired, collaborative, and adopt primary care community and workforce. **Conclusions:** Primary Care Progress at UCSF represents an interdepartmental, organized movement of change-minded and united future and current primary care providers, who are dedicated to taking real steps towards transforming primary care.

**10. Serum ammonia level does not affect anion gap measurement**

LI C, MORTIMER R, HUGHES S

**Context and Objective:** Serum anion gap (AG) is calculated from the formula: 
AG=measured cations-measured anions (Equation 1). Since the concentration of positive charges (cations) is always equal to the concentration of negative charges (anions), AG can also be presented as: AG=unmeasured anions-unmeasured cations (Equation 2). Ammonia exists as the form of ammonium ion (NH₄⁺), which is a cation. According to Equation 2, increased ammonium could possibly lead to elevated unmeasured cations, resulting in a decrease in AG. Therefore, our research is to investigate the correlation between ammonia level and AG. **Setting/Populations:** Anyone who had an AG measured at the laboratory of Community Regional Medical Center, Fresno, CA in 2008. **Intervention/Study Design:** After IRB approval, data from a random sample of patients who had serum ammonia and AG level (part of basic metabolic panel or complete metabolic panel) measurements were obtained from electronic laboratory records. We also collected albumin and globulin measurements that were taken at the same time or on the same day as AG. **Outcomes/Results:** Information from 70 patients was collected.
Medical-student-driven telephone intervention. **Setting/Populations:** Patients with poorly controlled diabetes mellitus (DM) type I or II (defined as HAIc>7%) and receiving their primary care at the UCSF Lakeshore practice are eligible for participation in the intervention. **Intervention/Study Design:** Patients receiving their care at UCSF Lakeshore practice and suffering from poorly controlled DM were identified using the clinical databases. Patients are being contacted to determine interest in participation. Patients who would like to participate are then involved in the three-step intervention. Step 1: A third-year medical student administers the Problem Areas In Diabetes (PAID) survey, a validated survey designed to identify obstacles in DM management. This survey was selected by reviewing clinic-based interventions and seeking feedback from Lakeshore clinicians. Based on survey results, the student helps the patient develop a specific goal targeting one of the identified obstacles. Step 2: A packet of information is mailed to the patient, including a reminder of his/her goal, and DM education material relevant to the patient’s problem areas. Step 3: A follow-up telephone call is conducted two to three weeks after the initial call, to re-administer the PAID survey (to assess any changes in perceived obstacles in management), and to discuss the patient’s progress towards his/her chosen goal, as well as patient satisfaction with the intervention. Outcome measures are: the difference in pre- and post-intervention PAID results, proportion of patients still practicing the lifestyle modification at the second telephone call, and patient-reported satisfaction with the program. **Outcomes/Results:** Early experiences show that recruitment is particularly difficult for non-English speaking patients, as protocols have not yet been implemented for utilizing interpreter services during patient phone calls. Results are pending additional recruitment. **Conclusions:** A telephone-based intervention program is being piloted to improve patient management of DM. The intervention is still in its early stages and additional patients should be recruited. 8. Food insecurity in the inpatient setting BRUCKNER J, HORWITZ M, LANDE C, LOEB A, LOPEZ A, SATO A, SOMMOVILLA N, WAHL M, WHEELER M, SELIGMAN, H **Context:** Over 14% of U.S. households are food insecure. Food insecurity is associated with increased chronic disease risk and healthcare utilization, yet few studies have examined food insecurity in the inpatient setting. **Objective:** To determine the prevalence and correlates of food insecurity among inpatients at a safety net hospital. **Setting/Populations:** The survey was administered by a group of six third-year medical students under the direction of Dr. Hilary Seligman to inpatients at San Francisco General Hospital (SFGH), which serves a diverse population in San Francisco. **Intervention/Study Design:** We administered the five-item Household Food Security Survey Module to all medicine and cardiology inpatients at SFGH on a single day (January 23, 2011). Exclusion