

Primary
Care
Leadership
Academy

And **primarycare**
PROGRESS

Primary Care Showcase 2013

November 7, 2013

5:30-7:30pm

San Francisco General Hospital
Family Health Center
995 Potrero Ave, Building 80
San Francisco, CA

Agenda

5:30-6:00	Reception and poster viewing	Ward 85 Rm 505
6:00-6:15	Opening Remarks- Margo Vener and Beth Wilson	Ward 85 Rm 505
6:15-7:15	Presentations and discussion in conference rooms	
	• Clinical Care	Ward 85, Waiting Area
	• Practice Redesign/ Quality Improvement	Ward 85, Rm 505
	• Team-Based Care	Ward 83, Rm 319
	• Education + Global/Community Health	Ward 83, Rm 335
7:15 – 7:30	Introduction to Iora Health Elective- David Gellis	Ward 85, Rm 505
	Next Steps and Closing Remarks- Margo Vener and Beth Wilson	

PRESENTATIONS BY GROUP

CLINICAL CARE

Ward 85, Waiting Area

1. Clinical Interventions to Address Social Determinants of Health: Examples from Bay Area Safety-Net Hospitals	Abby Burns
2. Rethinking the HEADSSS Assessment	Lauren Ciszak
3. Improving Clinical Care for Commercially Sexually Exploited Children in Oakland	E. Maggie Dietrich
4. Piloting “Brief-Counseling Stress Reduction” in Primary Care: A Medical Student Quality Improvement Project at the UCSF Family Medicine Center at Lakeshore	Jacob Mirsky
5. Outpatient intranasal naloxone training and distribution to avert prescription opioid overdose at San Francisco Community Health Network clinics	Adam Visconti
6. Educational tools for clinicians to empower HIV-affected families, to foster healthy relationships	Hana Lim

PRACTICE REDESIGN AND QUALITY IMPROVEMENT

Ward 85, Rm 505

Facilitated by Brandon Perkovich

1. Center for Excellence in Primary Care (CEPC)’s Share-the-Care Model based on 10 Building Blocks of High Performing Primary Care	Sarah Colvario
2. Population Management as an essential component of high-performing primary care	Jennifer Wong
3. Seeking Continuity in Academic Practices	Kate Dube
4. Improving outcomes for heart failure patients in the CHN through patient education and reducing barriers to timely primary care access	Maya Overland
5. Patient and staff impressions on the utilization of Community Health Workers (CHW) in primary care settings in urban West Philadelphia.	Christopher Sha
6. Perceptions of high-risk patients and their primary care staff of the Patient-Centered Medical Home.	Christopher Sha
7. Using Cycle Time Observations for Practice Transformation	Shannon Satterwhite
8. Improving FIT Kit Return Rate Among African American Patients	Sonali Sheth

EDUCATION, GLOBAL & COMMUNITY HEALTH

Facilitated by Nat Gleason
Ward 83, Rm 335

Facilitated by Erica Brode

1. Integrating deaf and hard of hearing patients into the UC Berkeley-UCSF Joint Medical Program curriculum	Margot Brown
2. Innovation in Primary Care Education: A Nurse Practitioner's Perspective	Erin Bowman
3. Team Based Training: Second Year Nurse Practitioner Student's Perspective	Elda Kong
4. Projected Impact of the Primary Care Residency Expansion Program and Prospects for Sustainability	Rossan Chen
5. Jail Health: Bringing Peer Education to San Francisco Jails	Jordan Nahas-Vigon
6. Communitas: Using Mind-Body Medicine in a Group Setting for Teens with Chronic Illness	Milana PeBenito
7. Health Education Camps for Disabled Children in Rural India	Tuhina Srivastava

TEAM BASED CARE

Ward 83, Rm 319

Facilitated by...

1. Team-Based Care as an essential component of high-performing primary care	Claire Richardson
2. Health Coaching Primary Care	Camille Prado
3. How Do Peer Coaches Improve Diabetes Care for Low-Income Patients?: A Qualitative Analysis	Matthew Goldman
4. “I don’t see myself as a medical assistant anymore”: Learning to become a health coach, in our own voices	Adriana Najmabadi
5. Building team-based provider models in continuity clinic	Yamini Rao
6. Team structure and culture are associated with lower burnout in primary care practices	Kate Dube

ABSTRACTS

Clinical Care

Clinical Interventions to Address Social Determinants of Health: Examples from Bay Area Safety-Net Hospitals

Abby Burns, MDc, MSWc

Numerous studies have shown that social determinants of health are just as, if not more critical to mortality, morbidity, and health outcomes than health care access and genetic factors. Yet there is a lack of evidence on how to address the root causes of disease from within clinical systems. Interdisciplinary champions at Bay Area safety-net hospitals, including Highland Hospital, San Francisco General Hospital (SFGH), and Children's Hospital, Oakland (CHO) are launching coordinated research trials of innovative, tiered resource intervention programs. These programs harness the volunteer power of undergraduate and graduate students to provide social needs assessment and resource linkage for families seeking medical care. Each program has an affiliated medical-legal partnership (MLP) and social work support to provide more intensive interventions for families with complex needs.

As a medical and social welfare student, I have been involved in the design, implementation, and evaluation of these programs and have few takeaways to share.

(1) Collaborate with key stakeholders and pilot programs first. Understanding and working with clinical stakeholders is an important step of launching new programs. At both Highland and SFGH, getting input and buy-in from nurses, social workers, and physicians was critical to implementation success. Additionally, starting with smaller pilot interventions—fewer hours, volunteers, and narrower focus—helped with clinical integration and trouble-shooting at all sites.

(2) Evaluate rigorously. While teams at all sites struggled with the ethics of withholding full services in this setting, research is critical for demonstrating program impact. The intervention group gets case management while the control groups get a resource handout.

(3) Share tools and clinical roadmaps. The Highland program launched in March 2013, and lessons learned at that site have been shared and integrated into the development of the other programs. This has improved the quality of the intervention and also enabled faster growth across multiple sites through efficiency gains such as sharing intervention tools and joint volunteer recruitment and training. Our potential impact grows from sharing tools and collective action. In total, we have recruited 85 volunteers and expect to screen nearly 5,000 patients in the next two years across the sites.

Rethinking the HEADSSS Assessment

Lauren Ciszak

Because adolescents are a generally healthy population, it is increasingly recognized that screening them for a host of risk factors is appropriate and necessary virtually any time they present to primary care. In general, primary care for the adolescent should focus on the psychosocial and environmental factors that dominate their lives and have the most impact on their health. The HEADSSS assessment is a tool that helps physicians screen teens for a host of risk factors from safety to academics to sexuality and mental health.

As good as this tool is, when asking about drug and alcohol abuse, the HEADSSS assessment falls short. Though it asks about the teen's substance use and use of the teen's peers, it omits a critically important and predictive factor: exposure to use, family history. Because family history and age of onset of substance use are two of the most critical factors determining a teen's risk for future abuse and dependence, we are doing them a grave disservice by not asking this question. In addition, many adolescents living with substance abuse face violence, fear, responsibility beyond their years and social and educational consequences as a result. Though it may seem that we would catch some or all of those cases through the other HEADSSS questions, as we all know, in medicine, if you don't ask specifically about something, you may never find out.

