Overview

• News and recognition
• Progress on departmental strategic plan
• New challenges
UCSF Department of Family and Community Medicine

UCSF Ranked #10 Among US Departments of Family Medicine in 2006
Faculty Recognition: Teaching Awards

• Diane Rittenhouse
  – Medical School Class of 2006 Excellence in Teaching Award
  – Class of 2008 Award for Innovative Teaching

• Dan Ciccarone
  – Class of 2009 Outstanding FPC Facilitator Award
  – Nominee Class of 2008 Commitment to Teaching, Inspirational Teacher, Small Group Teaching Awards;
    Nominee Class of 2009 Innovative Teaching Award
  – Elected to Academy of Medical Educators
Faculty Recognition: Teaching Awards and Nominations

• Albert Yu
  – Class of 2009 Outstanding Contribution to an Elective Award
  – AMSA Paul R. Wright Excellence in Medical Education Award
  – Nominee for Kaiser Award for Excellence in Teaching

• Academy of Medical Educators Direct Teaching Awards:
  – Todd May
  – Susan Runyan
  – Katherine Strelkoff
Faculty Recognition

• Bill Shore
  – The Permanente Medical Group Endowed Chair in Primary Care Education in the Department of FCM

• Betty Dong
  – American College of Clinical Pharmacy 2005 Clinical Practice Award

• Naomi Wortis
  – UCSF Hellman Family Award for Early Career Faculty
  – Nominated for Kaiser Teaching Award
Faculty Recognition

• Hali Hammer
  – SF Health Plan “Healthy Hero” Award

• Norma Jo Waxman and team:
  – PRCH Model Family Medicine Residency Program in Options Counseling for Unintended Pregnancy
Faculty in the News

UCSF Newsbreak
First Appeared Friday, 10 February '06

Teresa Villela: Practicing True Family Medicine

The life of Teresa Villela is the realization of every immigrant family’s dream.

Villela’s family moved to Tucson, Arizona, from Mexico when she was 10 years old. Her father sold furniture. Her mother cleaned offices. Still, they managed to send the eldest of their five children to Yale University. Villela graduated from Yale and went on to medical school at the University of Connecticut. She now practices and teaches at UCSF in one of the top medical schools in the country.

The Global Health Sciences Initiative In Tanzania

03.27.06

Stephanie Taché (middle) with UCSF visiting team. Photo by Mwenzo Millinge.

The UCSF Global Health Sciences’ (GHS) capacity building effort with the Muhimbili College of Health Sciences (MUCHS) in Tanzania is being anchored by Dr. Stephanie Taché, assistant professor of family & community medicine, who moved to Dar-es-Salaam in September to lead this program. The recent visit of the school’s medical education team to MUCHS is one component of a multi-pronged program to increase the quantity and quality of healthcare workers in Tanzania. It is funded by the Centers for Disease Control, with the National Institute for Medical Research in Tanzania as the lead institution. UCSF GHS is a subcontractor.
FHC Awards

- SFGH Staff Recognition Award: Entire FHC
- SFHP Healthy Kids and Young Adults Initiative: FHC Teen-Friendly Clinic
- Asthma and Diabetes Collaboratives Team Awards
- Hearts in SF Grants
Faculty, Resident and Staff Productivity

- Barash
- Budd
- Delisser
- May
- Reynolds
- Rittenhouse
- Runyan
- Valencia
- Vener
Faculty Additions

• 2005:
  – Beth Wilson
  – Catherine Cubbin
  – Katie Murphy
  – Stephanie Taché
  – Manju Deshpande
  – Brian Herrick
  – Shira Shavit
  – Elena Tootell

• 2006:
  – Lisa Ward: FHC Assistant Medical Director
  – Shelley Adler
  – New SFGH Positions Posted
New Program Managers

• Roberto Ariel Vargas, Community Programs

• Joanne Keatley, Correctional Medicine Consultation Network
FCM Strategic Planning Priorities

• Improve finances
• Innovate in primary care practice
• Education
  – Residency
  – Medical student
  – Research fellowship
• Community Programs
FCM Strategic Planning Priorities

- Diversity
- Build bridges within the department
- Space
- Academic productivity
- Leadership within UCSF
- Well-being and professional development
Building Bridges:

Healthy Communities

COLLOQUIUM 2005

University of California, San Francisco
DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE
Thursday, October 6, 2005
Medical Students: UCSF PRIME-US Program

- Program in Medical Education: Urban Underserved
- New Medical School Student Track
- Beth Wilson Leading Planning Group
- Plan for first increase in UC medical student #s in 3 decades
Goals of UCSF PRIME Program

• Attract medical students with strong interest in caring for the urban underserved.

• Provide a medical education experience to equip and support them to become leaders in care of urban underserved.

• Enable students to serve as a catalyst at UCSF.

