Medical Care of Vulnerable and Underserved Populations

March 10-12, 2016
Westin St. Francis Hotel
San Francisco, California

Dean Schillinger, MD
Margaret Wheeler, MD
Welcome to the first (and hopefully, with your help, ANNUAL) UCSF CME course on the Care of Vulnerable and Underserved Patients. This course has been a long time in the making. It has its origins in discussions that began over 20 years ago when we first began working at San Francisco General and were struggling to improve the care of our patients. Insights from caring for our patients have been spun into research studies, changes in our approach to our patients, our practice and clinical systems. These discussions have been rich, sometimes difficult and always worthwhile. A shared vision of medicine as an agent for social justice has brought meaning, joy and sustained our passion for our work. Our first attempt at expanding our conversation was to put together a book on the care of the underserved. A generous grant from the California Healthcare Foundation allowed us to take the next step and create this course. We hope to share some of what we have learned with you in this course, but also to expand the conversations to a larger audience from whom we can learn, gain inspiration and create a community of those at UCSF, San Francisco and beyond who share our commitment to improving the health and health care of the poor.

We look forward to meeting you, hearing your stories and getting your feedback!

Dean Schillinger, MD
Margaret Wheeler, MD
To be of use

BY MARGE PIERCY

The people I love the best
jump into work head first
without dallying in the shallows
and swim off with sure strokes almost out of sight.
They seem to become natives of that element,
the black sleek heads of seals
bouncing like half-submerged balls.

I love people who harness themselves, an ox to a heavy cart,
who pull like water buffalo, with massive patience,
who strain in the mud and the muck to move things forward,
who do what has to be done, again and again.

I want to be with people who submerge
in the task, who go into the fields to harvest
and work in a row and pass the bags along,
who are not parlor generals and field deserters
but move in a common rhythm
when the food must come in or the fire be put out.

The work of the world is common as mud.
Botched, it smears the hands, crumbles to dust.
But the thing worth doing well done
has a shape that satisfies, clean and evident.
Greek amphoras for wine or oil,
Hopi vases that held corn, are put in museums
but you know they were made to be used.
The pitcher cries for water to carry
and a person for work that is real.
THURSDAY, MARCH 10, 2016
7:30 am Registration and Continental Breakfast

8:00 INTRODUCTION Neil R. Powe, MD, MPH, MBA

Moderator- Margaret Wheeler, MD

8:15 Overview of Care of Vulnerable Patients  Dean Schillinger, MD

8:55 Management of Cardiovascular Disease in Vulnerable Populations (HTN AND CHF)  Kirsten Bibbins Domingo, MD, PhD, MAS

9:35 Management of Depression and Anxiety in the Primary Care Setting: Focus on New Medications and Models of Integration  Melissa Nau, MD

10:15 Break

10:30 Trauma Informed Care  Leigh Kimberg, MD

11:10 Caring for Patients with Disabilities in the Safety Net  Nathaniel Gleason, MD

11:50 Lunch (On Your Own)

Moderator- Margaret Wheeler, MD

1:00 pm Introduction: Notes from a Career in the Safety Net  Kevin Grumbach, MD

1:15 Optimizing Care for Patients with Food Insecurity  Hilary Seligman, MD, MAS

1:55 Updates in HIV Care in Vulnerable Patients  Susa Coffey, MD

2:35 Smoking Cessation in Underserved Settings  Maya Vijayaraghavan, MD, MAS

3:15 Leadership in the Safety Net  Jeffrey Critchfield, MD, Claire Horton, MD, MPH

4:00 Break

4:15 Workshop: Preventing Burn-out  Diana Coffa, MD

5:15 pm Adjourn

FRIDAY, MARCH 11, 2016

7:30 am Continental Breakfast

8:00 INTRODUCTION Sandra R. Hernández, MD

Moderator- Dean Schilinger, MD

8:15 The Affordable Care Act and Vulnerable Patients: from Policy to Practice  Andrew Bindman, MD

8:55 Caring for Underserved Patients with Chronic Pain  Soraya Azari, MD
9:35 Management of Obesity and Diabetes in Patients in the Safety Net
Sarah Kim, MD

10:15 Break

10:30 What Can Geriatrics Teach Us about the Care of Vulnerable Patients?
Helen Kao, MD

11:10 Management of Chronic Kidney Disease in Vulnerable Patients
Delphine Tuot, MDCM, MAS

11:50 Lunch (On Your Own)

Moderator- Vanessa Thompson, MD

1:00 pm Notes from Caring for the Underserved
Jennifer Liu, FNP-BC

1:15 Updates in the Care of Underserved Patients with Hepatitis C and Hepatitis B
Annie F. Luetkemeyer, MD

1:55 Medical Care of Patients with Severe Mental Illness
Christina Mangurian, MD, MAS

2:35 Patient-Centered Medical Home for Vulnerable Patients and Transitions in Care
Liz Goldman, MD
Reena Gupta, MD

3:15 Addressing Disparities in Contraception and Abortion
Elizabeth Harleman, MD
Karen Meckstroth, MD, MPH

4:00 Break

4:15 Workshop: Advanced Cases in Anxiety and Depression
Liz Goldman, MD
Christina Mangurian, MD, MAS
Lisa Ochoa-Frongia, MD
Margo Pumar, MD

5:15pm Adjourn

SATURDAY, MARCH 12, 2016

7:30 am Continental Breakfast

8:00 INTRODUCTION: Narratives from the Safety Net
Alicia Fernandez, MD

Moderator- Katherine Lupton, MD

8:15 Perspectives on Care of the Underserved
Talmadge E. King, Jr., MD

8:55 Optimizing Care for Patients with Limited Literacy and Limited English Proficiency
Alicia Fernandez, MD
Dean Schillinger, MD

9:35 Optimizing Care for Older Homeless Patients
Margot Kushel, MD

10:15 Break
10:30 Care of the Patient with History of Incarceration  
Shira Shavit, MD

11:10 Updates on the Care of People with Addiction  
Diana Coffa, MD

11:50 Lunch (On Your Own)

Moderator- Margaret Wheeler, MD

1:15 pm Caring for the Transgender Patient  
Barry Zevin, MD

1:55 Telemedicine to Improve Care for the Underserved  
George Su, MD

2:35 Advances in Palliative Care in Underserved Settings  
Heather Harris, MD
Anne Kinderman, MD

3:15 Case Management for Frequent Users of Health Care  
Elizabeth Davis, MD
Devora Keller, MD, MPH

4:00 Break

4:15 Workshop: Care of Patients with Alcohol and Opiate Addictions  
Paula Lum, MD, MPH
Jacqueline Tulsky, MD

5:15pm Adjourn

G - Geriatric Credit

REMINDER-

WANT ABIM MOC Credit?  
This course offers an MOC Part II self-assessment for the ABIM diplomats.  
To complete the application for credits, please visit ucsfcme.com/2016/MDM16M22/info.htm to learn more.
Caring For Vulnerable Patients in the Era of Health Reform

Dean Schillinger MD, UCSF Professor of Medicine in Residence
Chief, Division of General Internal Medicine
Director, Health Communications Research Program
UCSF Center for Vulnerable Populations @ SF General Hospital

Objectives
- Review impact of ACA on underserved populations
- Deconstruct the construct of vulnerable populations
- Present an integrated approach to vulnerable patients
- Provide 3 examples of social vulnerabilities & impacts
  - Limited health literacy
  - Food insecurity
  - Intimate Partner Violence
- Find joy and a feeling of alignment in one’s work

ACA reduced uninsured by 50% and increased Medicaid by 36%

Drops in the uninsured rolls much greater for minorities

By race

- Hispanic
  - 16.5
- Black
  - 26.1
- White
  - 15.1
- Asian
  - 11.8

School of Medicine - University of California, San Francisco
Vulnerable Populations Defined

- Vulnerable Populations are subgroups of the larger population that, because of social, economic, political, structural, and historical forces, are exposed to “greater risk of risks”, and are thereby at a disadvantage with respect to their health and health care.

Exemplar Case

- Ms J is a 57 yo English-speaking Latina, mother of 5, with 3 grandchildren, with HTN, depression, DJD and IDDM with A1c of 8.6%. She presents for the first time after having been hospitalized for 3 days for hypoglycemia. The inpatient service was unable to identify a trigger for the hypoglycemia.

- Question for you is WHY?

Mnemonic Devices Can Make you a Better Clinician!

- My
- Neurons
- Erase
- Memory.
- Only
- Names
- Improve
- Cognition
Common Social Vulnerabilities

- Violence
- Uninsured
- Literacy and Language
- Neglect
- Economic hardship/food insecurity
- Racial/ethnic discordance, discrimination
- Addiction
- Mental disorders, e.g., depression, dementia
- Immigrant
- Legal status
- Isolation/Informal caregiving burden
- Transportation problems
- Illness Model
- Yes and Ears
- Shelter

Schillinger 2007

What are We Up Against? Reversing The Inverse Care Law

- “Access to and quality of healthcare is inversely proportional to the needs of the population”

- Tudor-Hart, 1971

Jerry Garcia

“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”

“3 Mechanisms Whereby Vulnerability is Associated with Poor Health”
**Finding the Sweet Spot for Effective Intervention with Vulnerable Patients**

This approach uniformly allows a clinician to navigate the social distance and create the human connection that underlies therapeutic relationships.

**Eliciting the Patient’s Story: Reveals Hidden Treasures that Humanize**

**Finding Resilience**

- Religion
- Expertise/Employment
- Social support & Network
- Intimates
- Laughter
- Institutions
- Energy & Enthusiam
- Navigate Life’s Difficulties
- Cultural Assets
- Entertainment/Enjoyment

**Common Social Vulnerabilities**

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Schillinger 2007
**What is Health Literacy?**

- “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make [informed] health decisions.”
- 3 domains: oral (speaking, listening); written (reading, writing); numerical (quantitative)
- Web? Patient portals?
- Capacity/Preparedness ↔ Demand Mismatch

**Patients with Diabetes and Low Literacy Less Likely to Know Correct Management**

**Need to Know:**
- symptoms of low blood sugar (hypoglycemia)

**Need to Do:**
- correct action for hypoglycemic symptoms

**Limited Health Literacy Patients Experience More Serious Hypoglycemia/year N>14,000**

**Exemplar Case: Clearly this was Limited Health Literacy, right?**

- Ms J is a 57 yo English-speaking Latina, mother of 5, with 3 grandchildren, with HTN, depression, DJD and IDDM with A1c of 8.6%. She presents to you for the first time after having been hospitalized for 3 days for hypoglycemia. The inpatient service was unable to identify a trigger for the hypoglycemia.
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The Old Face of Hunger

- The uneasy or painful sensation caused by lack of food, or the recurrent and involuntary lack of access to food.

The New Face of Food Insecurity

- The limited or uncertain
  - availability of nutritionally adequate and safe foods or
  - ability to acquire acceptable foods in socially acceptable ways

Cycles of Food Adequacy & Inadequacy Wreak Havoc

- Compensatory Strategies during Food Adequacy
  - Avoidance of food waste
  - Systematic overconsumption

- Compensatory Strategies during Food Shortage
  - Skipped meals
  - Reduced caloric intake

Hyperglycemia

Hypoglycemia
Cycles of Food Adequacy & Inadequacy Wreak Havoc

Hyperglycemia ↔ Hypoglycemia

Compensatory Strategies during Food Adequacy
- Avoidance of food waste
- Systematic overconsumption

Compensatory Strategies during Food Shortage
- Skipped meals
- Reduced caloric intake

Hypoglycemia & Food Insecurity
- Patients with diabetes in a safety net hospital
  - 1/3 of those who reported hypoglycemia attributed it to the inability to afford food
- Primary care patients with diabetes at community health centers (38% food insecure)
  - Blood sugar ever gotten too low because you couldn’t afford food? (33% FI vs. 5% FS)
  - Ever been to the ER because your blood sugar was too low? (28% FI vs. 5% FS)

Risk Factors for Severe Hypoglycemia

<table>
<thead>
<tr>
<th>Factor</th>
<th>AOR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Insecurity</td>
<td>3.0</td>
<td>(1.5-5.9)</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>2.2</td>
<td>(1.1-4.5)</td>
</tr>
<tr>
<td>Comorbid illnesses</td>
<td>1.5</td>
<td>(1.1-2.0)</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.3</td>
<td>(0.1-0.7)</td>
</tr>
</tbody>
</table>

Exemplar Case: Clearly this was Food Insecurity, right?

- Ms J is a 57 yo English-speaking Latina, mother of 5, with 3 grandchildren, with HTN, depression, DJD and IDDM with A1c of 8.6%. She presents to you for the first time after having been hospitalized for 3 days for hypoglycemia. The inpatient service was unable to identify a trigger for the hypoglycemia.
Common Social Vulnerabilities

- Violence
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- Isolation/Informal caregiving burden
- Transportation problems
- Illness Model
- Yes and Ears
- SHELTER

What is intimate partner violence (IPV)?

**PATTERN of abusive behaviors**
- Including physical, sexual, verbal, emotional, economic, and/or psychological abuse
- Includes interfering with medical care
- Used by adults or adolescents
- Against current or former intimate partners, and sometimes against other family members
- In ANY intimate relationship: LGBTQ/straight/all gender identities

Exemplar Case: Clearly this was Intimate Partner Violence, right?

- Ms J is a 57 yo English-speaking Latina, mother of 5, with 3 grandchildren, with HTN, depression, DJD and IDDM with A1c of 8.6%. She presents to you for the first time after having been hospitalized for 3 days for hypoglycemia. The inpatient service was unable to identify a trigger for the hypoglycemia.

Where Have We Been?

- Deconstruct the construct of vulnerable populations
- Present an integrated approach to care of vulnerable patients
- Provide 3 examples of social vulnerabilities & DM
  - Limited health literacy
  - Food insecurity
  - Intimate Partner Violence (IPV)
- Find the joy and a feeling of alignment in one’s work
Care of Vulnerable Patients

“There needs to be a little Don Quixote in all health practitioners... locked in on the mission, undaunted by the doubters and the half-hearted”

- Fitzhugh Mullan, MD

Interrupting the Cycles of Vulnerability & Poor Health

TWO DEAD MEN

A POEM....

One: a refugee from Cuba.
Always in white,
Skin black and smooth,
Fitting the mold from bottom top:
White leather shoes,
White pants,
White linen shirt,
Crowned with a Havana,
Of course.

The other: tall, lanky,
Happy and old.
A former ball player
In the West Coast Negro League.
Pitched for the Sea Lions
Until he threw his shoulder
Out of its socket,
And could throw no more.

The First: always smiling,
Laughing even.
Gold sparkling from a tooth.
Bejeweled with bling
Like epaulettes
From his favorite pastime:
Reno with Maria

The Second: never sure of his age,
Either 93 or 88,
His Louisiana birth certificate,
Unable to read it,
But he knows it bears false witness.
Keeps his daughter’s number safe:
Pearline - on the inside brim
Of his omnipresent
Baseball cap.
The Former: still alive
‘Cause he quit tobacco 25 years ago
After being filleted open
To plumb his heart.
 Proud of his medical survival skills,
And grateful for his doctor.
While smacking his big round belly,
Pregnant with hope and worry.

The Latter: still alive
Because he quit smoking 25 years ago
After being told his lungs are vanishing.
Owe my life to my doctor,
So he says and so he believes.
Now chained to an oxygen tank,
Not sure if it’s worth it,
Anymore.

Two Brothers,
Resilient,
Living in parallel,
Struggling in parallel,
Full lives behind them.
Now both suddenly dead,
Within days of each other.
Leaving behind their doctor

How can it be
That these two men,
Bedeviled by society
Could become the favorites
Of their doctor?
What can fill the absences,
When one is robbed of one’s favorites
And their love is lost?

END
Heart failure and Hypertension

Kirsten Bibbins-Domingo, PhD, MD, MAS
Lee Goldman, MD Endowed Chair in Medicine
Professor of Medicine and of Epidemiology and Biostatistics
University of California, San Francisco

Objectives

• To understand the features of heart failure and hypertension that are specific to poor and minority populations.