In this project, I interviewed a small group (less than 10) of adolescents in an adolescent medicine clinic in Fresno, CA. The two resulting cases are illustrations of why asking about substance abuse in the home can be a critical aspect to caring for adolescents. Through these two cases, I argue that this question should be included in all formal HEADSSS assessments. Not only can it help prevent teens' substance abuse in the future by helping us identify those adolescents at increased risk, it can help us direct affected patients to support groups such as Al-anon, Ala-teen, or other social services. Though this is just a small project I hope and intend to continue it in a larger capacity into the future.

Improving Clinical Care for Commercially Sexually Exploited Children in Oakland

E. Maggie Dietrich

Background: Commercial sexual exploitation of youth is a major problem in nationwide, affecting an estimated 100,000 children in the U.S. each year, with an average age of entry of 12 years old. Native American Health Center (NAHC) is located on International Boulevard in Oakland, a street widely known as a major site of commercial sexual exploitation of youth. A number of community-based organizations focused on commercially sexually exploited children (CSEC) exist in Oakland, but fewer clinic-based programs have been established.

Intervention: We took a three-pronged approach to improve clinical care for CSEC at NAHC:

- 1) Build staff awareness about CSEC: We partnered with MISSEY, an organization in Oakland focused on this population, to provide a series of lectures for NAHC staff about CSEC and health issues commonly affecting them.
- 2) Develop streamlined protocols for rapid reproductive health visits at NAHC: We worked with clinic staff to develop a simple note template for drop-in visits with a chief complaint related to reproductive health (e.g., request for pregnancy or STI testing, request for birth control refills, or request for birth control counseling), designed so that any patient seeking reproductive health care would consistently have as comprehensive a drop-in visit as possible. This template will be used with all female patients, with the idea that it will also better serve CSEC who visit clinic.
- 3) Develop age-appropriate health education materials targeted toward the self-identified needs of CSEC: We investigated what teen-appropriate health education materials and curricula are currently available, and we modified existing materials to better suit an audience of teen girls. We hope that some of the materials we found and created will be used in the future at MISSEY and NAHC.

Current Status and Next Steps: In collaboration with MISSEY, NAHC completed a three-part lecture series for staff about CSEC. The note template we created for rapid reproductive health visits is currently in use at NAHC. NAHC is now a referral clinic for MISSEY, and we hope to conduct a formal reproductive health and health care survey among MISSEY clients in order to better inform clinical practice at NAHC and beyond.

Piloting “Brief-Counseling Stress Reduction” in Primary Care: A Medical Student Quality Improvement Project at the UCSF Family Medicine Center at Lakeshore

Jacob Mirsky, MA (MS3) and Laura Hill-Sakurai, MD

The burden of patient stress in primary care is staggering, with up to 80% of primary care visits including a stress-related component and almost half of Americans reporting increased psychological stress over the past 5 years. Surprisingly, primary care providers devote less time counseling for stress management than nutrition, physical activity, weight reduction, or tobacco cessation. The effects of stress are likely profound given the high incidence of mental illness in the United States.

Complementary and alternative approaches to stress reduction have grown in popularity recently. Several studies demonstrate the benefit of "Mindfulness-Based Stress Reduction," a clinically standardized meditation technique taught in a classroom setting, in both patient populations and healthy people. Recently, the effect of single-session meditation training was shown to reduce stress in healthcare workers. To our knowledge, the benefit and feasibility of standardized stress

counseling in the primary care setting has not been assessed. We have created a “Brief-Counseling Stress Reduction” (BCSR) technique involving yoga breathing, which takes approximately 3 minutes to discuss with patients. Our QI project goals are 1) to assess provider's opinions on BCSR, 2) to gauge patient interest in BCSR, and 3) to evaluate the feasibility of BCSR in the primary care setting. We will present preliminary results from our needs assessment and a plan to investigate feasibility. We envision BCSR as an integral component of future team-based approaches to managing psychosocial disease in the primary care setting.

Outpatient intranasal naloxone training and distribution to avert prescription opioid overdose at San Francisco Community Health Network clinics

Adam Visconti, Mat Kladney, Victoria Chu, Elisabeth Powelson

Context and Objective: During 2010, prescription opioid overdoses were responsible for 4,441 emergency department admissions and 158 unintentional overdose deaths in San Francisco. The Community Health Network serves a sizable number of chronic pain patients on routine opioid analgesic therapy and are at high risk for overdose. Naloxone has been successfully distributed in San Francisco to at-risk individuals for over 10 years, but never on an outpatient basis for prescription opioid overdose.

Intervention/Study Design: In conjunction with clinic coordinators, city pharmacists, and an existing naloxone distribution program, training was developed for medical providers to identify individuals at-risk for opioid overdose and provide them naloxone prescriptions. A 25-minute presentation was developed for medical professionals at each clinic. This included guidelines on identifying at-risk patients, clinical scenarios, scripts for discussing opioid overdose, and instructions on how to train patients to use naloxone. Clinics were given kits for providers that included an intranasal distribution atomizer, an informative brochure for patients, and instructions on how to prescribe naloxone. Outreach material was developed to inform patients on the risk of opioid overdose and information about naloxone.

Outcomes/Results: For the project, twelve training presentations were conducted for medical providers, nurses, and allied health staff at the community sites. On-site provider counseling were completed at General Medicine Clinic to assist medical providers in clinical discussions with patients about naloxone prescriptions and opioid overdose. Over three hundred individuals receiving chronic opioid prescriptions will receive mailings discussing opioid overdose and information about naloxone prescriptions. The project was continued as the NOSE project by the Department of Public Health which is currently rolling-out trainings and naloxone distribution to all DPH run clinics.

Conclusions: Intranasal naloxone is a safe, inexpensive, and cost-effective means to avert the growing problem of opioid analgesic overdose. Medical providers can be trained to identify at-risk patients and prescribe naloxone given active support from

clinic directors, a coordinated training schedule, and established reimbursement for naloxone prescriptions.

Educational tools for clinicians to empower HIV-affected families, to foster healthy relationships

Hana Lim, Mina Matin, MD

Purpose and Objective: The Family Health Center's Family HIV Clinic (FHIVC) at San Francisco General Hospital needs educational tools for empowering HIV-affected families to protect HIV-negative partners, and to decrease stigma and secrecy from children. Educational tools explaining the risk of HIV transmission between serodiscordant couples per specific sexual act, respective protective measures, and discussions of disclosure are not readily available in simple language.

Setting/Populations: The FHIVC fosters healthy beginnings for infants born to HIV-positive parents. These families routinely have concerns about the risk to HIV-negative partners and their children. Many HIV-positive patients, and especially women, lack a sense of community in living with a communicable chronic illness, and seek guidance from their providers for navigating relationships in their families.

Methods: We created educational brochures as visual tools to aide discussions during patient visits. We used lay language and accessible imagery to aide clinicians in starting open discussions with patients and families. Brochures describe the risk per sexual act, including cartoons to quantify risk, and discuss risk-reduction with condoms, circumcision, and antiretroviral medications. Additional pamphlets include evidence-based information for guiding parents in discussing their HIV status with their children, outlining steps for disclosure and anticipate children's questions.

Outcomes/Results: The FHIVC providers routinely facilitate open discussions between HIV-positive persons and their families. The educational tools we developed may help to achieve higher rates of disclosure to partners and children, and help us to foster healthier relationships. We plan after intervention analysis of indicators that can extrapolate a change in planned disclosures. Before and after intervention questionnaires will be used quantify on a scale of 1-5 the patient's sense of comfort with talking to family, friends, partners, about their HIV-status. A secondary goal will be improvement of medication adherence by measuring before and after intervention HIV viral loads.

