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To make a contribution to the
Jack Rodnick Memorial Fund
and help ensure our department’s continuing
support of scholarly work in family medicine, please visit
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The Rodnick Colloquium
Innovations in Family & Community Medicine

UCSF Department of Family & Community Medicine
UCSF Laurel Heights Conference Center
March 23, 2012
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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
<table>
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| 10:45am| **Registration and Check-In**  
*Auditorium Foyer, Lower Level, S1*                                                                                           |
| 11:00am| **Lunch**  
*Auditorium Foyer, Lower Level, S1*                                                                                           |
|        | **Informal Poster Viewing**  
*Garden Room (231), 2nd Floor*                                                                                               |
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*Auditorium, St-24*  
*Opening Remarks: Kevin Grumbach, MD*                                                                                      |
|        | **The Building Blocks of High-performing Primary Care: Lessons from the Field**  
*Rachel Willard, MPH*  
*Abstract: Page 10*                                                                                                            |
|        | **South Sudan Medical Education Collaborative: An Innovative Partnership**  
*Matthew Fentress, MD*  
*Abstract: Page 10*                                                                                                            |
|        | **Changing the World, or Just Changing Our Minds? After Nearly 40 Years of a Family Medicine Clerkship, Have We Made a Difference?**  
*Margo Vener, MD, MPH*  
*Abstract: Page 11*                                                                                                            |
| 1:20pm | **Poster Session, Poster Tours**  
*See page 6 for locations and detailed listings*                                                                                  |
| 2:50pm | **Concurrent Talks—Session 1**  
*See page 4 for locations and detailed listings*                                                                                |
| 4:00pm | **Concurrent Talks—Session 2**  
*See page 4 for locations and detailed listings*                                                                                |
| 5:00pm | **Break and Refreshments**  
*Auditorium Foyer, S1*                                                                                                          |
| 5:15pm | **Keynote Address**  
*Auditorium, St-24*  
**Being a Family Doctor**  
*Kevin Grumbach, MD*                                                                                                          |
| 5:45pm | **Wine and Cheese Reception**  
*Auditorium Foyer, S1*                                                                                                          |
**CONCURRENT TALKS**

**Session 1**

**Clinical Improvement**

**Moderator:** Mithu Tharayil, MD  
3rd Floor, Room 376

- **Fluoride Varnish: Preventing Early Childhood Caries in Contra Costa**  
  Diane Dooley, MD, MS  
  Abstract: Page 14
- **Veggie Rx: Can Prescribing Fruits and Vegetables Impact Consumption and Health Outcomes in Pregnant Women at Risk for Gestational Diabetes?**  
  Rachel Friedman, MD  
  Abstract: Page 15
- **The FLU-FIT Program at Kaiser Permanente: Results from a Multi-site Randomized Trial**  
  Michael Potter, MD  
  Abstract: Page 19

**Care of the Older Patient**

**Moderator:** Christina Rincón, MD  
3rd Floor, Room 384

- **Cultural and Spiritual Beliefs about Advance Care Planning of Chinese- and Vietnamese-American Christians and Catholics**  
  Quynh Bui, MD  
  Abstract: Page 13
- **Advance Care Directives: Realities and Challenges in Central California**  
  Marc Tunzi, MD  
  Abstract: Page 24
- **Clinical Utility of Brief Mental Status Exams in Identifying Early Dementia**  
  Alex Sherriffs, MD  
  Abstract: Page 22

**Medical Education**

**Moderator:** Paola Case, MD, MPH  
4th Floor, Room 474

- **Redesigning Inpatient Medicine: A Curriculum to Promote Effective, Efficient Communication within a Shift-work Model**  
  Margaret Stafford, MD, and Lydia Leung, MD  
  Abstract: Page 23
- **Collaborative, Learner-centered Curriculum Design: Combining Resident and Faculty Expertise to Create a Patient-centered Curriculum**  
  Diana Coffa, MD  
  Abstract: Page 21
- **Toward a Culturally Responsive Medical Curriculum**  
  Mariah Hansen, PsyD, Jimmy Wu, MD, and Lisa Wards, MD, MscPH, MS  
  Abstract: Page 17

Excluded. **Results:** IDU-related IE cases decreased by 5% between 1993 and 2000 (4.6 to 4.3 cases per 100,000 US population). Between 2000 and 2007, however, the number of hospitalizations for IDU-related IE steadily increased by 28% (4.3 to 5.5 cases per 100,000). Multivariate analysis of the IE trend reveals a statistically significant U-shaped quadratic curve (p=0.007). The Northeast region has higher rates of opiate-related IE than other US regions. Amphetamine-related IE admissions comprise a small proportion of total IE cases, but they have risen dramatically since 1993. **Conclusions:** This study reveals a rebound, following a historic decline, in IDU-related IE cases in the US from 1993 to 2007. Drug market cycles are relatively unexamined as public health risks, e.g., our previous work demonstrated a historic 72% decline in nationwide retail heroin price between 1990 and 2004. Future multivariate models will examine associations between heroin market forces, including price, purity and heroin type/source/qualities, and cyclical trends in IE, as well as regional differences in IE.

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DEKKER M, EGERTER S, BRAVEMAN P. Implementing the new California black infant health program model: experiences at eight local health jurisdictions.  
**Context and Objective:** Following a program assessment completed in 2008, the California Department of Public Health, Maternal Child and Adolescent Health Program (CDPH/MCAH) redesigned its Black Infant Health Program (BIH) model to better reflect current knowledge about the causes of poor birth outcomes and health disparities affecting African-American women and infants. Previously, the BIH Local Health Jurisdictions (LHJs) statewide provided a range of services with an emphasis on individual case management. The new standardized program model features a group-based approach, supported by individual-based services; it focuses on increasing social support, building personal capacity, and health promotion. Eight pilot LHJs began implementing the new model in 11/2010. The Center on Social Determinants of Health (CSDH) has collaborated with CDPH/MCAH to evaluate the pilot implementation process to guide future implementation across all 15 BIH LHJs. **Setting/Populations:** BIH serves pregnant and parenting African-American women in 15 LHJs statewide where >75% of California’s African American births occur. This evaluation focused on experiences at the 8 pilot BIH LHJs during FY2010-2011. **Intervention/Study Design:** This process evaluation was informed primarily by qualitative findings based on data collected from BIH staff during regular conference calls, written feedback, and quarterly and annual reports to CDPH/MCAH. More limited quantitative data on client caseloads and characteristics were also available. **Outcomes/Results:** The new BIH model was successfully implemented at all eight pilot LHJs, despite differences in their prior service models, staffing and other available resources. Key aspects of the implementation process contributing to success included comprehensive staff training, frequent and regular communication, and focused efforts to build staff capacity. Client caseloads and characteristics did not appear to change dramatically during the transition year, and preliminary findings on program impacts indicate benefits to BIH clients, staff and local communities. **Conclusions:** Findings from this evaluation are important for improving future implementation of the new BIH program model at LHJs statewide. At the same time, because many of the challenges encountered during the pilot implementation are not unique to BIH, lessons learned may be relevant for other public health programs—particularly those seeking to expand their focus to services beyond the traditional scope of health promotion.
valve replacements, rheumatic heart disease, and congenital heart disease, were diagnosed for IDU and IE. Admissions with non-classification of diseases (ICD-9) codes were created to assess for admissions co-diagnosed for IDU and IE. Outcomes/Results: Providers commented on the potential utility of video use in the clinical context. Video is a unique and effective way to enhance the clinical history. Providers learned more about their patients’ food environment, hobbies, and utilization of the internet as motivational tool. This added history is important in the context of the pediatric obesity clinic, where access to healthy foods, level of physical activity, and motivation for behavior change are central to successful disease management. Furthermore, providers envisioned using patient-created video as a health education teaching aid, more effective and less judgmental than simply ‘talking at’ the patient. Finally, by literally shifting the lens through which the provider observes the patient, the videos have the potential to induce a heightened level of empathy. Conclusions: By giving patients a voice to express themselves and their experiences living with chronic disease in their everyday world via the rich audio-visuals of video, providers can gain a deeper clinical history. The video content can be incorporated into the clinical visit to discuss with the patient healthy and unhealthy aspects of their environment and activities. Video diaries are a unique opportunity to enhance the clinical history. Providers learned more about their patients’ food environment, hobbies, and utilization of the internet as motivational tool. This added history is important in the context of the pediatric obesity clinic, where access to healthy foods, level of physical activity, and motivation for behavior change are central to successful disease management. 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Community Engagement
Moderator: Anika Russell, MD, MPH
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Youth with Special Health Care Needs in California: Challenges and Recommendations for Successful Transition to Adult Care
Jennifer Rienks, PhD
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Ellen Goldstein, MA
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Transforming Primary Care in the Safety Net: Lessons from PCASG Evaluation in New Orleans
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Engaging the Underrepresented
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AASAP: A Program to Increase Recruitment and Retention in Clinical Trials
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Reproductive Health
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Variation in Labor and Delivery Attitudes, Opinions, and Practices among Three Types of Practitioners
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From Last Resort to Best Practice: A Hidden Lesson of the Rapid Testing at Labor and Delivery Project
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CONCURRENT POSTER TOURS

Tour 1: Community Engagement and Underserved Populations
Guide: Amiesha Panchal, MD
Garden Room (231)

1 Community Fundraising to Support the Spanish Language Patient Advisory Board at the Family Health Center
Lucia Angel
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2 Reach Out and Read Fresno: Ongoing Benefits in Early Literacy Practices among Underserved Families
Lydia Herrera-Mata, MD
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3 An Exploratory Analysis of Successful Peer Coaches: Our Assumptions about Important Characteristics May Not Be Correct
Elizabeth Rogers, MD
Abstract: Page 25

4 PRIME Community Engaged Group Projects
Aisha Queen-Johnson, MSW
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Tour 2: Hot Topics in Diversity
Guide: Beth Wilson, MD, MPH
Garden Room (233)

5 Attempting to Eliminate Bias in the Use of Patient-Provider Agreements and Urine Toxicology Screening of Chronic Pain Patients
Lauren Strelitz (MS3), Jonathan Snyder (MS3), and Diana Coffa, MD
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6 Safe and Efficacious Protocol for Treatment of Male-to-Female Transsexuals
Jennifer Burnett, MS, MD, FAAFP
Abstract: Page 28

7 Defining and Measuring Integrated Care to Eliminate Inequities in Care among Older Diverse Populations
Kara Odom Walker, MD
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8 Healing through Testimony: A Curriculum for Asylum Evaluation That Incorporates Recovery with Testimony
Mary Puttmann, MD, MSc; Lucia D. Roncalli, MD; and Tara Scott, MD
Abstract: Page 29

9 Mental Illness among Us: A Medical School Curriculum Innovation That Decreases Stigma about Medical Students’ Psychiatric Illnesses
Anuj Aggarwal (MS4)
Abstract: Page 30

Implementing a new model of labor and delivery, a study was conducted to explore maternity care providers’ explanations for the differences in C-section rates. **Setting/Populations:** The setting is a medium-sized community hospital located in northern California, and participants include obstetricians-gynecologists (OB-GYNs) in private practice, OB-GYNs working as hospitalists, certified nurse midwives (CNMs), and labor and delivery nurses. **Intervention/Study Design:** Before implementation of the new model, participants completed a survey that specifically noted the caesarean rate difference by payer type for low-risk births, and then responded to the open-ended question, “what are the main factors are that explain the lower C-section rate for women covered by MediCal.” Their qualitative responses were analyzed for key themes. **Outcomes/Results:** The primary reason given across respondents for the lower C-section rate was midwifery care and elements of midwifery practice. Respondents identified several provider factors and practice- and system-level explanations, such as MD-patient relationships, CNMs giving better labor support, increased patience for labor, and fewer epidurals and inductions. Some respondents listed patient factors, such as education and culture. **Conclusions:** These findings are consistent with recent research that has found that provider and system factors play a larger role in explaining variations in C-section rates than do patient factors or medical indications. Expanding the role of CNMs in the labor and delivery for women covered by private insurance or encouraging OB-GYNs to adopt the labor and delivery methods utilized by CNMs may be effective approaches to reducing the C-section rate in this population.

35 MILLS W, GUTFREUND C. Integrative medicine: a core curriculum for PCMH training in family medicine clerkships.

**Context and Objective:** The patient-centered medical home (PCMH) holds "whole-person medicine" as a core tenet. Family Medicine is built on the biopsychosocial model of care. Integrative Medicine incorporates a holistic approach using a mind-body-spirit-environment paradigm. The Santa Rosa Kaiser Medical Student Program implemented a new Medical Student Integrative Medicine Consultation Clinic as part of its Family Medicine Clerkship for third-year students in 2011. Using the STFM Integrative Medicine Core Curriculum for medical student education, goals and objectives were identified. **Setting/Populations:** Third-year medical students and patients. **Intervention/Study Design:** Didactics, reading, online simulation, and most importantly experiential learning with patient care were used. The IM Clinic measured patient satisfaction as well as surveying students’ experience. **Outcomes/Results:** 1) Patients were satisfied with their experience in regards to their clinical care and the enriching experience with medical students; 2) medical students were able to better appreciate possible applications to clinical care of mind-body, herbal/supplements, manipulative medicine, and traditional complementary and alternative styles of care (TCM and Ayurveda); and 3) students were able to better describe what "whole-person care" in the PCMH might mean to them and their patients. **Conclusion:** Third-year medical students and patients benefit by including a clinical experience in Integrative Medicine as a part of the new model. More active research into the best means of teaching such principles will further leverage the transformation of evidence-based, whole-person, patient-centered approaches to care. This policy, the council has redesigned appointment cards, appointment call reminder scripts, and the new patient letter to inform patients of arrival time expectations.
estranged), one patient had transferred care out of network, and all other phone numbers were disconnected. Of the 81 HIV-positive patients LTC at FHC, 73 were prescribed antiretroviral medications, and eight were not. Patients not prescribed treatment were either late progressors or had not consented to treatment.

**Conclusions:** Creating an HIV registry is useful for monitoring quality of care and making improvements. Since the initiation of our FHC registry project, the CHN has begun a wider initiative (using the same search criteria as ours) to establish registries of HIV-positive patients at each network clinic. As a result of our work, we now sit on the CHN HIV QI Committee.