• To develop approaches to diagnosis and management of heart failure and hypertension in these vulnerable populations.

• To review recommendations for pharmacotherapy for heart failure and hypertension in African American patients.

HEART FAILURE

Definition & epidemiology of heart failure

• Complex clinical syndrome
  – Structural or functional impairment that impairs the ventricle's ability to fill or eject blood effectively
  – Clinical manifestations of dyspnea, fatigue, and fluid retention

• Lifetime risk in adults of 20%
• Increasing in prevalence
• Most common reason for hospitalization among Medicare recipients
First acute decompensated heart failure annual event rates per 1000 from Atherosclerosis Risk in Communities community surveillance (2005–2012)

New Cases of Heart Failure in the Black and White Young Adults

In CARDIA, >5000 young adults in their 20’s and 30’s followed for 20 years:

- 1 in 100 black men and women develop heart failure before age 50.
- Blood pressure elevation in 20’s was strongest predictor, as well as development of diabetes over 20 years.

Diagnosis of heart failure in primary care

- Most common presentation is fatigue
- Risk factors for heart failure
  - Hypertension (most common modifiable risk factor)
  - Diabetes/Metabolic syndrome/Obesity
  - Atherosclerotic disease

Additional etiologies to consider

- Toxins
  - Alcohol - heavy consumption >10 years, men
  - Cocaine
- Infectious
  - HIV - 8% dilated cardiomyopathy in long term f/u
  - Chagas disease – central/south America, 10-30% of those infected, conduction abnormalities
- Inflammatory
  - Sarcoidosis – more common in African Americans
- Idiopathic cardiomyopathy – more common in African Americans
Stages of heart failure

At risk for heart failure

Stage A
At risk for HF but no structural heart disease or signs or symptoms

Stage B
Structural heart disease but no signs or symptoms of HF

Stage C
Structural heart disease with prior or current symptoms

Stage D
Structural heart disease with symptoms of HF refractory to treatment

Heart Failure

Treatment of heart failure

• Goals
  – Improve symptoms
  – Improve health-related quality of life
  – Increase patient education
  – Prevent hospitalizations
  – Prevent mortality

• Additional considerations
  – Limited literacy
  – Financial barriers
  – Other competing demands

Treatment of heart failure

• Treatment strategies in HF with preserved EF
  – Diuretics for congestion
  – Management of associated factors
    • Hypertension
    • Atrial fibrillation
    • Diabetes
    • Atherosclerotic disease
Treatment of heart failure

• Treatment strategies in HF with depressed EF
  – Diuretics for congestion (most require chronic use)
  – ACE inhibitors or ARBs
  – Beta Blockers (carvedilol, metoprolol XL, bisoprolol)
  – Spironolactone (if still symptomatic)

• Consider in the appropriate patient
  – Revascularization
  – Resynchronization therapy (CRT)
  – ICDs

Treatment of heart failure with refractory symptoms (Stage D)

• Goals
  – Improve symptoms
  – Improve health-related quality of life
  – Reduce readmissions
  – Establish end of life goals

• Treatments
  – Transplant
  – Hospice

• Additional considerations
  – Access to care
  – Financial
  – Limited literacy
  – Advocacy in navigating health system

Pharmacotherapy in African Americans

• Hydralazine – isosorbide dinitrate
  – Originally studied in V-Heft and considered an alternative to ACE inhibitors
  – Re-analysis - largest effect in African Americans
  – Studied again in A-Heft
    • RCT of African Americans with depressed EF
    • Mortality benefit when added to standard therapy
  – First drug approved for a specific race/ethnic group

Pharmacotherapy in African Americans

Considerations for use of hydralazine-isosorbide dinitrate

1. Should be added to standard therapy (ACE/ARB, beta blocker, diuretic), and not replace standard therapy.

2. Hypotension and headache are important side-effects that limit use. Limit use to those with hypertension.

3. Significant pill burden. In fixed dose combination of BIDIL, dosed three times daily - more if dosed individually.
Conclusions – Heart Failure

• Heart failure is a common cardiovascular disease, with high morbidity and mortality, that is increasing in prevalence.

• African Americans are disproportionately affected by heart failure, particularly at younger ages.

• High degree of complexity in the diagnosis and medical management of heart failure may pose particular challenges for vulnerable populations.

HYPERTENSION
Summary of epidemiology

- Although BP control has improved, prevalence of hypertension is increasing.

- Highest prevalence in African Americans, lowest control in Latinos

- Lowest rates of awareness, treatment, and control in young adults.

- Within each race/ethnic group, men at risk for poor control.

Diagnosis

- Recent guidelines, trials have raised question about the appropriate thresholds for hypertension
  - Association of BP and CVD risk is linear across a wide range, down to SBP of 110.
  - 140/90 mmHg is target in most people
  - In elderly risk of lowering BP must be balanced against benefit of BP lowering.

- Diagnosis requires BP measured correctly in clinic and should ideally be confirmed with out of office BP.
Lifestyle approaches to BP control

**Lifestyle Modifications to Manage Hypertension**

<table>
<thead>
<tr>
<th>Modification</th>
<th>Recommendation</th>
<th>Approximate BP Reduction (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight reduction</td>
<td>Maintain a normal body weight (body mass index 18.5-24.9 kg/m²).</td>
<td>6-12 mmHg systolic blood pressure</td>
</tr>
<tr>
<td>Adopt DASH-style diet</td>
<td>Consume a diet rich in fruits, vegetables, and low-fat dairy products with a reduced content of saturated and total fat.</td>
<td>3-6 mmHg diastolic blood pressure</td>
</tr>
<tr>
<td>Dietary sodium reduction</td>
<td>Reduce dietary sodium intake to no more than 300 milligrams per day (3.4 g sodium chloride).</td>
<td>3-6 mmHg diastolic blood pressure</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Engage in regular aerobic physical activity with a brisk walking all 5 days per week.</td>
<td>4-6 mmHg diastolic blood pressure</td>
</tr>
<tr>
<td>Moderation of alcohol consumption</td>
<td>Limit consumption to no more than 2 drinks (1 oz [30 mL] alcohol, e.g., 2 oz of beer, 1.5 oz of 80-proof whiskey, or 5 oz of 100-proof whiskey) per day, or no more than 1 drink per day in women and lighter weight persons.</td>
<td>3-4 mmHg diastolic blood pressure</td>
</tr>
</tbody>
</table>

JAMA May 21, 2003

General principles of pharmacotherapy

- Calcium channel blockers, diuretics, ACE/ARBs all can be considered first line therapies and effective in combination.
- Goal is regimen that maximizes adherence with additional consideration of therapeutic benefit for other conditions.
- Two agents achieve greater BP control than max dose of a single agent
- Fixed dose combination medications have been shown to improve adherence and BP control
- Stage 2 hypertension (>160/100) requires two agents (at least)

Additional considerations

- Calcium channel blockers - highly effective BP control agents with minimal side-effects. Consider for patients when follow-up is uncertain
- ACE/ARB - important in multiple conditions (diabetes, albuminuria, CHF, GDM)
  - Requires follow-up labs
  - Better BP control when administered with diuretic
- Diuretic -
  - Chlorthalidone - longer acting, greater BP control, but also side effects, most evidence
  - HCTZ - most widely used, often in fixed combo
  - Loop diuretics - if CKD
- Beta blockers
  - Not great BP control agents and side-effects for patients
  - Reserve for post-MI and CHF

Pharmacotherapy in African Americans

- Most African Americans achieve BP lowering with ACE inhibition, but mean BP reduction is less in African Americans than Whites.
  - African Americans are also more likely to develop angioedema
  - Many recommend starting with diuretics or C channel blockers.
- ACE inhibitors less effective in high sodium states
  - Work better with lower sodium intake
  - Work better when combined with diuretics
- African Americans may have other indications for ACE inhibition
  - Diabetes, albuminuria, heart failure
  - Use with diuretic
Resistant hypertension

- Definition: BP elevated despite 3 agents, or controlled on 4

Work-up
1. Rule-out “pseudo-resistance” - assess adherence, other contributors to BP elevation
2. Consider work-up of secondary causes as indicated by other patient factors
3. Add spironolactone to regimen that includes Ca channel blocker, ACE/ARB, diuretic

Kaiser Northern California HTN Program

- Comprehensive HTN registry
  - Central HTN management team
  - Dissemination of successful practices
- Performance metrics
- Evidence-based treatment algorithm
- Medical assistant visits for BP measurements
- Single-pill combination drugs

How can these approaches be translated to other healthcare systems that are more resource constrained?

- Safety net settings
- Rural settings
Conclusions - Hypertension

- Hypertension is the most common modifiable risk factor for CVD and increasing in prevalence.
- Despite improvements in control of blood pressure, many at-risk populations continue to have high rates of uncontrolled BP and suffer consequences of hypertension-related CVD.
- Complex medical management of this asymptomatic condition may pose particular challenges for vulnerable groups.

MOC question

Mr. G is a 55 year old African American man with hypertension and diabetes. He has a remote history of drug and alcohol use, but denies use over the past 20 years. He was recently evicted and now sleeps on the couch in his brother’s apartment. His blood pressure has been difficult to control, and several changes have been made to his medication regimen recently.

His medications include:
- Hydrochlorothiazide 25 mg daily
- Benazepril 40 mg daily
- Amlodipine 10 mg daily
- Metformin 1000 twice daily
- Atorvastatin 80 mg daily
- Aspirin 81 mg daily

Today’s vital signs: Temp 37, BP 165/90, pulse 70.

What’s the best next step?

a) Assume medication non-adherence, and remind Mr. G during today’s visit that he needs to take all medications as directed.

b) Assume Mr. G is lying about his drug use, and send a urine toxicology screen on this visit.

c) Send urine metanephrins to rule out pheochromocytoma immediately.

d) Review and reconcile Mr. G’s medications, paying particular attention to comprehension, errors that may have resulted from multiple recent changes, and potential financial barriers to chronic medication regimen.
Management of Depression and Anxiety in the Primary Care Setting: Models of Integration and Treatment Approaches

Melissa L. Nau, MD
Assistant Clinical Professor, UCSF

Objectives

- Review the Collaborative Care model of integration
- Describe best practices for management of depression in a primary care setting
- Describe best practices for management of anxiety in a primary care setting
- Review when to consult a psychiatrist or behavioral health specialist

Case Examples

- Patient with multiple medical problems (HTN, CAD, DM2) who presents c/o depressive sx.
  - Ptnt does not adhere to your treatment recommendations despite saying he or she will.
- Ptnt has a history of and current sx of anxiety. On standing benzo x 2 years.
- Ptnt c/o new onset anxiety, wants treatment.
- Patient has failed 2 antidepressant trials and is not improving.

Disclosures

I have nothing to disclose
Burden of Mental Illness

- 1 in 4 Americans struggle with a mental health or substance use problem at some point in their lives. No family goes untouched.\(^1\)
- Behavioral health disorders cause nearly 25% of all disability worldwide.\(^1\)
- Depression alone accounts for 10% of health-related disability.\(^1\)
  - Years Lost to Disability (YLD) from depression = 3x diabetes; 8x heart disease; 40x cancer

Why treat depression in primary care?

- 10-15% of pts in a Primary Care setting suffer from a depressive disorder\(^2\)
- 50% of depressed pts present with somatic complaints rather than typical depressive symptoms\(^2\)
  - Insomnia, fatigue, HA, weight change
  - Anxiety, irritability, apathy
- Higher risk with comorbidities, worse prognosis\(^3\)
- Depression is treatable; untreated can lead to death

**Depression and Medical Illness**

- **Cardiovascular disease**
  - Increased risk of CAD\(^1\)
  - 4x mortality after MI, 3x more common post MI\(^2\)
  - Depression before CABG doubles risk of death\(^3\)
- **Diabetes**
  - 2x higher odds of depression\(^4\)
  - Earlier life depression doubles risk of DM\(^4\)
  - Symptom severity → poorer diet, medication compliance, self-care; functional impairment

---

2. Maske et al., Prevalence and correlates of DSM-IV TR major depressive disorder, self-reported diagnosed depression and current depressive symptoms among adults in Germany, J Affect Disord., 2015
4. Wulsin et al, Do depressive symptoms increase the risk for the onset of CAD? A systematic quantitative review. Psychosomatic medicine 2003
7. Lin et al, Relationship of depression and diabetes self-care, medication adherence, and preventive care, Diabetes care, 2004
Quality of Care

- ~30 million people receive a prescription for a psychiatric medication in primary care each year but only 25% improve.
- Patients with serious mental illness die 20 years earlier. Most have poor medical care.
- Services are poorly coordinated.


Collaborative Care Model

- Primary Care Practice – Patient Centered Team Care
  - Primary Care Physician
  - Patient
  - Behavioral Health Professional
  - Psychiatric Consultant
- Outcome measures, Treatment Protocols, Evidence Based
- Population registry, psychiatric consultation

http://impact-uw.org
Aims.uw.edu

Quick Fact: Only 30–50% of patients have a full response to the first treatment plan. That means 50–70% of patients need at least one change in treatment.

Key Points: Large burden/poor access

- Mental illness and substance use are major drivers of disability & health care costs.
- <50% have access to effective specialty mental health care.
- Effective integration of behavioral health care can achieve:
  - Better access to care
  - Better health outcomes
  - Lower cost


Depression: Diagnosis

- Familiarize yourself with DSM V criteria.
- Use the PHQ-2 to start...
- ASK about suicidality (plan, intent, means)
- Consider:
  - Dysthymia, Bereavement, Bipolar disorder, Psychosis
  - Substance use
  - Social situation/stressors
  - Comorbid disorders (medical and psychiatric)
- Get collateral, involve family if pt willing

**Principles**

- Consider both:
  - FUNCTIONAL IMPAIRMENT
  - DURATION of episode
- Consider how other factors may be contributing
- Cultural competency!

**Common presentations**

- Multiple (more than five per year) medical visits
- Multiple unexplained symptoms
- Work or relationship dysfunction
- Dampened affect, weight changes, sleep disturbance, fatigue
- Memory/other cognitive complaints: difficulty concentrating or making decisions
- Irritable bowel syndrome
- Poor behavioral follow-through w/ ADLs or tx recs
- NOTE: Medical issues should still be specifically addressed, especially when new symptoms are reported.

**Don’t forget to rule out…**

- Biological causes
  - Chronic fatigue
  - Thyroid function
  - IBS
  - Obesity
  - CVA, cancer, dementia
  - Delirium
  - Parkinson’s
  - Connective tissue diseases
- Other
  - Chronic pain
  - Substance Use
  - May exist as a co-morbid disease state

**Medications that may lead to Depressive Symptoms**

<table>
<thead>
<tr>
<th>Medications that may lead to Depressive Symptoms</th>
<th>Medical Conditions That May Lead to Depressive Symptoms</th>
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</thead>
<tbody>
<tr>
<td>Baclofen</td>
<td>Chronic Pain</td>
</tr>
<tr>
<td>Interferon</td>
<td>Dementia (e.g. neurodegenerative disorders)</td>
</tr>
<tr>
<td>Ritalin</td>
<td>Drug toxicities and withdrawal</td>
</tr>
<tr>
<td>Levodopa</td>
<td>Endocrine disorders (e.g. thyroid)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Metabolism Disorders (e.g. anemia, malnutrition, electrolyte disturbance)</td>
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<tr>
<td>Methyldopa</td>
<td>Metoprolol</td>
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<td>Inhalers</td>
<td>Metoclopramide</td>
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<td>Cimetidine</td>
<td>Opiates</td>
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<tr>
<td>Propranolol</td>
<td>Oral Contraceptives</td>
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<td>Ranitidine</td>
<td>Propranolol</td>
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<tr>
<td>Reserpine</td>
<td>Steroids</td>
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</tr>
<tr>
<td>Interferon</td>
<td>Nephrolithiasis</td>
</tr>
</tbody>
</table>

**Low intensity psychosocial interventions**

- Antidepressants NOT recommended as 1st line in recent onset, mild depression
- So... what should we do?
  - Individual guided self-help based on CBT principles
  - Computerized CBT (CCBT)
  - Structured group physical activity program
  - Does patient need support from a trained practitioner?
  - Monitor
- RESILIENCE and HOPE

---

**Factors to consider when choosing an antidepressant**

- Patient preference
- Nature of prior response to medication
- Relative efficacy and effectiveness
- Safety, tolerability, and anticipated side effects
- Co-occurring psychiatric or general medical conditions
- Potential drug interactions
- Half-life
- Cost

Adapted from APA practice guidelines 2010.