Conclusions: Systematic review of global literature shows that planned disclosures empower patients and families for building healthy relationships [AIDS Behav. January 2013, Volume 17, Issue 1, pp 369-389]. If helpful for patient-centered care, our newly created FHIVC resources can be exported to other community clinics caring for HIV-affected families.

Education & Community Health

Integrating deaf and hard of hearing patients into the UC Berkeley-UCSF Joint Medical Program curriculum

Margot Brown, M.S.

Approximately 36 million American adults report some degree of hearing loss and three out of 1,000 children will be born deaf or hard of hearing. Although hearing loss impacts a significant number of people, medical students and practicing physicians are often not educated regarding how to provide effective and culturally appropriate healthcare to this population. The UC Berkeley-UCSF Joint Medical Program (JMP) utilizes a problem-based learning curriculum and currently does not have cases that feature patients with deafness or hearing loss. Accordingly, I am working with JMP faculty and members of the deaf community to revise two cases from the first year JMP curriculum. These cases will incorporate some of the many communication and access barriers that deaf and hard of hearing patients face when attempting to seek medical care. The revised curriculum will be piloted to the current first year JMP class in the spring of 2014. The goal of the project is to increase awareness of the challenges that patients with hearing loss face and to stimulate discussion about providing medical care to this population within the problem-based learning environment. Students will complete a short survey after concluding the cases to assess the effectiveness of the revised curriculum.

Innovation in Primary Care Education: A Nurse Practitioner's Perspective

Erin Bowman, RN, NP

In 2011, the San Francisco VA was awarded one of five Centers of Excellence in Primary Care (CoEPC or COE) to develop new models of teaching and interprofessional team-based, patient-centered care. Building on the VA's model of a medical home called Patient Aligned Care Teams, (PACT), the COE designed "EdPACT" for the UCSF internal medicine residents and 2nd year NP students. Residents and NP students serve as clinical team leads for their PACT team, which includes an RN, LVN, and a clerical associate. This experiential training not only improves care for veterans, but also equips trainees with greater role clarity and an in-depth understanding of team-based care. EdPACT also provides curricular theme months with four key domains, reflective of national standards for the patient-centered medical home. These domains are:

- Interprofessional Collaboration
- Patient-Centered Communication & Shared Decision-Making
- Sustained Relationships
- Practice Improvement

In addition to the resident/NP student training, EdPACT offers a unique opportunity to newly-graduated nurse practitioners. The NP Fellowship (NPF), a one-year post-graduate fellowship, is one of few offered in the country and is gaining ground in academic and national standards committees. With just 2-3 years of clinical training, new NP graduates often feel unprepared to practice given the demands of a full-time primary care job that usually lacks the mentorship and consultation they received as students. The NPF offers an opportunity to practice in real-time within the EdPACT team-based interprofessional model. The NP Fellow practices under attending mentorship (like medicine fellows) and have twofold goals: to improve clinical skills and independence and to learn leadership skills by working with program faculty to implement the EdPACT curriculum.

This presentation will provide an overview of EdPACT with a special emphasis on the role of the NP Fellow. Using my personal experience during NPF year, I will review the role transition from NP student to Fellow and provide an overview of scholarship activities (leading QI curriculum, group visits, new programs). Lastly, I will share insight on my role as part of a PACT at the Downtown Homeless VA Clinic as an example of how this model benefits delivery of care (or systems), clinical training (trainees), and patients.

Team Based Training: Second Year Nurse Practitioner Student's Perspective

Elda Kong

The San Francisco VA Medical Center (SFVAMC) is one of five designated Centers of Excellence (COE) in Primary Care Education. Using the VA medical home model as a foundation to deliver primary care to patients the SFVA COE focuses on providing an interdisciplinary approach through patient aligned care teams (PACT). The COE created Education in Patient Aligned Care Teams (EdPACT) in 2011, a 5 year pilot program to design, implement, and evaluate a curriculum that trains second year internal medicine resident physicians and second year nurse practitioner students in the five functions of the patient centered medical home: Comprehensive care, Patient centered care, Coordinated care, Accessible services, Quality and safety (Agency for Healthcare Research and Quality, 2013).

The curriculum is based on experimental training and classroom-based exercises. In the VA PACT, the team consists of one primary care provider, one RN, one LVN and a clerk. Under EdPACT, the PACT uses the model of two 2nd year internal medicine residents and one 2nd year nurse practitioner (NP) student to fill the role of primary care provider. Creating this unique team based training highlights EdPACT measures of role clarity, effective interprofessional education, improved patient communication, and improved panel management and patient satisfaction.

To foster the experimental training, the didactic aspects of EdPACT focuses on improving clinical knowledge, written and verbal patient and interprofessional

communication, and system wide quality of care. Aside from the clinical and interprofessional team development skills, EdPACT provides opportunities for real time team based primary care and engagement in quality improvement projects throughout the year.

This presentation will provide a brief overview of EdPACT through a NP student's experience. The presentation will look at this redesign in team training, the role and value of the NP student within this team setting, and the influence of EdPACT on an NP student's overall clinical practice. I will highlight how the PACT model at a homeless VA clinic, which includes mental health, pharmacy, and social worker professionals/trainees, has greatly influenced my training in delivering care to high risk, vulnerable populations – an insight that has been invaluable for my career.

Projected Impact of the Primary Care Residency Expansion Program and Prospects for Sustainability

Rossan Chen, MD MSc

Purpose: To project the impact of the Primary Care Resident Expansion (PCRE) program using historical trends in graduate placement and evaluate the prospects for sustaining the expanded residency positions beyond the expiration of the grant in 2015.

Methods: The authors projected the numbers of PCRE funded residents who will enter practice in primary care, health professional shortage areas (HPSAs), and rural areas by primary care discipline using historical trends in graduate placement. The authors also administered an online survey to the program directors of the 78 active primary care residency programs that had received the PCRE grant to assess the impact of the PCRE program and their plans for sustaining the expansion beyond the grant.

Results: The PCRE program will support the training of 900 new residents, of which 601 are projected to practice primary care, 218 are projected to work in HPSAs, and 67 are projected to practice in rural areas. The survey response rate is over 50%.

Conclusions: Current projections of the supply and distribution of primary care physicians fall vastly short of the anticipated need as health care utilization continues to climb due to an aging, expanding, and newly insured population. The PCRE program is an example of a targeted approach to increasing the numbers of primary care residency training positions. The results highlight the potential impact of directed investment in primary care residency training, with family medicine residency programs representing the highest return on investment for production of physicians working in primary care, HPSAs, and rural areas. Survey results found that many PCRE funded residency programs established new primary care and rural health tracks, added new clinical rotations in underserved areas, and enhanced the

allure of primary care careers through curriculum innovations. Most PCRE residency program directors do not have funding secured to continue to support the expanded residency positions, resulting in a loss of significant numbers of new primary care physicians being trained every year. Future directions in GME funding should focus on programs that have a proven track record of producing physicians working in shortage areas to better align taxpayers' investment in physician training with society's pressing health care needs.

Jail Health: Bringing Peer Education to San Francisco Jails

Jordan Nahas-Vigon

Incarcerated men and women are a vulnerable population, with many risk factors for multiple diseases, from hypertension and diabetes to sexually transmitted infections. Many inmates participate in risky health behaviors before, during and upon release from incarceration. Health education is essential to increase inmate knowledge of disease and prevent transmission of sexually transmitted infections in prisons and jails, as well as to improve safety upon release from incarceration. Many inmates are curious about their health and about the diseases affecting their family, friends and communities, but aren't aware of, or don't have access to, the appropriate resources to gain this information. Any intervention in prisons or jails can have a much broader public health impact.