33 **MOONEY C, STAFFORD M.** Increasing documentation of advance directives in hospitalized patients on a family medicine inpatient service.

**Context and Objective:** Discussions regarding advance directives allow hospitalized patients to express their wishes and guide family and health care professionals in providing medical care that is consistent with their decisions. Through clearly and consistently documenting these discussions continuity from inpatient to outpatient care is created. The goal of this quality improvement project is two-fold: to assess the current documentation of code status and durable power of attorney (DPOA) in the discharge summaries of patients on the San Francisco General Hospital (SFGH) Family Medicine Inpatient Service and plan an intervention to increase documentation. The intervention will be done using the Plan-Do-Study-Act (PDSA) model.

**Setting/Population:** The setting and population of this quality improvement project will be the SFGH Family Medicine Inpatient Service and thereby the patients discharged from this service.

**Intervention/Study Design:** Through the medical chart review of dictation summaries the current documentation rates of code status and DPOA are being measured. The intervention will be to alter the current dictation cards that the interns and residents use to dictate their discharge summaries to include whether code status and DPOA were discussed and the result of that discussion. This PDSA cycle will be done over the course of a month looking at all the discharged patients by the interns using the altered dictation cards.

**Outcomes/Results:** The documentation of code status and DPOA are currently being measured. Subsequently, after the intervention is implemented the documentation of code status and DPOA will be measured to assess whether documentation of advance directives increased as a result of the intervention.

**Conclusions:** Given that this quality improvement project is currently in the stage of measuring current documentation rates of advance directives and setting up the planned intervention, no concrete conclusions have been reached. However, the proposed hypothesis is that through this intervention, documentation of advance directives will increase in the dictation summaries.

34 **RIENKS J, GILLESPIE K, NIJAGAL M, OLIVA G.** Exploring explanations for the difference in rates of cesarean sections at a community hospital.

**Context and Objective:** Rates of cesarean sections increased 50% between 1998 and 2008 with no evidence of improved health benefits for moms or babies in most cases. Instead, public health researchers have noted a corresponding and worrisome increase in maternal morbidity and mortality that has prompted California to convene a maternal quality improvement collaborative. In one northern California community hospital, privately insured women have twice the rate of C-sections compared to uninsured or publicly insured women who receive low-risk labor and delivery care from certified nurse midwives. As part of a larger project looking at the impact of
INDEPENDENT POSTER PRESENTATIONS

Although not on a formal tour, these posters are available for viewing—please enjoy!

18 Strategic Considerations for Recruiting and Retaining Ethno-racial Minorities in Primary Care research: A PRIME Net Report
   K. Campbell-Voityall and Michael Potter, MD
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19 Health at a Glance: Enabling Easier Health Communication in the Developmentally Disabled
   Zoe Quandt (MS3)
   Abstract: Page 37

20 UCSF Lakeshore Clinic as a Patient-centered Medical Home
   Mala C. Mandyam (MS3)
   Abstract: Page 37

21 How the Sing-along Creates Community in the Nursing Home
   Theresa A. Allison, MD, PhD
   Abstract: Page 38

22 Primary Care Protocol for Transgender Patient Care
   Jamison Green, PhD, and Nick Gorton, MD
   Abstract: Page 39

23 An Innovative Longitudinal, Integrated Substance Abuse Curriculum: Six-month Evaluation (Work in Progress)
   Kenneth Saffier, MD
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24 Community-oriented Primary Care: A Collaboration between Family and Community Medicine Residents and San Francisco’s Adolescent Health Working Group
   FCM Residency Class of 2012, Alicia St. Andrews, Joanne Donsky, MSW, and Naomi Wortis, MD
   Abstract: Page 40

25 Resident Research and Scholarly Activity in Family Medicine: A Residency Program’s Five-year Experience
   Michelle Tinitigan, MD
   Abstract: Page 41

26 Developing a Comprehensive Family Medicine Didactics Curriculum: Applying the AAFP Guidelines
   Christine Hancock, MD, MS
   Abstract: Page 41

27 Warmline and CDC Collaboration toward Increasing Routine HIV Screening among Primary Care Clinicians
   Sharon Weber, MSW
   Abstract: Page 42

are lacking. Medical-financial partnerships may be a viable model for addressing such social needs in clinical settings. We evaluated the patient-rated effectiveness and satisfaction of the pilot Financial Fitness Clinic (FFC) at San Francisco General Hospital (SFGH). Setting/Population: A convenience sample of patients from SFGH that came to the FFC completed a cross-sectional anonymous questionnaire. Intervention/Study Design: The FFC was established in February 2011 through a partnership between volunteer SFGH clinicians and professional financial planners. The clinic meets regularly to provide patients access to money-saving public services and resources, financial education, and personal financial consultations. We created a scaled questionnaire to assess domains of patient satisfaction and ask whether the FFC meets participant needs. A subset of patients was sampled with an expanded questionnaire assessing income, household size, credit score, self-rated health, and demographic characteristics. Outcomes/Results: Among 51 patients surveyed, when asked how helpful the FFC session was on a scale of 0-10 (0=not helpful, 10=very helpful), patients rated the FFC’s helpfulness as 8.2 on average. Seventy-three percent of patients reported that they learned what they had hoped to from the FFC session, 94% reported that they would come to the FFC again, and 94% would recommend the FFC to a friend. Of the subset sampled with the expanded survey, 68% had income below the Federal Poverty Level (FPL), and 81% had incomes below 200% of the FPL. Conclusions: Medical-financial partnerships such as the FFC represent a promising clinical strategy to address economic determinants of health, with reported high satisfaction and engagement among patients with financial hardship. This model also provides service-learning opportunities for clinicians and financial planners interested in working together to improve patients’ overall health by improving their financial health. The FFC has received funding for 2012 and is working with University Community Partnerships, Clinical Translational Science Institute, and the SF Department of Public Health COPC to further expand, improve, and evaluate the impact of our model.

32 WATCHA D, STERN RJ, MATIN M. Creating a registry of HIV-positive patients at San Francisco General Hospital’s (SFGH) Family Health Center (FHC) for quality improvement (QI) purposes.
   Context and Objective: Many HIV-positive patients seek care at the FHC, but a complete registry has not been established. We aimed to create a registry of HIV-positive patients to ensure linkage to care. Setting/Population: Community Health Network (CHN) patients who have sought care at the FHC since 2008. Intervention/Study Design: SFGH uses the electronic medical Longitudinal Care Record (LCR). We used an LCR tool called “I2I” to perform a query to find patients meeting any of the following: designated ICD-9 code 042; HIV viral load (VL) of any value; or confirmed positive HIV antibody. We then performed chart biopsies to determine: 1) patient HIV status; 2) linkage to care (LTC); and 3) whether identified HIV-positive patients are prescribed antiretroviral treatment. In order to facilitate linkage to care, we then attempted to make contact with patients lost-to-follow-up (LTFU), i.e., those who had not engaged in care within the previous 12 months. Outcomes/Results: We found 235 patients who met our search criteria. Of those, 96 were HIV-positive, 83 HIV-negative, and 56 were likely negative (i.e., with a recorded undetectable VL but no other clarifying labs, notes, or medication lists indicating HIV treatment. This likely indicates that the majority of these VL assays were erroneously requested for HIV-screening purposes). Of the 96 HIV-positive patients, 85 were LTC (81 at FHC; 4 at other CHN), 10 were LTFU, and one was deceased. Of the 10 LTFU, we reached families of two (now
“worry”: in pain patients these did not correlate with each other ($r = -.11$) or with any other MAIA scale ($r < .20$). In mind-body trained individuals, lower “ignoring” and “worry” scores correlated with higher scores on MAIA scales for attention regulation, emotion self-regulation, and trust in meaningfulness of body sensations ($r = .20$ to $- .35$, $p < .001$).

**Conclusions:** Data suggest that Primary care patients with current or past pain endorse an ignoring coping style in response to pain and discomfort, whereas mind-body trained individuals may have learned a new coping style. Mind-body trained individuals use an alternate coping style of less ignoring and less worry about pain or discomfort than common pain patients; it goes along with greater self-reported skills in self-regulation of behavior and emotions. Cross-sectional data suggest that mind-body trained individuals, different from primary care patients with past or current pain, may have learned a new style of coping with pain/discomfort. Whether this is true deserves further (longitudinal) study.

30 **BENNETT H, MENDEZ J, AZZAM A.** Becoming the patient: UCSF medical students explore personal illness in a facilitated-group setting.

**Context/Objective:** Medical illness and disability are prevalent in the medical provider community, as is significant stigma surrounding physicians as patients. The “Becoming the Patient” project began with a partnership between two UCSF medical students who were coping with serious illness and wanted to foster awareness, support, and professionalism around the topic of healthcare professionals as patients.

**Setting/Participants:** Longitudinal ‘Foundations of Patient Care’ (FPC) small groups in the pre-clerkship UCSF medical school curriculum. UCSF first-year medical students, divided into small groups of eight students facilitated by two faculty members.

**Design/Intervention:** Working with the FPC course core curriculum faculty, we designed a facilitated, small-group session in which medical students prepare by reviewing selected literature and then participate in a two-hour session in which they complete a reflection exercise, view videotaped interviews of medical students describing their journey as patients, and discuss their reactions and thoughts with the group. At the end of the session, students complete scaled and free-response evaluations.

**Outcomes/Results:** Twelve outcome measures in three domains: 1) knowledge of the literature and themes common among healthcare providers as patients (i.e., disclosure of personal illness to colleagues and patients); heal2) attitude toward personal health/illness as well as colleagues’ health/illness; and 3) intent to behave in a supportive and sensitive manner with regard to healthcare providers as patients. Evaluations from 135 students and facilitators demonstrated that for nearly all scaled outcomes, greater than 90% of responders “agreed” or “strongly agreed” that the objective had been met. Qualitative free responses were overwhelmingly positive, as well. The preliminary data demonstrate that students found the session effective, valuable, and impactful.

**Conclusions:** The “Becoming the Patient” session provides future doctors with the opportunity to learn to cope with, find resources for, and share experiences of personal illness. By exploring this issue early on, they may be more prepared to face illness or disability themselves or to support a colleague. The session received encouraging feedback in its pilot year, and based on this evaluation data will be modified for 2012.

31 **BENNETT H, SCHICKENDANZ A, GUILLEN N, GARZA T, WHITTLE A.** Strides and sustainability: the financial fitness clinic at SFGH, a medical-financial partnership to reduce financial hardship and improve patient health.

**Context and Objective:** Despite widespread knowledge that economic disparities are determinants of health inequity, clinical strategies to address financial barriers to health
many web-based programs have been developed and are in use, there is minimal information in the literature about how outcomes of the new formats compare with more traditional didactic presentations of core curricular content. In an effort to determine if we could replace didactic presentations of core content clerkship material with web-based on-line teaching modules, we developed a web-based program with standardized patients, on the topics of hypertension and working with medical interpreters. The case presented in the module was based on a real patient experience in the Family Health Center at San Francisco General Hospital (SFGH). We designed a study to compare the pre- and post- clerkship test results on knowledge of hypertension and working with medical interpreters for one academic year.

**Setting/Population:** All students assigned to the UCSF Family and Community Medicine clerkship at (SFGH) during the academic year 2010-11 were recruited to participate in the study. **Intervention/Study Design:** Students were assigned to two groups: 1) students taking the on-line module either alone or in conjunction to the didactic presentation; and 2) students who only attended the didactic presentation. We compared the results of pre- and post-clerkship tests for the two groups. **Results:** Out of 97 students, 67 (70%) completed both pre- and post-clerkship tests. After controlling for initial differences in the pre-clerkship test, the post-clerkship test results for the working with medical interpreter questions were the same for students in all groups. However, for the hypertension questions, students who attended the didactic presentations only (n=42) did better than students who took the on-line module (n=25). **Conclusions:** This initial study indicates that students’ knowledge of core content clerkship material is better taught in the traditional didactic seminar format and that we need to continue that teaching format.

29 MEHLING W, BARTMESS E, ACREE M, PRICE C, DAUBENMIER J, GOPISSETTY V, STEWART A. **Coping with pain: primary care patients versus mind-body trainees.**

**Context and Objective:** Interoceptive body-awareness is a multi-dimensional construct including: noticing, behavioral and emotional reactivity, attention regulation, emotional awareness, self-regulation, relationship, trust. Do subjects experienced in body-awareness approaches answer pain-related questions differently from primary care pain patients? **Setting/Populations:** We field-tested a new body-awareness questionnaire in two populations. Group 1: 443 primary care patients (Kaiser Permanente Northern California) following an episode of acute low back pain (LB); Group 2: 307 healthy individuals trained in mind-body therapies (yoga, tai chi, Feldenkrais, meditation and others). Pain patients in Group1 represent the usual population seen in primary care. Responses on the Multidimensional Assessment of Interoceptive Awareness (MAIA) scales were compared between groups using descriptive statistics and factor analyses. **Intervention/Study Design:** Cross-sectional survey data. **Outcomes/Results:** Pain patients report more frequently ignoring pain or discomfort compared with mind-body trained individuals. Pain patients report being more often worried when feeling pain or discomfort than did mind-body trained individuals. Pain patients scored “worse” on all pain-related body-awareness items and subscales compared with mind-body trained individuals (p < .001, controlled for age, gender, ethnicity, education). Pain patients with current chronic pain did not differ from patients with past acute pain (two years earlier). In an exploratory factor analysis with all MAIA scales, items related to ignoring pain or discomfort factor-loaded together with items related to worry in mind-body trained individuals, but loaded separately in pain patients. MAIA Scale Correlations were similar in both groups except “ignoring” and...
past lectures, and venue. Subsequently, we revised this spreadsheet based on published AAFP Curriculum Guidelines. Outcomes/Results: After obtaining IRB approval, our goal is to complete a pre-implementation survey of resident (n=36) and faculty (n=15) satisfaction with the current curriculum. Subsequently, we will implement the new structure, and then re-survey after six to 12 months to test perceived and actual changes in resident knowledge and engagement, as well as and faculty satisfaction. Both quantitative and qualitative survey instruments will be used. Conclusions: This presentation will describe the needs assessment and curriculum review process, as well as the proposed study design and the context of this project within didactics curriculum overhauls in other primary care fields.