criteria included altered mental status and inability to communicate in English, Spanish, or Cantonese. We used chi-square tests to compare food-secure and food-insecure participants. **Outcomes/Results:** The 40 patients in our sample were ethnically diverse (28% Black, 5% Latino, 20% Asian, and 32% White) and predominantly English-speaking (80%) with a mean age of 64 years. The prevalence of food insecurity was 48% (23% mild and 25% severe). Food insecure participants were more likely than food secure participants to report that their inability to afford food contributed to their need for hospitalization \( (p = 0.01) \). Food insecure participants were also less likely to have stable housing \( (p = 0.06) \), but were no more likely to be enrolled in a food assistance program \( (p = 0.8) \). **Conclusions:** The prevalence of food insecurity in inpatient safety net settings interventions to improve EPF management options counseling. **Setting:** Recruitment from outpatient primary care and gynecology clinics, and ultrasound suites at San Francisco General Hospital and UCSF medical centers. **Participants:** Women with recent EPF, approximately 30 individual interviews and three focus groups of five to seven women each. **Study Design:** Qualitative study with both semi-structured interviews and focus groups for in-depth exploration of topics and triangulation of identified themes. Theoretical sampling to achieve thematic saturation. **Results:** Interviews are ongoing; more complete data will be available April 2011. Preliminary review of the nine completed interviews reveals that several women described frustration with ambiguous language in their initial conversation around diagnosis and delayed confirmation of EPF. They instead appreciated providers who spoke candidly about the situation from the beginning. Women had varying preferences for provider involvement in the decision-making process. **Conclusions:** Women may benefit from an individualized level of support during the decision-making process for miscarriage management. These data can potentially inform the development of implementation strategies, including a decision aid, directed towards improving women’s experience of counseling during EPF management. **Medical Education** **Integrative Medicine for the Underserved: the report and tools of an international effort** BROWN B, HAMEED F, MCKINNEY R **Context and Objective:** The Integrated Medicine for the Underserved Collaborative (IM4U) grew out of the STFM Integrative Medicine interest group. Recognizing the perception of integrative medicine as “boutique medicine” with limited availability to underserved populations and the barriers to its introduction to this setting, over the last two years IM4U has gathered monthly to share our experiences of implementing evidence-based integrative medicine for these populations. We have developed a web-based toolkit of teaching materials and patient handouts describing affordable, time-efficient integrative approaches to a range of common conditions. **Setting/Populations:** Monthly conference calls focused on issues of IM4U and creation of an online tool kit available to all. Most participants are academic family physicians. **Intervention/Study Design:** The initial challenge was in creating a sustainable collaborative group and discovering the tools to facilitate this. Sharing of materials naturally led to production of the online toolkit. Our presentation includes: 1) overview of IM4U; 2) common barriers to implementation and teaching; 3) common medical conditions with high-yield integrative solutions; 4) introduction to the online toolkit, organized by modality and diagnosis; and 5) practical strategies. **Outcomes/Results:** Participants will be able to 1) describe and access a web-based toolkit designed to allow easy incorporation of evidence-based, affordable, and time-efficient integrative medicine into underserved teaching and practice; 2) understand and define “Integrative Family Medicine” as an expansion of the role of the generalist in primary care providing whole person care; 3) develop an initial facility with the principles of Integrative Medicine for the Underserved. **Conclusions:** For the past two years, we have sustained monthly collaborative conference calls involving participants from 10 major universities, four time zones, and one international border. We have gathered a core set of teaching materials and patient handouts in order to share them freely with teachers and clinicians everywhere. Our presentation will feature lessons learned regarding group
A qualitative study of Latina immigrants’ perceptions of family centered prenatal care  

