UCSF Department of Family & Community Medicine

17-18

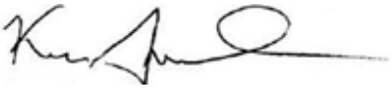
Annual Report

Contents

Message from the Chair

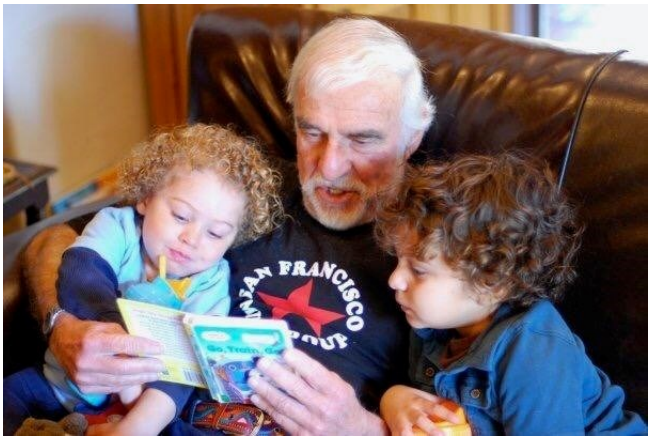
The UCSF Department of Family and Community Medicine was founded in 1980 as an autonomous division of the School of Medicine, and became a full-fledged department in 1987. I recently read through archival records on the history of the department, including a report from a School of Medicine committee appointed by the Dean that recommended establishment of a Division of Family and Community Medicine. One of the most intriguing aspects of that report is the selection of the name Family and Community Medicine and not just Family Medicine. Inclusion of the word “community” was a carefully considered decision, intended to recognize the social context of health and illness and the need for family physicians to be community engaged and address the social determinants of health and health equity. Dr. Don Fink served on that committee before becoming one of the department’s founding faculty members (and an interim Department Chair), and was a strong voice for including “community” in the department’s title and scope.

In this annual report, I highlight some of the ongoing work that illustrates our abiding commitment to the community medicine dimension of our department's identity. Featured are inspiring projects ranging from developing the capacity of barbers to serve as health coaches for people with hypertension in the African American community to community based training and patient care services for individuals with developmental disabilities. Don died in January, 2017. This work is a fitting legacy to his determination to make community an essential part of family medicine.



Kevin Grumbach, MD

Hellman Endowed Professor and Chair



Donald L. Fink, MD, 1932-2017.

Department at a Glance

Faculty

60	Core faculty
>50	Part-time, joint appointment, non-faculty academics
>300	Volunteer and affiliate residency faculty

Staff

80	Academic staff
>125	Clinic staff

Funding

$38.3 Million total budget	$17.9 Million extramural grants and programs	$14.4 Million clinical practice

Our Mission

To improve health through excellence and innovation in patient care, education, research, advocacy, and community empowerment.

We are dedicated to building a just and equitable society, recognizing that health and illness are shaped by the contexts of people's lives.

To accomplish our mission, we:

- Provide comprehensive patient care built on trusting and healing relationships with individuals, families, and communities.
- Advance and apply knowledge in patient care, population health, community engagement, and public policy.
- Educate learners in the principles and practice of family and community medicine, emphasizing the interconnectedness of people and systems.
- Promote a culture of inclusion, mutual support, and meaningful work.

Acknowledgments

The Department of Family and Community Medicine would like to give special mention to the following major donors for their contributions this year.