27 WEBER S, GOLDSCHMIDT R. Warmline and CDC collaboration toward increasing routine HIV screening among primary care clinicians.

Context and Objective: In 2006, the Centers for Disease Control and Prevention (CDC) published revised recommendations for HIV testing, suggesting routine, opt-out screening for all persons aged 13-64 years. Previous risk-based testing failed to identify the estimated 25% of persons in the US who are HIV-infected but are unaware of their status. More than five years later, many patients have not been tested. The CDC identified primary care providers as key to routine HIV screening implementation. The CDC tasked the National HIV/AIDS Clinicians Consultation Center (NCCC) Warmline with increasing efforts to encourage clinician callers to offer routine HIV testing. Setting/Populations: The NCCC Warmline is staffed by a multidisciplinary team based in the UCSF Department of Family and Community Medicine at SFGH. CDC’s “HIV Screening. Standard Care.” (HSSC) campaign targets primary care clinicians to implement routine HIV screening. Intervention/Study Design: During 2010-2011, HSSC collaborated with the Warmline to promote routine HIV screening among primary care clinician callers. Warmline faculty reviewed the CDC recommendations to understand characteristics of routine vs. risk-based testing. During a five-week period, Warmline callers (n=46) were surveyed regarding their HIV screening practice. Other approaches included: HIV testing resources and the NCCC’s Compendium of State HIV Testing Laws were posted on the NCCC website; Warmline and CDC shared promotional efforts; and presentations were given. Outcomes/Results: Discussions with primary care clinicians revealed large deficits in knowledge, interpretation and implementation of CDC guidelines. Clinicians often believed they provided routine HIV screening but their description was more aligned with risk-based testing. Other clinicians reported knowing about the CDC recommendations but did not have a testing practice in place. Many clinicians did not know the difference between opt-in and opt-out testing. The CDC was informed of these findings. The online NCCC Compendium of State HIV Testing Laws received 14,500 and 17,200 hits during 2010 and 2011, respectively. Conclusions: Additional education of primary care clinicians is needed regarding routine HIV screening if the CDC recommendations are to be realized. Ongoing clinical telephone consultation for clinicians with questions about HIV testing can be a valuable adjunct to wider educational efforts. The NCCC Warmline and CDC HSSC continue to collaborate, encouraging more HIV screening by primary care clinicians.

28 SHORE W, BOSCARDIN C, WANG J. Can a web-based module replace lecture presentation format to present core material to clerkship students?

Context and Objectives: In recent years, there have been many recommendations to develop on-line web based teaching formats for medical student education. Although

Intervention/Study Design: Physician-educators from SSMEC provide didactic education to medical students and junior physicians through structured lecture series. To date this has included 1500 hours of pre-clinical sciences for the medical students (2010), two six-week courses in clinical medicine for the medical students (Aug-Sept and Nov-Dec 2011), and two months of biweekly lectures for the junior physicians (Nov 2011 to present). These same physician-educators also provide clinical education to medical students and junior physicians at Juba Teaching Hospital on the SSMEC Inpatient Teaching Service, where they are responsible for daily teaching ward rounds and provide direct patient care for a 36-bed medical ward (Oct 2011 to present).

Outcomes/Results: A formal relationship with the Ministry of Health and the Juba Teaching Hospital has been established to support clinical medical education. SSMEC attending-level clinicians are now recognized as consultants at Juba Teaching Hospital within the Department of Medicine. SSMEC provides high-quality daily teaching rounds for a rotating group of medical students, interns, and medical officers, as well as directly overseeing patient care. There are currently one to four SSMEC-affiliated physicians in Juba at any given time, most of them family physicians. Future directions include expanding the project to include the hospital’s triage area, outpatient clinics, and a small resuscitation/acute care area for the most acutely ill patients. Conclusions: SSMEC is committed to supporting medical education of medical students and junior physicians in South Sudan by providing physician-educators for didactic and clinical teaching. This innovative partnership between Contra Costa Family Medicine Residency Program and MGHI will help to develop and sustain this important project, and help improve the quality of healthcare in the newly formed country of South Sudan.

VENER M, SHORE W. Changing the world or just changing our minds? After nearly 40 years of a Family Medicine clerkship, have we made a difference?

Context and Objective: Do changes we make in a Family and Community Medicine clerkship actually make a difference in residency selection for our students? A meaningful third-year FCM clerkship is essential for educating students about primary care and supporting primary care career interests. The literature suggests that medical schools that do not. Yet little is known about whether the nature of the clerkship affects trends in students’ interest in FCM. From 1974 to present, the UCSF FCM clerkship changed in length, format, and content. Since 1974, the clerkship shortened from 12 to six weeks, lecture time decreased, and the COPC curriculum evolved into individual community projects. In addition, students today work with preceptors who face greater productivity demands and an increasingly challenging primary care environment. However, interested students may now select to do their FCM clerkship in a longitudinal, integrated model for six or 12 months, and increasing collaboration between departments is common. Setting/Populations: Third- and fourth-year UCSF medical students. Intervention/Study Design: We reviewed residency match data for UCSF students matching in FCM from 1974–2011. We compared this with changes in clerkship length, content, and format during the same time. We evaluated our data for qualitative and quantitative changes in the clerkship evaluations and also for the number of students matching into FCM. Outcomes/Results: Peak years of students matching in FCM were 1990, 1995, and 2000 (20-25 students each). The nadir was 2002-5. Students in certain longitudinal clerkships match into FCM at a higher rate than traditional students. Quantitative clerkship evaluations have improved significantly in the past 7 years. This associates most closely with decreasing lectures time and increasing options for clerkship format to offer more longitudinal and continuity
experiences. Qualitative comments have remained overall positive. **Conclusions:** The number of UCSF students matching in FCM correlates more closely with national trends than with changes in clerkship content, format, or length. However, having several possible models for the FCM clerkship allows individual students to select a “best fit” option that may best to support their learning needs and interests in FCM.

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Francisco. Trainings based on the brief will be developed to aid with dissemination. All partners hope this will result in better identification and treatment of San Francisco youth exposed to trauma.

25 TINITIGAN M, NADEAU M, TYSINGER J. **Resident research and scholarly activity in family medicine: a residency program’s five-year experience.**

**Context/Background:** Scholarly activity is an important component of family medicine education. One of the required competencies of the Accreditation Council for Graduate Medical Education (ACGME) for residency programs involves incorporation of scholarly activity into the patient care experience. The Residency Review Committee for Family Medicine states that every resident must participate in scientific inquiry. Resident research activities have several benefits, including imparting skills relevant to evidence-based medicine, promoting lifelong learning, and influencing residents’ career choices and continued scholarly works. Encouraging resident scholarly activity is challenging, and University of Texas Health Science Center at San Antonio (UTHSCSA) family medicine residents also struggled producing resident research and scholarly activity in the past. Faculty noted a significant increase in the amount and quality of family medicine research in the past five years and therefore decided to look retrospectively to test their assumption that improvement had taken place. **Objective:** To describe research designs and presentation rates at state, national, and international scientific meetings of a university-based family medicine residency program over a five-year period. **Setting/Populations:** The UTHSCSA Family Medicine Residency Program is a post-graduate, PGY1 to -3 program that began with 12 residents per year and grew to 13 residents per year in 2011. The primary training site is an urban, academic university hospital and clinic serving underserved, largely Hispanic, patient population. **Intervention:** From 2006 until present, the UTHSCSA Family Medicine Department made a substantial commitment to residents’ scholarly activity through providing increased faculty mentoring and support, informal resident curriculum, a forum to present projects, a scholarly atmosphere of encouragement, and funding support. Research faculty at UTHSCSA made a substantial commitment to mentoring residents. **Study Design:** Retrospective review of resident scholarly projects over a span of five years (2006-2011). **Outcome/Results:** Data will be collected on research designs and the number of abstracts/research projects presented at state, national and international annual meetings. Scholarly projects published in peer-reviewed journals will also be identified. **Conclusions:** Preliminary analysis of scholarly activity will be presented at the time of presentation.

26 HANCOCK C, SCHNEIDER D. **Developing a comprehensive Family Medicine didactics curriculum: applying the AAFP guidelines.**

**Context and Objective:** Structured and step-wise didactics curricula are a staple of pre-clinical education, but are often difficult to formulate and coordinate in clerkship and residency settings. Both the availability of appropriate faculty/speakers and the time to design a curriculum remain major barriers. **Setting/Populations:** Community-based residency program/residents and faculty. **Intervention/Study Design:** In our community-based residency program, we developed a committee to overhaul our existing didactics series with the goal of creating a comprehensive, engaging, and practical progression of daily and Thursday afternoon lectures. We first completed a needs assessment, involving residents and department heads and reviewing topics and their appropriate venue and presentation mode. We then created a spreadsheet of all topics by discipline, incorporating presenter information, the timing of presentation, ratings for
weekly in an outpatient drug and alcohol treatment program’s group therapy sessions. During this time, new clients in need of family doctors, as well their families, can be invited to be part of residents’ continuity family medicine practices during treatment and subsequently for one to two years. After the next intense, in-patient rotation, residents rejoin the new patients’ treatment program and observe how they and other patients are progressing. During the first block, residents also participate in buprenorphine therapy groups with a family physician faculty who teaches motivational interviewing (MI). Intervention/Study Design: Retrospective pre- and post-intervention surveys to assess medical knowledge and patient care management were administered at the end of the third rotation. The content included basic about MI, buprenorphine treatment, and screening for harmful alcohol and drug use and a brief attitude scale. After six months, as part of a PDSA cycle, residents will participate in a focus group to discuss their experiences, identify educational gaps, and suggest means of overcoming educational barriers. Outcomes/Results: Results from the surveys and focus group will be available after February 2012. Conclusions: An innovative, longitudinal substance abuse curriculum for second-year family medicine residents can be integrated into three traditional “block” rotations. Important addiction medicine content areas can be included during training when clinical and teaching time is at a premium.


Context and Objective: The goal of the UCSF-SFGH Family and Community Medicine Residency Program’s Community-oriented Primary Care (COPC) curriculum is for residents to learn community-engagement skills to improve health at a community level. It includes a one-year class project in PGY3, with preparation in PGY1 and PGY2. As R1s, the residents are introduced to COPC and to local communities, and the class picks one target community. As R2s, they learn about community assessment, community partnerships, and project design and evaluation, and they participate in community rounds and key informant interviews. The class forms a partnership with one or more community-based organizations by the end of PGY2. With their partner(s), they develop and implement an intervention as R3s. Setting/Populations: The class of 2012 chose to work in the Mission District and focused on adolescents and young adults exposed to trauma. They formed a partnership with the Adolescent Health Working Group (AHWG), an organization whose mission is to advance the health and well-being of youth and young adults in San Francisco and beyond. Intervention/Study Design: The residents and AHWG agreed to develop and disseminate a trauma brief, targeting the staff of schools, community organizations, and clinics serving youth/young adults. The goals of the project are to 1) increase awareness of trauma and appropriate interventions and 2) develop culturally appropriate trainings to improve the capacity of providers to address trauma. The brief will include definitions of trauma, causes of trauma, signs and symptoms, evidence-based assessments, best-practice interventions, available services and trainings in San Francisco. Outcomes/Results: The partners have conducted a literature review and key informant interviews with local experts and service providers. This information is being compiled into a draft brief which will then be shared with key informants for feedback in spring 2012. Conclusions: The brief will be piloted, finalized, posted on AHWG’s website, and disseminated throughout San Francisco and beyond.
In Oaxaca were carried out in 2009. Topics focused on health beliefs, views about clinical care, and differences between the US and Oaxaca. Qualitative analysis methods were used to identify key themes with strong counseling implications in primary care practice that could be linked to specific health communication strategies. For the clinician training, we selected exemplary quotations, identified counseling implications, and created patient vignettes based on perspectives of participants for targeted discussion. These trainings have been piloted in diverse primary care training settings in California. Implications and created patient vignettes based on perspectives of participants for targeted discussion. These trainings have been piloted in diverse primary care training settings in California.


Context and Objective: Women in the US have extraordinarily high rates of unintended pregnancy, with the highest rates among poor and minority women. This high rate of unintended pregnancies is caused in part by the under-use and misuse of effective contraceptive methods. Clinicians who provide contraceptive counseling have an opportunity to positively impact contraceptive use, yet little research has investigated this interaction. In addition, this interaction has not been investigated from the perspective of health care disparities. As contraception is a preference-sensitive decision and raises issues of sexuality, we hypothesize that in this context, variations in provider-patient communication by race/ethnicity are pronounced. This cohort study was designed to determine if providers discuss contraception with their patients differentially depending on the patients' race/ethnicity and which aspects of communication impact contraception use. Setting/Populations: Women who self-identified as black, white, or Hispanic and who wished to discuss family planning methods were recruited at the time of their visit to one of six clinics in the San Francisco Bay Area. Intervention/Study Design: Participants completed a pre- and post-visit survey and had their visits audiotaped. Three- and six-month follow-up phone surveys assessed contraceptive continuation and adherence. Audiotaped visits are analyzed using a modified Four Habits Coding Scale (a measure of interpersonal quality of care) a facilitation score to measure shared decision making, and a content checklist. Outcomes/Results: To date, 342 patients have been recruited at six clinical sites, with a 90% follow-up rate at six months. Recruitment will be completed by the end of January, 2012, and analysis of baseline data will begin then. These analyses will include the association of provider behaviors with patient race/ethnicity, correlation between the patient's assessment of quality of care with patient race/ethnicity and with contraceptive continuation and adherence, and association between contraceptive method use and specific counseling behaviors. Conclusions: These data have the potential to expand our understanding of contraceptive counseling and inform counseling interventions to improve contraceptive use in diverse populations.