CUNNINGHAM C, MIRANDA K, NEUHAUSEN K, DEHLENDORF C

Context and Objective: Latinos are the largest and fastest growing minority population in the United States. Many Latinos’ first encounters with the U.S. healthcare system occur when they seek out prenatal care. Their experiences and perceptions of the care they receive has the potential to impact their decisions to seek out future medical care, including post-partum care, well-child care for their children, future reproductive health services, and care for chronic illnesses as they age. Latinos face greater disparities in accessing prenatal care compared to white patients and also report less satisfaction with prenatal care. One way to provide culturally appropriate care that has the potential to increase patient satisfaction is to provide family centered prenatal care. Family-centered care is an approach that brings the perspectives of patients and families into all aspects of care, which is critical in Latino cultures that value family and community. Extensive research supports the provision of family-centered maternity care during the in-hospital labor and delivery, but little research has been conducted on family-centered prenatal care. Setting/Populations: A total of 20 Spanish-speaking women who self-identify as Latina and receive prenatal care at the Family Health Center will be enrolled.

Intervention/Study Design: This is a qualitative study combining individual interviews and focus groups designed to assess Latinos’ experiences and preferences regarding family-centered prenatal care. Outcomes/Results: We are currently conducting focus groups and interviews. To date we have completed one focus group and six individual interviews. Preliminary themes include the importance of the relationship with the provider, the amount of time spent in a visit, Latinos’ appreciation for being asked questions about their families and partners, and the importance of answering questions and providing “correct” medical care. It also emerged that Latinos had very complex feelings about how they defined family and whether they wanted family members involved in their prenatal care. While family involvement in general was valued, at least one participant had a strained relationship with her partner and did not want him involved in her prenatal care. Conclusions: Our preliminary results suggest that involving families in prenatal care contributes to a positive relationship with and trust in prenatal providers, with exceptions when a patient’s relationships with family members are under stress. Prenatal providers can integrate a family-centered approach with a patient-centered approach by asking their prenatal patients how they define their families and offering to engage families in prenatal care if patients desire family involvement.

Meaningful innovation or rearranging deck chairs? Comparing three formats for a family medicine clerkship  

VENER M, BRUCKNER J, SOMMOMILLA N, TEHERANI A

Context and Objective: Continuity has value as an organizing principle in medical education; however, block rotations inherently limit continuity. In longitudinal outpatient rotations, students value continuity with patients and preceptors. To explore innovative third-year models, UCSF offers the required Family Medicine clerkship in three formats—a six-week block rotation, six-month longitudinal rotation (Model SFGH), or 12-month longitudinal-integrated experience (PISCES). Our objective was to compare experiences and outcomes among students participating in these formats.

6. The experience of primary care clinicians who use a telephone consultation service for HIV management assistance  

WALDURA J, NEFF S, GOLDSCHMIDT R

Context and Objective: The National HIV/AIDS Clinicians’ Consultation Center’s HIV Warmline has been providing live, free, telephone consultation on HIV/AIDS care to clinicians since 1992. This study sought to discover if primary care providers found the service to be an efficient and effective way to obtain HIV patient-related information.

Methods: Primary care providers who had used the HIV Warmline for consultation between 1/1/2008 and 12/31/2009 were recruited for a short survey online and by postal mail. Participants were asked to evaluate their experiences of using the service using a five-point Likert scale (1 lowest, 5 highest). Results: A total of 216 clinicians responded to the survey (58%). Family medicine providers (54%), providers in community clinics (44%), and those in urban settings (59%) were the most common respondents. About half (51%) cared for >25 HIV+ patients, but only 40% considered themselves to be HIV experts. Respondents generally found the HIV Warmline to be quicker (66%), more applicable (70%), and more trustworthy (57%) than other HIV resources. Aside from the HIV Warmline, respondents favored using online resources, such as UpToDate or HIVinsite (36%) and informal consultations with colleagues (21%) over formal referral to specialists (16%) or other resources. Almost all respondents (91%) reported improved confidence in their HIV care, and 76% stated that the HIV Warmline had helped them avoid referring patients to specialists. Finally, 99% believed that their patients’ health had improved because of HIV Warmline consultation. Conclusions: HIV teleconsultation provided by the HIV Warmline is a quick and effective way to deliver HIV information and consultation to primary care clinicians. The service improves providers’ confidence about caring for HIV and enables clinicians to provide a higher level of HIV care without having to refer to specialists.