Education serves multiple purposes in the correctional setting, and numerous studies of educational programs--whether in the form of GED, college credit or vocational training--have shown that they reduce the rate of recidivism. I would like to establish peer health education program in the San Francisco jails to combine the goals of health education and correctional education. There are established peer education programs in some prisons, and although the shorter sentences in jail compared to prison can make establishing peer educators more difficult, the model can still be effective. The high turnover may serve to increase the number of health educators that are trained and released back into the community..

Establishing a peer health education program in the San Francisco jails would benefit the inmates by increasing their knowledge and hopefully decreasing risky behaviors. Additionally, training health educators would allow inmates to leave jail with a new skill set and--if it is like other correctional education programs--would decrease recidivism.

Communitas: Using Mind-Body Medicine in a Group Setting for Teens with Chronic Illness

Milana PeBenito, MS3 / Brittany Blockman, PGY2

Communitas is a pilot program for adolescents living with life-altering chronic illness and their families. The mission of this program will be to meet some of the unmet

needs of underserved San Francisco Bay Area teens living with chronic illness and their families by:

- Empowering them with mind-body skills to improve coping and reduce illness-associated stress and mental distress, with the ultimate goal of fostering resilience in the face of adversity.
- Facilitating peer support and sharing to promote engagement with a diagnosis, emotional support, self-awareness, and a sense of connectedness.
- Encouraging creative expression through storytelling to discover the meaning in an illness experience.
- Providing a forum for discussion of the more practical aspects of navigating the health system and chronic illness during the transition from adolescence to adulthood.

The program will provide a five-month workshop that meets twice per month (10 sessions total), serving approximately 12-15 families during the initial pilot. The workshops will consist of a didactic lesson on a mind-body technique, an experiential exercise, and an opportunity for sharing in a group. The techniques taught will include: relaxation techniques, biofeedback, meditation, breathwork, mindfulness, positive reappraisal, guided imagery/visualization, movement, journaling, mindful nutrition, forgiveness/gratitude, storytelling through images. The emphasis will be on self-care techniques that can be practiced anywhere. This group will serve to nourish and support connections between those who are sharing a similar experience and to provide educational, support, and creative outlets for families.

The research aims are:

- 1) Investigating the preliminary effects of the Communitas program on perceived stress, unwanted symptoms, overall well-being, coping, and positive and negative affect in a sample of adolescents living with chronic illness.
- 2) Examining the preliminary effects of the Communitas program on self-management, adherence to medical regimens, as needed pain and symptom-control medicine usage, and unplanned visits to hospital, specialty physician or primary care doctor for an issue related to their chronic illness.
- 3) Determining whether proximal improvements in self-care, overall well-being, stress, affect, and coping are related to improved distal health outcomes, such as illness trajectory.

Health Education Camps for Disabled Children in Rural India

Tuhina Srivastava

Health education camps for disabled children were developed in Anandwan, Maharashtra, India, a sustainable commune for leprosy patients and others with disabilities. The idea formed when we witnessed mundane general health presentations given there by visiting doctors. Children ages 4-13 were put in a room together and talked to about really broad concepts that they did not all understand. The students soon got bored and became restless. In order to remedy this, we developed camps that were organized into hour-long seminars that used tactile diagrams and visual aids in order to educate them appropriately and effectively. The camps were first introduced in the summer of 2012, and the topics covered were hygiene, first aid, and nutrition. Volunteers went to India, and over a two-week period children were divided into different age groups and presented with material they would understand. We created an interesting curriculum and fun activities to engage the children in the material, and the response was encouraging. The kids were excited to participate in the activities and willing engaged with the material. They even received small health kits and certificates of completion at the end of the camps.

In light of all the recent media coverage of sexual assault in India, sexual health is also being integrated into these camps. The blind and deaf schools lack the proper models and know-how to effectively teach the children the difference between a “good” or “bad” touch, and we plan to work with resource centers for those with disabilities to find the best way to structure these camps.

There are multiple tools we use to measure the success of our camps: the number of children attending the camps, the amount of audience participation, the surveys given to children and administrators after the seminars, and the frequency of people seeking help. This will help us gauge the breadth of our outreach and show us how engaged the children are in the content and activities. Surveys will help us quantify how much information the children absorbed from the seminars, and using this information we can better tailor our efforts in the future.

Practice Redesign/Quality Improvement

Center for Excellence in Primary Care (CEPC)'s Share-the-Care Model based on 10 Building Blocks of High Performing Primary Care

Sarah Colvario*, Jennifer Wong, Claire Richardson, Amireh Ghorob, Nwando Olayiwola, and Tom Bodenheimer / *for sure will present, others may accompany

Primary Care in the US is undergoing a transformation. The Center for Excellence in Primary Care (CEPC) has developed the Share-the-Care Model based on 10 Building Blocks of High-Performing Primary Care. This presentation will share an overview of

what the 10 Building Blocks are, how they were identified as principles from high-performing primary care sites, and how CEPC helps San Francisco safety net clinics implement any of the Building Blocks in the process of Practice Transformation.

Population Management as an essential component of high-performing primary care

Jennifer Wong*, Claire Richardson, Sarah Colvario, Amireh Ghorob, Nwando Olayiwola, and Tom Bodenheimer

Primary Care in the US is undergoing a transformation. The Center for Excellence in Primary Care (CEPC) assists San Francisco Safety Net clinics in implementing 10 Building Blocks to become high(er)-performing and more patient-centered. One of the ways we do this is train and provide support to clinical staff on Population Management. Population management involves providing appropriate services to subgroups within a population, a population refers to all patients assigned to a clinic, team, or a provider (not just those patients who come in for an appointment). There are three levels of population management: panel management, self-management support (or health coaching), and complex care management. We will briefly explain what population management is, provide concrete examples of how the three components of population management are implemented in practice in real primary care clinics, and why it is so important for primary care.

Seeking Continuity in Academic Practices

Kate Dubé, Reena Gupta, Janhavi Athavale

Introduction: Continuity of care, one of the building blocks of high-performing primary care, is associated with improved preventive and chronic care, higher patient and clinician satisfaction, and lower costs. Academic clinics face significant challenges to maintaining continuity of care due in part to a continual rotation of trainees and an often large proportion of part-time faculty clinicians. Continuity of care is critical to engaging trainees to pursue careers as generalist practitioners, as well as to providing effective care to the large populations of patients who seek care at these sites. This study sought to identify promising practices to improve continuity among academic health centers.

Methods: We conducted site visits at ten primary care residency clinics using a structured site visit guide as well as semi-structured interviews with clinic leadership and staff. Site visit reports were analyzed using iterative analysis by two independent members of the research team.

Results: We identified two main models aimed at improving continuity of care in the academic clinic setting. One model includes a team continuity anchor who is in clinic

full-time or almost full-time, in most cases a nurse practitioner (NP) or physician assistant (PA), who co-manages a panel of patients with several resident or faculty physicians and acts as the continuity anchor on the team. A second model consists of resident practice partners with paired schedules who see and follow-up on their shared patients when one resident is not in clinic.

Conclusions: Clinicians in academic teaching centers face numerous challenges to maintaining continuity of care with their patients. Team-based care models using either a full-time clinician or a practice partner system are two identified methods of improving continuity in this setting. More research is needed to assess how these models impact continuity rates and how other high performing academic clinics promote continuity within the complex framework of a teaching institution.