Context and Objective: Early childhood caries is the most common chronic disease of childhood, affecting more than one-fourth of children aged 2-5 years. Rates are highest for low-income children, particularly Latino and Asian children. Lack of early preventive dental care and low health literacy have been chronic contributing issues. Fluoride varnish, a professionally applied topical preparation, has been shown to have a economic and social necessities that brought them together and create new social bonds. Note: This is a poster previously presented at the 2011 American Geriatrics Society Meeting.

22 GREEN J, GORTON N, KEATLEY J, REYES EM. Primary care protocol for transgender patient care.

Context and Objective: Needs assessment studies conducted in major cities across the United States since the late 1990s have shown that access to primary health care is highly problematic for many transgender and transsexual people. The objective of this project was to provide reliable primary care information in a readily-accessible form to physicians who may have had little or no experience caring for this population. Setting/Populations: Many thousands of transgender and transsexual people have been treated with cross-sex hormones and surgical procedures for over 70 years in Western Europe and over 60 years in America. Yet because of the stigma of gender-variance and sex reassignment, which discourages funding for research, and because of the difficulty of conducting randomized trials involving cross-sex treatments, very little specific information about treatment actually exists beyond case reports and small scale studies on specific clinical issues. Data collection weaknesses further impacting the marginalization of transgender and transsexual people include lack of researcher access to the population, lack of cohesive community networks within the population, disagreement with terminology used to refer to the population (which affects community trust and impacts researcher effectiveness; e.g., referring to transwomen as “male transsexuals” or “men who have sex with men (MSM)” alienates potential subjects, and researchers’ use of definitions to describe both transgender and transsexual people that artificially circumscribe the pool of available research subjects (e.g., describing transsexual people as only those who have previously undergone genital reconstruction). Intervention/Study Design: A review of existing protocol documents and gap analysis was conducted by CoE staff, and a team of nine medical providers collaborated to develop content for an easily-navigated, web-based protocol over a period of 13 months, using best evidence from the literature and consensus from clinical experience. Outcomes/Results: A concise, comprehensive protocol was launched on the World Wide Web April 8, 2011. Conclusions: Both community and provider feedback indicates that the accessibility and informative nature of the web-based protocol has been appreciated and effective in increasing provider comfort with treating this marginalized population. Ongoing maintenance of the protocol should be a priority for the CoE.

23 SAFFIER K. An innovative longitudinal, integrated substance abuse curriculum: six-month evaluation (work in progress).

Context and Objective: Several national studies and expert panels conclude that residency training in substance use disorders is deficient with core competencies not being consistently taught and faculty needing more curricular time and training. An integrated, longitudinal substance abuse curriculum was developed to increase curricular content and enhance resident education emphasizing the treatment of this chronic disease. This preliminary report describes our six-month evaluation of this work in progress. Setting/Populations: Beginning July, 2011, three new substance abuse experiences were integrated into three consecutive, four-week traditional “block” rotations for 14 second-year family medicine residents at Contra Costa Regional Medical Center. In the first block, during behavioral medicine, residents participate
to complete a survey. **Intervention/Study Design:** We designed separate descriptive surveys for patients and providers/staff listing various core components of the PCMH. We asked both groups to rank the top three components they believed Lakeshore successfully employed and the top three they wished would be improved. Providers/staff were additionally asked to rank which components they believed could feasibly be improved. Data was collected over six weeks, from March to April of 2011. **Outcomes/Results:** Patients believed that Lakeshore effectively considered patient’s perspectives (25%), provided good follow-up (17%), and discussed treatment options in an unbiased way (15%). Patients wanted same day appointments (24%), a clinic web portal (15%), and better follow-up (14%). Staff and faculty thought Lakeshore most successfully employed quality and safety measures. They believed Lakeshore should improve upon providing a good patient experience, and they believed that utilizing health information technology would be the most feasible change Lakeshore could undertake. **Conclusions:** Patients, providers, and staff all agree that core components of the PCMH involving patient-provider interaction are strong. Components involving ease of access to care, such as sooner appointments, follow-up, and use of technology, were thought to need improvement in all groups. Follow-up of care was perceived as both a strength and weakness by patients. These observations will guide further Quality Improvement efforts at Lakeshore.

21 ALLISON TA. **How the sing-along creates community in the nursing home.**

**Purpose:** Skilled nursing facilities provide many activities for their resident elders, including clichéd activities such as bingo games, concerts given by visiting carolers, and sing-along groups. Although it has been largely dismissed in the literature, the sing-along merits evaluation because it engages elders, staff members and visitors in an active, shared performance that can bring joy to an otherwise institutional environment. In this qualitative study, the sing-along is characterized and examined in terms of its significance to the members of one nursing home community. **Methods:** Fifty sing-along sessions were observed over two years at a 430-bed, not-for-profit skilled nursing facility. More than 200 nursing home community members were observed in public music performances, and 53 of these became longitudinally involved in the research. Interviews and observations were recorded with longhand field notes. Field notes were analyzed for thematic content. Themes were validated via two methods: through purposive recruitment of new participants and through solicitation of feedback from participants themselves. The themes were interpreted using theories of performance from anthropology and ethnomusicology in order to better understand how the sing-along creates bonds between group members. **Results:** In this nursing home, the sing-along represents one popular activity among 34 types of scheduled activities. The analysis yielded four themes: 1) more than any other musical activity, the sing-along compels both its participants and observers to spontaneously pass judgment on the activity; 2) the “good” sing-along possesses concrete, identifiable features, including language and song familiarity, meaningful interactions between leaders and groups, and issues of physical comfort; 3) a sing-along that is considered to be “good” by its participants leads to positive emotions and a sense of community; and 4) running a successful sing-along does not require formal musical training. **Conclusions:** The sing-along, the most common music activity in skilled nursing facilities, possesses the potential to transform a nursing home into a community. Through the repeated performance of shared songs, resident elders, staff members, and visitors can create common ground. As they sing together, individuals can move beyond the medical, significant protective effect for young children at risk for early childhood caries. Because primary care providers see children regularly in the first five years of life, the American Academy of Pediatrics recommends that providers apply fluoride varnish at least twice a year to prevent this disease in high-risk infants and toddlers. Along with oral health counseling, regular assessments, and exams, this intervention has been shown to be safe, well-tolerated, cost-effective. **Setting/Populations:** Contra Costa Regional Medical Center and Health Centers (CCRMC), a large safety-net health care system providing ~13,000 well child visits for children aged 1-5 years annually. **Intervention/Study Design:** In 2009, CCRMC partnered with the UCSF Center to Address Disparities in Children’s Oral Health (CAN DO) to implement a sustainable program of fluoride varnish applications during well child visits ages 1-5 years. The team developed policies, revised well child forms, ordered supplies, and trained 385 primary care providers and nurses on identifying dental caries, educating parents about oral health, applying fluoride varnish, and providing a dental referral to CCRMC dental clinics. **Outcomes/Results:** By August 2011, 77% of children seen for a well child visit aged 1-5 received fluoride varnish application with their visits; at this rate, 10,000 varnish treatments will be delivered annually. **Conclusions:** This project demonstrates that with adequate planning, hands-on instruction, and systems changes, a large safety net system can successfully adopt an effective intervention to reduce early childhood caries.

FRIEDMAN R, KOHATSU W, PRYSTOWSKY A, COHEN A, MURPHY S. **VeggieRx: Can prescribing fruits and vegetables impact consumption and health outcomes in pregnant women at risk for gestational diabetes?** **Context and Objective:** Rates of gestational diabetes (GDM) are increasing rapidly in the US, posing significant risk to both mothers and children. The highest rates of GDM are concentrated in underserved, low-income communities where families often lack access to fresh fruits and vegetables, the consumption of which can help manage or prevent the development of GDM. Preliminary evidence suggests that financial incentives to subsidize the purchase of fresh fruits and vegetables improves consumption, with the greatest improvement in families who shop at farmers markets. Building on promising results from pilot studies of Fruit and Vegetable Rx Programs (FVRx) on other high-risk, low-income patient populations (such as obese children) our research aims to test the feasibility of the FVRx with pregnant women. Our goal is to determine whether physician-prescribed farmers market vouchers and intensive nutrition counseling can help of women at risk for GDM consume at least one additional serving of fresh produce per family member per day; maintain healthy weight gain in pregnancy; and reduce risks of having GDM. **Setting:** Vista Family Health Center, an FQHC and site of the Santa Rosa Family Medicine Residency. **Patient Population:** English- or Spanish-speaking pregnant women at risk for GDM with Medi-Cal insurance who are at least 18 years of age and less than 14 weeks gestational age at enrollment. **Intervention/Study Design:** Eligible patients are identified during OB intake and invited to participate in the study. Subjects are then randomized to receive either nutrition education and healthy eating resources (control group), or education, resources, and farmers market vouchers (intervention). Recruitment began in September 2011. At each subsequent monthly prenatal care visit, all subjects fill out a brief questionnaire regarding fruit and vegetables consumption and receive a standardized “Nutrition Bite” explained by their provider. In addition, intervention subjects will receive an actual paper prescription that is redeemable for fruits and vegetables at the Santa Rosa Farmers Market in the amount of $7 per household family member per week. Vouchers will be distributed monthly through the
duration of the pregnancy. **Outcomes/Results**: The primary outcome variable is change in fruit and vegetable consumption during the intervention period, measured by monthly food frequency questionnaires. Secondary outcomes include coupon redemption, development of GDM, and changes in weight gain over pregnancy, blood pressure, and knowledge/skills/attitudes about healthy eating and farmers markets. We will present preliminary data on the first six months of the study. **Conclusions**: 1) GDM is a growing problem among low-income pregnant women, for whom limited finances may be the biggest barrier to increased consumption of fresh vegetables and fruits; financial incentive, not just education, may therefore be key to any effective intervention; 2) partnerships between physicians and community resources like farmers markets are at the foundation of true community health and good family medicine; and 3) each dollar invested in a program like FVRx pays forward threefold by nourishing the consumer, boosting local farmer’s revenues, and uplifting the community as a whole.

**GILLESPIE K, RIENKS J, OLIVA G. Youth with special health care needs (SHCN) in California: challenges and recommendations for successful transition to adult care. Context and Objective**: Youth with special health care needs face numerous challenges when transitioning out of a system of care designed for children and seeking adult care. The California Children’s Services Program (CCS) provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children and youth with special health care needs (CShCN) who meet medical, financial, and residential eligibility criteria. The Family Health Outcomes Projected (FHOP) conducted a needs assessment for CCS as required every five years by the Federal Title V program. One key focus was identifying challenges faced by transition-age youth and potential solutions for improving transition to adult care. **Setting/Populations**: The population of interest is children and youth with special health care needs in California. Data were gathered from transition-age youth, parents, providers, program staff, and other stakeholders in California. **Intervention/Study Design**: FHOP conducted an assessment of the needs and systems issues related to delivering services to children eligible for CCS. Methods included key informant interviews, focus groups, and web-based surveys for providers, for parents, and for hospitals, health plans, and County CCS programs. **Outcomes/Results**: The majority of families with youth with SHCN report not receiving transition services: only 41% report their child’s doctor talking about how health care needs might change; 26% report their child’s CCS case manager talking about their child’s transition; and 19% report their child receiving any vocational or career training. Major barriers to successful transition include: lack of access to providers; lack of training for adult providers; lack of case management and care coordination once the client transitions out of CCS; and burdensome procedures to access insurance. **Conclusions**: Suggestions identified to encourage doctors to take CCS clients as they age out of the program include offering training for adult providers, funding, and resources to help care for these patients. Clients having insurance that covers the costs of health care and care coordination was the most highly rated suggestion.

**GOLSTEIN E, GRUMBACH K, FLEISHER P, VARGAS R, ROUSE IÑIGUEZ J, LIU W, QUEZADA R. Evaluating San Francisco Health Improvement Partnerships (SF HIP): lessons learned in building community partnerships. Context and Objective**: In 2009, the Community Engagement and Health Policy (CE & HP) Program of UCSF’s Clinical and Translational Science Institute (CTSI) convened a research setting. Researchers must consider differences related to migration patterns, age, gender, class, and political history in their efforts to work with different ethno-racial groups. **Conclusions**: The research succeeded in identifying common strategies that are likely to be important in the recruitment and retention of ethno-racial minorities in primary care research. Further study is planned to determine how best to apply and tailor these guidelines within practice-based research networks.

**19 QUANDT Z, ANAYA A. Health at a glance: enabling easier health communication in the developmentally disabled. Context and Objective**: The Arc is a non-profit group based in San Francisco that provides services to adults with autism, Down syndrome, cerebral palsy, intellectual and developmental disabilities. Services include advocacy support, community training and employment, recreation, residential, and health and wellness. The Arc’s Health and Wellness Program serves its developmentally disabled clients with the majority of their health needs. Staff members, known as health advocates, act as health case managers for individual clients by working closely with health care professionals to ensure patient understanding of diseases, medications and health care follow up. These advocates have recognized limitations in current methods of recording health information, such as coordination and ease of access of information. We aimed to create a one-page summary of the most important health information to facilitate the advocates’ responsibilities. **Setting/Populations**: A handful of “health advocates” accompany approximately 100 Arc clients to medical appointments and keep records of their health history, treatments, and upcoming needs. **Intervention/Study Design**: With the help of the director of the Health and Wellness Program, we identified that information retrieval from voluminous health records was one of the main grievances of the program employees. We then reviewed existing documents that the program used and conducted key informant interviews to learn what information was most important to have quickly accessible and what health concerns most impacted the Arc clients. **Outcomes/Results**: Our review led to the creation of a one-page (front and back) overview (“Health at a Glance”) that was electronically interactive and updateable, but also easily printable, that contained current and past medical problems, medications, basic labs, health maintenance, activities of daily living, instrumental activities of daily living, and needs specific to the disabled population such as assistive devices. **Conclusions**: Easy retrieval of a patient’s specific disabilities and health records is an essential but often neglected step in improving care in the outpatient setting. Our ‘Health at a Glance’ worksheet streamlines this communication while focusing on the specific needs of this patient population.