Paula A. Braveman '79 and John F. Levin

Joanne Donsky and Stuart Oremland

F. Dorsey Tax Services

Daniel Farrish

Fidelity Charitable Gift Fund

John Frost

Patricia and Richard Gibbs

Catherine and Ronald H. Goldschmidt

Health Improvement Partnership of Santa Cruz County

Terry and Lawrence N. Hill '67

Joyce F. Iseri

Catherine M. and William A. Norcross

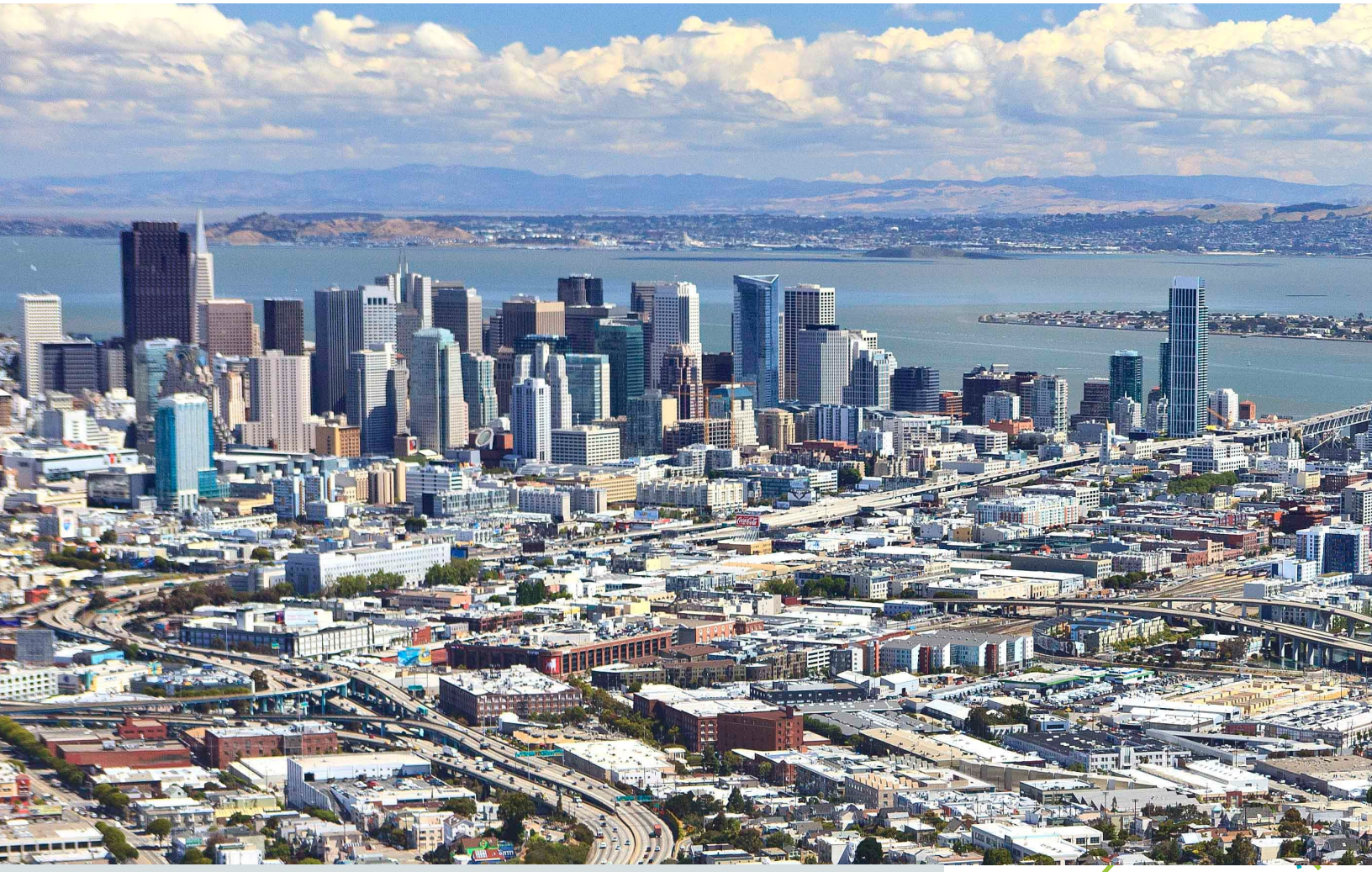
Patricia E. Perry and Stephen J. McPhee

Schwab Charitable Fund

Mary J. and Theodore P. Shen

Barbara L. Wing

Leadership



FCM Executive Council

Kevin Grumbach, MD *Chair*
Ronald Goldschmidt, MD *Vice Chair of Academic Affairs*
Teresa Villela, MD *Vice Chair, ZSFG Chief of Service*
Margo Vener, MD, MPH *Vice Chair of Education*
Christine Dehlendorf, MD *Vice Chair of Research*
Danielle Hessler-Jones, PhD *Vice Chair of Research*
Constance Yu, MHA, *Associate Chair of Administration and Finance*
Diana Coffa, MD *Residency Program Director*
Katherine Strellkoff, MD *UCSF Health Chief of Service*
Lydia Leung, MD *FHC Medical Director*
Laura Hill-Sakurai, MD *Lakeshore Medical Director*
Lan Pham, MPA *ZSFG Unit Manager*
Shelley Adler, PhD *Member at Large*
Coleen Kivlahan, MD, MSPH *Member at Large*
Thomas Foster *Member at Large*
Ivan Gomez, MD *Vice Chair Fresno*

Residency Program Affiliates

Zuckerberg San Francisco General Residency Program

45 Residents

3 Chief Residents

UCSF Fresno Community Regional Medical Center
Contra Costa Regional Medical Center
John Muir Health
Kaiser Permanente Napa-Solano
Kaiser Permanente San Jose
Kaiser Permanente Santa Rosa
Natividad Medical Center
Sutter Santa Rosa

184 Residents from affiliate Bay Area programs

In the News

San Francisco leaders see big benefits in sanctuary. Trump administration sees danger

-San Francisco Chronicle

March 10, 2018

"Lydia Leung, medical director at San Francisco General Hospital's Family Heath Center, said doctors interact daily with undocumented patients — people who consistently share that they feel secure seeking care in the city because they know their visit will not trigger immigration consequences. Failing to treat a portion of the population for disease could endanger public health in general, Leung said.

"If we want to create a healthier society, it requires us to pay attention to the health of all," she said. "As a public health system, there is not an upside to ignoring any segment of society, because illness does not discriminate."

news

They're Out of Prison. Can They Stay Out of the Hospital?

-The New York Times

May 29, 2018

"Mr. [Ronald] Sanders works for the Transitions Clinic Network, which has doubled in size over the past five years and now works out of 25 health centers in eleven states and Puerto Rico. It has treated some 5,000 patients since it got its start here in 2006 at a city-run clinic for low-income residents in Bayview-Hunters Point, a neighborhood heavily affected by incarceration.