---

**Drug treatment of depression**

1. Discuss choice of drug w/ patient
2. Start antidepressant
3. Assess weekly for a further 1-2 weeks
4. Effective
5. Continue for 6-9 months at full treatment dose
6. Poorly tolerated
7. Switch to a different antidepressant
8. No effect
9. Switch to a different antidepressant
10. Consult!
11. No effect

Adapted from the Maudsley Prescribing Guidelines in Psychiatry, 2015

---

**True or False?**

Antidepressants do not exert their effects for 2-4 weeks

1. True
2. False
Drug treatment of depression, cont.

- Use rating scales
- Poor tolerability:
  - In theory, switch class of drug
  - In practice, many patients who cannot tolerate one SSRI will readily tolerate another
- If there’s a non-response, best to switch class but you could also stay w/in the class
  - NICE (National Institute for Health and Clinical Excellence) and the APA recommend both options


Mixed evidence regarding increasing dose of SSRIs after a moderate dose has been tried. Bottom line: balance w/ tolerability.

- Increasing the dose of venlafaxine, escitalopram and tricyclics may be helpful.
- Switch treatment early (after a week or two) if adverse effects are intolerable or if no improvement at all is seen by 3-4 weeks.

1. Adli M et al, The early course of schizophrenia and depression, Eur Arch Psychiatry Clin Neurosci 2005

When to consult?

- Clinical complexity, diagnostic clarification
- Failed 2 med trials
- Active suicidality
- Psychosis or bipolar disorder
- Likely to benefit from psychotherapy
- Considering specialized tx (ECT, light therapy)
- You want help! The patient wants it!
- For treatment-resistant depression:
  - augmentation with lithium or an antipsychotic
  - addition of a second antidepressant, ECT
- 2 prior episodes + functional impairment= at least 2 years of treatment

Antidepressant pearls

- SSRIs are 1st line.
- SSRI side effect profiles do differ.
  - Fluoxetine, fluvoxamine, and paroxetine are associated w/ a higher propensity for drug interactions than other SSRIs.
  - Dual reuptake inhibitors (venlafaxine and duloxetine) tolerated less well than SSRI but better than TCA
- Discontinuation can be rough – worse with short t1/2
- Marked individual variation – be flexible!
Some specific SSRI pearls

- Citalopram/escitalopram: CYP friendly
- Fluoxetine: Dirty
  - More “activating”
  - Can alter insulin requirements
- Sertraline
  - Often used in pregnancy
  - See more diarrhea
- Paroxetine
  - More sedating, wt gain, sex dysfxn
  - Discontinuation rough – withdraw SLOWLY!
- Fluvoxamine
  - Potent inhibitor of CYP1A2 → e.g. increase theophylline serum level

SSRI side effects

- Most common:
  - Headache, GI, drowsiness, sexual, dizziness, anxiety
- More serious:
  - Hyponatremia
  - Bleeding
    - Especially in older people or people taking other drugs that have the potential to damage the GI mucosa or interfere with clotting
      - Consider rx of gastroprotective drug in older people who are taking NSAIDs or aspirin
- Caution with EtOH, NSAIDs, tryptophan, warfarin
  - Avoid MAOIs, St John’s Wort, QT prolonging drugs

Side effects matter…

Citalopram warning

- “not recommended” for patients with congenital long QT syndrome
  - discontinuation was recommended when QTc > 500ms.
  - Maximum daily dose 20mg/day age >60
- SO: check EKG and proceed with caution, but proceed.
**Dual reuptake**

- Higher doses Venlafaxine can exacerbate cardiac arrhythmias and increase blood pressure

- **Mirtazapine**
  - Weight gain, helps w/ insomnia
  - Sedating at lower levels
  - Better for nausea/sexual dysfunction, good in combo

- **Buproprion**
  - Don’t use in EtOH, bulimia
  - Can be activating
  - A great ADHD alternative, great for depression

**Other classes**

- **TCAs**
  - Cardiovascular s/e
    - Hypotension, Tachycardia, QTc prolongation
    - Cardiotoxicity of TCAs can be exacerbated by diuretics (e.g.) that can cause electrolyte disturbances
  - TOXIC in overdose

- **MAOIs**
  - Potential for hypertensive crisis (via interaction with tyramine-containing foods)

**Suicidality**

- SSRI may increase risk of suicidal thoughts and acts, particularly in adolescents and young adults
  - Informed consent discussion is key
  - All have been implicated

- Note:
  - Relative risk may be elevated (approx 2x) but absolute risk remains small (0.5%)²
  - Most effective way to prevent suicidal thoughts and acts is to treat depression

1. Schneeweiss S et al. Variation in the Risk of Suicide Attempts and Completed Suicides by Antidepressant Agent in Adults Arch Gen Psychiatry 2010

**Treatment of Anxiety in Primary Care**

- All principles of treatment of depression apply!
- Difficult to dx, takes time to engage, pts often don’t recognize need for tx
- Prevalence 18%¹
- Equally debilitating as depressive disorders³
- Generate increased costs due to diagnostic³ procedures

2. C racke et al. Treatment for Anxiety Disorders: Efficacy to Effectiveness to Implementation. F. Med Care 2005
**Primary Care Anxiety**

- 4 most common anxiety disorders found in primary care:
  - Panic disorder
  - Generalized anxiety disorder
  - Social anxiety disorder
  - PTSD

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**Consider GAD if…**

- Chronic physical health problem
- No physical health problem but are seeking reassurance about somatic symptoms
- Repeatedly worrying about wide range of different issues

---

**Begin with Screening and Assessment**

- Which anxiety disorders are present?
- What other conditions accompany it?
  - Pain, depression, substance use
- What treatments have been tried in the past?
- What are the patient’s expectations?

---

**The SIMPLE SCREEN for anxiety**

- Ask your depression 2-screen
- Assess suicide risk (active and passive), plan, access
- HAVE YOU...
  - Had a spell or attack where all of a sudden you felt frightened, anxious, or uneasy? (Panic)
  - Been bothered by nerves or feeling anxious or on edge for 6 months? (GAD)
  - Had a problem being anxious or uncomfortable around people? (SAD)
  - Had recurrent dreams or nightmares of trauma or avoidance of trauma reminders? (PTSD)
Anxiety: managing the initial visit

- Motivational interviewing
- Feedback about problem - how severe is it?
- Understand patient motivation for tx
- Review barriers to tx (psychological, social, logistical)
- Once ready for tx: changes in behavior and thinking will help improve before rx of medication → aim for state of "self-activation"
- Avoid authoritarian and prescriptive style
  - Focus on "supportive companion" and "knowledgeable consultant"
  - Conceptualize anxiety as a "behavior" (rather than sx)
- RESILIENCE and HOPE!!

Education and simple skills for anxiety

- Educate about cycle of anxiety
  - Anxious thoughts, physical symptoms, avoidance
  - Genetic vulnerability, stressful experiences, maladaptive thoughts
- Refer for CBT - 6 to 8 sessions
  - Behavioral avoidance: gradual exposure
  - Question cognitive distortions
  - Relaxation techniques
    - Progressive muscle relaxation
    - Diaphragmatic breathing
  - Exercise
  - Caffeine, ETOH, sleep hygiene
  - Manage expectations - symptom elimination unlikely

Pharmacologic Approaches

- Focus on:
  - cost and generic availability
  - Risk of breakthrough sx if dose missed (paroxetine, venlafaxine)
  - Ease of titration (SSRIs easiest)
  - CYP interactions (citalopram, escitalopram, venlafaxine best)
  - Risk of adverse effects
  - Treat the primary disorder first!
- History of prior tx response?
  - Adequate trial?
  - Monitor: GAD-7, Overall Anxiety Severity and Impairment Scale (OASIS)
    - Consider scale for a week before meds

- PRN or standing tx?
  - "spot treatment"
  - Standing
    - Buspirone
    - Hydroxyzine
    - Beta blockers
    - GABAergic
    - Low dose atypical
    - Benzos
  - SSRI or SNRI
    - Beta blockers
    - Buspirone - >60mg
    - GABAergic
    - Remeron
    - TCA

High placebo response!

**The Benzo question**

- Co-administration of benzo + SSRI has been shown to speed response...but not recommended routinely.
- If patients are taking regular benzo already (>4x/week), don’t taper immediately.
  - Start antidepressant, titrate to max dose, wait 12 weeks
  - Then reduce benzo dose gradually, 10%-20% at 2-4 week intervals
  - Substitute long acting (clonazepam)
  - Consider cognition (age?)


**Consult:**

**Benzo monotherapy?**

- IF:
  - Hx of nonresponse to several antidepressants
  - Hx intolerance caused by overstimulation
  - Other adverse effects
  - Concomitant medical illness makes SSRI not doable
  - No current substance use, or serious hx, no current depression
  - No demonstrated efficacy in PTSD, may be used to reduce hyperarousal
  - Be wary of GAD (can be confused with ADD, personality disorder, unrecognized substance use disorder, atypical bipolar)

**Anxiety resistant to 1st line tx...**

- Always reconsider the diagnosis
  - Combine SSRI+ benzo
  - Combine SSRI + venlafaxine
  - Combine SSRI + mirtazapine
  - Combine SSRI + TCA
  - Consider SSRI+ buproprion
- 3rd line: add atypical antipsychotic
- Don’t forget to consider risk of serotonin syndrome

**QUESTIONS??**
Thank you!
Trauma-informed care

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*Photo courtesy of Dr. Edward Machtinger, Women’s HIV Program, UCSF, collaborative partner in this work

Disclosures

I have nothing to disclose

Learning Objectives

- Define trauma
- Review how childhood trauma results in adulthood disease and poor outcomes
- Define “trauma-informed care” and describe ways of addressing trauma in health care
- Emphasize the importance of caring for yourself as you care for others

Define Trauma

- “an event, series of events, or set of circumstances [e.g., childhood and adult physical, sexual, and emotional abuse; neglect; loss; community violence; structural violence; war] that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects.”
  - The Substance Abuse and Mental Health Services Administration (SAMHSA)
- Trauma ruptures Relationships
**Trauma and Resilience: Socio-ecological model**

Trauma and adversity are SDOH that are inequitably distributed in society

[http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html](http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html)

**How Common Is Trauma?**

- Globally deaths from trauma exceed those from HIV, malaria and TB combined¹
- 51% of all deaths in 1-44 yr olds in US²
- 90% of US residents have experienced a serious traumatic event in their lifetimes³
- 53% of all adults are exposed to either physical or sexual interpersonal violence over their lifetimes³

2. CDC, [http://www.cdc.gov/injury/overview/leading_cod.html](http://www.cdc.gov/injury/overview/leading_cod.html)

**Trauma affects health: Adverse Childhood Experiences (ACE) study**

- 17,000 predominantly White, college educated Kaiser patients
- Surveys asked about 10 categories of childhood abuse, neglect and family dysfunction
- Cross-sectional study: compared answers to an array of current health behaviors and conditions
- Conclusion: ACEs are common; and are strong predictors of later health risks and disease in a graded dose-response relationship

**ACES Study: Prevalence of childhood physical and sexual abuse?**

1. 5% physical, 2% sexual
2. 10% physical, 5% sexual
3. 28% physical, 20% sexual
4. 60% physical, 40% sexual
What are Common Effects of Trauma?

1. Depression
2. Substance use
3. Homelessness
4. Chronic Illness
5. STIs
6. All of Above

ACE's: Childhood Experiences Affect health later in life...

Adverse behaviors:
- Alcoholism and alcohol abuse
- Illicit drug use
- Smoking
- Early initiation of smoking
- Early initiation of sexual activity
- Multiple sexual partners

Reproductive outcomes:
- Unintended pregnancies
- Adolescent pregnancy

Future violence:
- Risk for intimate partner violence

Adverse health outcomes:
- Depression
- Suicide attempts
- Fetal death
- Sexually transmitted diseases (STDs)
- Health-related quality of life
- Obesity
- Ischemic heart disease (IHD)
- Liver disease
- Chronic obstructive pulmonary disease (COPD)

Adverse social outcomes:
- Homelessness

Our experiences build our brains, bodies, and behavior...

Safe, Stable, Nurturing Relationships

Nature vs. Nurture
Nature ↔ Nurture
ACE study:

ACE's: Life Expectancy—adult health is affected by childhood experiences…

People with six or more ACEs died nearly 20 years earlier on average than those without ACEs.

ACE's: Life Expectancy—adult health is affected by childhood experiences…

Adulthood IPV: Health Effects

- Injuries and death
- Poor mental health (depression, anxiety, PTSD)
- Increased suicidality
- Poor physical health (eg's)
- Chronic pain
- Disability
- Asthma
- Stroke
- Heart disease
- STD's—risk doubled or tripled, HIV risk increased
- Unwanted pregnancy and abortions
- Substance addiction (ETOH) increased
- Overuse of health services and missed medical appointments and higher cost of healthcare

http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html

Other adverse experiences…

- Oppression and Discrimination
  - Racism
  - Homophobia/Transphobia
  - Many other
- Violence
  - Structural violence (police brutality/mass incarceration/gender-based violence)
  - Bullying
  - Community violence
  - War
- Poverty
  - Housing instability/substandard housing/housing discrimination
  - Food instability
  - Unemployment
- Poor education
  - Education system disparities
  - Poor school performance due to many adverse experiences…
- More…
Trauma is "contagious": transmitted through relationships

- Passed on through individuals, families, communities, systems
- Passed on through generations
- Passed on through power dynamics/discrimination
- Passed on to healthcare providers as vicarious traumatization

Experience of trauma can be mitigated by resilience

- The ability of an individual, family, or community to cope with adversity and trauma, and adapt to challenges or change.

  The Substance Abuse and Mental Health Services Administration (SAMHSA)

  Resilience is promoted by healthy relationships and social connectedness (at every level of socio-ecological model)

Trauma informed care:

- Strengths-based service delivery approach
- Grounded in an understanding of and responsiveness to the impact of trauma
- Emphasizes physical, psychological, and emotional safety for both providers and survivors
- Creates opportunities for survivors to rebuild a sense of control and empowerment.

SAMHSA
http://www.samhsa.gov/samhsaNewsletter/Volume_22_Number_2/trauma_tip/key_terms.html

Trauma Informed Systems Principles: San Francisco DPH

A system in which there is a healing space for all (all employees and all patients) created by continuous commitment to these "trauma informed principles":

- Trauma Understanding
- Cultural Humility & Responsiveness
- Safety & Stability
- Compassion & Dependability
- Collaboration & Empowerment
- Resilience & Recovery

**Ms. Jones:**

Ms. Jones is a 44-year-old woman who comes to her first primary care visit complaining of pain and insomnia.

She has diabetes and asthma—both poorly controlled. She seeks care frequently in the ED for pain and shortness of breath where she has been noted to smell strongly of alcohol.

She is very upset that you are late for her appointment.

---

**Trauma-informed Care: Calm**

- Calm
- Contain
- Care
- Cope


---

**Trauma-informed Care: Calm**

- Calm yourself to help model and promote calmness for the patient (Co-regulation)

---

**Trauma-informed Care: Calm**

- ASSUME trauma could be root cause of poorly controlled disease processes and alcoholism
- EXPECT that change will likely be slow
- GOALS (eg’s):
  - Model a respectful, healthy relationship
  - Prioritize safety, dependability
  - De-stigmatize adverse sequelae of trauma
  - Collaborate on shared agenda setting
  - Empower and focus on resiliency
  - Practice with cultural humility and attention to power dynamics
Ms. Jones: Childhood history

Ms. Jones’ father was incarcerated for DV when she was 10. Her uncle moved in to “help out” but sexually abused her for 3 years. Ms. Jones began drinking at age 10 and did very poorly in school. She was placed in a group home at age 13 when her mother felt she was “out of control”.