**20 MANDYAM M, WILDMAN-TOBRINER B, VENER M, HILL-SAKURAI L. UCSF Lakeshore clinic as a patient-centered medical home. Context and Objective**: The patient-centered medical home (PCMH) is a model for primary care organization and delivery that leads to reduced healthcare costs and better outcomes. Key practice components have been identified as part of the PCMH model. We sought to determine Lakeshore Clinic’s strengths and needed areas of improvement in relation to these components, as perceived by its patients, staff, and care providers. **Setting/Populations**: Lakeshore Clinic is composed of 17 providers who see adults and children at 21,000 visits annually. It serves patients from all socio-economic statuses, with a large number of first-and second-generation immigrants. Our study population consisted of Lakeshore staff, providers, and patients who volunteered in 2009, the Community Engagement and Health Policy (CE & HP) Program of UCSF’s Clinical and Translational Science Institute (CTSI) convened a
Theft of protected health information (PHI) in paper form, affecting over 400,000 patients. While protecting patient privacy is a priority of health institutions, there are no commonly accepted methods to de-identify PHI. Inpatient clinical services at San Francisco General Hospital (SFGH) keep track of clinical data and tasks through a variety of daily printed lists containing PHI. Changes in duty hours and the resulting increased number of patient care hand-offs, have compelled services to create more comprehensive printed sign-out lists to ensure patient safety, which has led to greater potential patient privacy violations. At academic institutions, clinical teams consist of individuals from various training levels. Each team member generates the same to-do list on separate pieces of paper and spends a significant amount of time throughout the day communicating his/her progress. Our current practices are redundant and inefficient. Setting/Populations: The Family Medicine Inpatient Service at SFGH will pilot a new electronic system, created by Radiologist Dr. Alex Rybkin, titled “Caredination” to eliminate the need for paper sign-out, decrease patient privacy breaches and improve work flow and team efficiency. Intervention/Study Design: Caredination is a multi-purpose electronic platform that generates comprehensive, shared patient lists stored in a secure server. When one member of the team marks a task as complete, the updated task list is instantaneously viewable by all other team members. The program was piloted for four weeks beginning January 30, 2012. Each resident carried a portable electronic device with access to Caredination to facilitate work flow. Outcomes/Results: We will conduct a pre- and post-Caredination work flow time study and collect surveys on resident satisfaction, patient safety, and potential privacy breaches. Conclusions: We anticipate the introduction of Caredination will better protect patient privacy without compromising patient safety, improve efficient communication between team members and optimize work flow. We will report on the pre and post-introduction data to support or disprove our hypothesis.


Context and Objective: An important step to reduce health disparities is to understand how to integrate diverse patient populations and the clinicians who provide their care, into practice-based research. The purpose of this study was to identify promising strategies for recruiting and retaining diverse primary care patients into practice-based research studies. Setting/Populations: PRIME Net is a consortium of eight practice-based research networks, five of which participated in this study. UCSF’s San Francisco Bay Area Collaborative Research Network was one of the five networks participating in this study. The ethno-racial populations that were the focus of the study were African Americans, Arab/Chaldeans, Chinese, Hispanics, and Native Americans. Intervention/Study Design: Sequential, qualitative research, including 18 key informant interviews and 18 focus groups including representative patients recruited from practice-based research network practices in PRIME Net. Outcomes/Results: We identified seven recommended recruitment and retention strategies: 1) build trust with community/clinic partners; 2) confirm topic relevance and feasibility; 3) assemble a culturally competent research team; 4) use flexible recruiting strategies; 5) nurture the implementation process; 6) communicate to sustain participation; and 7) close the study and maintain relationships. We found that these seven essential elements need to be tailored according to the specific ethno-racial group and overall context of the meeting of community and university partners to develop an approach to address community health. The goal of this project was to have “a measurable impact on community health indicators.” A year later, The San Francisco Health Improvement Program (SF Bay HIP) was launched to improve local community health by integrating the interests, assets, and expertise of UCSF and community stakeholders. SF HIP works to collaboratively plan, implement, evaluate, and disseminate sustainable efforts informed by science and community expertise. A multi-sector Coordinating Council was convened and identified 10 health issues based on recommendations in city and community health assessments; the first four Partnership Working Groups (PWGs) have been launched. Setting/Populations: PWGs convened for the launched health issues include UCSF faculty members, a C&HP Navigator, members of the SF Department of Public Health, and community stakeholders. Active PWGs include: Physical Activity and Nutrition; Hepatitis B Quality Improvement Collaborative; High Users of Multiple Services (HUMS); and Children’s Oral Health. Groups are in the process of launching are: Breastfeeding/Lactation Support and Alcohol Work Group. A Violence Prevention and Mental Health PWG began working, but was delayed for strategic reasons. Intervention/Study Design: PWGs have developed based on the circumstances and context of the Department of Public Health and community partner response to the health issue. UCSF’s partnership approach is necessarily tailored and responsive to the needs of the community, the resources, and the willingness of the partners. While the idiosyncratic nature of SF HIP is the only way we can move forward, it challenges the expectation of a linear program. Ongoing, iterative program evaluation is critical. Program outcomes are evaluated three ways: 1) an annual survey is administered to all Coordinating Council members, PWGs members, and health issue convening attendees based on several validated measures of academic-community partnerships, assesses domains such as trust, role clarity, shared mission, communication, self-reflection, and shared resources; 2) brief assessments of each meeting, which provide ongoing input by the Coordinating Council and Partnership Working Groups and allows for continuous improvement; and 3) assessment of PWG accomplishments and impact on community health through their identified policy or program interventions. Outcomes/Results: To date, 53 of 126 potential respondents have completed a baseline annual survey. An initial analysis reveals areas of success and areas for improvement over time. The meeting evaluation administration has primarily been conducted in the Coordinating Council and PAN Partnership Working Group meetings, with 24 meetings evaluated. Community interventions will be conducted and evaluated in the next two years. The most significant lessons occur in the Coordinating Council as we tailor each PWG to what is strategically possible given the priorities of SF DH, the community partners, and our faculty member’s capacity. Conclusions: SF HIP is an evolving initiative, with built-in quality and design improvement through the evaluation. The response to each health issue is negotiated with our SF DH and community stakeholder partners. Cross-initiative learning is important, but the most significant lesson is that UCSF’s role as partner rather than convener must remain clear if we are to support sustainable community health initiatives.


Context and Objective: The Santa Rosa Family Medicine Residency developed an innovative cross-cultural curriculum aimed at enhancing cultural awareness and
emphasizing its value toward improving patient care. The goals of this new curriculum are to utilize patients and medical assistants as the vehicle for cultural education and to deepen community involvement. A necessary corollary goal was to implement sustainable, budget-neutral curricular enhancements. Setting/Populations: The Santa Rosa Family Medicine Residency and the FQHC clinic worked in collaboration to facilitate educational and social activities at our shared clinic site for residents, faculty, clinic staff, and patients. Intervention/Study Design: The program’s Culturally Mindful Curriculum takes a three-pronged approach that spans the three years of residency training. First, there are formal resident didactics. These include targeted cultural exploration exercises for residents, a diversity lecture series, a medical Spanish course, resident culturally oriented talks, and medical-assistant-led panel discussions. Secondly, there are informal resident-sponsored activities that promote community-building among residency and FQHC staff. These activities include “Lunchtime en Español” and Diversity Movie Night. Finally, in order to enhance community involvement the residency continues its sponsorship of the Latino Health Forum and has integrated patient participation in the resident educational activities listed above. Outcomes/Results: Prior to this intervention, two surveys identified a need for curricular development and diversity recruitment. First, an annual curriculum review highlighted a gap in residency education. Secondly, thematic analysis of the 2010 post-match applicant survey from resident applicants revealed unfavorable ratings on staff and resident diversity. Our Culturally Mindful Curriculum has operationalized 26 hours per resident year of additional culturally focused training. It has formalized diversity recruitment and diversity curriculum workgroups made up of residents, faculty, and staff. We have new initiatives geared toward increasing community involvement between the residents and community groups. We will be analyzing this year’s post-match survey, feedback from 2012 curriculum review, and residency ratings of newly added cultural activities to measure satisfaction of current curriculum. Conclusions: By prioritizing cultural competency curriculum development in the residency setting, we have created a sustainable, cost-effective, and valuable educational curriculum that enhances our patient care, deepens community involvement, and strengthens relationships between the residency, patients, and FQHC staff.

HESLERS D, FISHER L. AASAP: A program to increase recruitment and retention in clinical trials. Context and Objective: Problems with subject recruitment and retention are frequently experienced in observational and interventional studies. The purpose of the current study was to evaluate a theory-based, subject-centered, staff/subject communication program—AASAP (Anticipate, Acknowledge, Standardize, Accept, Plan)—to increase recruitment and retention in randomized controlled trials. Setting/Populations: AASAP was introduced to a three-arm RCT to reduce disease distress in a community sample among highly distressed subjects with type 2 diabetes. Included were 250 subjects not exposed to the AASAP program and 338 exposed to the AASAP program. Intervention/Study Design: AASAP was evaluated with logistical regression by comparing rates of recruitment (at telephone screening, baseline assessment, initial intervention) and intervention retention (over 16 weeks) before (-AASAP) and after (+AASAP). Outcomes/Results: Significant improvement in recruitment for those in the +AASAP group occurred at each of the three recruitment stages: agreed at screening (OR=2.52; p<0.001); attended baseline assessment (OR=1.91; p<0.001); and attended initial intervention (OR=1.46; p<0.03). Higher education and shorter diabetes duration predicted better individuals could do outside of meeting time. “Change fatigue” and the complexity of primary care were addressed through staggering the dates that specific work flows are implemented. Additionally, lively and humorous role plays of the new work flow assists in effectively teaching these complex tasks and overcoming resistance. Conclusions: We are overcoming challenges implementing standardized workflows by utilizing a multidisciplinary team including experts in OID and all stakeholders, efficiently utilizing our time, creatively sharing workflows through multiple media and staggering the rate of implementation to avoid “change fatigue.”

16 MILLS W, HANEY J. Performance improvement and innovation: software for the patient-centered medical home. Context and Objective: The Santa Rosa Family Medicine Residency Patient-centered Medical Home (PCMH) Ambulatory Care Curriculum prepares residents for future practice. The complexity of the curriculum is enormous and contains a wide variety of methods. The curriculum is geared to develop servant leaders who facilitate change, and physicians who utilize advanced technologies to maximize care of individuals and populations in a patient centric manner. The curriculum was implemented in December 2010 as a three-year project. Of the 12 initiatives (advanced access, group visits, integrated technology, re-designed didactics, chronic care model, virtual care, team based care, etc.) our hypothesis is that according to Pareto’s 80/20 rule, Leadership and Performance Improvement will determine the success of the other elements of the PCMH. Setting/Populations: This project focused on the effectiveness of several teaching methods of the Improvement Model to third-year residents during their Ambulatory Care Chief rotations. Each of our 12 R3s spends three months as Chief of their Module (~20 clinicians, of which 12 are residents), responsible for many dimensions of their clinic’s performance. Intervention/Study Design: 1) Offsite Strategic Planning at the start of the year identifying key areas for clinical/operational improvement and innovation; 2) small-group didactics throughout the year with a Faculty PI Director; 3) mentoring by the Clinic’s Physician Leads; 4) Team Care Meetings; 5) Performance/Quality Improvement Demonstration Projects at the capstone and PI Colloquium attended by residents, medical students, faculty, staff, patients, and the FQHC/FMC Board of Directors. 6) Faculty Development in PI. Outcomes/Results: 1) Pre-survey revealed negligible knowledge of the Improvement Model; 2) post-survey results obtained at the end of each month (six months thus far) and qualitative formative feedback demonstrate new knowledge, appreciation, and facility with PI; 3) Performance Improvement Projects intended for poster presentations at national conferences (in process at this time, to be completed by June 2012). Conclusion: Active teaching of the Improvement Model can be effectively incorporated into PCMH curriculum. Graduating residents will demonstrate a unique preparedness to practice 21st century medicine in a variety of environments (solo practice, group practice, internationally, FQHCs, etc.).

17 LEUNG L, MATATHIA S, MURPHY K, STAFFORD M, RYBKIN A, COFFA D, VILLELA T. Implementation of an innovative electronic platform to improve inpatient team efficiency & decrease privacy breaches of Protected Health Information. Context and Objective: With the passage of The Health Insurance Portability and Accountability Act (HIPPA) in 1996, the physician’s commitment to patient privacy became a national priority. Between 2009 and 2011, the Department of Health and Human Services received 98 reported cases of patient privacy breaches due to loss or
process, determine the average time for a refill to be processed, and to quantify patient satisfaction with regard to their refills. Setting/Populations: Lakeshore serves 12,000 patients; about 40% are Asian/Pacific Islanders, 35% are Caucasian, 7% are Latino, and about 5% are African-American. About 70% have HMO-type insurance. Intervention/Study Design: 1) Interviews with staff members (n=10) including providers, administrators and APEX specialists to clarify the different steps required for a refill request to be completed; 2) chart review (n=90) using the APEX routing history to determine how many days it took from the time a refill request was made to the time a provider approved the request; and 3) patient survey (n=20) to assess average perceived wait time for refills, preferred method of request, and overall satisfaction with process. Outcomes/Results: There are four different commonly used methods for patients to make prescription refill request. The most direct route is through pharmacies that use the Surescripts service. The other three routes all need to be filtered through the one clinic advice nurse. Chart review found refills were quickest when patients requested a refill through MyChart (average: 1.3 days) or pharmacies requested refills electronically (average: 1.6 days). Patients calling Lakeshore directly took the most time (average: 2.1 days). Of patients surveyed, 40% request refill with less than three days of medication left, 75% receive refill in one to two days, and 95% are satisfied with the process. Conclusions: Despite the complex prescription refill process, patients are generally satisfied. This data suggests that patients should be encouraged to use MyChart and/or pharmacies that use the Surescripts service. Also, Lakeshore QI groups are currently working to streamline responses to patient phone call requests so that all methods of requests can be improved.