There is some evidence that the program helps people stay out of emergency rooms and hospitals: A study in the American Journal of Public Health of 200 chronically ill former inmates in San Francisco, half assigned to a Transitions clinic and half to a primary care program, found that the Transitions patients' use of emergency rooms was 50 percent lower.

"People coming home have many health needs," said Dr. Shira Shavit, the network's executive director and a clinical professor of family and community medicine at the University of California, San Francisco. "They need food, a place to stay and a job, and many face discrimination in housing and employment. They may have lost connections with family. So it is important to address the big picture."

As opioid crisis grows, medical schools bolster addiction training

-San Francisco Chronicle

June 15, 2018

"The program, funded by the city and county of San Francisco, is designed to give doctors such as [Hannah] Snyder [FCM assistant professor and fellow] extensive training in addiction medicine at the beginning of their careers. It is part of a broader shift by medical schools around the country to adapt to the opioid crisis by better incorporating addiction medicine — historically a field within psychiatry — into overall medical training.

As part of the training, Snyder works at Ward 93, a methadone clinic at San Francisco General Hospital, where she meets with patients to discuss treatment options and reviews results of medical tests to monitor whether, among other things, higher doses of methadone are causing heart damage.

Snyder also is working with hospitals across the United States to create new protocols for treating patients with opioid-use disorder, using San Francisco General and Oakland's Highland Hospital as models. That primarily means getting patients started on buprenorphine or methadone — two long-term prescription medications for opioid-use disorder — when they come to the hospital after overdosing or having severe withdrawal symptoms. Many public health officials and addiction experts have advocated this approach in recent years as the number of deaths from opioid overdoses continues to climb."

Office of Developmental Primary Care

The Office of Developmental Primary Care (ODPC) was established in the Department of Fa
developmental disabilities through clinical services, advocacy, research, training and techn
care needs among individuals with developmental disabilities, particularly as they transition
these individuals and their families. ODPC programs include the Developmental Primary Ca
and a home-based primary care practice for residents of group homes. The Developmental
physician, Dr. Andrew Wang, to the team. Northern California Access to Care Initiative focu
provided 18 trainings to 785 participants. The CART Services Team, a multidisciplinary mob
family members and support professionals throughout northern California. The team includ
provided both direct assessment and consultation services, as well as safety net building a
institutions to the community or clients with complex, multi-dimensional problems who wer
than 704 people through 14 trainings, and produced the *Update in Developmental Disabiliti*
self-advocates to create three new resources: *Everybody Communicates: A Toolkit for Acc*
Guide to Relationships, Romance, Sexuality and Sexual Health; and *Planning Life Goals for*
People with Developmental Disabilities. Moving forward, the CART Services Team will
focus its efforts on training and technical assistance.

amily and Community Medicine to build the healthcare system's capacity to serve adolescents and adults with
ical assistance. ODPC was established by Dr. Clarissa Kripke as a response to the tremendous degree of unmet health
out of pediatric care settings, and the lack of preparation of most health professionals in the skills needed to care for
are Practice, Northern California Access to Care Initiative, CART Services Team Developmental Primary Care Practice,
Primary Care Practice has expanded the number of group homes served to 24 homes and welcomed another
ses on end of life care, supported decision-making, and trauma-informed behavioral health. This past year, ODPC
bile health care consult team, provided services to adolescents and adults with developmental disabilities, clinicians,
es experts in primary care, nursing, psychiatry, psychology and parent-to-parent support. The CART Services Team
ctivities. Referrals for assessment and consultation were primarily for people with complex needs transitioning from
e at risk of losing their community placement. This past year, ODPC provided nearly 100 consultations, trained more
es conference, which 254 people attended and has been viewed over 300,000 times online. ODPC also partnered with
cessing Communication Assessments, Funding, and Accommodations; *Our Sexuality, Our Health: A Disabled Advocate's*