Ms. Jones remembers a favorite aunt as the only person she ever felt truly loved her.

Trauma-informed Care: Contain

Introduce or ask about the topic of trauma in a way that:
- will allow the patient to maintain emotional and physical safety;
- offers choice and control,
- respects the time-frame for your interaction;
- allows you to offer the patient further trauma-specific treatments without disclosure.

Adulthood intimate partner violence screening...

- Safe, effective, increases disclosure, multiple validated tools (HITS, HARK for example)
- SFDPH questions:
  - “Has your partner (or anyone else) hurt you, hit you or threatened you?
  - “Has your partner (or anyone else) forced you to have sex or do something sexual you didn’t want to do?”
  - “Has your partner (or anyone else) tried to force you to get pregnant or interfered with your birth control?”

Non-disclosure based universal trauma education:

- NON-DISCLOSURE based education about trauma is likely the SAFEST way to introduce this topic – gives patient more control and choice
- TIME-CONSTRAINTS: do not inquire directly about trauma if you do not have time to listen compassionately to the answer.
- CARE and trauma-specific service referrals can be offered without the need for very much or any disclosure.
**Lifetime trauma screening: Early onset clues...**

- Young age of onset of substance use or mental health problem or first sexual experiences is highly suggestive of trauma
- Always ask age of onset
- "How old were you when you first started drinking alcohol?"
- "How old do you think you were when you first ever became depressed?"

**Lifetime trauma screening: If screening, then how?**

- **FRAMING:** "How we were treated when we were children can affect our health later in life so I would like to ask you about your childhood"
- "Who did you grow up with?" (parent(s)?, grandparent?, others?)
- How did [insert person(s)] treat you?
- Provide examples if unclear: "Sometimes family members cheer you on and support you and sometimes family members criticize you, put you down, hurt you or hit you?" "How did [insert person] treat you?"

**Trauma-informed care: Contain**

So, for example... When Ms. Jones tells me on the very first visit that she first began drinking at age 10, I would say...

"In my experience, when a patient tells me that she began drinking at age 10, it is often because she was experiencing very difficult things during childhood. We are just meeting each other for the first time today, so we don’t need to go into those details right now. I do want you to know that I am open to discussing those things in the future or referring you to a counselor who specializes in trauma treatment if you think that would be helpful!"

**Trauma-informed care: Contain**

Ms. Jones discloses trauma briefly without obvious distress

- **Acknowledge courage:** "Thank you for sharing this information with me"
- **Provide validation and support:** "I am so sorry this happened to you"
- **Inquire re impact:** "How do you feel this experience has affected you?"
**Trauma-informed care: Contain**

Ms. Jones becomes upset, tearful or distressed:

- **CONTAIN:** "I am hoping that we will gradually get to know each other over time. I would like to help make this clinic a place that feels healing to you. So it is very important that we only discuss the level of detail that will allow you to feel as calm as possible when you leave the appointment. Would you like a referral to a therapist who specializes in trauma care?"

- **CALM:** "Let’s take a deep breath together. Let’s sink into our chairs and feel the earth supporting us"

**Trauma-informed care: Care**

- Emphasize good self-care and compassion for both yourself and the patient
- De-stigmatize harmful behaviors...
  - NOT—what’s wrong with you?
  - Instead...What happened to you?
- Guilt and shame common—create non-judgmental space in which all feelings are valid
- Distinguish FEELINGS (never wrong, often conflicting,) from EXPLORING(without criticism) whether a relationship/behavior is harmful

**Trauma-informed care: Cope**

- Emphasize skills and interventions that build upon strength, resiliency, social connectedness and hope.
- Help patient identify as the SURVIVOR that she/he actually is!!
  - "Look at how strong you are to survive such difficult circumstances"
  - "I am so glad you had the strength to reach out for help today."
  - "I hear how loved you felt by your favorite aunt. It sounds like she was really important in your life."

Express CARE and COMPASSION (especially about stigmatized behaviors and conditions):

- "No wonder you started drinking when you were 10. It was so important for you to find a way to cope with an impossible and painful situation"

- "It can be very hard to learn to take good care of yourself when you were hurt as a child"

- "We all deserve to be treated well. "I am so sorry those things happened to you"
**Trauma Informed Care: Cope**

- **Coping Techniques:**
  
  "When you feel stressed, what do you do to cope?"

- **Discuss the benefits of adverse coping techniques:**
  
  "It sounds like alcohol really helps you cope. How does it help you? What do you like about drinking?"

- **Discuss alternatives:**
  
  "Can you think of anything else besides alcohol that helps you feel better?"

---

**Trauma Informed Care: Cope**

- Refer to evidence-based trauma-specific treatments*

- **Trauma treatment:**
  
  - Emotional regulation skills
  - Relationship skills
  - Re-framing of the trauma narrative

- Address adverse and traumatic social determinants of health (housing, food insecurity, etc.)

*http://www.samhsa.gov/nrepp

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**Caring for ourselves: Practice**

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**Trauma-informed care allows you to care for yourself while caring for others**
Summary

- Trauma is common
- Trauma is a risk factor for:
  - early mortality,
  - chronic illnesses,
  - adverse behaviors,
  - more trauma
- Resilience factors can mitigate trauma’s effects
- Trauma-informed Care
  - Integrates recognition of high prevalence
  - Builds on resilience—Calm/Contain/Care/Cope
  - Recognizes need to care for patients and providers
Optimizing Care of Patients with Disabilities
- Visual Impairment
- Mobility Impairment

Objectives

- Challenges commonly encountered by people with disabilities in clinical care
- The difference between disability and illness
- What can disability advocates teach us about our broader patient population?
Objectives

- People with visual impairments
- People with mobility Impairments
- Cultural competencies
  - Accommodations in the clinical setting
- Important adaptive strategies

How can we talk about “culture” and disability?

“People with disabilities do have a distinctive culture, founded on their shared history of discrimination and common experiences of stigmatization, poverty, social isolation, lack of self determination, and “imposed immobility” — all of which combine to produce a common sense of identity”

Spectrum of Identity

Established Dx.
May identify as disabled.
Often knows more than we do.

Chronic disease with an evolving mobility impairment.

Declining mobility.
Unaware / unacknowledged.

Blindness and Visual Impairment
The “sighted-guide” technique
Cultural Competencies

- Announce yourself
- Announce your departure
- The group conversation
- Be precise with directions
  - The clock face

Clinical Accommodations

- Announce physical contact
- Assist with paperwork in private
- Ask about reading format
- Braille and large-type pharmacy labels
Getting to know your patient

- Blind does not mean total loss of vision
- “Legal blindness” tells us fairly little
  - 20/200 or field < 20 degrees
- Method of reading?
- Orientation and mobility?
Adaptive strategies for reading

- Digital Magnification
- Closed circuit television (CCTV)
- Adaptive computer software
- Large print
- Audio
  - Bookshare
  - Newsline

Adaptive strategies for “Orientation and Mobility”
Orientation and Mobility

“The white cane tells me everything I need to know about my surroundings.”

“It represents independence.”

“A signifier that does the explaining”
US Census Definition:

Difficulty performing

- one or more functional activities (seeing, hearing, speaking, walking lifting/carrying);
- preforming ADLs (getting out of bed, bathing, dressing, eating, toileting);
- instrumental ADLs (keeping track of money and bills, preparing meals, housework, prescriptions meds;

...  

- mental or emotional condition that seriously interfered with everyday activities (learning disabilities, developmental disabilities, dementia, and mental illness)
Disability

Pathology  Impairment  Functional Limits  Disability
Macular degeneration  Decreased visual acuity  Can’t read small type  Can’t read Rx on bottle

Disability is a complex interaction between the health condition of the individual and the contextual factors of the environment. -WHO

Of the 38,000,000 seniors on Medicare…

- 12 million (31%) are fully independent (without accommodation, difficulty, or help) for self-care and mobility
- 9 million (25%) successfully adapted to disability
- 2.1 million (6%) have reduced activities without acknowledging limitations
- 7 million (18%) report difficulty but not assistance
- 7.7 million (20%) received assistance with ≥ one task
Prevalence of Visual Impairment

- 7.7 million adults have difficulty with newspaper print;
- of these, 1.8 million have no functional vision.

Language

- Evolving
  - Handicap
  - Disabled
  - People with disabilities
  - Visually impaired, low-vision, legally blind, partially sighted, totally blind
Language

“Where have you been? You must not know very much about my disability.”

Language

“How do you pronounce your name?”
Disparities in Care

- Increased susceptibility to secondary health problems
- Disparities in access
- Lower rates of preventive services
- Poorer health outcomes
- Important intersection with poverty

Mobility Impairments
Cultural Competencies

• A wheelchair is considered personal space
• Place yourself at the patient’s eye level when talking for more than a moment.
• Is a transfer to the exam table necessary?

Language

• Wheelchair bound
• Confined to a wheelchair
• Wheelchair user
• Mobility
Screening

“Timed Up and Go” (TUG) Test

a. rise from chair
b. walk 10 feet
c. turn around
d. return to seated position

>12 seconds = ↑ risk of falls

Mobility Aids

• Improve safety
• Decrease pain
• Decrease energy expenditure
• Restore independence
Canes

Standard cane  Offset cane  Quad cane
Proper fitting of canes & walkers

- Align with the wrist crease (with arm relaxed at side), wearing typical shoes
- Elbow flexed 15-30 degrees while walking

Social stigma & mobility aids

- Reframe the issue
  - Describe the aids as tools
  - “increased mobility”
  - “maximize potential”
- Not all or nothing.
Take home

• Disability = Functional Limit + Environment
• Address disability independent of the pathology
  - e.g. add *mobility* to the problem list
• Cultural competencies exist and can be mastered
Hunger

- The uneasy or painful sensation caused by a lack of food, or the recurrent and involuntary lack of access to food. (LSRO)

Food security:
Access by all people at all times to enough food for an active, healthy life

Food insecurity:
Household-level economic and social condition of limited or uncertain access to adequate food

Objectives

- Understand key differences between hunger and food insecurity and why these differences are important for clinicians
- Describe three mechanisms by which food insecurity increases risk of diet-sensitive chronic disease
- Learn how to screen for and respond to food insecurity in the clinical setting
Coping Strategies to Avoid Hunger

- Eating low-cost foods
  - Fewer F&V
  - More fats/carbs
- Eating highly filling foods
- Small variety of foods
- Avoiding food waste
- Binging when food is available

- Higher risk of obesity, diabetes, & other chronic, diet-sensitive chronic disease
- Once you are chronically ill, poorer ability to manage it your illness

Risk Factors (Household-Level)

- Children (19%)
  - Children under age 6 (20%)
  - Children with single mother (35%)
  - Children with single father (25%)
- Income <185% FPL (34%)
- Black (26%) or Latino (22%)
- Smoker in the household

Food Insecurity

What we know today
Across the lifespan, food insecurity is associated with:
- Poorer dietary intake
- Poorer physical, psychological, and behavioral health
- Poorer disease management

What we think we know
Improving food security results in:
- Better dietary intake & lower weight
- Improved disease management
- Lower healthcare costs
- Higher quality (broadly) of health
Across the Lifespan:

- **Kids:** Fe-def anemia, behavioral problems, mental health sx’s, poor cognitive development & academic achievement, hospitalizations, obesity
- **Adults:** obesity, DM, HTN, CVD, depression, hospitalizations, ED utilization
- **Elderly:** reduced independence
- **HIV:** poorer viral suppression, decreased medication adherence

These are just a few of the MANY associations.

---

**Obesity-Hunger Paradox**

- **Dietary Quality**  
  - Food affordability
- **Eating Behaviors**  
  - Episodic food inadequacy
- **Bandwidth & Stress**

---

**Relation between the energy density of selected foods and energy costs (¢/MJ)**

Food Costs, Dietary Intake, & Obesity

- Diet recommended by USDA requires low-income family spend 43-70% of their food budget on F&V’s.

- Increasing dietary potassium to meet 2010 USDA Dietary Guidelines for Americans would add $380 to the average consumer’s annual food costs. Meanwhile, each 1% additional calories from saturated fat and sugar results in significant decrease in food costs.

Diabetes and Dietary Intake

<table>
<thead>
<tr>
<th>Population</th>
<th>Food Insecure</th>
<th>Food Secure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty Following a Diabetic Diet</td>
<td>64%</td>
<td>49%</td>
</tr>
<tr>
<td>Seligman, Diabetes Care 2012</td>
<td>OR 2.00 (1.44-2.78)</td>
<td>AOR 1.46 (1.01-2.11)</td>
</tr>
<tr>
<td>OR 2.00 (1.44-2.78)</td>
<td>Age, sex, race/ethnicity, income, education, BMI, insulin, medication adherence</td>
<td></td>
</tr>
<tr>
<td>Daily Servings of Fruit</td>
<td>0.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Lyles, Diabetes Care 2013</td>
<td>p&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>(no longer significant after adjusting for age, sex, income, race, intervention arm, time, food insecurity*time)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Servings of Vegetables</td>
<td>1.8</td>
<td>2.1</td>
</tr>
<tr>
<td>Lyles, Diabetes Care 2013</td>
<td>p&lt;0.001</td>
<td></td>
</tr>
</tbody>
</table>

Obesity-Hunger Paradox

- **Dietary Quality**
  - Food affordability
- **Eating Behaviors**
  - Episodic food inadequacy
- **Bandwidth & Stress**

Cycles of Consumption

- Food insecurity is cyclical & episodic
  - Monthly SNAP ("The Food Stamp Cycle") or pay checks
  - Seasonal variation
  - Periodic, unforeseen expenditures
- Food insecure households are food insecure during 7 months of the year on average
- Month-to-month variability in intake is seen most acutely among mothers

Cycles of Food Adequacy and Inadequacy

- Compensatory Strategies during Food Adequacy
  - Avoidance of food waste
  - Systematic overconsumption
- Compensatory Strategies during Food Shortage
  - Skipped meals
  - Reduced caloric intake

Hyperglycemia Hypoglycemia

Cycles of Demand

- Food banks & soup kitchens
- Big-box retailers (Walmart, Target, etc.)
  - Inventory and staffing
- Grocery store scanning receipts
- Dietary intake among women
  - Decreasing calorie, carb, vitamin, fruit and vegetable intake over course of month

Disordered Eating Practices

- Binge eating
- Hoarding
- Food obsessions
- Extreme avoidance of food waste
- Strong preferences for highly filling foods

Hypoglycemia & Food Access

- Pre-recession: Patients with diabetes in an urban, safety net hospital
  - 1/3 of those who reported hypoglycemia attributed it to the inability to afford food
- Post-recession: Primary care patients with diabetes at community health centers (38% food insecure)
  - Blood sugar ever gotten too low because you couldn’t afford food (33% FI vs 5% FS)
  - Ever been to the ER because your blood sugar was too low (28% FI vs 5% FS)

Nelson, JAMA, 1998; Seligman, JHCPUs, 2010.

Food Insecurity and Hypoglycemia

Of the 711 participants, 197 (28%) reported at least one significant hypoglycemic episode in the previous year.

4+ episodes: AOR 1.9 (1.1-3.5)

Seligman, Arch Int Med, 2011.
Risk Factors for Severe Hypoglycemia (Self-Reported)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>AOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Insecurity</td>
<td>3.0 (1.5-5.9)</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>2.2 (1.1-4.5)</td>
</tr>
<tr>
<td>Comorbid illnesses</td>
<td>1.5 (1.1-2.0)</td>
</tr>
<tr>
<td>Obesity</td>
<td>0.3 (0.1-0.7)</td>
</tr>
</tbody>
</table>

Not significant: renal disease, insulin use, hypoglycemia knowledge, English proficiency, age, race/ethnicity, education, income, tobacco use, glucose monitoring, and medication adherence

Seligman, Arch Int Med, 2011.