Context and Objective: The implementation of a robust Electronic Medical Record (EMR) such as Apex (aka EPIC) provides great opportunities to improve patient care while also creating tremendous ambiguity and variability in workflows. We will describe the challenges we noted in developing and implementing standardized workflows and will outline here how we are overcoming them. Setting/Populations: UCSF Family Medicine at Lakeshore is a community Family Medicine outpatient practice in San Francisco providing primary care for approximately 11,000 patients of all ages. Six months after the EMR Apex was implemented, a team was created to create process maps of workflow to identify the most effective and efficient workflow. We focused on each step in the patient’s experience enabling the staff member to perform at their maximal competency within their scope of training, eliminating unnecessary actions and rework. Intervention/Study Design: Challenges that have arisen include: 1) variable needs and priorities of different clinic staff; 2) Insufficient time for representatives of all clinic roles to meet; 3) Resistance to and volume of change aka “change fatigue”; and 4) Complexity of primary care practice. Outcomes/Results: Variable needs and priorities of different clinic staff have been addressed by the formation of a multidisciplinary team including clinical nursing staff members, clerical staff members, and a physician. The presence of two consultants from UCSF Operational Improvement Department (OID) help the group overcome differences by focusing on the shared goal of high-quality patient care. Time limitations have been addressed through float coverage for the nursing and clerical staff when the team meets. In addition the group prioritized our goals and developed a timeline. There was homework assigned between meetings that

recruitment in -AASAP (OR=2.23; p<0.001), but not in +AASAP, suggesting that following AASAP, successful recruitment was no longer differential by key demographics. AASAP also improved intervention retention over 16 weeks (OR=3.46; p<0.05). Conclusions: AASAP is a structured program of subject/staff communication that helps improve external validity by enhancing both subject recruitment and retention. AASAP can be taught to non-professional staff and can be adapted to a variety of health settings. AASAP can also be used by clinicians to help subjects begin and continue in ongoing programs of care, such as education, disease management, and decisions to begin new treatment.

NEWSTETTER A, WEBER S, WALKER C. From last resort to best practice: a hidden lesson of the RTLD (Rapid Testing at Labor and Delivery) project.

Context and Objective: Perinatal HIV transmission in the US can be lowered to less than 1% by implementing current testing and treatment recommendations. Both California law and CDC guidelines require clinicians to routinely screen pregnant women for HIV during first trimester and provide a rapid HIV test at labor and delivery for those women with an undocumented HIV test result. This project helped birthing hospitals and prenatal providers address these issues to help prevent perinatal HIV transmission.

Setting/Populations: Birthing hospitals and prenatal providers in California.

Intervention/Study Design: An assessment of California’s 232 birthing hospitals found most did not routinely offer rapid HIV testing to women resulting in multiple missed HIV prevention opportunities. In 2006, the Pacific AIDS Education and Training Center formed the Rapid Testing at Labor and Delivery (RTLD) project to improve hospital capacity to offer rapid testing. This multidisciplinary team provided training and technical assistance to hospital staff from labor and delivery clinicians to laboratorians to risk management to assess current hospital practice and assist with full implementation of RTLD.

Outcomes/Results: Though RTLD became widely implemented, it was increasingly apparent rapid testing in labor and delivery is a last resort presenting numerous challenges to both patients and providers. Unconfirmed test results, false positives, less time for antiretroviral treatment and multiple discharge issues could often be avoided by engaging prenatal providers in implementing routine HIV screening practices in early pregnancy. Additionally, the project helped to facilitate increased communication between prenatal providers and hospital staff including documentation of confirmed test results to hospitals. Conclusions: Each woman’s interaction with the medical system can be an opportunity to discuss either HIV testing, HIV status or reproductive health desire. The RTLD team realized rapid testing in labor and delivery is only one piece, the final safety net, in the cascade of perinatal HIV prevention. Shifting the focus to include prenatal providers already committed to optimizing women’s health extended the impact of the RTLD project. The RTLD team developed a Best Practices Overview for Providers, a guide to maximizing reproductive health outcomes for women and optimal care for HIV+ women who are or want to become pregnant.

POTTER M, GOMEZ V, ACKERSON L, WALSH J, GREEN L, SOMKIN C. The FLU-FIT program at Kaiser Permanente: a multisite randomized trial demonstrates the effectiveness of providing fecal immunochemical test kits with annual influenza vaccinations.

Context and Objective: Offering home stool tests to screen for colorectal cancer screening with flu shots is effective in primary care settings in safety net settings. We sought to demonstrate the “real world” effectiveness of offering home fecal immunochemical tests (FIT) with flu shots (FLU) when conducted by flu shot clinic

SOLOMON B, CRONIN M, WALKER C. Opting in to Home Stool Tests for Colorectal Cancer Screening: a randomized controlled trial.

Context and Objective: Offering home stool tests to screen for colorectal cancer screening with flu shots is effective in primary care settings in safety net settings. We sought to demonstrate the “real world” effectiveness of offering home fecal immunochemical tests (FIT) with flu shots (FLU) when conducted by flu shot clinic
personnel in high-volume flu shot clinics at Kaiser Permanente. This is the first report of results from our randomized trial conducted in 2009 and 2010. Setting/Populations: Flu shot clinic staff conducted the intervention for adults aged 50-75 years who came to regularly scheduled flu shot clinics at Kaiser Permanente sites in Redwood City and Richmond in October/November 2009 and in Fresno, South San Francisco, and Union City in October/November 2010. Intervention/Study Design: Randomized Clinical Trial. On randomly selected dates, flu shot clinic staff either offered FIT to eligible patients with their flu shots (intervention arm) or offered flu shots in the usual manner (control arm). We compared outcomes between the two study arms. Outcomes/Results: Of 28,436 adults aged 50-75 years who received flu shots at these five sites on study dates, 6,235 (21.9%) were due for colorectal cancer screening (3,351 in the intervention arm, and 2,884 in the control arm). In the intervention arm, flu shot clinic staff successfully provided FIT to 53.9% (1,805/3,351) of eligible patients. Three months after receiving flu shots, 26.9% of all eligible patients in the FLU-FIT arm (900/3,351) had completed FIT compared to 11.7% (336/2,884) in the FLU-only arm (p value<0.0001). In bivariate analyses, the effectiveness of the intervention was significant at all five sites and for patients regardless of gender, age, ethnicity, primary language, or healthcare utilization. In multivariate analyses, the adjusted odds ratio for completing FIT within three months in the intervention group compared to the control group was 2.75 (95% confidence interval 2.40-3.16). Conclusions: The FLU-FIT Program was effective at increasing colorectal cancer screening in flu shot clinics at Kaiser Permanente Northern California. Studies of the maintenance of this program at these sites, as well as efforts to implement the FLU-FIT Program in all 47 flu shot clinic sites at Kaiser Permanente Northern California, are underway.

RIENKS J, NIJACAL M, GILLESPIE K, OLIVA G. Variation in labor and delivery attitudes, opinions, and practices among three types of practitioners. Context and Objective: A community hospital is implementing a new model of inpatient labor and delivery with the goals of increasing financial sustainability and expanding access of privately insured patients to Certified Nurse Midwives (CNMs). Previously, the hospital had two separate systems, with privately insured women delivering with an obstetrician-gynecologist in private practice (PrivOB), and publicly insured and uninsured women delivering primarily with a CNM for uncomplicated births and the remainder with a hospitalist obstetrician-gynecologist (HospOB). As the new model will be staffed by three types of practitioners, and as large differences have been noted in the C-section rates for nulliparous, term, singleton, vertex births between the two systems (30.4% for private pay, 15.6% for publicly or uninsured women), there is interest in understanding the attitudes, opinions, and experiences related to labor and delivery, use of CNMs, C-sections, and vaginal birth after C-section (VBAC) among these practitioners prior to implementing the model. Setting/Populations: The setting is a medium-sized community hospital located in northern California, and participants include PrivOBs, HospOBs, CNMs. Intervention/Study Design: Participants completed a survey on attitudes about midwives, attitudes and practices regarding C-sections, and experiencing pressure to perform an elective C-section from different sources. The survey also described labor and delivery scenarios with varied patient characteristics and asked participants about the degree to which they would encourage a vaginal birth or a VBAC. T-tests were conducted to assess for differences in mean responses between different types of providers (PrivOBs, HospOBs, and CNMs). Outcomes/Results: Our presentation will highlight the many significant differences between CNMs and PrivOBs, prophylaxis (PrEP) and timed intercourse. Conclusions: Ninety-four clinicians or patients requested information or referral for reducing the risk of HIV transmission during conception. Most callers sought referrals to clinics with assisted reproductive technologies. Both patients and clinicians desire access to clinically sound advice and referrals to reduce HIV transmission risk during conception among serodiscordant couples. Providing information and referral to clinicians and serodiscordant couples meets the National AIDS Strategy goals of preventing new infections and increasing access to care.

13 ADLER SR, COULTER YZ, WHITFORD J, ACREE M, STONE KM. Quality of life for underserved women at the end of life: an exploratory study. Context and Objective: The burden of cancer mortality is disproportionately borne by low-income women. What is known about the experience of the end of life (EOL), however, including ways to improve quality of life (QOL), may not apply to underserved women. Additionally, existential concerns and symptoms relating to psychological distress may be more prevalent than pain and other physical symptoms. In order to develop an integrative approach to EOL care, we developed and tested a patient-centered, relationship-based intervention to reduce suffering at the EOL by enhancing meaning. Setting/Populations: The study population comprised 15 networks of underserved women with advanced cancer (recruited from the Charlotte Maxwell Complementary Clinic, Oakland, CA) and their primary informal (family or friend) caregivers, physicians, CAM practitioners, and hospice nurses. Intervention/Study Design: This is a before-and-after, mixed-method, exploratory, community-based participatory research project. We studied women’s experiences of the EOL and tested the feasibility of a narrative QOL intervention known as an “ethical will”—a document that expresses an individual’s values, beliefs, life lessons, hopes, love, and forgiveness. We conducted in-depth, semistructured interviews with all participants and administered visual-analog-type QOL scales to the patients pre- and post-intervention. We met weekly to code verbatim transcripts for major themes using principles of qualitative content analysis and to reconcile differences in interpretation through refined definitions and recording. Outcomes/Results: We recruited 55 participants (88% of those known eligible) and conducted 111 interviews. We demonstrated the feasibility of enrolling terminally ill participants, administering the intervention, and obtaining measurements as patients’ health deteriorated. Of the 24 visual-analog-type scales, nine showed a change in the expected direction of 1 point or more and six of these were statistically significant despite the very small sample size. The patients’ report of how they felt physically increased 1.40; energy, 1.53; pleasure, 1.60; and comfort by spirituality, 1.20. Suffering decreased 1.47, and weariness decreased 1.40. During thematic analysis, patients’ concerns over financial needs emerged not only as most salient, but also as far more pressing than cancer-related health issues. Conclusions: Principles of integrative medicine facilitate decreasing suffering through enhancing meaning. This narrative intervention shows promise for enhancing QOL at the EOL for underserved women with metastatic cancer.

14 WHITE T, WILSON K, HILL-SAKURAI L. Prescription refill process at Lakeshore. Context and Objective: The prescription refill process at the UCSF Family Medicine Center at Lakeshore (Lakeshore) is a multi-step procedure at which many patients and providers have expressed frustrations due to long wait times, complexity, and redundancy. This quality improvement project aimed to clarify the medication refill
speak either English or Spanish fluently. Participants or their children are FHC patients.

**Intervention/Study Design:** Participants are involved in a semi-structured interview facilitated by questions developed by the investigators regarding mothers’ experiences with feeding their infants with emphasis on the first six months of life. Interviews occur in person or over the phone and are recorded and transcribed by the investigators, who also write memos at the end of each encounter. **Outcomes/Results:** The study is still in progress and some preliminary results are as follows: Family encouragement and pressure to breastfeed are strong supports for exclusive breastfeeding for the first six months. Foreign-born Latina mothers at FHC are more successful at exclusively breastfeeding than Latinas born in the US. Women who supplement within the first six months of their infants’ lives are more likely to wean off breastfeeding entirely before their infants reach six months. Most mothers who participate in WIC for their children are unaware that they can receive free breast pumps, depending on their work/study schedule. Every woman we have interviewed thus far believes that breast milk is the best form of nutrition for the first six months of a child’s life. Most Latinas we interviewed believe that breastfeeding should continue well beyond the first year of an infant’s life, and those that weaned before one year felt their milk supply was inadequate. **Conclusions:** Further research is needed to show if certain interventions help improve duration and exclusivity of breastfeeding among Latinas at the FHC. However, given the benefits of breast milk for children and women, it is still imperative for providers to develop culturally appropriate and innovative ways to encourage and facilitate breastfeeding among their mother-child patients.

**12** WEBER S, GOLDSCHMIDT R, COHAN D. Preventing HIV transmission during conception: Information and referral for HIV serodiscordant couples.

**Context and Objective:** HIV-infected individuals desire children with their often-uninfected partner. Safer conception options are available, but serodiscordant couples may not know the options and may not have access to services. Clinicians based in HIV programs may have interest in helping discordant couples, but might not provide care to HIV-uninfected partners. Reproductive health clinicians without HIV experience may lack basic information on HIV transmission risk and risk reduction interventions. To help address these gaps in knowledge and access to services, the National Perinatal HIV Clinicians’ Network provides information and referral to clinicians and serodiscordant couples seeking conception. **Setting/Populations:** The National Perinatal HIV Hotline/ Clinician’s Network is part of the UCSF National HIV/AIDS Clinicians’ Consultation Center offers telephone consultation and referrals to US-based clinicians caring for HIV-infected pregnant women and their exposed infants. **Intervention/Study Design:** Calls to the Perinatal HIV Clinicians’ Network from clinicians and patients seeking information and referrals for safer conception options were analyzed to determine the number of calls, the direction of serodiscordance in the couple, and the types of questions asked. **Outcomes/Results:** From August 2006 - January 2010, the Perinatal HIV Clinicians’ Network received 94 calls regarding conception for serodiscordant couples. Fifty-five calls (57%) were from patients, and 41 (43%) were from clinicians. In 90.4% of calls, the male was HIV-infected and the female HIV-uninfected. Seventy-seven percent of callers specifically requested referrals for themselves or their patients to clinics with assisted reproductive technologies (sperm washing, intrauterine insemination, oligospermia cup, or in-vitro fertilization). Twenty percent of callers requested information about periconception risk reduction options when assisted reproductive technologies were either unavailable or unaffordable; these calls included questions about pre-exposure and HospOBs and PrivOBs, and the fewer differences between CNMs and HospOBs. PrivOBs (M=2.5, SD=0.53) are less likely to agree that midwifery care will reduce the hospitals overall intervention rate than are HospOBs (M=1.5, SD=0.88, t(15)=2.63, p<0.02) and CNMs (M=1.10, SD=0.31, t(16)=6.93, p<0.001). Overall, PrivOBs expressed the greatest willingness to perform C-sections in various scenarios and were less encouraging of VBAC. **Conclusions:** There are significant variations between provider groups regarding labor and delivery practices, and these may partially explain the difference in C-section rates and suggest areas for future research and provider education.
skills and attitudes necessary for working in a PCMH, including patient-centered care, community engagement, leadership, and teamwork. In addition to designing the content to match our educational objectives, we applied activity-based learning theory to engage in a learner-centered, activity-based approach to curricular design. Through this learner-driven process, which combined the expertise and goals of both residents and faculty, the curricular design project itself became a teaching tool. The design team created 11 unique seminars, including the Patient Experience, Outpatient Efficiency, and Panel Management.