• Increase number of UCSF medical school graduates pursuing careers devoted to improving the health and health care of the urban underserved.
Family Practice Positions Offered and Filled With US Seniors, 1991 - 2001

Offered

Filled
Education: Residency

- Recruits and Graduates
- RRC Accreditation & New Requirements
- Resident involvement in FHC PDSA projects
- Global health clinical scholars program
  – Jessica Evert & Jennifer Shen
Family Practice Inpatient Service
Total Admissions by Year

Year vs Total Admissions Graph

- Year: 1992 to 2005
- Total Admissions range from 0 to 1600
Recent Threats to UCSF Affiliated Family Medicine Residencies

- Santa Rosa
- Salinas-Natividad
Education: Fellows

• Research
  – Olivia Sampson
  – Rosalia Mendoza
  – Christine Dehlendorf
  – Laura Eaton
  – Jennifer Edmond

• Faculty Development
Academic Productivity

• 4th Most prolific US Family Medicine department in research publications in peer-reviewed journals

• 4th Among US Family Medicine departments in annual NIH research funding
Academic Productivity

Forthcoming Book in Collaboration with SFGH DGIM:

Medical Management of Vulnerable & Underserved Patients

Talmadge E. King, Jr., MD
Margaret B. Wheeler, MD
Andrew B. Bindman, MD
Alicia Fernandez, MD
Kevin Grumbach, MD
Dean Schillinger, MD
Teresa J. Villela, MD

LANGE
Community Programs

• FCM Community Partnership Resource Center
  – HUD COPC Grant
• COPC Curricula
• New UCSF University-Community Partnership Program
  – Grumbach, Wortis on Council
• Correctional Medicine Consultation Network
  – Lori Kohler, Director
• FHOP, PAETC/ITECH, NCCC
• Reproductive Health
• Rebuilding SFGH
  – Mayor’s Blue Ribbon Task Force: Rebuild on Potrero Site
  – UCSF Academic Space Planning Committee for SFGH
  – Building 80/90

• Space Station Parnassus….?
Faculty, Resident, Staff Well-Being

- Hali Hammer: member of Chancellor’s Council on Faculty Life

- Bill Shore to lead new structured DFCM faculty mentoring program

- Additional ideas welcomed
Diversity

• Standing DFCM Committee on Diversity
  – Chairs: Kirsten Day, Kara Odom
• Dean’s Task Force on Underrepresented Minorities
  – Villela, Grumbach members
• Chancellor’s Advisory Committee on Diversity
• Exec Vice Chancellor’s Initiative on Diversity
• Health Disparities Curricula
  – Medical Students
  – Residents
• LEARN Multicultural Health Symposium
DFCM Core Faculty by Rank and Sex

- **Total**
  - Men: 21
  - Women: 27
- **Assistant**
  - Men: 5
  - Women: 18
- **Associate**
  - Men: 7
  - Women: 8
- **Professor**
  - Men: 9
  - Women: 1
DFCM Core Faculty by Rank and Race-Ethnicity

- **Total**
  - White: 41
  - Latino: 3
  - African American: 2
  - Asian: 2

- **Assistant Professor**
  - White: 20
  - Latino: 0
  - African American: 1
  - Asian: 1

- **Associate Professor**
  - White: 11
  - Latino: 3
  - African American: 0
  - Asian: 0

- **Professor**
  - White: 10
  - Latino: 0
  - African American: 0
  - Asian: 0
Diversity: Beyond the Numbers

R is for Respecting Differences
Primary Care Innovation

Royal College of GP:

“Do we have a future,
or are we an unwanted anachronism?”
A 20th Century Model of Primary Care Will Not Meet the Demands of 21st Century Health Care
The UCSF Lakeshore Family Medicine Center
Envisioning a New Practice Model
Lakeshore Redesign Effort:

“You must be the change you wish to see in the world.”

Mahatma Gandhi
How stressful would you say it is to work in this practice?
• What would make this practice better for those who work here?

• What would make this practice better for patients?
Rapid cycle improvement

- Plan
- Plan
- Plan
- Panic
- Plan
- Do
- Study
- Act
“You Can’t Leap Across the Chasm in Two Steps”

- Consequence of Time Out for Clinic Planning:
  - Reduced Visit Volume → Reduced Revenues
- Perverse payment incentives
- Need for institutional buy-in
Keeping the Vision: UCSF Center for Excellence in Primary Care

• Center goal:
  – serve as a resource for catalyzing the transformation of primary care through advancing
    • evidence base for primary care redesign
    • sharing tools and strategies for translating evidence into practice
    • advocating for policy change

• Partnership between UCSF DFCM and The Permanente Medical Group

• Inaugural April 2006 Conference:
  – “Primary Care at the Crossroads: New Models for the 21st Century”
Center for Excellence in Primary Care