Improving outcomes for heart failure patients in the CHN through patient education and reducing barriers to timely primary care access

Maya Overland, Richard Santana, Michelle Schneidermann, Christopher Barnett

Over 1 million patients are hospitalized each year with a primary diagnosis of heart failure, with over 20% returning for readmission within the first 30 days after discharge and over 50% readmitted within the first 6 months. Studies have shown that several discrete socioeconomic risk factors (including poverty, education, and living situation) are associated with higher readmission rates, identifying the post-discharge environment as an important target for interventions to reduce unnecessary readmissions. Readmissions place a heavy burden on the patient as well as the healthcare system and hospitalizations for worsening heart failure are associated with a substantially higher risk of mortality. We are developing a dedicated management program aimed at improving outcomes for the sickest heart failure patients in the CHN.

Our interventions focus on increasing patients' understanding of their illness and encouraging early contact with primary care. In an attempt to reduce barriers to timely access to care, we provide patients with self-monitoring tools to identify early symptoms of a heart failure exacerbation and with scripts for calling their primary care providers. Based on materials developed at the Cecil G. Sheps Center for Health Services Research at UNC Chapel Hill, we generated low literacy level patient education materials in English, Spanish, Cantonese and Mandarin that are tailored to our patient population in the San Francisco CHN. As part of a broader effort by the SFGH Transitions Team, we are currently targeting patients admitted to the Cardiology, Family Medicine, and Internal Medicine services with a diagnosis of heart failure. The Transitions RNs use motivational interviewing and teach-back techniques to assess patients' post-hospitalization needs, create a personalized discharge plan for each patient, and follow up by phone after discharge. Any issues identified during follow-up conversations are communicated to the patient's primary care provider. We are optimizing our efforts at SFGH using rapid cycle outcomes analysis and, once

we have identified an effective combination of interventions to reduce ED visits and readmissions, we will distribute our materials to other clinics in the CHN with the goal of improving outcomes for heart failure patients throughout the safety net.

Patient and staff impressions on the utilization of Community Health Workers (CHW) in primary care settings in urban West Philadelphia.

Christopher Sha

The Patient-Centered Medical Home has become a term commonly known within medicine, and has been noted to be a model that provides care that is "accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective." (AAFP 2007) Understandably, this model functions better when healthcare systems have close relationships with the community, are cultural competent, have continuity of communication between providers and patients, and engage patients directly in their disease management. (Brownstein 2011)

We conducted a qualitative study of 21 patients and 30 clinic staff from four primary care practices in West Philadelphia, to elicit feedback on a planned intervention involving Community Health Workers (CHWs), and to identify barriers and facilitators to a positive clinic experience for low-income, high-risk patients. We were interested in exploring the possible benefits CHWs could have on a clinical team and patient care from both the patient perspective as well as that of clinic staff.

Overall, patients and clinic staff were encouraged by the possibility of adding CHWs to the clinical care team, and noted the potential to improve patient outcomes and experiences within the health system. CHWs were perceived as a positive intervention that would not only assist patients with obstacles, but could also teach sustainable methods of problem solving to allow patients to become more self-sufficient. CHWs were also seen as a possible bridge between patients and providers and as a source of surveillance for new issues arising, which could help ameliorate an inherent mistrust likely rooted in miscommunication between patient and provider, as well as a general lack of information. Lastly, CHWs are poised uniquely in positions because their knowledge of community resources can be more extensive and relevant than a medical practitioner's knowledge. In an era with increasing complexity of care, decreased numbers of primary care providers, and limited resources, our study supported the idea that CHWs may provide a very necessary and incredibly insightful connection between patients and providers.

Perceptions of high-risk patients and their primary care staff of the Patient-Centered Medical Home.

Christopher Sha

In 2007, four primary care physician specialty societies, representing 333,000 physicians announced the joint principles of the patient-centered medical home (PCMH). Five of these principles –enhanced access, continuity, physician-led teams, whole-person care, and coordination – were intended to improve the experience and value of care, particularly for high-risk patients with chronic conditions. However, PCMH principles were developed and operationalized under the leadership of providers with less input from the patients they were intended to benefit. While several studies examine the perspectives of providers and primary care practice staff on PCMH implementation, only a handful of studies explore the patient perspective. It is possible that patients have different mental models of the PCMH principles than the primary care staff responsible for their operationalization. This disconnect may explain why, six years into a widespread movement of primary care redesign, the evidence for PCMH’s impact on patient experience is mixed.

We wanted to triangulate perspectives of high-risk, chronically-ill patients with those of their primary care practice staff in order to explore areas of agreement and tension between these two groups of PCMH end-users. We were interested in understanding end-users’ perceptions of the PCMH principles themselves, and on the strategies that have been used to operationalize the principles thus far.

In this qualitative study of low-SES, chronically-ill patients and their primary care practice staff, we observed three findings that will likely influence whether or not PCMH principles have their intended effect. First, our study confirmed the importance of timely access to care to a high-risk patient population, however this concept often was constrained within study practices, forcing a trade-off: delayed access to one’s actual personal physician or timely access to an unknown provider. Second, our study raises concerns that operational strategies designed to enhance access –such as online portals and same-day scheduling—were actually decreasing access for low-SES, chronically ill patients. Third, practice staff want high-risk patients to obtain acute care in primary care clinics, rather than the ER, however these clinics are often ill-equipped to actually handle sub-acute complaints, necessitating an ER visit anyways.

Using Cycle Time Observations for Practice Transformation

Shannon Satterwhite

The purpose of this presentation is to outline the methodology of cycle time observations and potential uses of cycle time data. In July and August of this year I volunteered with the Center for Excellence in Primary Care (CEPC), conducting cycle

time observations in community clinics with which CEPC collaborates. I collected data in three clinics, including two pediatric primary care clinics and one adult clinic. Two of these practices were resident clinics.

Observations were conducted by following patients through an entire visit from check in to check out and recording the length of each stage of the visit. I also recorded qualitative observations regarding points of delay or efficiency in the clinic workflow. Data from these observations were submitted to each clinic and will hopefully serve as a tool for increasing visit quality and efficiency and reducing wait times. In this presentation, I will define “cycle time” and outline the purpose and methodology of cycle time observations. I will also present a sample cycle time report. I will conclude by offering some examples of opportunities for practice improvement uniquely highlighted by this approach.

Cycle time observations are a useful tool in primary care innovation and practice improvement. They are also an excellent opportunity to include patients and interested health sciences or pre-health students and volunteers in the improvement process. By sharing this work at the Primary Care Showcase, I hope that other clinics will consider using this approach.

Improving FIT Kit Return Rate Among African American Patients

Sonali Sheth (Jiajia Zhang, Allen Seoul, Michael Melgar, Aidan Tain, Nicole Betenia, Chloe LeMarchand, Molly Elmer-Dewitt)

Purpose: Colon rectal cancer is the third leading cause of cancer in the United States. Screening has shown to reduce morbidity and mortality associated with disease. Kaiser Permanente employs annual at-home Fecal-Immunochemical Test kits as the primary CRC screening modality, providing a less invasive test that improves screening in patients who would otherwise go unscreened.

Disparities in screening, however, exist. Our project addresses barriers of CRC screening in African American population at Kaiser East Bay, which data shows has a 5% reduction in FIT return rate, and aims to increase screening.