Outcomes/Results: We conducted this rotation three times with five residents participating each month. Evaluations were uniformly positive about both the content and the process of the month. Continuing the learner-centered approach, this year’s current residents will participate in the refinement of the curriculum for next year. In fact, the colloquium presentation itself will be a collaboration between R1s who have been through the curriculum and the faculty who taught it. Conclusions: Utilizing a learner-centered, activity-based approach to curricular design can lead to both an important change in residents’ ability to identify their own learning needs, participate with faculty in crafting a curriculum, and gain the necessary clinical and professional competencies to work effectively in new models of primary care.

SHERRIFFS A, GREENLEE A, HUGHES S, HEWETT L. Clinical utility of brief mental status exams in identifying early dementia.

Context and Objective: Cognitive functional decline including dementia is increasingly common with our aging patient population. The failure of health care providers to recognize this disease spectrum has many adverse consequences including elder abuse, medication errors, increased care giver stress, and overutilization of resources including ED visits. Folstein’s mini mental status exam (MMSE) is the most commonly utilized clinical assessment tool; advantages include being a well validated tool that takes five minutes to administer. Drawbacks include evidence that it is not particularly sensitive in identifying early dementia and intellectual copyright assertions that have clouded use in the public domain. In contrast, the St. Louis University mental status exam (SLUMS) is a public domain tool that also takes five minutes and may be particularly sensitive in identifying early stage dementias.

Setting/Populations: All patients assessed for dementia at the UCSF Fresno Alzheimer’s and Memory Center since August 2010.

Intervention/Study Design: Cross-sectional review of three clinical assessment tools for dementia and diagnosis determined by a team (family physician geriatrician, neuropsychologist, and neurologist). Team diagnosis depended on patient and family questionnaires, cognitive history, physical, neurological exam, laboratory, and extensive neuropsychometric testing. The three instruments used were MMSE, SLUMS, and Kokmen’s short test of mental status (Kokmen).

Outcomes/Results: One-hundred-thirteen individuals were assessed. The sample was 63% female, 82% non-Hispanic White, and 76% had at least a high school degree. Diagnoses included 72% with Alzheimer’s disease, 16% non-Alzheimer’s dementia, 11% mild cognitive impairment, and 2% normal. Sensitivity and specificity were calculated for each instrument using the multi-disciplinary team diagnosis as the gold standard. Dementia categories consisted of Alzheimer and non-Alzheimer, while non-dementia categories were mild cognitive impairment and normal. Sensitivity was 62% (95% CI 51%-71%) for MMSE, 99% (95%-100%) for SLUMS, and 89% (81%-95%) for Kokmen. Specificity was 100% (77%-100%) for MMSE, 83% (52%-98%) for SLUMS, and 62% (32%-86%) for Kokmen.

Conclusions: MMSE in this population was specific, but not very sensitive meaning it correctly

10 MIN Y, GOMEZ-GONZALEZ M. Awareness, knowledge, and attitude of HPV among underserved women in Fresno County.

Context and Objective: The Fresno County mortality rate for cervical cancer (2003-2007) is 3.2 per 100,000—the third highest rate in California after Tulare and San Bernardino Counties. While the mortality rate is high, the incidence rate is low, implying cervical cancer screening for early detection is not happening. This results in later diagnosis and increased mortality. To explore Fresno County’s cervical cancer mortality, a survey regarding awareness of cervical cancer, attitude and acceptance of Pap test, human papilloma virus (HPV) screening and HPV vaccine was done. Setting/Populations: Adult females (aged 18 to 65 years) attending a federally qualified health center caring for underserved low-income families in Fresno County, CA.

Intervention/Study Design: An anonymous bilingual Spanish/English survey was given to adult females after rooming and vitals, to be completed while waiting for the doctor to arrive. Questionnaires asked basic demographics of age and race/ethnicity. Respondents were asked thirteen yes/no questions about cervical cancer, Pap tests, HPV, and the HPV vaccine. One multiple-choice question was used to explore why they would choose not to vaccinate a hypothetical daughter against HPV.

Outcomes/Results: In preliminary analysis, 81 women have completed the survey. Average age was 33 years (range 19 to 63 years), and 78% were Latina. Pap test: 75% have ever had one, while 93% plan to get one in the future. Awareness: 85% had heard of cervical cancer, 77% had heard of HPV, and 62% had heard of the HPV vaccine. Knowledge: 63% believed HPV is a STD and believed it causes cervical cancer, 54% believed it causes genital warts, and 21% believed the HPV vaccine prevents all HPV. Twenty-four percent have received the vaccine. Attitude: 75% said they would vaccinate their daughter if they had one. Of those who would not, most cited a daughter who was not sexually active and concern about safety of the vaccine.

Conclusions: The majority of adult women surveyed are aware of cervical cancer, HPV and the HPV vaccine. In a hypothetical situation, most women would have their daughter vaccinated against HPV.

11 VAZQUEZ A, MITTAL P, IRELAND L. Barriers and supports for Latina women at the Family Health Center to exclusively breastfeed their infants for the first six months of life.

Context and Objective: With dwindling rates of breastfeeding, the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) developed the Baby Friendly Initiative (BFI), a ten-step approach to improve the rates of breastfeeding initiation worldwide. In the United States, BFI has helped increase initiation and exclusivity of breastfeeding on a national and local level. Considering several benefits from breastfeeding for women and children and the role that exclusivity and duration of breastfeeding have on overall health for women and children (3-6), among the goal to improve rates of breastfeeding, providers should also strive to increase rates and duration of exclusive breastfeeding among their mother-and-infant patients. Nationally, immigrant Latinas have high rates of breastfeeding initiation but low rates of exclusivity. There are many factors that could explain this, including age, education, social-economic status, cultural beliefs, social support and the availability of free infant formula through supplemental nutrition programs. This study will attempt to identify factors that influence duration and exclusivity of breastfeeding among Latina women at the Family Health Center (FHC) clinic at San Francisco General Hospital (SFGH).

Setting/Populations: The FHC is a community-based urban underserved family practice. Participants are 40 women over 18 years old with children under five years old who...
Mind and Behavior (BMB) comprehensive psychiatry and neurology course for three successive years, 2009-2011. Intervention/Study Design: This study analyzes a student-created innovation in the medical curriculum wherein first-year students who have struggled with mental illness (in themselves or loved ones) volunteer to work together to prepare a two-hour session entitled “Mental Illness among Us” (MIAU). In the first hour of the session, five of these students address the whole-class student-only audience about their personal experiences with mental illness. In the second hour, they facilitate small-group seminars, allowing classmates to hear each other’s experiences and to open up about their own. We surveyed students before and after the intervention using a validated social distance scale. Students also wrote qualitative comments about the intervention in their overall evaluation of BMB.

Context and Objective: Medical students have an alarmingly high rate of psychiatric difficulties, including depression, substance abuse and even suicide, yet few acknowledge these difficulties with peers and many do not seek treatment. This stigmatized view of mental illness follows them into their careers as doctors, negatively affecting their own lives, their relationships with coworkers, and their care for patients with mental illness. We designed a study to measure how a novel two-hour intervention in medical school could change students’ stigma about mental illness. Setting/Populations: The UCSF School of Medicine’s first-year medical student class in the Brain Mind and Behavior (BMB) comprehensive psychiatry and neurology course for three successive years, 2009-2011. Intervention/Study Design: This study analyzes a student-created innovation in the medical curriculum wherein first-year students who have struggled with mental illness (in themselves or loved ones) volunteer to work together to prepare a two-hour session entitled “Mental Illness among Us” (MIAU). In the first hour of the session, five of these students address the whole-class student-only audience about their personal experiences with mental illness. In the second hour, they facilitate small-group seminars, allowing classmates to hear each other’s experiences and to open up about their own. We surveyed students before and after the intervention using a validated social distance scale. Students also wrote qualitative comments about the intervention in their overall evaluation of BMB. The student psychiatric clinic monitored the number of first-year medical students who seek treatment for the first time after MIAU and compared this number with the average during other months. Outcomes/Results: Students showed a statistically significant increase in positive attitude towards those with mental illness. The BMB course also correlated its increased measure of the presence of compassion in the course with the implementation of MIAU. In addition, more students sought care for the first time at the student psychiatric clinic following the intervention. Conclusions: Implementing a structured and safe venue for medical students to share their personal experiences with mental illness increases their compassion towards each other, improves the likelihood they will seek psychiatric treatment for themselves, and decreases their stigma toward peers and patients with mental illness.

9 FALIK R, THOMPSON M, AGGARWAL A, SHAW A, LOWENSTEIN D. Mental Illness among Us: a medical school curriculum innovation that decreases stigma about medical students’ psychiatric illnesses. Context and Objective: Medical students have an alarmingly high rate of psychiatric difficulties, including depression, substance abuse and even suicide, yet few acknowledge these difficulties with peers and many do not seek treatment. This stigmatized view of mental illness follows them into their careers as doctors, negatively affecting their own lives, their relationships with coworkers, and their care for patients with mental illness. We designed a study to measure how a novel two-hour intervention in medical school could change students’ stigma about mental illness. Setting/Populations: The UCSF School of Medicine’s first-year medical student class in the Brain Mind and Behavior (BMB) comprehensive psychiatry and neurology course for three successive years, 2009-2011. Intervention/Study Design: This study analyzes a student-created innovation in the medical curriculum wherein first-year students who have struggled with mental illness (in themselves or loved ones) volunteer to work together to prepare a two-hour session entitled “Mental Illness among Us” (MIAU). In the first hour of the session, five of these students address the whole-class student-only audience about their personal experiences with mental illness. In the second hour, they facilitate small-group seminars, allowing classmates to hear each other’s experiences and to open up about their own. We surveyed students before and after the intervention using a validated social distance scale. Students also wrote qualitative comments about the intervention in their overall evaluation of BMB. The student psychiatric clinic monitored the number of first-year medical students who seek treatment for the first time after MIAU and compared this number with the average during other months. Outcomes/Results: Students showed a statistically significant increase in positive attitude towards those with mental illness. The BMB course also correlated its increased measure of the presence of compassion in the course with the implementation of MIAU. In addition, more students sought care for the first time at the student psychiatric clinic following the intervention. Conclusions: Implementing a structured and safe venue for medical students to share their personal experiences with mental illness increases their compassion towards each other, improves the likelihood they will seek psychiatric treatment for themselves, and decreases their stigma toward peers and patients with mental illness.

recognized those without dementia but misdiagnosed some with dementia as normal. In contrast, SLUMs was very sensitive and fairly specific, correctly recognizing almost everyone with dementia, and most without dementia.

STAFFORD M, LEUNG L, COFFA D, VILLELA T. Redesigning inpatient medicine: a curriculum to promote effective, efficient communication within a shift-work model. Context and Objective: Over the past decade, the ACGME has mandated shorter shifts for residents and decreased total duty hours. Beginning in July 2011, intern shifts were limited to 16 hours, leading most residency programs to adopt shift schedules on their inpatient medicine services. Many programs are struggling to balance the quality of patient care and resident education in the setting of shortened resident hours. The shift-work model leads to an increased number of handoffs, which in turn leaves less time for residents to make clinical assessments of newly admitted patients and perform tasks related to direct patient care. It is necessary for residency programs to improve the quality and efficiency of patient handoffs, patient presentations and task achievement in order to successfully meet duty hour requirements while protecting residents’ educational time. Setting/Populations: In anticipation of the change in duty hours in July 2011, the Family Medicine Inpatient Service at San Francisco General Hospital (part of the UCSF-FCM residency program) took several steps to improve residents’ efficiency and communication to meet the new shift-length requirements and preserve the quality of patient care. Intervention/Study Design: We implemented four major changes in curriculum and service structure: a sign-out curriculum; an oral presentation curriculum; formalized guidelines for efficient and effective walk-rounding; and an additional evening admission rounds with an attending present to supervise the hand-off from day to night team. We taught the curricula to interns during the first three months of the year, and we had special sessions for senior residents to learn the same concepts. Outcomes/Results: We plan to obtain qualitative data about resident experience and satisfaction after implementation of the curricula and evening rounds compared with the experience prior to the changes. We will use the results to further refine and improve the curriculum. Conclusions: We anticipate that the addition of a formal curriculum in effective and efficient presentation, rounding, and handoffs has improved residents’ competence in those tasks and resident satisfaction with work performed. We also anticipate that the addition of evening admission rounds has enhanced the care of newly admitted patients by having an attending present to provide more immediate feedback on the resident assessment and treatment plan.