Admissions Attributable To Hypoglycemia Among Patients Ages 19+ To Accredited California Hospitals On Each Day Of The Month, By Income Level, 2000–08.

27% increase in hypoglycemia admissions during 4th week of month (compared to 1st week of month) for low-income group only, p<0.01

Seligman H K et al. Health Aff 2014;33:116-123

Cost of A Health Care Visit for Low Blood Sugar vs. Food

- $17,564 INPATIENT ADMISSION
- $1,387 EMERGENCY VISIT
- $394 OUTPATIENT VISIT
- $657* MONTHLY FOOD COST (FAMILY OF 4)

American Journal of Managed Care, 2011.

*Thrifty Food Plan

Cycles of Food Adequacy and Inadequacy

Compensatory Strategies during Food Adequacy
- Avoidance of food waste
- Systematic overconsumption

Compensatory Strategies during Food Shortage
- Skipped meals
- Reduced caloric intake

Hyperglycemia

“In the beginning of the month I eat more meats, salads and fruits...At month’s end I have to eat whatever is in the cupboard....”

“The end of the month, I start getting out of food...but I have to eat something, ‘cause if I don’t eat behind my [insulin] shot, that shot will make you so sick. I just eat anything I can find during that time just to keep me from getting sick.”

Wolfe, 1998; Wolfe, 2003; Hamelin 2002

Food Insecure Adults with Diabetes Have Higher Average Blood Sugars

<table>
<thead>
<tr>
<th></th>
<th>Food Secure</th>
<th>Food Insecure</th>
<th>Adjusted RR 1.35 (1.05-1.74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c &gt;7% (NHANES, known diabetics &lt;200% FPL)</td>
<td>49%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Mean HbA1c (ICH, n=711)</td>
<td>8.1%</td>
<td>8.5%</td>
<td>p=0.007</td>
</tr>
<tr>
<td>Mean HbA1c (MFFH, n=621)</td>
<td>8.0%</td>
<td>8.4%</td>
<td>p=0.01</td>
</tr>
</tbody>
</table>

Seligman, J Nutrition, 2010; Seligman, Diabetes Care, 2012; Lyles, Diabetes Care, 2013.

Food Insecure Adults with Diabetes Have Higher Average Blood Sugars

<table>
<thead>
<tr>
<th>HbA1c</th>
<th>Food secure (n=354)</th>
<th>Food insecure (n=296)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=7.0</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>7.1-8.0</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>8.1-9.0</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>9.1-10.0</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>10.1-11.0</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>&gt;11</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Seligman, Diabetes Care, 2012.

Obesity-Hunger Paradox

- Dietary Quality
  - Food affordability
- Eating Behaviors
  - Episodic food inadequacy
- Bandwidth & Stress
Hunger Takes Up a Lot of Brain Space

- Less space left over for:
  - Registering/re-registering for benefits
  - Applying for/maintaining employment
  - Taking care of health needs
  - Parenting children

---

Key Points in AAP Policy Statement

- Recognizes importance of food insecurity for children’s physical and mental health, behavior, and developmental outcomes
- Recommendations:
  - 2-item screening tool (with yes/no response options) “at scheduled health maintenance visits”
  - Pediatricians should familiarize themselves with community resources
  - Pediatricians should learn how food insecurity impacts health outcomes
  - Pediatricians should be advocates for increasing access/funding to nutrition programs

---

American Association of Pediatrics Recommends Universal Screening

**POLICY STATEMENT**

Organizational Principles to Guide and Achieve the Optimal Health Care Service and/or Improve the Health of All Children

Promoting Food Security for All Children

Available at: [http://pediatrics.aappublications.org/content/pediatrics/136/5/S401.full.pdf](http://pediatrics.aappublications.org/content/pediatrics/136/5/S401.full.pdf)

---

Resources Suggested to Clinicians

- 2-item screen
- Sparse resources
  - 2-1-1
  - Healthy Food Bank Hub
  - MyPlate

---

Please don’t use this screener!
2-Item Clinical Screening for Food Insecurity

1. Within the past 12 months we worried whether our food would run out before we got money to buy more.
2. Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.

– Often or sometimes true to EITHER question suggests food insecurity (97% sensitivity, 83% specificity)

HKS phrasing: “How often during the last year would you say you....? Often, sometimes, or never?”

Only Very Early Data on Clinical Screening Programs Available

• Kaiser Permanente of Colorado experience (Dr. Sandra Stenmark):
  http://healthaffairs.org/blog/2015/07/13/linking-the-clinical-experience-to-community-resources-to-address-hunger-in-colorado/

• Passive referrals are much less efficient than active referrals

AMERICAN DIABETES ASSOCIATION

STANDARDS OF MEDICAL CARE IN DIABETES—2016

• Two A recommendations
  – “Providers should evaluate hyperglycemia and hypoglycemia in the context of food insecurity and propose solutions accordingly.”
  – “Provider should recognize that homelessness, poor literacy, and poor numeracy often occur with food insecurity, and appropriate resources should be made available for patients with diabetes.”
• Day without food “may mirror “sick day” management protocols”
• Long-acting insulin without peaks may reduce risk for hypoglycemia; short-acting insulin immediately after food consumption
• Glipizide preferred sulfonylurea immediately before meal
• Secure places to keep diabetes supplies & refrigerator access to store insulin

Clinical Implications
• In the setting of frequent/severe hypoglycemia:
  – Before you liberalize glycemic targets, screen for food insecurity
  – If food insecure:
    • Tie medications to meals, rather than time of day
    • Prioritize medications with low hypoglycemic risk (short half-life or MTF)
    • Prescription labels
    • Expanding definition of a “sick day”
• Smoking cessation

Clinical Implications
• Refer to food assistance programs
  – SNAP—50% of eligible Californians not enrolled, particularly seniors
    – SSI recipients in CA still not eligible
    – Former drug felony in CA are now eligible
  • Elder nutrition programs (congregate meal sites)
  • Meals on Wheels
  • Food pantries/soup kitchens
• Address stigma
  – “This is as important for your health as the medicines I am prescribing.”

Dietary Counseling
• Stress portion control rather than dietary substitutions
• Frozen (not canned) fruits and vegetables
• Farmers’ markets
• Nutritionist & SW referral for other strategies
Thank You

hilary.seligman@ucsf.edu
Updates in HIV Care for Vulnerable Patients

Susa Coffey, MD
UCSF Division of HIV, Infectious Diseases and Global Medicine
San Francisco General Hospital

Objectives
To learn about recent developments in:

- HIV epidemiology in the U.S.
- PrEP
- Treatment 
  ◆ When to start
  ◆ What to start
  ◆ ARV update (TAF)
  ◆ Immediate ART initiation
  ◆ Adherence and retention
- Shifting mindsets: PrEP, universal treatment, immediate ART initiation

Intro
- Why are we still talking about HIV?
  ◆ Nearly 50,000 new infections/year in the U.S.
  ◆ Approx 1.1 million living with HIV
  ◆ If untreated, inevitably causes illness and death
  ◆ Disproportionately affects vulnerable populations

Disclosures
I have no disclosures
**Intro (2)**

- HIV inherently is a disease of vulnerable and underserved populations
  - Disparities related to race, sexual orientation, gender identity, poverty, geography, education level, insurance status, access to health care, substance use, addiction, mental health, immigration status, unstable housing, etc.
- STIGMA continues to shape responses to HIV

**Intro (3)**

- But, it’s a preventable disease, and a treatable disease

---

**HIV by Race/Ethnicity in the U.S.**

Rates of Diagnoses of HIV Infection among Adults and Adolescents, by Sex and Race/Ethnicity, 2014—U.S.

**Incidence of HIV in MSM**

Diagnoses of HIV Infection among Adult and Adolescent Males, by Transmission Category, 2013-2016 United States and 6 Dependent Areas
**Lifetime Risk of HIV**

- **African American Men:** 1 in 2
- **Hispanic Men:** 1 in 4
- **White Men:** 1 in 11
- **African American Women:** 1 in 6
- **Hispanic Women:** 1 in 14
- **White Women:** 1 in 41

**In SF, recent study estimated 39% prevalence**

---

**HIV Rates in Transgender Women**

- **Incomplete data**
- **Meta-analysis:**
  1. 22% of U.S. transwomen (OR 34 vs all adults age 15-49)
  2. 28% of trans women tested HIV+
     - Black trans women 56%
     - Latina 16%
     - White 17%
- **In SF, recent study estimated 39% prevalence**

---

**Cases**

1) 22 yo AA MSM, 3 regular partners, 1 HIV+ and on ART, others on PrEP. Usually uses condoms (always with HIV+ partner).
   - Should he be offered PrEP?

2) 34 yo Latina, former IDU, now clean. Delivers 3rd child hospital. Rapid HIV Ab and HIV RNA are neg there.
   - Should she be offered PrEP?

3) 16 yo AA man, sex with girls. Gonorrhea 4 months ago.
   - Should he be offered PrEP?
**USPHS and CDC PrEP Recs**

Consider PrEP for individuals who are at substantial risk of HIV acquisition, including:

- Sexually active MSM
- Heterosexually active women and men
- Adult IDUs
- (Transgender women and men)*

Substantial risk includes:

- Using condoms inconsistently
- High number of sex partners
- HIV+ sex partner
- Recent STD
- HIV+ injecting partner
- Sharing injection or drug preparation equipment
- Commercial sex work

*Not a specific GL recommendation

**Question**

Which of the following is true about the number of people in the U.S. with an indication for PrEP?

A. More MSM than women  
B. The number of women and MSM is about the same  
C. More IDUs than MSM

**CDC indications for PrEP**

Number of U.S. adults with indication for PrEP

- Number of U.S. adults with indication for PrEP
- % of U.S. adults with indication for PrEP

**PrEP: Pre-Exposure Prophylaxis**

- What do we know about efficacy and safety?
  - Tenoforv + emtricitabine (TDF/FTC, Truvada), 1 pill once daily
  - Highly effective if taken as directed (preferably daily)
  - Does NOT work if not taken regularly*  
    - eg, VOICE and Fem-PrEP studies in women
  - AE: mild “start-up syndrome” (GI); rare serious AEs. Possible renal and bone AEs

* # of doses/week required for efficacy is not well defined; may be higher for women than for men.
**Question**

Intermittent PrEP (TDF/FTC), or “event-driven” PrEP, has been shown to be effective in which of the following populations:

A. Cisgender women  
B. Transgender women  
B. Men who have sex with men  
C. Injection drug users  
D. None of the above

---

**PrEP – “Real World”**

- PROUD study
  - 554 high-risk HIV-neg MSM
  - STD clinics in England
  - Randomized immediate vs deferred PrEP (TDF/FTC [Truvada])
  - New HIV infections: 3 vs 19; incidence 1.3 vs 8.9 per 100 py
  - 86% reduction in HIV infection (p=0.0002)
  - NN to prevent: 13
  - Study stopped early

---

**PrEP – “Event-Based”**

- IPERGAY study
  - Event-based PrEP (randomized TDF/FTC vs placebo)
  - 400 high-risk MSM (≥2 partners in previous 6 mos)
  - 2 tabs before sex, 1 tab 24 hrs after, 1 tab 48 hrs after
  - New HIV infections: 2 (PrEP) vs 14 (placebo); incidence 0.94 vs 6.6 per 100 py
  - 86% reduction in incidence, p=0.002
  - NN to prevent: 18
  - Median 16 pills/month

---

**PrEP – Transwomen**

- Efficacy in transgender women– subgroup analysis of iPrEx (RTC + open-label extension)
  - N=339 TG women
  - HR= 1.1 (95% CI 0.5-2.7)
  - Adherence vs other issues:
    - No detectable drug in seroconverters
      - Incidence 4.9/100 p-y if no detectable drug
      - Incidence 0 if detectable drug

Deutsch, Lancet HIV 2015
**PrEP**

**Summary**
- PrEP works if people take it!
- Close adherence required, *ideally* 7 days per week
  - Some data in MSM suggest 4 doses/week may be adequate (fewer is not protective)
  - In women, daily dosing may be very important
    - No data support less frequent dosing
    - Tissue drug levels may be very low
- May take 2+ weeks to achieve adequate drug levels

**Summary (2)**
- Monitor creatinine, ?bone parameters
- Test HIV regularly
- PrEP failure can result in HIV infection with ARV resistance
- Women (cis- and transgender), AA, Latino, IDU, other risk groups are underserved re PrEP and may need focused PrEP outreach and education efforts

---

**PrEP**

**Caution**
- TAF: no clinical data as PrEP
  - PK data in HIV neg women show low TFV-DP concentrations in cervical, vaginal, and rectal mucosa
    - 2-fold lower in cervicovaginal tissue, 11-fold lower in cervicovaginal fluid, 10-fold lower in rectal tissue

---

**TFV concentrations up to 100-fold higher in rectal than in cervicovaginal tissues**

**Mucosal Tissue Pharmacology**

**Days after TDF/FTC dose**

Patterson et al. Sci Transl Med 2011, Garrett KL, CROI 2016, Abs 102LB.
Cases

1) 22 yo AA MSM, 3 regular partners, 1 HIV+ and on ART, others on PrEP. Usually uses condoms (always with HIV+ partner).
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2) 34 yo Latina, former IDU, now clean. Delivers 3rd child hospital. Rapid HIV Ab and HIV RNA are neg there.
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3) 16 yo AA man, sex with girls. Gonorrhea 4 months ago.
   - Should he be offered PrEP?

When to Treat: DHHS Recommendations for ART

- Antiretroviral therapy (ART) is recommended for all HIV-infected individuals, regardless of CD4 T lymphocyte cell count, to reduce the morbidity and mortality ...(AI).

- ART is also recommended for HIV-infected individuals to prevent HIV transmission (AI).

New: A1 recommendation for ALL

START Study

- CD4 cell count >500, randomized to immediate ART vs deferred until CD4 <350 or AIDS, n = 4685
- Primary EP: serious AIDS event, serious non-AIDS related event, or death

\[ HR = 0.43 (95\% CI: 0.30 - 0.62; P < 0.001) \]
“Most of the AIDS-related and non–AIDS-related events occurred when patients had a high CD4+ count. Immediate antiretroviral therapy benefited even those with a latest CD4+ count of more than 500 cells per cubic millimeter, which may indicate that a substantial part of the beneficial effect of immediate treatment is due to changes induced by antiretroviral therapy in markers other than the CD4+ count.”

### What to Start: DHHS Recommended Regimens for 1st ART

<table>
<thead>
<tr>
<th>Integrase Inhibitor based</th>
<th>Dolutegravir/ABC/3TC; only if HLA-B*5701 negative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dolutegravir (QD) + TDF/FTC</td>
</tr>
<tr>
<td></td>
<td>Elvitegravir/COBI/TAF/FTC; only if pre-ART CrCl ≥30</td>
</tr>
<tr>
<td></td>
<td>Elvitegravir/COBI/TDF/FTC; only if pre-ART CrCl &gt;70 mL/min</td>
</tr>
<tr>
<td></td>
<td>Raltegravir + TDF/FTC</td>
</tr>
</tbody>
</table>

| PI based                  | Darunavir (QD) + ritonavir (QD) + TDF/FTC        |

**Note:** alternatives may be optimal for individual patients

### New NRTI: Tenofovir alafenamide (TAF)

- **New tenofovir prodrug**
  - 90% lower plasma tenofovir levels, higher intracellular levels than with TDF
  - Appears safer for kidneys (less proteinuria, slightly less decrease in eGFR), bones (less adverse BMD change)

- **Available**
  - EVG/cobi/TAF/FTC (Genvoya)
    - Efficacy equivalent to EVG/cobi/TDF/FTC (Stribild)
    - Approved for eGFR ≥30
  - Rilpivirine/TAF/FTC (Odefsey): just approved
  - Approval expected April: TAF/FTC
    - Substitution of TAF/FTC for TDF/FTC effective

### Question

Which ART regimens are recommended by DHHS Guidelines for initial treatment?