Significance: African Americans are at increased risk for CRC compared to the general population. Increasing screening in this group would improve cancer prevention and progression.

Design/Background/Rationale: Our initiative began with case reviews of patients diagnosed with cancer via FIT screening. We deepened our understanding of possible system failures and root causes of each incidence of CRC that could have been prevented with adequate screening. We identified barriers to screening via interviews, data review, and research, which led us to investigate the regional and local FIT distribution process.

Our findings suggest a multifactorial cause of reduced screening in African Americans, including but limited to: unclear FIT instructions, reduced patient buy-in for CRC screening, and inadequate staff education and training.

Methods/Description: Our team will implement changes in one Internal Medicine clinic. This would allow us to measure FIT return rates due to our initiatives in comparison to other Internal Medicine clinics.

Our plan: 1. FIT contents-replace written instructions with graphics to improve comprehension.

2. Training- educate staff on CRC screening protocols and appropriate FIT education for patients. Develop incentive program for staff member with most FIT returns.
3. Publicity-create posters for the Kaiser campus and streamline take-home education material for at risk patients after each clinic visit.

Conclusions: We expect to see increased FIT return rates among African Americans belonging to our Internal Medicine clinic with the hopes of implementing our changes across Kaiser.

Team Based Care

Team-Based Care as an essential component of high-performing primary care

Claire Richardson*, Jennifer Wong, Sarah Colvario, Amireh Ghorob, Nwando Olayiwola, and Tom Bodenheimer

Primary Care in the US is undergoing a transformation. The Center for Excellence in Primary Care (CEPC) assists San Francisco Safety Net clinics in implementing 10 Building Blocks to become high(er)-performing and more patient-centered. One of the ways we do this is training and providing support to clinical staff on implementing Team-Based Care. Teams include clinicians, medical assistants, registered nurses, front desk personnel and behaviorists. All members of the team are responsible for the quality of patient care. Effective teams rely on core values: an explicit vision and clear principles, the same members working together almost every day in a shared space, defined workflows, established channels of communication, training and cross-training to build skills, ground rules, and clinician-approved standing orders for routine medical issues. This presentation will describe the rationale and role of team-based care in achieving high-performing primary care.

The effectiveness of medical assistant health coaching for low-income patients with uncontrolled diabetes, hypertension, and hyperlipidemia: a randomized controlled trial

Prado C, Willard-Grace R, DeVore D, Chen EH, Hessler D, Bodenheimer T, Thom DH

Context and Objective: Many patients with chronic disease do not reach goals for management of their conditions. Medical assistant health coaching is an innovative way to provide self-management support through team-based care, particularly in the safety net, but most studies to date lack statistical power or methodological rigor. This study examines the effectiveness of health coaching by medical assistants on clinical outcomes and patient self-management.

Setting/Populations: A total of 441 patients from two San Francisco primary care safety net clinics were enrolled and randomized to receive a health coach (n=224) or usual care (n=217).

Intervention/Study Design: This randomized controlled trial evaluated the effectiveness of clinic-based medical assistant health coaches to improve clinical outcomes and self-management skills among low-income patients with uncontrolled type 2 diabetes, hypertension, or hyperlipidemia. Patients participating in the health coaching group received coaching for 12 months from medical assistants trained as health coaches. The primary outcome was a change in hemoglobin A1c, systolic blood pressure, or LDL cholesterol among patients with uncontrolled diabetes, hypertension and hyperlipidemia, respectively. Self-management behaviors and chronic disease self-efficacy were measured at baseline and after 12 months.

Outcomes/Results: The primary outcome was a composite measure of glycemic control, cholesterol, and systolic blood pressure. At the end of the study period, 46.4% of health coaching patients, compared to 34.3% of control patients, met clinical goals for at least one measure for which they were previously above goal (p=.02). Among patients who had poor glycemic control at baseline, 48.6% of health coaching patients compared with 26.6% of usual care patients achieved a Hemoglobin A1c <8 at 12 months (p=.01). At one site, health coaching patients were also statistically more likely to reach goal on cholesterol (41.8% v. 25.4%; p=0.4).

Conclusions: Medical assistants are an untapped resource to provide self-management support for patients with uncontrolled chronic disease.

How Do Peer Coaches Improve Diabetes Care for Low-Income Patients?: A Qualitative Analysis

Matthew L. Goldman

PURPOSE: The purpose of the study was to explore the perspectives and roles of peer coaches, who are patients with diabetes trained to provide diabetes self-management support (DSMS) to other patients.

METHODS: A focus group and 17 qualitative semi-structured interviews were conducted with community-based peer coaches in San Francisco in order to better understand the process by which these coaches engaged with their patients. Transcripts were coded and analyzed using methods based on grounded theory to

develop a theoretical model of peer coach roles.

RESULTS: Peer coaches play 3 principal roles in providing DSMS: advisor, supporter, and role model. While working with patients, peer coaches had different approaches to setting emotional boundaries and to allocating responsibility for implementing health behavior changes. Peer coaches were more consistent in how they sought resources from providers. Peer coaches also became empowered to better manage their own diabetes.

CONCLUSION: Peer coaches are a highly motivated potential workforce uniquely positioned to teach and empower patients by building trust through shared experiences. The variability in coaching styles suggests an inherent diversity among peer coaches that must be accounted for in future strategies for design, recruitment, training, and oversight of peer coaching programs.

“I don’t see myself as a medical assistant anymore”: Learning to become a health coach, in our own voices

Adriana L. Najmabadi , Najmabadi A*, Araujo C, Canizalez D, Prado C, DeVore D, Ghorob A, Gardner H, Willard-Grace R, Chen EH, Hessler D, Bodenheimer T, Thom DH

Context and Objective: Health coaching conducted by medical assistants may improve the health of patients with chronic conditions, and the model is growing in popularity. However, little is known about the experience of becoming a Health Coach. This study explores the experiences of medical assistants as they moved into a new role as a health coach.

Setting/Populations: The study was conducted with 3 Health Coaches and 1 Health Coach Trainer working in 2 San Francisco safety net clinics as part of a large randomized, controlled trial, the Health Coaching in Primary Care Study (2010–2013).

Intervention/Study Design: A focus group was conducted in November 2012 and subsequently transcribed. Using participatory methods, all of the participants of the focus group and the research assistants on the project took part in data analysis and identification of codes and themes.

Outcomes/Results: Several themes emerged from this focus group. Learning to become a Health Coach was a surprisingly emotional process that entailed not only learning new skills but also learning to have uncomfortable discussions and becoming highly aware of one’s own body language, behavior, and feelings. Assuming the new role required unlearning things that we had been taught as medical assistants, such as the unspoken rule that medical assistants are primarily concerned with the provider’s needs rather than the patient’s needs. As Health Coaches, we were given the freedom and time to get to know patients more deeply, and our connection with patients and understanding of their barriers enabled us to be successful at helping patients manage their chronic illnesses. Finally, becoming a

Health Coach had profound impacts on our personal lives by helping us open up on an emotional level not only with our patients but with our families, and the experience helped us build confidence to speak up during our own medical visits and those of our families.

Conclusions: Being a Health Coach is a transformative experience and an ongoing learning process. Organizations training Health Coaches should be aware of the dramatic shift in perspective that this new role requires and the support that is required to help medical assistants as they move into this new role.

Building team-based provider models in continuity clinic

Yamini Rao

The objective of this project is to improve clinic efficiency along with patient and provider satisfaction in a resident continuity primary care clinic. We are working with the Center for Excellence in Primary Care. This is a works in progress.