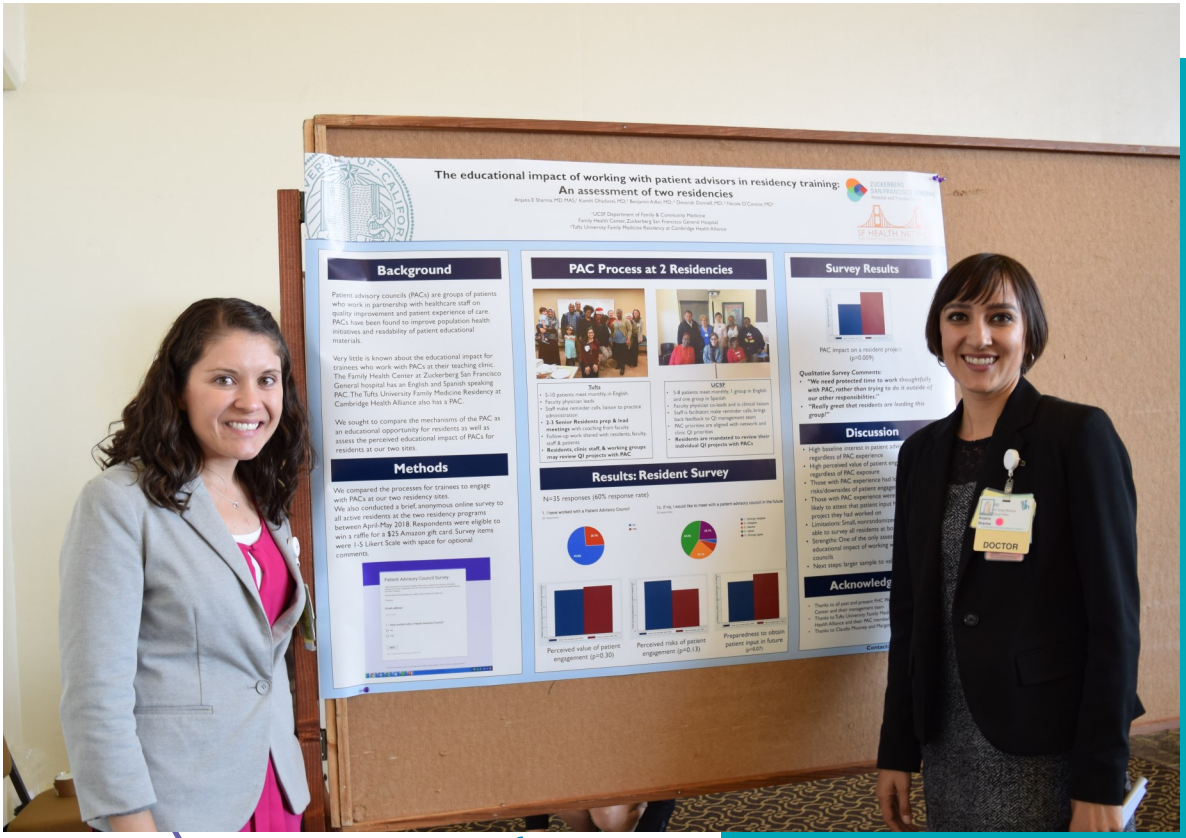
PAC

Patient Advisory Councils

The Patient Advisory Councils (PACs) at the Family Health Center at San Francisco General Hospital have been active for more than 10 years and are closely integrated with our Quality Improvement Management Team. English and Spanish language PACs meet monthly to share their experiences and lend their voice. The PACs are composed of diverse groups of insightful individuals who truly care for patient wellness and empowerment. The PACs and clinic leadership are closely tied, with PAC initiatives and concerns being a central focus of our monthly Quality Improvement Management meeting. We routinely discuss our “True North” values in PAC meetings so that PAC initiatives are in alignment with health system priorities. Our recent collaboration with the English-language PAC has been to improve hypertension control rates in Black/African-American patients as part of our commitment to

promote health equity. Together with our PAC members, we have reviewed data on disparities in care for AA/black patients with HTN and collaboratively brainstormed about possible barriers and solutions. The Spanish language PAC has prioritized improvement of the patient experience at the Family Health Center. Through a “flow mapping” exercise where the group reviewed each step of a patient’s journey through the clinic, the PAC identified improving the registration process as a promising way to increase patient satisfaction. This has been followed by in-depth observations and suggestions from our PAC members to reduce inefficiencies during check-in.

The Family Health Center strives to make patient-centered care a reality by engaging with patient advisors for their input in a meaningful, longitudinal partnership. Our nurses, doctors, residents, students, medical staff and office staff recognize our patient advisors as valuable members of our clinic community and are grateful for the positive and wonderful impacts they have had on Family Health Center.



The Cut Hypertension Program

The Cut Hypertension Program (CHP) is a program borne out of evidence that African American barbershops can be places of health prevention, community building, outreach, and treatment for African American men, a community affected by alarming health disparities in cardiovascular disease, cancer, HIV and mental illness. UCSF-SF General Hospital Family and Community Medicine resident Dr. Kenji Taylor started The Cut Hypertension Program as a medical student at the University of Pennsylvania in 2010 because his father, who is African American, passed away suddenly from a heart attack and likely suffered from high blood pressure. His father had never seen a doctor because he was uninsured and deeply mistrusted the medical system. Kenji found out his father's story was not an uncommon occurrence. Research evidence at the time supported barbershop-based blood pressure outreach as a way to address this alarming health disparity. Kenji also brought the program to Atlanta, GA through HealthStat as a fellow with the Centers for Disease Control and Prevention in 2014 in between his third and fourth years of

medical school. He continued to build the program here in the Bay Area as a resident. With support from the department's Center for Excellence in Primary Care and in partnership with several local community health centers and groups, CHP is training barbers in three barbershops in San Francisco and Oakland to be health coaches so that they can provide blood pressure screenings, education and referrals to primary care providers. Health professional students also partner with barbers to provide blood pressure screening and education events. CHP hopes by to disrupt the alarming health trends in African American men by: 1. Strengthening the capacity of barbers to be health educators, navigators, coaches, and community leaders. 2. Empowering individuals, families, and African American communities to become literate in their own health and wellness with an emphasis on cardiovascular health of black men, while inspiring the next generation of black providers. 3. Build trust between health providers and African American men.