A. Efavirenz/TDF/FTC (Atripla)
B. Atazanavir + ritonavir + TDF/FTC (Reyataz + Norvir + Truvada)
C. Dolutegravir/abacavir/3TC (Triumeq)
D. Elvitegravir/cobicistat/TAF/FTC (Genvoya)
E. All of the above
F. C and D
G. This craziness is why I refer my HIV patients to a specialist....
**New NRTI: Tenofovir alafenamide (TAF)** (2)

Cautions:
- HBV: limited data in HIV/HBV coinfection; appears effective against hepatitis B
- PrEP: no clinical data
  - PK data in HIV neg women show low TFV-DP concentrations in cervical, vaginal, and rectal mucosa
    - 2-fold lower in cervicovag tissue, 11-fold lower in cervicovag fluid, 10-fold lower in rectal tissue
  - DO NOT USE AS PrEP
- Limited data in moderate-severe CKD
- Dosing: 10 mg/day with PK boosters, 25 mg/day if no PK booster

New: TAF = as effective against HIV, perhaps safer than TDF (follow the data)

---

**Case**

- 36 yo Turkish man, in US x 2 years (refugee)
- Referred from STD Clinic with + rapid HIV Ab test
- Last HIV test >2 yrs ago in Turkey: neg
- MSM
- Always used condoms in his country, in SF always ... except once, several months ago
- 2 months ago, seen in urgent care clinic for sore throat: rapid strep test negative
- HIV testing not done

---

**Question**

When would you start ART?

- A. Today
- B. After getting to know the patient over several visits
- C. After results of baseline labs and HIV genotype are available
- D. If CD4 is <500 cells/mm³

---

**Rapid (Same-Day) ART**

SFGH Ward 86 RAPID Program

- Pt referred from HIV testing site
- SW intake, counseling, insurance/benefits activation (eg, emergency Medi-Cal)
- Intake labs
- Clinician intake visit including patient education about ART
- Start ART immediately, unless there is a clear contraindication
- F/u next day with SW + prn, clinic visit (SW and clinician) ≤1 week: close f/u for weeks-months
Immediate (Same-Day) ART

- Rationale for immediate start:
  - Achieve health benefits earlier (morbidity and mortality)
  - Reduce size of HIV reservoir (especially important in acute/early HIV)
  - Prevent HIV transmission
  - Early linkage to care
  - Patient expectation
- Rationale for delayed start:
  - No baseline test results
  - Patient may not be ready
  - Adherence may be threatened
  - "Too difficult"

RAPID Program at SFGH

Time to VL suppression by ART initiation strategy, 2006-2014

Supporting Adherence

Simplifying ART:
- Single-pill regimens
  - Atripla: efavirenz/TDF/FTC
  - Complera: rilpivirine/TDF/FTC
  - Genvoya: elvitegravir/COBI/TAF/FTC*
  - Stribild: elvitegravir/COBI/TDF/FTC*
  - Triumeq: dolutegravir/ABC/3TC*
  - Odefsey: rilpivirine/TAF/FTC (just approved)
- 2 pill regimen
  - Dolutegravir + TDF/FTC*

*DHHS recommended regimens

Supporting Adherence

- #pills, dosing frequency
- Tolerability, food requirements (eg, Complera), AEs, DDIs (eg with methadone, OCPs, PPIs)
- Pill packets/medisets
- HIV-savvy pharmacies
- Expert SW: benefits, housing, etc.
- Patient navigators
- DOT, eg, with methadone clinic, TB clinic
- Co-located psych, substance abuse services
- Teamwork!
Retention

- Retention remains a major issue
  - Barriers: socioeconomic, unstable housing, unstable insurance, addiction, stigma, denial, food insecurity, fragmented health system, unwelcoming clinic environments, mental health, etc.
  - Requires intensive and ongoing work by multidisciplinary team
- But what’s new about that, to this audience? – we continue the work....

Summary

- (Test), Prevent, Treat, Retain!
- PrEP – consider for all patients at risk; get it to all at-risk populations
- Treat all HIV+ persons, as early as possible
  - Consider immediate treatment upon diagnosis
- Integrase inhibitors preferred for first-line ART
  - Choose simple, tolerable combinations
  - Goal is viral suppression
- TAF – may be safer than TDF (look for further data)
- Support adherence and retention in care

“Getting to Zero” in San Francisco

Zero new HIV infections
Zero HIV deaths
Zero stigma and discrimination
TOBACCO USE IN UNDERSERVED SETTINGS
Maya Vijayaraghavan, MD MAS
Division of General Internal Medicine
San Francisco General Hospital

Acknowledgments
Obtained slides/pictures from:
• CDC Tips for former smokers campaign; www.cdc.gov/tobacco/campaign/tips/
• Slides from Rx for change: Rxforchange.ucsf.edu

Disclosures
I have nothing to disclose

Objectives
• Review epidemiology of tobacco use
  □ Prevalence in low-income populations
  □ Factors influencing tobacco use and cessation
  □ Health effects of tobacco
    □ CDC Tips for Former Smoker’s Campaign
    □ Health benefits of tobacco cessation
• Review treatment options
  □ Medications
  □ Counseling
  □ Policy interventions
High prevalence low-income populations

- Significant decline in the past 4 decades.
  - Prevalence of smoking ~ 18%
- 3-5 times higher among underserved and vulnerable populations:
  - Persons living below the federal poverty line
  - Persons with a history of homelessness
  - Persons with a history of incarceration
  - Persons with mental health disorders
  - Persons with substance use disorders
  - Racial/ethnic minorities
  - Gender and sexual minorities

A PUBLIC HEALTH CHALLENGE OF OUR TIME: DISPARITIES IN TOBACCO-ATTRIBUTABLE DEATHS

- Morbidity & mortality 2 to 4 times higher than general population
- Tobacco-attributable diseases are leading causes of morbidity & mortality
- Underserved have not benefitted from population-wide tobacco control efforts

Factors that influence tobacco use and cessation

Cigarettes:
- Most common form of tobacco in the U.S.
- Usually sold in packs of 20

Cigars:
- Have more nicotine than cigarettes.
- One cigar can have enough nicotine to make a person dependent

Clove cigarettes:
- Mixture of tobacco and cloves
- Have twice the nicotine compared to cigarettes

What are the different forms of tobacco?
What are the different forms of tobacco?

Bidis:
- Look like marijuana joints; come in candy flavors
- Higher levels of tar, carbon monoxide, and nicotine than cigarettes

Waterpipe smoking (hookah):
- Tobacco flavored with fruit pulp, honey
- Often used for longer amounts of time than cigarettes, so more smoke is inhaled

Pipes:
- Puffed into the mouth, typically not inhaled
- Least commonly used forms of tobacco

Smokeless or ‘spit’ tobacco include:
- Chewing tobacco and snuff (snus)
- More men than women

Most commonly used by:
- Young adults (18-25 years old)
- American Indians & Alaskan Natives
- Residents of the southern U.S. and rural areas

Electronic nicotine delivery systems – Electronic cigarettes
- Generally similar in appearance to cigarettes, cigars, pipes, or pens
- Battery-operated devices that create a vapor for inhalation
  - Simulates smoking but does not involve combustion of tobacco
- Also known as:
  - E-cigarette
  - E-hookah, Hookah pen
  - Vapes, Vape pen, Vape pipe
- Electronic nicotine delivery system (ENDS)

Health effects of smoking – CDC Tips for Former Smoker’s Campaign

- Cancer
- Cardiovascular diseases
- Respiratory disease
- Diabetes
- Fertility/Reproductive problems

Health effects include:
- HIV
- Teeth
- Eyes
- Immune function
- All organs are involved…

http://www.cdc.gov/tobacco/campaign/tips/
Health benefits from smoking cessation

**Circulation improves, walking becomes easier**
- Lung function increases

**Excess risk of CHD decreases to half that of a continuing smoker**
- 1 year
- Risk of stroke is reduced to that of people who have never smoked
- 10 years
- Risk of CHD is similar to that of people who have never smoked

**Lung cancer death rate drops to half that of a continuing smoker**
- 2 weeks to 3 months
- 1 to 9 months
- 1 year
- 5 years
- 10 years
- After 15 years

**Ability to clear lungs of mucus increases**
- Coughing, fatigue, shortness of breath decrease

**Risk of cancer of mouth, throat, esophagus, bladder, kidney, pancreas decrease**

**Risk of CHD is similar to that of people who have never smoked**

---

**Treatment for tobacco dependence**

---

**Mr. P**

Mr. P is a 55 yo man with a previous history of homelessness, substance use, traumatic brain injury, mild cognitive impairment, and depression, who has been 1 ppd smoker for 40 years.

- He lives in a board and care facility for persons with dual diagnoses where smoking is not allowed indoors.
- He is not ready to quit smoking, stating “I will never quit smoking”.
- How would you counsel this patient?

---

**Tobacco dependence – A 2 part problem**

**Tobacco Dependence**

- **Physiological**
  - The addiction to nicotine
  - Treatment
  - Medications for cessation

- **Behavioral**
  - The habit of using tobacco
  - Treatment
  - Behavior change program

Treatment should address the physiological and the behavioral aspects of dependence.
Nicotine is very addictive

- Nicotine is the addictive substance in all forms of tobacco
- Over 30% of people who smoke develop nicotine dependence.
  - Less than 20% of people who use cocaine, heroin, or alcohol develop dependence.
- Nicotine causes pleasurable effects that reinforce tobacco use.
- Nicotine cessation leads to severe withdrawal symptoms and craving that make tobacco cessation challenging.

Nicotine replacement therapy – First-line FDA approved medications for smoking cessation

- Reduces physical withdrawal from nicotine
- Eliminates the immediate, reinforcing effects of nicotine that is rapidly absorbed via tobacco smoke
- Allows patient to focus on behavioral and psychological aspects of tobacco cessation.

NRT products approximately double quit rates.

Nicotine Replacement Therapy

- Polacrilex gum
  - Nicorette (OTC)
  - Generic nicotine gum (OTC)
- Lozenge
  - Nicorette Lozenge (OTC)
  - Nicorette Mini Lozenge (OTC)
  - Generic nicotine lozenge (OTC)
- Transdermal patch
  - NicoDerm CQ (OTC)
  - Generic nicotine patches (OTC, Rx)
- Nasal spray
  - Nicotrol NS (Rx)
- Inhaler
  - Nicotrol (Rx)

First-line FDA approved pharmaceutical therapy - Bupropion and Varenicline

- Psychotropic medications
  - BUPROPION/ZYBAN
    - Reduce withdrawal
    - Reduce cravings

- Nicotine receptor partial agonist
  - VARENICLINE/CHANTIX
    - Reduce withdrawal
    - Blocks dopaminergic reward pathway
Combination first-line pharmaceutical therapy (not FDA-approved, but evidence-based)

- Bupropion + NRT
- Transdermal patch + short-acting NRT (gum/spray)

Second-line pharmaceutical therapy

- Nortriptyline
- Clonidine

The efficacy of combination medications for smoking cessation

<table>
<thead>
<tr>
<th>Pharmacotherapy</th>
<th>Estimated Abstinence rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>13.8</td>
</tr>
<tr>
<td>First-line agents</td>
<td></td>
</tr>
<tr>
<td>Nicotine gum</td>
<td>19.0 (16.5-21.9)</td>
</tr>
<tr>
<td>Nicotine inhaler</td>
<td>24.8 (19.1-31.6)</td>
</tr>
<tr>
<td>Nicotine lozenge</td>
<td>24.2</td>
</tr>
<tr>
<td>Nicotine patch</td>
<td>23.4 (21.3-25.8)</td>
</tr>
<tr>
<td>Nicotine nasal spray</td>
<td>26.7 (21.5-32.7)</td>
</tr>
<tr>
<td>Varenicline</td>
<td>33.2 (28.9-37.8)</td>
</tr>
<tr>
<td>Bupropion SR</td>
<td>24.2 (22.2-26.4)</td>
</tr>
<tr>
<td>Combination therapy</td>
<td></td>
</tr>
<tr>
<td>Patch + gum or inhaler</td>
<td>36.5 (28.6-45.3)</td>
</tr>
<tr>
<td>Nicotine patch + bupropion</td>
<td>28.9 (23.5-35.1)</td>
</tr>
</tbody>
</table>


Medications for individuals with mental illness

<table>
<thead>
<tr>
<th>Persons with:</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>• Bupropion</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>• Bupropion (need to be on stable antipsychotic regimen)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>• Bupropion (consider using a lower dose at 150mg and monitor)</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>• Nortriptyline</td>
</tr>
<tr>
<td>Anxiety/insomnia</td>
<td>• Nortriptyline</td>
</tr>
<tr>
<td></td>
<td>• Clonidine</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>• Guidelines do not recommend the use of any FDA-approved medications for treatment of tobacco dependence</td>
</tr>
</tbody>
</table>

E-cigarettes – to use or not to use?

- Most common reasons for using e-cigarettes:
  - Youth: flavors, experimentation
  - Adults: cessation aid, circumvent indoor smoking rules, flavors/taste

- Evidence is limited but what is known:
  - E-cigs have not been shown to increase successful quitting
  - E-cigs may serve as a gateway to cigarette smoking among youth
  - E-cigs may encourage polyuse of tobacco products
**E-cigarettes – to use or not to use?**

- What to tell patients:
  - E-cigarettes are not approved by the FDA for smoking cessation
  - They are unregulated
  - Safety is a concern
  - Encourage smoking cessation but suggest use of FDA approved medications for cessation

Grana et al, 2014; King et al., 2015; Dutra et al., 2015; Popova et al., 2013

**Tobacco cessation requires behavior change**

- Fewer than 5% of people who quit without assistance are successful in quitting for more than a year.
- Few patients adequately PREPARE and PLAN for their quit attempt.
- Patients think they can just “make themselves quit”

Behavioral counseling is a key component of treatment for tobacco use and dependence.

**Effects of clinician interventions**

With help from a clinician, the odds of quitting approximately doubles.

- **n = 29 studies**

<table>
<thead>
<tr>
<th>Type of Clinician</th>
<th>Estimated abstinence at 5+ months</th>
</tr>
</thead>
<tbody>
<tr>
<td>No clinician</td>
<td>1.0</td>
</tr>
<tr>
<td>Self-help material</td>
<td>1.1</td>
</tr>
<tr>
<td>Nonphysician clinician</td>
<td>1.7</td>
</tr>
<tr>
<td>Physician clinician</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Compared to patients who receive no assistance from a clinician, patients who receive assistance are 1.7–2.2 times as likely to quit successfully for 5 or more months.

**Number of clinician interventions also help**

- **n = 37 studies**

<table>
<thead>
<tr>
<th>Number of Clinician Types</th>
<th>Estimated abstinence rate at 5+ months</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1.0</td>
</tr>
<tr>
<td>One</td>
<td>1.8 (1.5,2.2)</td>
</tr>
<tr>
<td>Two</td>
<td>2.5 (1.9,3.4)</td>
</tr>
<tr>
<td>Three or more</td>
<td>2.4 (2.1,3.4)</td>
</tr>
</tbody>
</table>

Compared to smokers who receive assistance from no clinicians, smokers who receive assistance from two or more clinician types are 2.4–2.5 times as likely to quit successfully for 5 or more months.

The 5 A’s

- **ASK**
- **ADVISE**
- **ASSESS**
- **ASSIST**
- **ARRANGE**

5A’s – ctd.

- What should you ask?
  - Do you ever smoke cigarettes or use any form of tobacco?
  - How many cigarettes do you smoke every day?
  - How soon after you wake up do you smoke your first cigarette?
  - Where do you smoke?

5A’s – ctd.