“Building effective primary care teams”

San Francisco, CA, April 25-26, 2006

Charles S. Burger, MD, Eastern Maine Medical Center, Norumbega Evergreen Woods, Bangor, Maine
207-942-1565, cburger@emh.org
Norumbega Evergreen Woods

- Owned by Eastern Maine Medical Center in turn part of the integrated Eastern Maine Heath Care System.
- 5900 active patients
- We draw from a broad socio-economic group with some charity care
- 250 visits per week
- 1.2 FTE MD, 2 FNPS, 1 Family therapist, and 11.5 FTE support staff (3.4 support staff per provider)
The practice innovation

- Coupling the principle that all care team members function at the highest possible level regardless of degrees or tradition using:
  
a. modern information tools (EMR/PKC)
b. highly defined work processes
c. performance based training
d. one on one coaching to proficiency
e. quality management training

Building on the shoulder of giants: Dr. Lawrence Weed, Dr. Harold Cross and Dr. John Bjorn - 1971
Practice roles

- Patient representatives: triage including phone advice and treatment of common problems
- RN’s: manage chronic disease/group care visits
- Involving patients in the visit process
- CMA’s: collect histories and physical exams to include PAP’s and periodic health reviews
- Providers: increasingly manage the system as well as see higher risk individual patients
- Collaboration with mental health provider
PATIENT REP TRIAGE

• Computerized triage system using Problem Knowledge Coupler software

• Developed over a 20 yr. period and updated by myself

• Six week training with one on one coaching
**TRIAGE FUNCTIONS**

- Determines if patient needs to be seen or not and if so how much time needed and should further testing be obtained before visit

- May treat independently common problems: URI, cystitis, antibiotics before dental work, motion sickness, etc.

- Automatic medication refills
INVOLVING PATIENTS IN THE DIAGNOSTIC VISIT PROCESS

• Patient completes problem specific PKC questionnaire either on line or on kiosk in office

• Responses validated by the MA/RN who sets up record and completes most of PE

• Providers main function is reviewing options and decision making
Impact of the innovation on patients

- Our current patient satisfaction score using the Avatar system is 96%.


- National comparisons through the Medical Quality Information consortium.
TEAM INTERACTION

- Weekly combined team meetings – 1 hour
- Morning huddles – 15-20 min
- Occasionally close for an afternoon for extensive team building training
- Weekly leadership meetings – 1 hour
Impact of the innovation on clinicians

- High provider morale and no burnout.

- One FNP retired after 20 years and the current FNP has been here 15 yrs.

- One FNP left after 2 years. Never committed to system.
Impact of the innovation on staff

- Staff satisfaction high – Team Life Survey

- Turnover low - 1 in the last year. Most leave for change in career, family issues, having babies, etc. Average length of employment 9 yrs.
Key lessons learned

• With a new vision primary care can continue to be financially and emotionally rewarding

• The physician’s role must include leadership and system management as well as direct patient care

• Change will be relentless

• Significant cultural and system barriers exist limiting full implementation of the system I have described
Center for Excellence in Primary Care

Karen Nelson, MD, MPH
UNITE HERE Health Center, NYC
Testing a Progressive Wellness and Primary Caring Center for Low Wage Immigrant Workers
UNITE HERE Health Center

- Originally founded 1916 by the ILGWU
- 2004 UNITE merger with HERE
- 12,000 active patients, union members

• Very Low Wage Immigrant Workers
  - 1300 diabetics; 1400 CAD
  - 59% Latino; 66% women
  - 85% < 200% poverty level
  - Self-insured through Health and Welfare Fund
  - 25% retirees w/Medicare

• 1000 office visits/week
• 12 PCPs: All 3-5 days/week (sole job)
• 40 Specialists: 3-18 hours/week at HC
• Bilingual MA and clerical staff
Pre-PWPCC Pilot: Traditional Ambulatory Health Center

- 54 exam rooms, PT/Radiology/Pharm/Lab
- EMR, advanced access, re-engineered
- Participant NYCDOH Diabetes Collaborative
- Impetus for Testing PWPCC Model
  - Skyrocketing health care premiums for H&W Fund
  - Providers on diabetes collaborative sensing “plateau” in improvements in outcome measures; frustration with their ability to successfully manage chronic disease
  - Payment to HC converted from FFS to capitation
“First Floor”

- Staffed entirely by MA’s with NP/RN supervision

- MA’s teach self-management skills to patients with chronic disease (initially diabetes, CAD, asthma, obesity); serve as liaison to PCPs

- Patients with chronic disease frequently seen exclusively on first floor without PCP visit

“Second Floor”

- Primary/specialty MD visits with MA staffing

- Visits enhanced by EMR & support of “first floor”
Piloting New PWPPC Model

• Three providers (2 MDs, 1 NP) chosen along with their already-established panels at HC
  • Currently, 2000 patients in three panels