We instituted a "huddle" at the beginning of each clinic to review pertinent patient information, clinic flow information, and staffing concerns. LVNs/MAs lead the huddle by reviewing the patients' charts and discussing pertinent issues. The Social Work team, front desk, and physician providers will add in any additional pertinent information in the large group setting.

Our assessment has been by observation of the huddles by resident leaders, attending physicians, nursing supervisors and outside observers. We meet monthly with representation of from each department to provide feedback on effectiveness of the clinic huddle.

Initial outcomes have shown that attending providers are more aware of clinic flow and time intensive patients, therefore helping to support residents and LVN staff concerns. Patients with Social Work concerns are identified early so time can be built into their visit for meeting additional needs. LVNs and Front desk staff have felt this has improved use of our patient tracking system in the EMR.

Our goal moving forward will be to pair LVN/MAs with a physician provider to maintain consistency in work flow and foster a stable and cooperative team model.

Team structure and culture are associated with lower burnout in primary care practices

Kate Dube

Context and Objective: Burnout is a threat to the primary care workforce. We investigated the relationship between team structure, team culture, and emotional exhaustion of clinicians and staff in primary care practices.

Setting/Populations: We surveyed 231 clinicians and 280 staff members of 10 public

and 6 university-run primary care clinics in San Francisco in 2012.

Intervention/Study Design: This cross-sectional survey examined predictor variables including team structure, such as working in a tight teamlet, and perception of team culture. The outcome variable was the Maslach emotional exhaustion scale. Generalized Estimation Equations (GEE) models were used to account for clustering at the clinic level.

Outcomes/Results: Working in a tight team structure and perceptions of a greater team culture were associated with lower clinician exhaustion. Team structure and team culture interacted to predict exhaustion: among clinicians reporting low team culture, team structure appeared to have little impact on exhaustion, while among clinicians reporting high team culture, tighter team structure was associated with lower exhaustion. Greater team culture was associated with lower exhaustion among staff. However, unlike for clinicians, team structure failed to predict exhaustion among staff, either alone or as part of an interaction term.

Conclusions: Team culture was strongly associated with emotional exhaustion among clinicians and staff in the primary care practices studied. Among clinicians, a tighter team structure was also associated with less exhaustion when team culture was high. These findings suggest that fostering team culture may be an important strategy to protect against burnout in primary care.

IORA Health Elective

Real-Time Engagement in Primary Care Innovation: Elective Experiences at Iora Health

David Gellis, MD, MBA; Ali Khan, MD, MPP

Despite mounting enthusiasm for and commitment to careers in primary care innovation, few opportunities for meaningful immersion in that arena exist for medical trainees - which poses a considerable challenges to that translation of commitment to action. / / A strategic elective opportunity with Iora Health, focused on physician-leader pipeline development, aims to meet that challenge readily. Through carefully structured elective rotations at Iora Health practices, Primary Care Progress members and allies engage trainees in real-time clinical and practice innovation through service as an embedded practice team member. / / In doing so, we aim to advance a new national model for public-private partnership in medical education and public service. Its intended aim, however, remains most tantalizing: the development of an engaged, skilled and passionate physician corps, ready to continue the transformation of American primary care for decades to come.

Posters & Additional Abstracts

“I don’t see myself as a medical assistant anymore”: Learning to become a health coach, in our own voices

Adriana L. Najmabadi , Najmabadi A*, Araujo C, Canizalez D, Prado C, DeVore D, Ghorob A, Gardner H, Willard-Grace R, Chen EH, Hessler D, Bodenheimer T, Thom DH

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Conclusions: Being a Health Coach is a transformative experience and an ongoing learning process. Organizations training Health Coaches should be aware of the dramatic shift in perspective that this new role requires and the support that is required to help medical assistants as they move into this new role. Education & Community Health

Quality of Life and mental health among children living with HIV at a Care Home in Southern India

Tess Lang, MD; Elsa Heylen, MA; Wayne Steward, Phd, MPH; Emily Shamban, MPH; Maria Ekstrand, PhD

This study was designed to evaluate the quality of life of children living with HIV at an institutional care home in Bangalore, India. The Sneha Care Home is a unique residence that provides educational and community support with a focus on physical, nutritional, medical, and psychological care for orphans and vulnerable children. Cross-sectional health measures and interview data were collected from 97 residents between 5 and 12 years of age. A screening

questionnaire (the Strengths and Difficulties Questionnaire, SDQ) was used to indicate levels of caregiver concern about emotional or behavioral difficulties. SDQ scores showed 53% of children scored in the “borderline range”, 47% are in the “abnormal range, and peer problems were most frequently reported. The Quality of Life (QOL) of each child was measured with the Pediatric Quality of Life (PedsQL) Inventory questionnaire. Caregivers perceived children to have an overall higher QOL than was self-reported by children (Total Score 83 vs. 78). Emotion and School functioning means were higher according to child self-report than caregiver proxy-report (Emotion 72 vs. 65; School 79 vs. 76, resp.). PedsQL subcategory scores that were indicative of potentially impaired QOL were in social functioning (21%), according to child-report, and school functioning (26%), according to caregiver-report. Our findings indicate maternal orphans to be six times more likely to have psychological difficulties compared to children whose parents are living but unable to care for their child. The age of the child and age of joining the care home were found to be significantly negatively associated with quality of life reported by children and positively associated by caregiver-proxy reports. Despite living with ongoing disease, the children’s clinical severity of disease has remained well-controlled living in a residential, values-based care home. Clinical Care

Evaluation of use of a Family Information Table to improve pediatric HIV testing and enrollment into care in Kenya

Michelle Meyer (other names on the abstract include Molly Elmer-DeWitt, Dr. Cinthia Blat, Dr. Starley Shade, Dr. Ijaa Kapule, Dr. Craig Cohen, and Dr. Lisa Dillabaugh) /

Aims: This study examined current utilization of the family information table (FIT) for HIV-positive adults with children to identify children at risk of HIV infection, uptake of HIV testing, and enrollment of positive children.

Methods: A cross-sectional study was conducted among a convenience sample of HIV-infected adults with children at five Family AIDS Care and Education Services (FACES) affiliated clinics in Western Kenya. Information on uptake of HIV testing for children aged ≥ 18 years and enrollment status of positive children (if applicable) was gathered from patient files and compared to reports from in-person interviews. Factors associated with child testing were analyzed using general estimating equations to account for correlated outcomes among children of the same parent.

Findings: A total of 384 HIV-infected adults with children were identified with median age 36 years (IQR 30-43); 59% female; and median of 2 children (IQR 1-3). Review of the FIT found 323 (84%) correctly listed all children, and 340 (89%) documented a testing status (including not tested) for all children. Adults interviewed were more likely to report all children tested (75%) versus review of the FIT alone (46%) (OR 13.5, 95% CI 6.5-27.8). In multivariate analysis, odds of being tested were 1.9 times higher among children < 4 years old compared to those ≥ 4 (95% CI 1.3-2.8). Of 63 adult patients with HIV-positive children, 60 (95%) reported enrolling that child into care.

Conclusions/Relevance: This study confirms the efficacy of the FIT as a resource for identification and enrollment of HIV-positive children. The discrepancies between the interviews and the FIT may reflect social desirability bias or highlight the need for improved updating of the FIT to further enhance its utility. Additional strategies to improve updating the FIT should be attempted to improve testing, identification, and linkage to care of HIV-infected children.