THOM D, GHOROB A, HESSLER D, DE VORE D, CHEN E, BODENHEIMER T. Peer health coaching improves glycemic control in low-income patients with diabetes: results of a randomized controlled trial. Context and Objective: Peer health coaches offer a potential model for extending the capacity of primary care practices. The peer coaching model creates a structure whereby volunteer patients with diabetes contribute to the work of primary care teams by providing self-management support for other diabetic patients. Prior to this study, the effectiveness of peer coaching in improving diabetes control had not been established. Setting/Populations: Participants were low-income English- or Spanish-speaking patients from San Francisco public health clinics with a HbA1c < 8.5%. Intervention/Study Design: We conducted an unblinded, randomized, controlled trial to test whether clinic-based peer health coaching, compared with usual care, improves glycemic control for low-income patients with poorly controlled diabetes. Twenty-three patients with a glycosylated hemoglobin (HbA1C) < 8.5%, who completed a 36-hour
health coach training class, acted as peer coaches. Patients with HbA1C≥8.0% were recruited and randomized to receive health coaching (n=148) or usual care (n=151). The primary outcome was the difference in change in HbA1C at six months. Secondary outcomes were proportion of patients with a drop in HbA1C of ≥1.0% and proportion of patients with HbA1C<7.5% at six months. Data was analyzed using a linear mixed model with and without adjustment for differences in baseline variables. Outcomes/Results: At six months, HbA1C levels had dropped by 1.07% in the coached group and 0.3% in the usual care group, a difference of 0.77% in favor of coaching (p=0.1, adjusted). HbA1C levels dropped ≥1.0% in 49.6% of coached patients vs 31.5% of usual care patients (p=0.01, adjusted) and levels at six months were <7.5% for 22.0% of coached vs 14.9% of usual care patients (p=0.05, adjusted). Conclusions: Peer health coaching significantly improved diabetes control in this group of low-income primary care patients.

TUNZI M. Advance care directives: realities and challenges in central California. Context and Objective: To discover where patients with advance directives (ADs) obtain them and to learn what patients’ understanding is of how ADs function. Setting/Populations: Adult patients with ADs admitted to all four acute-care hospitals in Monterey County, California July 1 to September 8, 2009. Intervention/Study Design: A survey instrument was administered to study participants in either English or Spanish after contact by project staff in their hospital rooms and after obtaining informed consent. Follow-up phone calls were made to a subset of study participants after discharge. Outcomes/Results: Of 5,811 total admissions, 455 patients (7%) had an AD. Of these 455 patients, 204 (45%) completed the survey. Participants included 146 patients (72%) with a power of attorney for health care and 21 patients (10%) who were unable to identify the type of AD they had. Attorneys provided ADs to 99 participants (49%) and personal physicians to 12 participants (6%). Most participants (181; 89%) had spoken to their family about their AD; fewer (131, 65%) to their physician. Of the 146 participants with a power of attorney, only 73 (50%) said they had spoken to their agent. Family members (38%) and attorneys (35%) were seen as helpful in completing ADs; physicians were not. Follow-up phone calls identified three general themes: doctors are not interested in ADs; participants completed ADs either because their attorney suggested it or because of direct, personal experience with end-of-life issues; participants want agents to use their judgment in making decisions.

Conclusions: Few hospital patients had ADs. Of those who did, many more obtained them from and discussed them with their attorneys than from and with their physicians. Because many patients with ADs do not fully understand them, new approaches to advance care planning must be developed. The Monterey County Compassionate Care Alliance is currently developing education programs targeting primary care office staff and community-based health professionals to serve as advance care planning counselors.

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7 ODOM WALKER K, SCHMITTDIEL J, STEWART A, GRUMBACH K. Defining and measuring integrated care to eliminate inequities in care among older diverse populations. Context: Research has identified many factors that contribute to racial and ethnic disparities in health care, including the way in which care is organized and structured. Recent work has found that racial and ethnic disparities in access to care, preventive service use, and management of chronic conditions were virtually eliminated if patients had a regular source of primary care that included “coordinated” and “integrated care” services. Measurement and survey instruments are needed that can measure integration from a variety of vantage points, including a patient’s experience of integration. Objective: To use participatory research principles and qualitative research methods, to engage ethnically diverse patients to explore their understanding and experiences of integrated care and refine a conceptual model of integrated care; and to use these concepts to develop and pilot test questionnaire instruments to systematically measure care integration among ethnically and socioeconomically diverse patient populations. Setting/Participants: Men and women, aged 50 and older who self-identified as African American, Latino, Asian, and non-Latino White patients, those with at least one chronic illness, at least two visits to care in the past year, and include those receiving care in more formally integrated systems such as Kaiser Permanente and those in less integrated systems in the San Francisco Bay Area (n=29 participants). Study Design: Using qualitative methods, we conducted focus groups with patients in English and Spanish. We prompted along domains of integrated care guided by the results of the literature review and also elicited additional experiences that may suggest new domains not apparent from a literature review. Transcripts of the audio taped sessions were systematically analyzed using grounded field theory. Preliminary Results: This information was used to identify dimensions and aspects of the experience with a medical home and integrated care that are underdeveloped or have not been incorporated into existing measures. We found that when describing patient experience of integrated care, themes emerged that described information sharing, patient communication, cost barriers, patient navigation and community based resources. The patient experience of integrated care is described in their words by the themes of poor coordination, patient experience and information availability. Conclusions: The concept of integrated care is clearly explained by patients and differs from those already existing about the medical home. As health care reform is implemented, many efforts to improve healthcare systems could benefit from further understanding of integrated care delivery, particularly for older populations with chronic disease.

8 RONCALLI L, PUTTMANN M, SCOTT T. Healing through testimony: a curriculum for asylum evaluation that incorporates recovery with testimony. Context and Objective: Immigrants who apply for refugee status have a much higher success rate with physician documentation to witness to their experiences of torture. At Santa Rosa Family Medicine Residency we set out to develop a sustainable curriculum for training family medicine residents in asylum evaluations. However, too often the asylum application process merely retriggers nightmares, anxieties, and fears. The goal of our evaluations is to not only provide official documentation of the atrocities suffered by the individual but to allow the narrative to become a healing process. Setting/Populations: Asylum applicants through the law office of Robert Jobe. Intervention/Study Design: Each resident interested in doing evaluations goes through an intensive workshop and receives a binder of related readings. Part of the training
identify those patients who receive long-term opioid prescriptions. Those patients’ charts were reviewed for the purpose of this study. **Intervention/Study Design:** Retrospective within-group study design looking at frequency of urine toxicology screening before and after implementation of policy, and comparing groups by race, age, and gender. Presence or absence of a substance abuse contract was also analyzed on the basis of race, age, and gender. **Outcomes/Results:** There is a significant difference between patients who have patient-provider agreements by race, with Asian patients being significantly less likely to have a patient-provider agreement than other patients. There is also bias in the use of urine toxicology screening, with Asian and Hispanic patients less likely to be screened by urine toxicology annually for drugs of abuse both before and after implementation of the policy. No gender or age differences were found in urine toxicology screening or patient-provider agreements. Although the policy did not decrease racial biases, it did increase the percent of patients in each racial group who received annual urine toxicology screening. **Conclusions:** Despite the best intentions of providers, the data indicate that there is racial bias in selection of patients to be screened for illicit drug use and required to sign patient-provider agreements and that, as currently implemented, the policy of annual urine toxicology screening has not eliminated that bias.

6 BURNETT JA. Safe and efficacious protocol for treatment of male-to-female transsexuals. **Context and Objective:** Many transsexuals (TS) are highly motivated by their extreme gender dysphoria to seek cross-gender hormones by any means possible. There is a significant subset of TS who subsist below the poverty level and, due to lack of a stable job, societal restraints (e.g., unable to qualify for any type of welfare-sponsored medical care), or other factors, are unable to obtain any medical care for their condition. Many of these will seek out hormones through the “black market” and use them with little or understanding at what type(s) or dosages they are giving themselves. Most of these illicit preparations are highly unsuitable, even dangerous for those using them, and are administered with the only directions being by “word of mouth,” passed on by peers or other non-medical personnel. My research describes a model project that has enabled such a subset of TS patients to obtain a high-quality hormone regimen at a cost below what they were paying annually for their illicit medications. Through this project they were able to significantly reduce their risk for complications, receive needed patient education and also be evaluated and treated for other [often previously unknown] medical problems that, due to their socio-economic status, had gone undiagnosed/untreated. **Setting/Populations:** UCSF-Fresno’s Rural Family Medicine Clinic in Selma, CA; transsexual patients from all over California’s Central Valley. **Intervention/Study Design:** Retrospective, chart-review study of my TS patients who had received a dual-hormone protocol of IM estradiol and Depo-Provera, evaluated over 4+ years of this study. **Outcomes/Results:** Satisfaction rating of 4.7/5, no serious complications, and only one withdrawal due to side effects. **Conclusions:** My research has shown that a cost-effective, safe, and highly efficacious treatment program for transsexuals can be implemented, even in a rural Family Medicine clinic setting.
intervention to post-intervention time points. In this study the impact of ROR Fresno was investigated in community clinic settings where the program was already in existence in some form for at least three years. Longitudinal surveys were conducted to understand if time of exposure continues to impact literacy practices. Setting/ Populations: We targeted caregivers of pediatric program participants, ages 0 to 36 months old at the time enrolled into the study. Subjects were enrolled at two participating ROR outpatient sites in community clinics, one urban, the other rural; both are resident training sites. Intervention/Study Design: Baseline (in-person) and serial 4-month follow-up (telephone) surveys were completed with the caregivers of pediatric program participants. Reading frequency practice was assessed at three time points. Data was grouped into two categories based on reading frequency (3 or more times a week vs. less) and analyzed using McNemar’s tests. Outcomes/Results: Three hundred seven participants had four month follow-up information. There was a statistically significant association between increased reading frequency and participation in ROR (p < 0.0001). Data was available for 61 participants at 8 months and showed a significant difference in reading frequency from baseline (p = 0.003), but no difference between the four- and eight-month follow-up reading frequency (p = 0.167). Conclusions: This study confirms that ROR Fresno continues to positively impact the practice of reading frequency among participating families. Furthermore, it supports the notion that residency training sites in community clinics contribute to promoting enhanced approaches to primary care, thereby improving the medical home concept and reality.

3 ROGERS E, HESSLER D, BODENHEIMER T, THOM D. An exploratory analysis of successful peer coaches: our assumptions about important characteristics may not be correct.

Context and Objective: Training lay personnel to provide self-management support is proving effective for chronic diseases such as diabetes. However, little has been published about whether characteristics of lay personnel are associated with effective coaching. Setting/Populations: We carried out a cohort study of diabetic patients from six urban health centers serving a low-income population who participated in a randomized controlled trial to assess the impact of peer health coaching on patient change in glycosylated hemoglobin (HbA1c). The cohort included 25 well-controlled diabetic patients trained as peer coaches and 123 poorly controlled diabetic patients who were assigned to coaching. All spoke English or Spanish. Intervention/Study Design: We defined level of peer coaching success as the degree of improvement in patient HbA1c from baseline to six months. We used linear regression, to account for clustering by coach, to assess the association between patient change in HbA1c and baseline coach age, gender, number of years with diabetes, body mass index (BMI), HbA1c level, and scores on two Likert-scale validated questionnaires – Perceived Diabetes Self-Management Scale (PDSMS) and Diabetes Distress Scale (DDS). Outcomes/Results: Average patient change in HbA1c by coach over six months ranged from an increase of 0.7% to a decrease of 2.7%. Higher coach BMI (p=0.01), a lower coach PDSMS score (lower perceived self-management, p=0.04), and a higher DDS score (higher levels of diabetes-associated distress, p=0.04) were associated with a greater reduction in average patient HbA1c. Conclusions: Contrary to our hypothesis, coaches with lower BMI, higher perceived self-management of diabetes, and lower diabetes distress were not more successful in reducing the HbA1c levels of the patients they coached and may in fact be less successful. One could hypothesize that those coaches struggling with their own disease management and lifestyle may make more empathetic patient connections to prompt improvement in a patient’s self-management. Coach age, gender, years with diabetes, and HbA1c were not important for successful coaching. These findings could help guide peer coach selection in future interventions.

4 QUEEN-JOHNSON A, WILSON E, LUI B, MARTINEZ A. PRIME community engaged group projects.

Context and Objective: UCSF’s Program in Medical Education for the Urban Underserved (PRIME-US) is a special track for medical students committed to working with urban underserved communities. Our community engagement curriculum includes site visits, individual projects, and service learning opportunities. Although group cohesion is an essential element of PRIME, there has been little opportunity for students to work on projects together. Last fall, our new “Capstone” course for senior students piloted small group projects to reiterate best principles and practices of community engagement and to foster team-based learning and group support. Setting/Populations: Eleven PRIME seniors participated in the month-long Capstone course. Two small-group projects were developed in collaboration with 1) Mentoring in Medicine (MIM), a health care pipeline program and 2) the Peralta Wellness Center (PWC) at Laney Community College working with Asian Health Services to plan a new school based clinic. Intervention/Study Design: Eleven PRIME students were divided into two groups to work with MIM and PWC. The students spent seven full days, as well as time in between, working on projects identified by MIM and PWC prior to the course. Students with MIM worked with pipeline students to develop a new E-Health curriculum for program outreach. Those at PWC conducted a client needs assessment to inform the direction for clinic programs. Regular meetings were held between students and their community partners, as well as with course leadership. Outcomes/Results: Students achieved project objectives, enjoyed working together, and learned about the rewards and challenges of working with community partners in real-time. They presented their final projects to their peers, community partners and program leadership on the last day of the course. Although this curriculum innovation was constrained by limited time, early preparation and close follow-up by course leadership ensured maximum impact for both students and community partners. In the future, we hope students can start working ahead of time with partners to identify and design a project together. Conclusion: Group projects can be a successful method for strengthening community engagement curriculum and enhancing group cohesion.

5 STRELITZ L, SNYDER J, COFFA D. Attempting to eliminate bias in the use of patient-provider agreements and urine toxicology screening of chronic pain patients.

Context and Objective: To make patient care more consistent, the Family Health Center (FHC) instituted a policy requiring chronic pain patients on long term opioid therapy to undergo annual urine toxicology screening and sign a patient-provider agreement or “pain contract.” This study attempts to elucidate whether provider bias influences screening and agreements, and to explore whether implementation of the policy was successful in standardizing the approach to chronic pain patients and reducing bias. Setting/Populations: The FHC provides primary care to an uninsured and publicly insured population and serves as a teaching site for medical students and residents. All FHC providers were given written lists of their primary care patients and asked to...