7. A Pilot telephone-based intervention for patients with poorly controlled diabetes mellitus  

STAVES J, SINGER L, SANCHEZ M, HAUSAUER A, BYRNE L, HILL-SAKURAI L

Context and Objective: The aim of this quality improvement project is to assist patients with poorly controlled diabetes through the development and implementation of a
4. Examining barriers to chronic care management at Southeast Health Center
ECHIVERRI A, OWEN M, FRANKLIN R, VENER M

Context and Objective: Meeting quality standards of care in chronic disease management is important to prevent morbidity and mortality, yet underserved patient populations may face challenges in meeting these goals. Students on their FCM 110 clerkship identified barriers to care and potential strategies to address them. Setting/Populations: We assessed patients with chronic illnesses at Southeast Health Center (SEHC), a community health center providing healthcare services to residents of the Bayview-Hunters Point neighborhood. Intervention/Study Design: Initially, we conducted chart reviews of patients with inadequately controlled diabetes (HgbA1C ≥ 8%) or hypertension (BP ≥ 140/90) at each of their last three visits. We used a telephone survey to assess barriers to care, including: patient knowledge; adherence to medication and lifestyle modification; use of available programming; and personal barriers. Data were analyzed to quantify and to provide a qualitative assessment of these barriers from the patients’ perspectives. Outcomes/Results: A large proportion of patients with poorly controlled diabetes or hypertension reported barriers to care. These included a lack of knowledge and/or adherence to lifestyle modification, medication regimens, or clinic resources, as well as personal barriers to care. Of poorly controlled diabetics (n=12), 75% were unaware of diet and exercise guidelines. Furthermore, 50% were unaware that diabetes health education classes were available at SEHC. Among patients with inadequately controlled hypertension (n=19), though every patient strongly agreed that it was “important to control BP,” only eight patients strongly agreed that they were “able to control BP.” Though a moderate percentage reported changes to their diet and exercise (53.3%, and 64.3%, respectively), the three most common reasons cited for not consistently following these recommendations were: 68.4%, co-morbid health conditions (i.e., chronic pain); 31.6%, life stressors (i.e., caretaker for dependents, domestic violence); and 26.3%, mental health disorders. Conclusions: The majority of patients with inadequately controlled diabetes and hypertension report barriers to care that impede their chronic illness management. Discussing the impact of co-morbid health conditions on chronic disease management, addressing mental health issues, and expanding group visits with diabetes and/or hypertension education may help address some of these barriers. These changes would help provide systems-level support and resources to empower patients with chronic disease to effectively manage their illness.

5. Retention rates during transition of stand-alone HIV clinic to a network of HIV practices in community health centers
BROMER S, BALANO K

Context and Objective: The system of care for people living with HIV in Sonoma County has recently undergone a significant transition. The Center for HIV Prevention and Care (CHPC), a county-run, publicly funded, stand-alone HIV clinic, which had provided medical care to approximately 550 people living with HIV, was forced to close because of changes in funding for HIV services in Sonoma County. Prior to the center closing, the Sonoma County Department of Public Health convened interested stakeholders to develop a transition plan. The planning team recommended that the CHPC transition its practice to “HIV centers of excellence” within the existing community health centers. The HIV Healthcare Network (HHN) is a collaboration two community determine which rotation model provided the most optimal Family Medicine learning experience. Setting/Populations: Third-year students in their FCM rotations. Intervention/Study Design: We assessed course evaluations, written exams, clinical practice exam (CPX) scores, and residency match results for 2008-2010. We also evaluated student responses to open-ended surveys. Outcomes/Results: Our analysis revealed no difference in written exams or CPX scores for any group. On course evaluations (1=poor; 5=excellent), PISCES students reported the highest teaching quality (block=4.25; 6-month=4.21; 12-month=4.46). Longer clerkship length correlated with students reporting better feedback on clinical skills (block=3.77; MSFGH=3.90; PISCES=4.29). Overall clerkship ratings increased in longer models (block=4.11; MSFGH=4.24; PISCES=4.32). Students in either longitudinal model were more likely to describe continuity relationships with patients and preceptors/role models as strong positive influences on their medical education. For 2008-2009, Model SFGH matched into Family Medicine at a higher rate than other students. Conclusions: Both the six-month longitudinal and the 12-month longitudinal integrated model seem to offer better feedback, positive continuity experiences, and more highly rated clerkship experiences than the traditional model. However, longitudinal models are also more resource-intensive. Any discussion of which model is optimal should include consideration of outcomes, as well as resource use. Future research will focus on how to extend optimal aspects of the longitudinal models to students in all FM clerkship models.