Anemia screening at the Family Health Center: Improving rates through CQI

Paola Case, Pooja Mittal, Hali Hammer

Context and Objective: Iron deficiency (ID) is the most common cause of anemia and is linked to impaired neurocognitive development in children. For these reasons, screening for iron deficiency anemia (IDA) is an important part of well child care. Children in San Francisco have an increased rate of anemia at younger ages compared to the state average. Specifically, at the Family Health Center (FHC), screening rates for children were 24%. A group of providers collaborated to address the low rate of anemia screening at the FHC.

Setting/Populations: The target population was children aged 9-18 months who were active patients at the FHC. This age range correlated to a pay-for-performance measure, which allowed the team to have a systematic method to record progress.

Intervention/Study Design: The intervention is designed as a continuous quality improvement (CQI) project with a primary goal of improving anemia screening rates for children ages 9-18 months at the FHC. The intervention began with a brief survey administered to assess anemia screening practices among providers. A lecture was also provided to providers at the FHC to discuss the relevance of anemia screening. A set protocol was subsequently developed to standardize when and how to screen for anemia, as well as how to treat anemia. The protocol was distributed to all teams at the FHC. In addition, variations in recording point-of-care hemocue testing were identified and addressed by establishing a systematic method to log screening results for higher accuracy in reporting.

Outcomes/Results: Monthly data is collected using a query through i2i software. The intervention has been effective and rates of anemia have increased steadily each month since the intervention began. Five months after the intervention began the screening rates at the FHC are 40%.

Conclusions: A CQI model for improvement has been effective in increasing the number of children who are screened for anemia. A key feature in the intervention involved the development of a screening protocol for all providers to reference. Clinical Care

Piloting a Geriatrics Outpatient Consult Service to Support Primary Care Providers

Anna H. Chodos, MD, MPH, Shirley Wong, PharmD, Edgar Pierluissi, MD, Christine Ritchie, MD, MSPH, Hali Hammer, MD

Background: Until this pilot, there were no outpatient geriatrics consult services in the SF DPH, where approximately 10% of patients are 65 and older. This population is growing and is expected to increase from 13.7% to 21% of the city by 2030. Complex older patients will increasingly be seen in DPH primary care and the need for geriatric expertise may grow. With the support of the Family Health Center who donated space and clinical staff, the Division of Geriatrics has been able to pilot geriatrics consult clinic.

Description of Service: The pilot service began accepting consults for patients 65 and older from primary care providers in Family Health Center and General Medical Clinic in October 2012. Via the eReferral platform, we respond to a referral by 1) providing e-advice based on the clinical question and a thorough chart review and, if needed, 2) comprehensive geriatrics assessment.

The assessment is done in a clinic held one half-day per month in the Family Health Center with 4 appointments per clinic. On-going communication with primary care providers regarding clinical management is case based.

Team: Our team consists of 2 geriatric MDs, 1 pharmacist, and clinic staff of MAs and RNs.
Evaluation: The service is in the process of evaluating multiple aspects of the pilot: 1) processes such as number of patients seen, primary reasons for consult, recommendations made, 2) provider satisfaction and acceptability of service via provider surveys and semi-structured interviews, and 3) short-term (6 month) outcomes of patients seen with regard to geriatric conditions and health care utilization.

Preliminary results: In 1-year we received 100 consults, approximately 2 per week. Approximately half were seen in clinic. Most patients (two-thirds) were referred for more than one issue. The most common clinical questions were related to cognitive impairment (two-thirds), medication review (one-third), psychiatric complexity or falls (both about one-fifth). Data on provider satisfaction and patient outcomes are still being collected.

Implications: The geriatrics service hopes to use this pilot data to expand the service in those areas most useful to primary care providers and older patients seen in SF DPH primary care clinics. Education & Community Health

Tenderloin Healthy Corner Store Coalition Case Study

Pocholo Selpides, Aurora Gomez, Especianise Loresca, Frank Myers, Kenneth Payan, Elizabeth Sanseau

Background: The Tenderloin (TL) is one of the only neighborhoods in San Francisco without a full service grocery store, making it a daily challenge for residents to access the healthy, nutritious foods that communities rely upon to lead healthy lives. At the same time, the TL is San Francisco's most saturated area in terms of liquor and tobacco retail outlets and is home to some of City's highest rates of chronic diseases such as heart disease and diabetes, posing some serious public health challenges.

The Tenderloin Healthy Corner Store Coalition (TLHCSC) was formed after a youth-led project by the Vietnamese Youth Development Center (VYDC) shed light on the high number of corner stores in the neighborhood that offered limited to no access to healthy food options for residents in the community. The TLHCSC has adapted the Southeast Food Access Healthy Retail Model, used to address food justice in the Bay View-Hunter's Point neighborhood, to address the following three goals: 1) To train, educate, and empower resident leaders of the TL to advocate for food justice in their community. 2) To collect data and information about the availability of fresh and healthy food in the neighborhood, evaluate specific ways to improve, and to create standards to measure a healthy food retailer. 3) To improve the overall community environment by investing in and changing some of the TL's unhealthiest elements, corner liquor stores, into vital community resources.

Purpose: To document the TLHCSC store redesign process through a case study narrative in order to provide a framework for other communities interested in addressing issues of food justice.

Methods: Interviews with TLHCSC key stakeholders, attendance at TLHCSC community

meetings and Food Justice Leader meetings, document analysis.

Assessment/Outcomes: The TLHCSC store redesign is ongoing; the TLHCSC announced the store chosen for redesign October 2013. The case study is in-progress.

Clinicians experience of health coaching: Qualitative interviews with primary care providers

DeVore D*, Prado C, Dubé K, O'Connell B, Willard-Grace R, Chen EH, Hessler D, Bodenheimer T, Thom DH

Context and Objective: Health coaching is designed to equip patients with the knowledge, skills, and motivation to better manage their chronic conditions. While health coaching is growing in popularity, little is known about the impacts of using health coaches from the perspective of primary care clinicians. The goals of this study were to understand how the use of health coaches (a) affects the work experience of primary care clinicians, and (b) impacts their assessment of overall patient care.

Setting/Populations: This study was conducted with 14 clinicians at 2 safety net clinics in San Francisco who were taking part in a randomized controlled trial (RCT) of health coaching in the primary care setting. Each participating clinician had at least one patient enrolled in the RCT.

Intervention/Study Design: We conducted in-depth, qualitative interviews. Interviews were recorded and transcribed. Analysis was conducted in Atlas.ti software using modified grounded theory.

Outcomes/Results: Several themes emerged from the interviews. Most clinicians felt that the use of health coaches improved patient care. Clinicians noted improvements in patient self-management, engagement, or outcomes. They attributed these benefits to: (1) the extra time and repetition that the health coaches provided, (2) additional "momentum" between visits that kept patients focused on their goals, and (3) empowerment of the patients to manage their conditions and voice their concerns during medical visits. Perceived improvements in patient care were closely interrelated to provider quality of work life. / When asked about their workload, clinicians described ways in which health coaches both reduced and augmented their workload. For example, health coaches reduced workload by reviewing the care plan with the patient after the provider left the visit but increased workload when a health coach advocated for the patient by reminding the provider of issues on the patient's agenda. However, most providers describing increased workload qualified their statements by asserting that their overall quality of work life was improved because they felt that their patients were receiving better care.

Conclusions: Health coaching appears to have a positive impact on clinicians' quality of work life that is driven primarily by the ability of health coaching to improve patients' health.