- Build motivation to change behaviors by eliciting (5Rs):
  - Relevance – Why is quitting important?
  - Risks – What are harms of tobacco?
  - Rewards – What are the benefits of tobacco?
  - Roadblocks – What are the barriers to quitting?
  - Repetition – Repeat the message at each encounter
- Arrange for follow-up after a quit attempt
- Most people try multiple times before they can quit smoking successfully:
  - Best predictor of successful quitting is the length of the last quit attempt

Brief Counseling: Ask, Advise, Refer

- **ASK** about tobacco USE
- **ADVISE** tobacco users to QUIT
- **REFER** to other resources
- **ASSIST**
- **ARRANGE**

Adapted from Rx for change, University of California, San Francisco; Rxforchange.ucsf.edu
**Brief Counseling: Ask, Advise, Refer (cont’d)**

- Brief interventions have been shown to be effective.
- In the absence of time or expertise:
  - Ask, advise, and refer local group programs or the toll-free quitline 1-800-QUIT-NOW /1-800-NO-BUTTS/1-855-DEJELO-...

This brief intervention can be achieved in less than 1 minute.

---

**Mr. P**

- Build awareness – Tobacco log, connect with health symptoms
- Encourage small steps – reducing consumption, practice quit attempts
- Enlist support of case manager/caretaker
- Provide a rx. for smoking cessation – wellbutrin+NRT
- He eventually cut down to 10 cpd
- Congratulated on efforts but did not stop there...

---

**Case Presentation of Mr. N**

55 yo man with a history of episodic cocaine use:

- Smokes 10 cpd
- Thinking about smoking cessation but not ready to commit to setting a quit date.
- Smokes in his apartment
- How would you counsel this patient?

---

**Policy interventions -- Smoke-free policies**

- Smoke-free policies very effective population-based strategy
- Smoke-free homes – voluntary no smoking at home is a powerful intervention
- Smoke-free homes are associated with:
  - Reduced secondhand smoke exposure
  - Decreased consumption
  - Increased cessation
  - Reduced relapse to smoking

---

Adapted from Rx for change, University of California, San Francisco; Rxforchange.ucsf.edu

Policy interventions – Smoke-free Homes

- Prevalence of smoke-free homes is low among low-income populations.
- Department of Housing and Urban Health recently proposed a rule for all public housing authority-managed housing to:
  - Implement indoor smoke-free policies
  - Restrict smoking outdoors to more than 25 feet from buildings

Smoke-free policies in 3100 PHA-housing will impact 1.2 million low-income housing units in the United States

Policy Interventions: Media Campaigns

Policy interventions – implications for clinical practice

- Ask smokers whether they smoke indoors.
- Ask all non-smokers whether they are exposed to secondhand smoke.
- What can you tell patients?
  - Secondhand smoke is linked causally with cancer, CV disease, respiratory disease.
  - Personalize a smoke-free home.
- Personalize message: target teens; pregnant women; parents

Substance use and smoking cessation

- 2-3 times more smoking with alcohol/illicit substance use
- Heavy smoking:
  - Increases use of cocaine and heroin
  - Makes alcohol use more pleasurable
- 50% those in substance use treatment die from tobacco-related diseases
- Quitting smoking may increase long-term abstinence from all substances by 25%
- Quitting smoking doesn’t interfere with recovery from other substances

Vijayaraghavan et al., AJPH, 2013; Mills et al., AJPM, 2011; Gilpin et al., NTR, 2006; HUD ruling 2015

Hurt et al., 1996; Prochaska et al., 2006
**Case Presentation of Mr. N – What we did**

55 yo man with a history of cocaine dependence who smokes 10 cpd in his apartment

- Congratulated him on his interest in smoking cessation
- Advised him to implement a smoke-free home
- Felt that smoke-free home helped him cut down
- Getting ready to make a quit attempt
- Working on stopping episodic cocaine use

**Many unanswered questions**

- Specific interventions for homeless adults?
- How to capitalize on the forced quit that occurs in jail/prison once released?
- Interventions for mentally ill or substance use?
- Will smoke-free policies in public housing increase rate of evictions?

**Take home messages**

- Ask smokers whether they smoke indoors
- Advise people to not smoke or use e-cigs indoors
- Ask about tobacco use and advise to quit
- Ensure that patients have resources for cessation
  - Refer to resources
  - Provide these resources
- Follow-up on tobacco use at every encounter
- Ask about exposure to secondhand smoke

**Smoking cessation resources**

- [http://rxforchange.ucsf.edu/](http://rxforchange.ucsf.edu/) -- Resources for smoking cessation
- [http://www.bhwellness.org/resources/toolkits/](http://www.bhwellness.org/resources/toolkits/) -- Resources for smoking cessation
- [http://www.cdc.gov/tobacco/campaign/tips/resources/](http://www.cdc.gov/tobacco/campaign/tips/resources/) -- CDC Tips from former smokers campaign
- [http://smokingcessationleadership.ucsf.edu](http://smokingcessationleadership.ucsf.edu) -- Smoking cessation leadership center
- [http://www.no-smoke.org](http://www.no-smoke.org) -- Americans for nonsmoker’s rights
- [http://www.changelabsolutions.org](http://www.changelabsolutions.org) -- Changelab solutions
Leadership in the Safety Net: Lessons from the field

Jeff Critchfield, MD
Chief Medical Experience Officer
Medical Director Risk Management, Zuckerberg San Francisco General
Professor, UCSF Department of Medicine

Claire Horton, MD MPH
Medical Director, Richard H. Fine People’s Clinic
Zuckerberg San Francisco General
Associate Professor, UCSF Department of Medicine

Disclosures
We have nothing to disclose!

Introductions…

Case
- 34 yo physician
- 3 years out of residency – in first job
- Leadership position opens up
- Now part of clinic’s management team
- No training in hiring, managing, balancing budgets, running meetings, strategic thinking...
- Can this leader be trained???
Are leaders... born?

Or made?

Leading in a safety-net setting – is there a difference?

- Lessons from the field
- Framework for leadership training
- Leadership pair-share and ask-and-answer

Lessons from the Field

- We surveyed colleagues of diverse backgrounds in various roles across the safety net.
- Responses to the following questions:
  - What did you wish you knew then?
  - Biggest support for your career path?
  - Resources you would recommend?
  - What surprised you about this path?
What did you wish you knew then?

- There are very few natural leaders. You can improve your skills over time.
- Leaders don’t have to have all the answers.
- Teams and coalitions are the answer.
- Focus on patients and staff.

“Leaders don’t need all the answers. A good team can accomplish great things.”

David Woods,
Pharmacy Director, SFDPH

What did you wish you knew then?

“Leadership is fundamentally about working with people, helping them see you are invested in them and their work so that they want to perform at the highest level.”

Tangerine Brigham,
Director, Office of Managed Care,
Los Angeles County DPH

What did you wish you knew then?

“I think there are many distractions along the way . . . tempting to chase the interesting many. Focus on the vital few and remember health is work of the heart.”

Anna Roth
CEO
Contra Costa Medical Center

What did you wish you knew then?
What was the biggest help on your career path?

- Commitment to life-long learning.
- Establishing strong relationships with mentors and coaches.
- Cultivating my sense of purpose.
- Trust your instincts, the power of integrity.

What was the biggest help on your career path?

"It is important to be a life-long learner who promotes learning and the success of others."

Sue Currin,
Former CEO of ZSFG

April 2016

What was the biggest help on your career path?

“A clear sense of purpose, trusting my instincts, seeking out mentors, pursuing education of all types, including education about being a leader.”

Susan Ehrlich,
Incoming CEO of ZSFG

What was the biggest help on your career path?

“Speaking truth, following instinct, focusing on doing right by and for others.”

Hal Yee, CMO,
LA County DPH
What resources would you recommend?

- Several key books recurred
  - Leadership on the Line
  - Getting to Yes

- Leadership programs
  - CHCF
  - HealthForce

- None – Get your hands dirty!!

What resources would you recommend?

- Mitch Katz, Director
  - Los Angeles County DPH

“For changing the world, nothing compares with real experience. Choose an issue that you are passionate about, establish a coalition of people, disarm your opposition and persist until you succeed.”

What surprised you about this path?

- Susan Ehrlich,
  - Incoming CEO of ZSFG
  - April 2016

“Recognition that as a leader it really isn’t about what you say. Its about what you do and how you act.”

What surprised you about this path?

- Roland Pickens, Director
  - San Francisco Health Network

“That there are people in the mainstream who care deeply about the underserved and they are willing to support the safety net with their money and advocacy.”
What surprised you about this path?

“The realization that with a bit of courage, resourcefulness and common sense there are really amazing opportunities to make a difference in the world.”

Hal Yee, CMO, LA County DPH

Leadership training – the nuts and bolts

- 360 degree assessment
- Managing vs. leading
- Communicating vision
- Running effective meetings
- Understanding healthcare as a financial system
- Hiring, managing, and mentoring
- Managing time; efficiency, delegating
- Experiential education: Project-based learning
- Conflict management
- Strategic thinking / organizational know-how
- Decision-making strategies

A Leadership Compass

Leadership - Vision - Tasks - Relationships

Additional Resources

Books:
- Leadership on the Line
- The Leadership Moment
- WHO
- Getting to Yes
- 5 Dysfunctions of a Team
- Death by Meeting
- Getting Things Done
- Crucial Conversations
- On Managing Yourself (HBR)

Trainings:
- HealthForce (UCSF)
- Coursera
- Coros at UCSF
- LEAN – ThedaCare

Other:
- TED talks
- Coaching
- IHI
- Quality Culture Series (SFHN, Redwood)
Greatest Resource: Peers!

- Pair-share exercise:
  - Pair up and share ONE leadership dilemma you’ve encountered or resource you’ve found helpful
  - 3 minutes for each partner
  - Report out at ask-and-answer at the end

Leadership in the Safety Net:
More challenging ...or more rewarding?

- Lower-resourced settings
- Staff turnover
- Patient vulnerabilities
- Uninsured or Underinsured patients

Leadership in the Safety Net:
More challenging ...or more rewarding?

- Mission-driven colleagues
- Multi-disciplinary teams
- Patient diversity
- Gratification of worthwhile work

What resources would you recommend?

- Barbara Garcia, Director
- San Francisco Department of Public Health

“The power of the people that we serve and their ability for their own transformation.”
In service with others

When we help, we become aware of our own strength. But when we serve, we don’t serve with our strength; we serve with ourselves, and we draw from all of our experiences. Our limitations serve; our wounds serve; even our darkness can serve.

Rachel Remen, MD
Professor, Family and Community Medicine
UCSF

Questions? Additions? Revelations?

Thank you!
The Science of Burnout

What Is It, What Causes It, and What Makes It Go Away

Diana Coffa, MD
Residency Program Director, Family and Community Medicine
University of California, San Francisco

Roadmap

• Define burnout and discuss its impact
• Describe risk factors and protective factors
• Define compassion fatigue, secondary traumatic stress, and compassion satisfaction
• Discuss strategies for preventing burnout and promoting compassion satisfaction

Herbert Freudenberger’s original conception of burnout

1. Compulsion to prove oneself
2. Working harder
3. Neglecting needs
4. Displacement of conflicts
5. Revision of values
6. Denial of emerging problems

Herbert Freudenberger’s original conception of burnout

7. Withdrawal
8. Obvious behavioral changes
9. Depersonalization
10. Inner emptiness
11. Depression
12. Burnout syndrome—physical and emotional collapse

The concept was refined by Christina Maslach, developer of the Maslach Burnout Inventory

• Emotional exhaustion
• Cynicism and depersonalization
• Loss of sense of efficacy

Impact of Burnout

• 25-75% of practicing physicians have burnout at any given time.
• Over a career, periodic episodes of burnout are virtually inevitable
Impact of Burnout

Increased rates of
- Depression
- Anxiety
- Suicidality
- Increased inflammatory markers
- Possible association with cardiovascular disease
- Increased sick calls
- Attrition from medicine

Adverse impacts spread

Increased
- Errors, both medical and surgical
- Patient dissatisfaction
- Postoperative recovery times
- Wound infections
- Patient nonadherence

Other Models

Secondary Traumatic Stress
- Compassion Fatigue

Compassion Satisfaction

What is Compassion Satisfaction?

The satisfaction derived from being able to help others.

“Incentivizing with money is a self-fulfilling prophecy of cynicism. We must promote compassion, courage, and wisdom among our physicians before we make a sordid business of this high and sacred calling.”

The Impact of Compassion Satisfaction

- Studies on the impact of emotional attunement and engagement
  - Higher adherence to medications and recommendations
  - Increased patient satisfaction
  - Increased placebo response

Describe a time when you felt compassion satisfaction at work

- What were the conditions that promoted it?
  - Personal conditions
  - Environmental/professional conditions
- How can you build more of those conditions into your work?
Risk Factors and Protective Factors

Work Related Risk Factors
- Lack of control
- Heavy workload
- Exposure to trauma

Work Related Protective Factors
- Shared mission
- Flexible schedule
- Teamwork
- Work friends
- Supportive culture
- Teaching and administrative roles
  - Opportunity for sense of effectiveness in the short to mid term

Personal Risk Factors
- Temperament and personality features
  - Alexithymia
- Life stress
- Personal history of trauma
- Approach to work
Approach to work

- Surface organized
  - Must be "just so"
- Surface disorganized
  - Overwhelmed
- Deep approach
  - Interested and engaged by complexity, problem solving

Personal Protective Factors

- Cultivating relationships with patients
- Cultivating relationships with colleagues
- Social support
- Empathetic concern coupled with emotional flexibility
- Openness to new experience
- Deep approach to work
- Self care practices

Risk Factors and Protective Factors

<table>
<thead>
<tr>
<th>Work</th>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Protection</td>
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<tr>
<td>Lack of control</td>
<td>Relationships with patients</td>
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<td>Deep approach to work</td>
</tr>
<tr>
<td>Self care practices</td>
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</tr>
</tbody>
</table>

Self-care practices

- Meditation
- Exercise
- Outside interests
- Psychological practices
- Therapy
- Micro-breaks
- Vacations

Meditation

- Increased attentional control
- Increased ability to notice and accurately label emotions
- Decreased impulsive reaction to negative emotion
- Shift from "brooding" or perseverative style to "compassionate noting" style of awareness
- Increased positive affective states
  - Happiness, joy, love, gratitude, contentment, hope, interest, amusement, awe
- Increased internal resources:
  - greater purpose in life, improved resilience, enhanced optimism, greater mindfulness, more self-acceptance, more hope
### Far Enemy vs. Near Enemy

<table>
<thead>
<tr>
<th>Compassion</th>
<th>Cruelty</th>
<th>Devastating Grief/Pity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loving-kindness</td>
<td>Hate</td>
<td>Desire</td>
</tr>
<tr>
<td>Resonant Joy</td>
<td>Jealousy</td>
<td>Giddiness</td>
</tr>
<tr>
<td>Equanimity</td>
<td>Agitation</td>
<td>Apathy</td>
</tr>
</tbody>
</table>

### Psychological Practices

- Gratitude list
- Taking in the good
- Perspective taking
- Deep breath
- Visualization

### Micro-breaks

- Short, dispersed throughout the day
- Work-related
  - Conversations with colleagues
- Physical
  - Walk down the hall
  - Stretch
- Relaxing
  - Deep breath
  - Visualization
  - Words

### Vacations

- Reduced work related stress and burnout for 1-2 months
- Shorter if high workload upon return
- Consider shorter, more frequent vacations

### Your assignment

- Notice the moments when you experience compassion satisfaction.
- Take the time to soak it in when it happens.
- Look for ways to build more in.
Andrew B. Bindman, MD
Professor of Medicine and Epidemiology & Biostatistics
University of California San Francisco

Case

- John Walsh is a 56-year-old African American man with hypertension and type 2 diabetes
- Since being laid off from full-time work, Mr. Walsh and his dependents, a wife and 2 children, were left without insurance
- Neither of his part-time jobs as a security guard and a deliveryman offer health insurance benefits

Prior to 2014 Mr. Walsh would have had difficulty purchasing health insurance because of his pre-existing conditions or to afford the premium of any available coverage.