Examining the relationship between clerkship continuity and third-year medical students’ perception of professional climate
HILL-SAKURAI L

Context and Objective: Research notes that third-year medical students perceive unprofessional behavior in the clinical environment. Experts suggest that “continuity”—increased opportunities to work at the same clinical location, with the same attendings and the same patients—could help students witness challenging clinical situation with a more nuanced view, thereby improving their perception of professional climate. Currently, UCSF medical students may do their required third-year clerkships in a traditional format, with “blocks” devoted to each required specialty, or in an integrated program with continuity of setting, attendings, and patients across one year. I wished to examine whether students in an integrated clerkship program perceive a more professional clinical learning environment than traditional clerkship students. Setting/Populations: UCSF third-year (clinical) medical students completing Family Medicine, Internal Medicine, and Pediatrics clerkships at the same clinical sites within the integrated clerkship program and the traditional clerkships. Intervention/Study Design: A validated instrument assessing medical students’ perception of the professional climate was administered to the students described above. Students’ ratings within each clerkship were compared using the unpaired T-test. Outcomes/Results: Students in the integrated clerkship rated their professional climate higher than students in the traditional clerkships. Mean ratings on the five-point Likert scale were 3.6 (n=16) and 3.2 (n=18) (p<0.01) in Family Medicine, 3.6 (n=16) and 3.3 (n=9) (p<0.01) in Medicine, and 3.6 (n=16) and 3.3 (n=10) (p<0.01) in Pediatrics. Conclusions: Although there are confounding differences between the groups, these results suggest our students in an integrated clerkship noted more favorable professionalism compared to traditional clerkship students. Further research should examine clerkship structure as a possible means to enhance professionalism within clerkship settings.
1. Integrative medicine pilot project in San Francisco Department of Public Health clinic

PAKTER D

Context and Objective: Many families are using complementary and alternative medicine (CAM) to improve their health (62% of adults in the U.S. on a yearly basis). According to the 2002 National Health Interview Survey, there are significant disparities in access to CAM therapies based on race, income level, and education. The Healing Project at Potrero Hill Health Center (PHHC) addresses this disparity by integrating CAM services into a conventional community health clinic. The project also seeks to evaluate the cost-effectiveness of this integrative model in an underserved population. Setting/Populations: San Francisco Department of Public Health community health clinic serving largely patients of lower income and minority ethnicity. Intervention/Study Design: The Healing Project offers free acupuncture, chiropractic, yoga, and organic gardening to patients of PHHC. The project is overseen by a physician who is trained in integrative medicine. Patients are discussed at monthly meetings in a multidisciplinary approach by the CAM practitioners and MD. Outcomes/Results: Preliminary review of 165 patients active in The Healing Project from the first nine months of services showed 98% agreed that they would like to continue taking part in the complementary health treatments, and 93% agreed that the services improved their overall health. In an internal survey of PHHC practitioners, 63% felt that patients who received the CAM services had decreased need for medical visits, 87.5% found that The Healing Project had increased their patients’ self-care and patient responsibility, and all practitioners gave highest agreement to the impression that The Healing Project been beneficial to their patients. Conclusions: This pilot project addresses healthcare disparities by improving access to CAM and is a step towards developing a more integrative model of care which may be more effective and less expensive.