Program Goals

1. Deepen and expand our connections with barbers by providing ongoing education, training and social events.

2. Create new partnerships with local health providers and community agencies to develop the "barbershop as health hub" model.

3. Provide technical support, consultation and training to others aspiring to build community partnerships through health coach training programs.

Summer Urban Health & Leadership Academy

Partnerships between health profession institutions and public schools are important ingredients in successful solutions for minority underrepresentation in health careers. The Summer Urban Health & Leadership Academy (SUHLA), directed by Department of Family and Community Member faculty member Dr. Manuel Tapia, has integrated a community-first approach in creating meaningful partnership between local San Francisco high schools and UCSF health professionals working at San Francisco General Hospital. Each summer for the past four years, the department has hosted 15 local students from John O'Connell High School, located a mere eight minute walk from the hospital, for a 3 week SUHLA program.

SUHLA's mission is to inspire youth from diverse backgrounds to invest in the health of their community; engage and empower youth through activities focused on mentorship and advocacy; strengthen and sustain relationships between SFGH and community partners; and increase diversity in the health workforce pipeline.

Students learn about social determinants of health while shadowing clinicians, design community projects on violence prevention, sustainable housing, and nutrition, and at the end of the summer showcase their work as advocates and agents of change by leading a community health and wellness fair in the garden of the SFGH Family Health Center. Program leadership applies an emphasis on health careers exploration and links students to mentors in the SFGH community.

As most family doctors will agree, "it's all about the relationships." SUHLA aims to build strong relationships with the youth in order to welcome them back for internship opportunities and additional academic mentoring. SUHLA emphasizes meeting students where they are, realizing that not all students will become doctors and nurses and promoting a student-centered pathway with exposure to diverse health careers.

Partnering with one or two schools ensures that SUHLA is able to build community and fortify bonds between teachers, program leadership and alumni to invest longitudinally in the SUHLA Family.

"Participating in SUHLA allowed me to see the real difference health professionals make into the lives of patients and inspired me to want to become the first person in my family to go to college and become a health professional ."

-Lilian Quijada

SUHLA Graduate

UC Berkeley Student

San Francisco Bay Area Collaborative Research Network

Under the direction of Michael Potter, MD, and program manager James Rouse Iñiguez, MA, MS, the San Francisco Bay Area Collaborative Research Network advances knowledge in family and community medicine builds partnerships between university-based researchers and community-based health systems that care for diverse communities. The San Francisco Bay Area Collaborative Research Network (SFBayCRN) has been actively supporting these partnerships since 1984. From its early phase within our department, SFBayCRN has grown to support the practice-based research mission of UCSF's Clinical and Translational Science Institute, with a steering committee representing all four of UCSF's professional schools and community-based health care organizations such as the San Francisco Health Network, Contra Costa Health Services, John Muir Health, One Medical Group, and Walgreens. Services provided by SFBayCRN include consultation on building successful research partnerships, assistance with research design and project implementation, and dissemination of research findings. SFBayCRN has provided nearly 100 consultations in the last 5 years, with many of these consultations leading to funded research, academic publications, or translation of evidence into sustainable clinical practice and population health innovation. The SFBayCRN Hypertension Data Collaborative identified common disparities in hypertension management in three bay area health systems,

demonstrating the feasibility and power of electronic data sharing to inform local and regional quality improvement initiatives. SFBayCRN research in colorectal cancer screening has informed strategies adopted by the SF CAN, a UCSF-led community partnership to reduce the burden of cancer in San Francisco.

SFBayCRN held its fourth annual stakeholder's meeting in the Presidio last May, showcasing exemplary practice-based research partnerships and highlighting new practice-based research priorities, such as the impending impact of cannabis legalization on clinical care. The meeting attracted a record of nearly 300 researchers, health care leaders, and policy makers from across the bay area. For more information visit SFBayCRN.

Active federally funded projects supported by ongoing SFBayCRN engagement include

Connection to Health (CTH):