• All patients with chronic disease have PCP but will be assigned “first floor” MA

• Staffing for 3-provider pilot team:
  4 “first floor” MA’s, 3 “second floor” MA’s, .5 NP, .5 RN, .5 clerical
"First Floor" Practice

• Provide Extensive Pt Education, Self-Management Teaching
  – All patients with chronic disease seen for education, reinforcement, self-management
  – Pts with poorly-controlled chronic disease booked back after PCP visit
  – Groups – planned and spontaneous
  – Oversee review of chronic disease registries

Initially, triage all walk-in patients. Patients who call in for sick visit will be directed based on sxsl-likely directly to "second floor."
“Second Floor” Practice

• Provide office-based medical visits (enhanced by EMR)
  – Patients with complex chronic disease
  – Patients with acute illnesses unless managed on “first floor” by protocol
  – New patients and annual exams

• Provide training for and supervision of “first floor” staff
What Do “First floor” MA’s need to know?

- Principles of Self-management
- “Living with chronic disease”
- New clinical model
- EMR templates/profiles/flow sheets
- Preventive protocols
- Diabetes care clinical parameters
  - HgbA1c, LDL, BP values
  - Foot exam, vaccinations, ophtho/podiatry appts

- “Second floor” MA’s need same skills but will primarily support provider office visits
How Are “First Floor” MA’s Trained?

- Classes/individual trainings/role playing with UHC providers
- Trainings by NYCDOH consultants on motivational interviewing
- Classes by HIP teaching self-management skills
- MA’s sent to Joslin Diabetes classes
- Diabetes disease management program trainings
- DME vendors provided CDE’s for diabetes support groups

How Are MA’s Evaluated?

Testing and observation by RN/NP/MDs
**How Is Data Used?**

- Provider/MA teams given patient registries
  - Sorted by Diabetes care parameters
  - Sorted by co-morbid illnesses and control
  - Sorted by missed appointments
  - Data is stratified by risk and follow up is determined by team based on risk

- Protocols are being designed to determine appropriate follow up (letters, calls, visits)
- Data distributed monthly to teams
Impact of the innovation after 3 month pilot

- **On patients**
  - By anecdote, very positive

- **On 3 test providers**
  - Initial increased work (huddles, training, data work) seems to be easier & more helpful now
  - 2/12 providers may have hard time working in team environment, supervising MA’s closely, changing practice patterns

- **On MA Staff**
  - MA’s in pilot: initially difficult, steep learning curve; practice substantially different from usual
  - 10/30 current MA staff may have difficulty w/increased responsibility, complexity of job on “first floor”
Key lessons learned

- Teaching and evaluating the skills of the MA’s very complicated and time-consuming.
- Need strong clinical evaluation skills on “first floor,” close supervision by and easy communication with “second floor” MD staff.
- Important to keep floors physically separate to keep practice from slipping back to traditional MD visit at each encounter.
- Need constant reinforcement to plan visits, use registries, and target & educate complicated patients.
Take Home Points from Conference on New Models of Primary Care

• Change is necessary
• Change is possible
• Change is difficult
• Key elements of new models:
  – Genuine teamwork and team ownership of practice performance
  – Redefined roles of team members
  – Electronic technology support
Center for Excellence in Primary Care

- Strategic planning post conference:
  - Regional transformation of primary care through reengineered practices
  - Policy advocacy to support practice change and needed resources
“Be the Change You Want to See…”

• Lakeshore Clinic plan:
  – Implement open/advanced access model
  – Development of ambulatory EMR
  – Performance-targeted medical center subsidies

• SFGH Family Health Center:
  – Integrating new models into a teaching clinic and residency education
  – Mayor’s Universal Health Care Council
Finances:
The Storm Has Arrived

Demise of Federal Title VII
Health Professions Programs:

• Primary Care Training Grants
• Diversity Pipeline Program Grants
Loss of Title VII Funding: Impact on DFCM

• July 2006:
  – Loss of $353,000 annually (predoc grant, residency grant)
  – UCSF Fresno losses

• July 2007:
  – Loss of $714,000 annually (departmental grant, faculty development/fellowship grant)

• Total equivalent to amount of UC state education funds annually budgeted to DFCM
DFCM Strategic Response to Budget Challenge

- Negotiation with SFGH for residency support
- Negotiation with UCSF for med ed support
- Grant proposals to foundations for med ed
- Fundraising and philanthropy
- Build support for increased state funding
  - eg, Song Brown program augmentation
- Educating Congress
  - e.g., Rittenhouse Title VII Study, Grumbach-Chen post-bac study
- Belt-tightening
“The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy.”

Martin Luther King Jr.,* Strength to Love, 1963
Thank you!