2. Evaluating and improving intimate partner violence screening and intervention at the UCSF student-run homeless clinic

JIANG V, KIMBERG L

Context and Objective: To develop and incorporate an Intimate Partner Violence (IPV) screening and intervention program into the UCSF Homeless Clinic and thereby 1) increase the frequency of IPV screening by medical students and 2) improve provider responsiveness to disclosures of IPV. Setting/Populations: UCSF student-run homeless clinic at MSC-South. All medical student volunteers and female patients seen at clinic. Intervention/Study Design: IPV screening questionnaires were developed both from scratch and by modifying tools developed by LEAP. All medical volunteers received a 10-minute orientation training on how to use the screening tools before they saw patients each clinic day. The program ran from July 14 to August 24, 2010. Pre- and post-training written evaluations were given to the medical student volunteers to assess the efficacy of the training in increasing their comfort and willingness to screen patients. The program was also evaluated by completing a “Delphi Tool” and chart reviews before and after implementation. Outcomes/Results: Data from the Delphi tool suggests that the clinic’s friendliness to IPV screening and intervention increased over five-fold from 8.8% to 49.7%. The fraction of female patients screened also increased significantly (40% to 72%) as did the fraction of positive disclosures (25% to 88%). The medical students who received the training generally expressed increased comfort in talking to patients about IPV and intervening with positive disclosures. Those medical students who had an opportunity to screen patients after the training reported higher levels of comfort post-training as compared to medical students who didn’t screen patients. Conclusions: These preliminary data indicate that implementation of this IPV Screening and Management program and having experience screening patients correlate with increased medical student comfort with asking about IPV and handling positive disclosures. On informal observation, students did not seem comfortable using the tool independently with just 10 minutes of training. Though patient opinions were not formally solicited, several medical students who had screened patients shared that patients seemed grateful for having the opportunity to share their stories. As a result of the positive feedback from the volunteers and faculty mentors, this program will be integrated into both the structure of UCSF Homeless Clinic as well as the MSCS shelter.

3. Assessing levels of inadequate health literacy among adults at Adventist Community Care Selma – Selma, California

GARCIA RM, LOPEZ RA

Context and Objective: Health literacy is the ability to read, understand, and act on health information. The Newest Vital Sign (NVS) is a relatively new clinic-oriented health literacy assessment tool. This project aimed to determine acceptability of the NVS and baseline health literacy among adults seeking services for chronic health conditions at a rural community health clinic in California’s Central Valley. Setting/Populations: Data were collected at Adventist Community Care Selma, a rural community health clinic in Fresno County. Patients are predominantly low-income, migrant, and Spanish-speaking. Intervention/Study Design: Over three weeks, patients were approached in the waiting room. Inclusion criteria: English- or Spanish-speaking, ≥18 yrs old, seeking medical services for routine or non-emergent health issues, and taking ≥2 medications daily. Exclusion criteria: unable to speak English or Spanish, <18 yrs old, with acute illness or mental/cognitive impairment, visually blind, or taking ≤1 medications daily. A convenience sample was orally administered the NVS, and completed a demographic survey. Analysis was limited to descriptive findings. Outcomes/Results: Of 33 qualifying patients, 28 (84%) successfully participated. Of participants, mean age was 54 yrs (range: 26-78 yrs), 12 (43%) were monolingual Spanish speakers, 17 (61%) identified as Latino, 20 (71%) were female, 19 (69%) were U.S.-born, and 14 (50%) had ≤ 11th grade education. Health literacy assessments using the NVS: 14 (50%) scored 0-1 suggesting high likelihood of limited literacy; three (11%) scored 2-3 indicating the possibility of limited literacy; and 11 (39%) scored 4-6 which almost always indicates adequate literacy. All 12 monolingual Spanish-speaking participants scored between 0-3 suggesting inadequate health literacy. Over half of participants (17/28, 61%) do not have adequate health literacy based on NVS. scores. Findings confirm rural Latino patients are likely to have inadequate health literacy, be greater than 50 years old and female, and suffer from multiple co-morbid conditions. Conclusions: In a rural community clinic, the NVS was acceptable, feasible, and indicated most patients lack adequate health literacy. Wider implementation, especially among monolingual Spanish-speaking patients, and statistically sound studies are needed to elucidate significant relationships between health literacy and clinical outcomes in rural Central Valley.