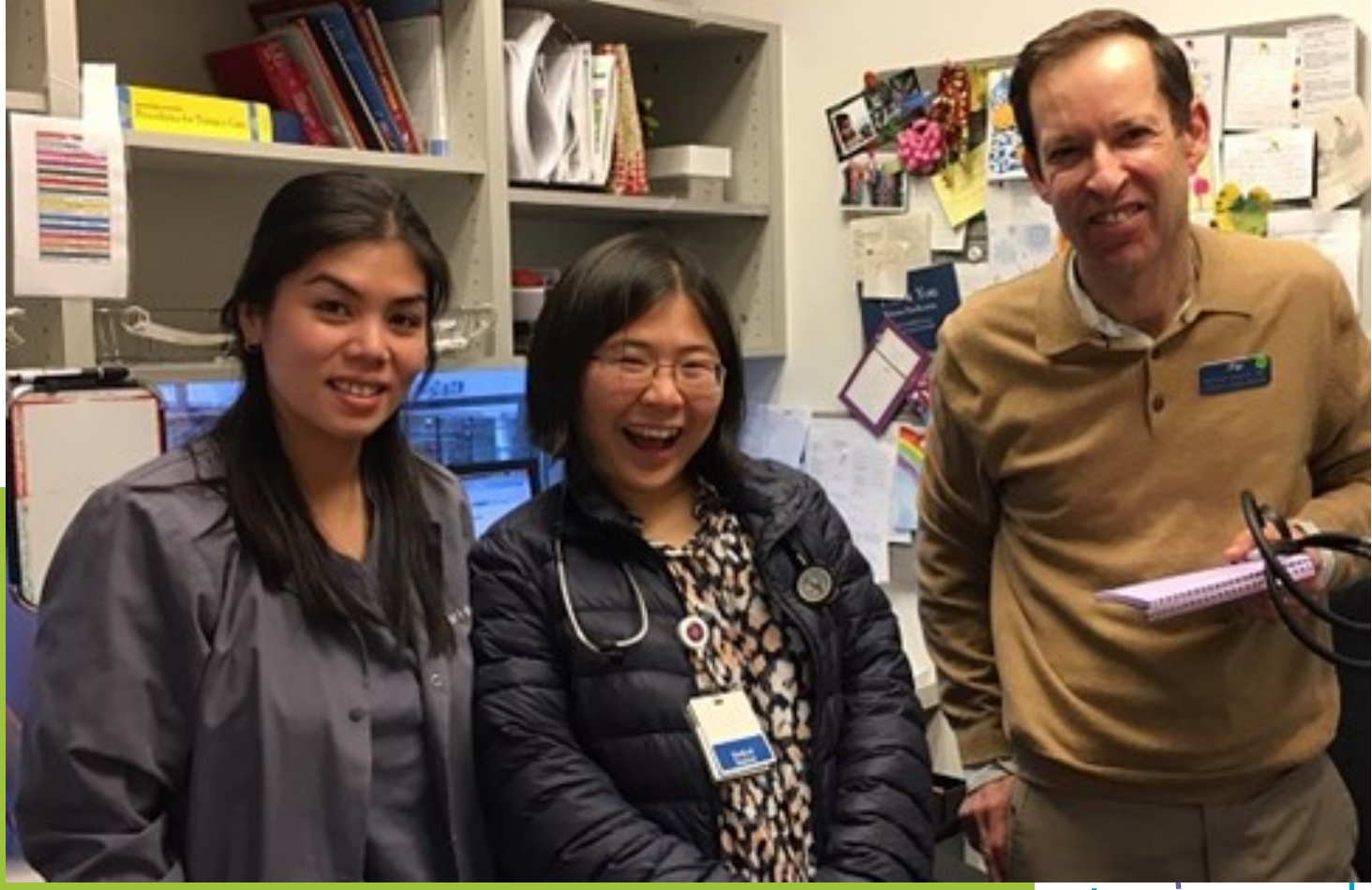
a 5-year program to test the effectiveness of web-based tools to facilitate patient-centered diabetes care in 13 community based clinics in 5 bay area counties

Sickle Cell Care Coordination Initiative (SCCCI):

a 6-year program to improve the care of adolescents and adults with sickle cell disease through regional collaboration focused on improved access to care, more effective medication management in primary care, and more effective pain management in emergency departments.

Pulmonary Specialist-Health Coach Consult Project (PuSHCon):

a 5-year program to test the effectiveness of trained health coaches to support better care for emphysema and asthma in San Francisco's community health centers.



Strengthening a Community of Practice to Reduce Family Medicine Clinician Burnout at UCSF Health

The work of being a family doctor is challenging. More than 60% of primary care physicians in the United States report high levels of burnout. The department's Center for Excellence in Primary Care helped put the concept of the "quadruple aim" into the national lexicon, with the fourth aim being joy in practice for clinicians and staff. Recognizing that much of burnout is rooted in a dysfunctional practice environment not structured or resourced to meet the demands of 21st Century primary care, the Center has advanced the model of the 10 Building Blocks of High Performing Primary Care to both improve the care of patients and the wellbeing of the people working in primary care. Foundational to the Building Blocks is a culture of teamwork and community within the practice.

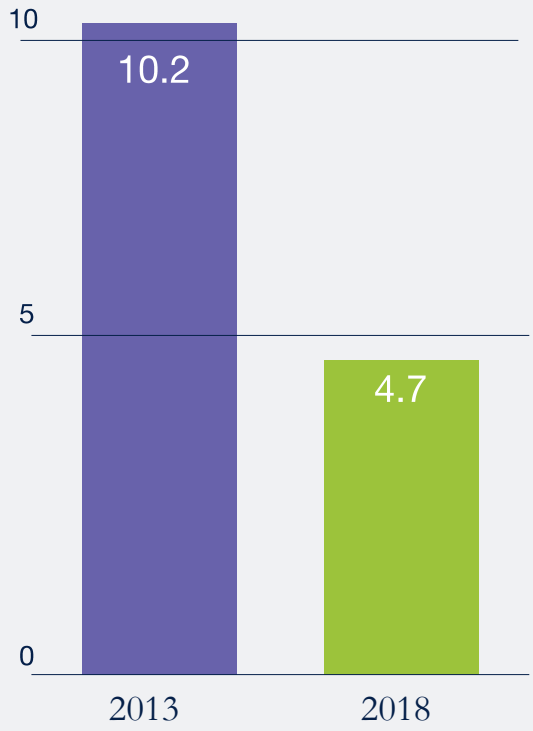
Family medicine practices at UCSF Health have made impressive strides in improving the practice environment and reducing burnout. One measure UCSF Health uses to assess physician experience is the "net promoter score," a scale ranging from -100 to +100 based response to the question, "How likely are you to recommend UCSF as a place for clinical work?" On the 2018 UCSF Health survey, the Department of Family and Community Medicine score of +34 was the third best score among the 21 clinical departments at UCSF. The UCSF Health Lakeshore Family Medicine Center

is where the majority of family physicians at UCSF Health practice, and is a case study in successful practice improvement. The net promoter score among physicians and nurse practitioners at Lakeshore increased from -22 to +57 from 2012 to 2018. There was comparable improvement on measures of burnout. For example, the "cynicism" burnout scale among Lakeshore clinicians decreased from an average of 10.2 in 2013 to 4.7 in 2018. (Cynicism is a 0-30 scale, with lower scores indicating less burnout.)

Lakeshore Medical Director Dr. Laura Hill-Sakurai believes that better teamwork has been a key ingredient in this improvement. Clinicians meet monthly for "practice inquiry" sessions, open-ended discussions in which clinicians can share their uncertainty about patient management. Structural changes have included pairing every clinician with a specific medical assistant in a "teamlet"model, with desks collocated to promote pre-clinic "huddles" about plans for the day's scheduled patients and ongoing communication throughout the clinic session. Lakeshore has been the first UCSF Health primary care clinic to participate in Lean improvement methods, resulting in simple but transformative changes such as "5S" procedures to ensure that all exam rooms always have the right medical supplies in the right place at the right time. UCSF Health has supported Lakeshore by providing scribe staff for high volume clinicians, to reduce the amount of time clinicians spend documenting in the electronic medical record.

The journey of practice transformation towards the quadruple aim is an ongoing one. The experience of the Lakeshore Practice demonstrate how strong teamwork and a sense of community among the people working at the practice are important elements of a successful journey.

Maslach Burnout Inventory Cynicism Scale



UCSF Lakeshore mean scores on 0-30 scale.

Encampment-Based Healthcare

Training Future Leaders in Low-Barrier Street-Level Care

Homelessness is one of San Francisco's most vexing public health issues, with about 7500 San Franciscans being homeless. In the Homeless Encampment Project, UCSF-SF General Hospital Family and Community Medicine residents and their faculty advisors collaborated with other UCSF students and residents to develop an innovative community-based program to bring services to homeless individuals. Although our residents are regularly tasked with caring for homeless patients in the clinic and hospital setting, they are not typically exposed directly to the environments where this population lives. Leaders in homeless healthcare within the SF Department of Public Health along with non-profit stakeholders facilitated healthcare events at encampment locations. UCSF residents and health professional students led multiple domains of the events, including patient care and linkage to primary care. Encampment health events were strategically held at large encampments where Homeless Outreach Team members identified a high burden of illness. Trainees provided testing and treatment for communicable diseases, including STIs and HIV, as well as pre and post-exposure prophylaxis, addiction

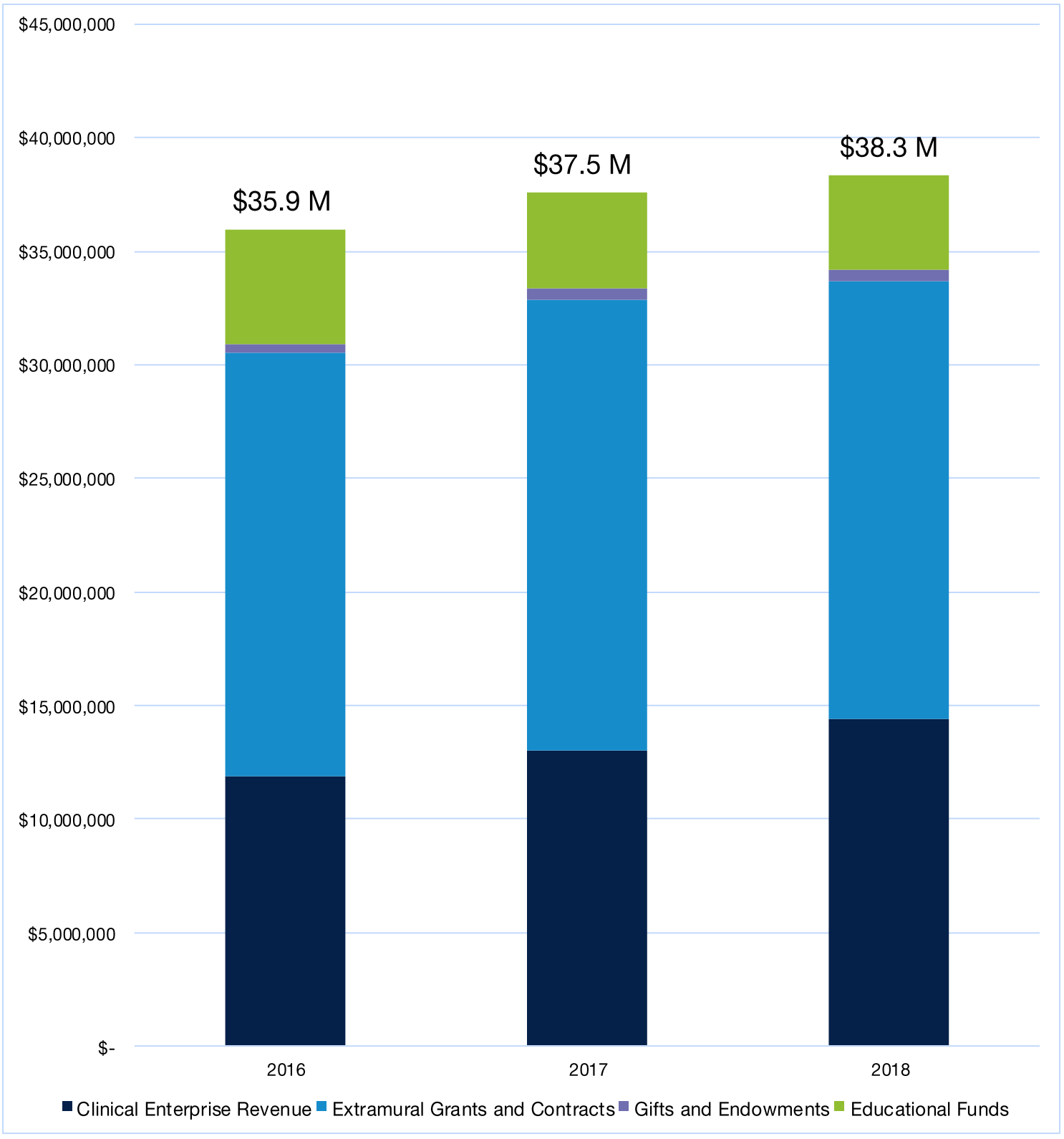
services, acute care, family planning, vaccination, and follow up coordination to more than 200 patients under the supervision of homeless healthcare expert attending physicians. In addition to bringing clinical services to the community outside the walls of a traditional clinic, the events successfully provided an opportunity for learners to build on-the-ground skills for providing care to patients living on the street. Ninety percent of participating students and residents surveyed after completing the experience stated that they would recommend the experience to other trainees.

90% Recommend this experience to other trainees

77% Report the learning experience improved understanding of barriers to care facing the SF homeless population

61% Report more comfort providing care to the SF homeless population, after participating in events

Annual Funding Trends



Faculty & Other Academics

Shelley Adler, PhD
Professor in Residence

Robert Bartz, MD
Assistant Clinical Professor

Thomas Bodenheimer, MD, MPH
Adjunct Professor

Paula Braveman, MD, MPH
Professor

Erica Brode, MD
Assistant Clinical Professor

Steve Bromer, MD
Adjunct Professor

Jordan Chase, MD
Associate Clinical Professor

Prescott Chow
Academic Coordinator III

Carolyn Chu, MD, MSc
Associate Clinical Professor

Daniel Ciccarone, MD, MPH
Professor of Clinical Family and Community Medicine

Diana Coffa, MD
Associate Clinical Professor

Kristen Day, MD
Associate Clinical Professor

Christine Dehlendorf, MD
Associate Professor in Residence

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Maggie Edmunds, MD
Assistant Clinical Professor

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Research Scientist

Lawrence Fisher, PhD
Adjunct Professor

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Sarah GaleWyrick, MD
Assistant Clinical Professor

Lauren Gannon, MD
Assistant Clinical Professor

Ronald Goldschmidt, MD
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Laura Gottlieb, MD, MPH
Associate Clinical Professor

Kevin Grumbach, MD
Professor

Monica Hahn, MD
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Rita Hamad, MD, PhD
Assistant Professor

Hali Hammer, MD
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Associate Professor

Laura Hill-Sakurai, MD
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Kelsey Holt, ScD
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Coleen Kivlahan, MD, MSPH
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Clarissa Kripke, MD
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Ina Park, MD
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James Park, MD
Assistant Clinical Professor

Christine Pecci, MD
Clinical Professor

Lealah Pollock, MD
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Adjunct Professor

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Jennifer Rienks, PhD
Associate Researcher

Diane Rittenhouse, MD, MPH
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Anjana Sharma, MD
Assistant Clinical Professor

Shira Shavit, MD
Clinical Professor

William Shore, MD
Adjunct Professor

Benjamin Smith, MD
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Margaret Stafford, MD
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Brianna Stein, MD
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Katherine Strelkoff, MD
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Naomi Wortis, MD
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Nghe Yang, MD
Assistant Clinical Professor

Orlando M, **Weber S,** Martinez R, Cohan D, Seidman D. Safer Conception and Contraceptive Counseling By Providers of Men Living With HIV in San Francisco. J Assoc Nurses AIDS Care. 2017 Nov - Dec;28(6):964-970.

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