The Affordable Care Act (ACA) provides a means for this family to obtain coverage

The health care safety net helps to ensure that there are available providers in his community where he and his family can receive care

Objectives

- Describe Affordable Care Act (ACA) main policies
- Describe ACA’s impact on coverage
- Describe ACA’s impact on the safety net
- Describe how political and financial environment could change things
- Describe practice changes underway in the safety net
Affordable Care Act: 2010

- Insurance regulation: no exclusion for pre-existing conditions
- Individual mandate for coverage
- Defined essential health benefits of coverage
- Financial support to help those <400% FPL obtain coverage

Non Elderly Uninsured Rate Over Time

20 million have gained coverage since ACA

Uninsured Rate by Race and Time

<table>
<thead>
<tr>
<th>Q1 2014</th>
<th>Q3 2014</th>
<th>Q1 2015</th>
<th>Q3 2015</th>
<th>Q1 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>-1.5</td>
<td>-4.8</td>
<td>-5.7</td>
<td>-6.0</td>
</tr>
<tr>
<td>African American</td>
<td>-3.9</td>
<td>-6.7</td>
<td>-9.8</td>
<td>-10.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>-3.4</td>
<td>-5.4</td>
<td>-10.5</td>
<td>-11.4</td>
</tr>
</tbody>
</table>

Slipping Through The Cracks

- Eligible for Financial Assistance due to Income 12%
- Eligible for Financial Assistance due to Coverage Status 19%
- Eligible for Coverage Eligible Child 10%
- Medici/CHIP Eligible Adult 18%
- Tax Credit Eligible 32%
- In the Coverage Gap 9%

Total = 32.3 Million Nonelderly Uninsured
State Variation in Expanding Medicaid

Eligible for Private Insurance Tax Credit

- Sliding scale premium subsidy (tax credit)
  - 100%-400% FPL ($12-44K indiv/ $24-97K family 4)
  - 138%-400% FPL in Medicaid expansion states

- No copayment
  - 100%-250% FPL

- 90% of those in exchange receive some subsidy

- On average subsidies cover 72% of premium

Not Maximizing Insurance Subsidy

- Consumer must choose 2nd lowest silver plan through an exchange to maximize subsidy

- 72% who enrolled through exchange could have paid a premium of less than $100 per month - only 48% did

Young and Invincible?

- ACA expanded dependent coverage until age 26
  - 6.1 million 19-25 year olds newly covered under ACA

- Still 7.7 million of uninsured citizens are 19-34 years old

- Uninsured:
  - Ages 19-34: 13.7%
  - Ages 35-64: 9.2%
Health professionals (and students) can help to educate patients about importance of and options for coverage.

**Medicaid Physician Participation**

- Physician participation in Medicaid varies with payment
  - California 2nd worst payer in nation

- ACA required states to pay primary care Medicare rates
  - Only for 2013/2014
  - California very slow to implement
  - 16 states (not California) have extended policy

- Nationwide policy increased number of Medicaid visits among Medicaid providers but not number of providers

**Impact of Coverage Expansion on Safety Net**

- Community Health Centers in Medicaid expansion states
  - 40% decrease in uncompensated care visits
  - 36% increase in Medicaid visits

- Community Health Centers in non expansion states
  - 16% decrease in uncompensated care visits
  - No change in Medicaid visits

- Safety net hospitals in expansion states about a 15-20% change from uncompensated to Medicaid
  - Little change in non expansion states

- Exit of patients from safety net eligible for exchange
Safety Net Forecast

- Have experienced financial benefits of retaining most patients
- Increased demand challenging capacity
- Political and financial environment unstable

Presidential Politics

- Health policy not main focus (ranks 8th)
- Range of opinions about health policy
- Affordable Care Act (ACA) is the reference point for debate

Congressional Democrats Wish List

- Improve Medicaid payment rates
- Make Medicaid expansion fully (permanently) federally funded
- Fix the “family glitch”
- Make coverage more affordable with lower cost-sharing limits
- Strengthen minimum required benefits package
- Improve network and formulary adequacy/transparency

Republican Health Care Plans

- Repeal ACA =
  - Eliminate individual mandate
  - Eliminate Medicaid expansion/cap traditional payments
  - Eliminate subsidies to purchase private insurance through an Exchange
  - Eliminate essential health benefits of plans
  - Relax non exclusion for pre-existing conditions
- Repeal ACA:
  - Children on parents coverage until age 26
U.S. Health Care Spending Per Capita Over Time

Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group
Note: 2014 to 2015 percent changes are calculated using 2014 actual and 2015 projected amounts.

Aging of the US Population

Number of People Age 65 or Older, by Age Group

Federal Mandatory Entitlements: 2015

Elderly

Social Security: 882
Medicare: 634
Medicaid: 350
Exchange Subsidies: 38
CHIP: 9

Poor

Billion $
Alternative Payment Models

- ACOs/bundled payments/PCMH
- Seeking to bend the cost curve and increase value
- CMS attempting to covert half of Medicare providers to alternative payments by 2018
- Incentivizing transition with higher predictable reimbursement and opportunity for shared savings

Safety Net Payment

- Medicaid is primary payer
- States shifting Medicaid financial risk to plans
  - 72% of Medicaid in managed care nationwide
  - 67% in California
- Medicaid plans shifting financial risk onto providers
  - capitation/bundled payments
- FQHCs have enjoyed relatively higher Medicaid fee-for-service payment rates
- Some state Medicaid programs using ACOs with shared savings to encourage FQHCs to accept financial risk

Future of Safety Net Practice

- Increasing accountability for quality and cost of care
- Collaboration/consolidation among providers to manage a shared population
- A need for innovative/disruptive strategies to support population management
- Evidence and advocacy to ensure payment incentivizes value and does not punish safety net providers and patients

Summary

- 20 million people have gained coverage under ACA
- 32 million non elderly adults remain uninsured
  - Latinos and African-Americans at highest risk
- Medicaid expansion has improved safety net finances
- There is political and financial uncertainty ahead
- Safety net providers face increasing responsibility for managing the quality and cost of a defined population
- Evidence/advocacy to ensure performance standards and payment are fair for safety net patients and providers
## Resources

- Assistant Secretary for Planning and Evaluation
  - aspe@hhs.gov
- Kaiser Family Foundation
  - KFF.org
- Commonwealth Fund
  - CMWF.org
Complex Chronic Pain: Cases from the Field
Soraya Azari, MD
Assistant Clinical Professor of Medicine

Objectives
- To develop empathic and sensitive ways of communicating with patients suffering from chronic pain
- To review the “four quadrants” of chronic pain treatment
- To improve recognition and diagnosis of an opioid use disorder in patients with chronic pain on opioids
- To be able to explain the risks associated with long-term opioid therapy to patients

Case 1
46yo M with a history of HTN, depression, generalized anxiety disorder, asthma/COPD, chronic low back pain on opioid therapy, HCV, hx “polysubstance abuse”, and homelessness is admitted to the hospital with a COPD flare and acute kidney injury (Cr 1.6, from 0.8).
He was taking: gabapentin, venlafaxine ER, amlodipine, inhalers, docusate, senna, and the following opioids:
- Morphine sulfate CR 30mg po tid
- Oxycodone IR 15mg po qid
- MED = 180mg daily
- http://agencymeddirectors.wa.gov/mobile.html
Case 1 continued

- He received treatment for his asthma/COPD exacerbation and intravenous fluids with improvement in his creatinine to 1.3.
- He reported doing well – taking his pain pills and abstaining from cocaine. He was buying diazepam off the street (10/d). He is homeless & estranged from family. Has few trustworthy friends.
- His main complaint is severe, uncontrolled pain in his back (sharp and tight, paraspinal), and closely watched the clock for his next PRN.
- He was seen by Pain Consult and described poor pain control. He’d been buying methadone off the street and that was helping much more than the morphine. He had been out of his gabapentin.

Case continued

- The patient was transitioned from morphine sulfate ER to methadone 20mg po TID + hydromorphone 8mg po q4hrs PRN in discussion with the PCP, pain consult, and hospitalist.
- The patient missed his initial follow-up appointment but then got repeat labs showing an increase of his creatinine back to 1.6. He could not be contacted by phone despite several attempts.
- 5 days after discharge he was found dead.
- Cause of death: acute mixed drug intoxication
  - Serum methadone = 1600ng/mL

Which of the following represents the best management plan with regard to his pain?

- A. Stop morphine sulfate ER and switch to methadone + short acting PRN
- B. Continue morphine sulfate ER and oxycodone and add non-opioid pain relievers
- C. Stop all opioids and refer to methadone maintenance treatment
- D. Increase dose of morphine sulfate ER + short acting PRN agent

Case continued

- Which of the following represents the best management plan with regard to his pain?
  - A) Stop morphine sulfate ER and switch to methadone + short acting PRN
  - B) Continue morphine sulfate ER and oxycodone and add non-opioid pain relievers
  - C) Stop all opioids and refer to methadone maintenance treatment
  - D) Increase dose of morphine sulfate ER + short acting PRN agent
Lessons: the New Epidemic

- Drug overdose
  - Leading cause of injury death in 2014 (>47,000 deaths), surpassing motor veh. accidents in 25-64 year olds
  - 51% of deaths related to prescription drugs
    - ~19,000 deaths from prescription opioid pain relievers
    - 10,000 deaths from heroin
  - Rx-opioid overdose: quadrupled (2000-2014)
  - Increased risk: high dose, hx of substance use or mental health disorder

Is this New?

TIME

Distinguishing between pain and an opioid use disorder?

- Opioid use disorder
  - 4 Rs
    - Risk of bodily harm
    - Relationship trouble
    - Role failure
    - Repeated attempts to cut back
  - 4 Cs
    - Loss of Control
    - Continued use despite harm
    - Compulsion (time & activities)
    - Craving
      - I need more; pain pills are not holding me
  - Withdrawal and tolerance

Lessons

Methadone

- serum half life: 15-60 hours; variable bioavailability; metabolized by CYP3A4
- 1999-2008: methadone poisoning increased 600%
- American Pain Society recs: 2.5mg q 8, inc q week

Conversion table from morphine to methadone (most commonly used in the USA)

<table>
<thead>
<tr>
<th>mg</th>
<th>Conversion ratio (oral morphine: oral methadone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>2.1 (2mg morphine to 1mg methadone)</td>
</tr>
<tr>
<td>31-99</td>
<td>4-1</td>
</tr>
<tr>
<td>100-299</td>
<td>8-1</td>
</tr>
<tr>
<td>300-499</td>
<td>12-1</td>
</tr>
<tr>
<td>500-999</td>
<td>15-1</td>
</tr>
<tr>
<td>1000-1200</td>
<td>20-1</td>
</tr>
<tr>
<td>&gt;1200</td>
<td>Consider consult with palliative care or pain specialist</td>
</tr>
</tbody>
</table>

Lessons

- Methadone
  - serum half life: 15-60 hours; variable bioavailability; metabolized by CYP3A4
  - 1999-2008: methadone poisoning increased 600%
  - American Pain Society recs: 2.5mg q 8, inc q week
Example:
- Morphine sulfate 60mg po bid → total 15mg methadone daily
- Morphine sulfate 200mg po tid → total 40mg daily

Conversion table from morphine to methadone (most commonly used in the USA)

<table>
<thead>
<tr>
<th>24 hour total dose of oral morphine</th>
<th>Conversion ratio (oral morphine: oral methadone)</th>
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</thead>
<tbody>
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<td>&lt;30mg</td>
<td>2:1 (2mg morphine to 1mg methadone)</td>
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<td>4:1</td>
</tr>
<tr>
<td>100-299mg</td>
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<td>&gt;1200mg</td>
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If you can... prevention

- $75/2 for Medicaid
- $15
- $500
- $75/2 for Medicaid
- $500
- $0

But this pain... do you want me to start shooting dope??

- No, I don’t want you to start injecting heroin. I don’t think you want that either. You should feel proud that you don’t use needles anymore.
- My job is to take care of you and make sure you’re safe.
- I don’t think you can safely continue on opioid pain pills. I want to give you a better, safer treatment because I think you have severe, uncontrolled pain, and an opioid use disorder.
- I’m not going to leave you. I know you are suffering right now.
- The treatments I can offer you are methadone maintenance programs, or buprenorphine-naloxone. Do you want to hear more about those?

Treatment Program Locator

- Buprenorphine-certified providers:
- To get trained: www.buppractice.com
- Opioid treatment program directory:
- Substance use treatment warm line: 1-855-300-3595. 10a-6pm EST
**Take-home points**

- Be the most sensitive and empathetic you can be when communicating discontinuation of opioids.
- Run towards the patient, not away.
- Avoid opioids in individuals with active substance use disorders given safety risks. Show caution with methadone, benzodiazepine, and alcohol use.

**Case 2**

- A 34yo F with a history of depression, obesity, PCOS, and low back pain presenting for primary care follow-up. She describes sharp pain in L back, 8/10, with occasional radiation down her leg x2 weeks. She denies weakness and numbness and has a normal neurologic exam.
- She says the pain is excruciating and she’s had difficulty at work. She’s been using her husband’s pain pills (hydrocodone-acetaminophen) and is wondering if you can prescribe some.
- You try NSAIDs, ice/heat, massage and basic wall exercises and ask her to return in 2 weeks.

**Case 2 continued**

- She returns in 2 weeks and says the pain is still very severe (8/10), “tight and throbbing”, almost constant. She tried the ibuprofen which had some effect, as does ice/heat, but it’s only temporary. She is still using her husband’s hydrocodone-acetaminophen and says that’s her preferred agent. She’s having difficulty sleeping, which is making her more tired throughout the day.
- She denies depressed mood or lack of interest in daily activities. She continues to feel stress and anxiety about life at home. She does not smoke or use drugs or alcohol.

**Evaluation**

- Empower
  - What are you doing to control your pain?
  - Acknowledge suffering while focusing on strength and recovery
- Educate
  - Back pain is common (mean point prevalence 18%; lifetime prevalence 39%)
  - At 1 mo. ~1/3 with mod. pain (20% activity); 1 year, ~1/3 with mod. pain
  - Opioid efficacy
- Evaluate
  - Function (work, apt), substance use, and psychiatric

Treatment: The Broader Context of Pain

Husband disabled. Sole wage earner. IHSS hours decreased.

Tired. Stressed. Depressed. Worried something is wrong with her body.

Lumbosacral strain

What Are My Alternatives?

Pharmacologic
- NSAIDs
- Neuroleptics
- Antidepressants
- Muscle relaxants
- Topicals
- Opioid medications/Tramadol
- Pumps (baclofen, lidocaine)
- Buprenorphine

Physical
- Physical Therapy
- Joint injections
- Directed Exercise Program
- Pacing daily activity
- Heat or ice
- Trigger point injections

Complementary and Alternative Medicine
- Acupuncture (community and schools)
- Mindfulness Based Stress Reduction and meditation
- Yoga
- Massage
- Supplements (glucosamine chondroitin, SAM-e)
- Guided imagery
- Breathing exercises

Cognitive and Behavioral
- Pain Groups
- Cognitive and behavioral therapy
- Visualization, deep breathing, meditation
- Sleep hygiene
- Gardening, being outdoors, going to church, spending time with friends and family, etc.
- Pain ToolKit


Can it work?

- Biopsychosocial Treatment
  - Patients with chronic neck or back pain >3mos (taken sick leave) (~50% depressed)
  - 3 week inpatient multidisciplinary treatment (5d/w; 8h/d)
    - Physical exercises
    - Ergonomic training
    - Psychotherapy
    - Patient education
    - Behavioral therapy
    - Workplace-based interventions
  - At 6 months: 67% returned to work; SF-36 score improved

Buchner et al. Scandinavian Journal of Rheumatology. 2006; 363
Case cont’d
- She was offered low-dose baclofen given her complaints of tightness in her muscles. She was referred to the Healthy Spine clinic.
- You check in with her by phone 1 week later and she says the baclofen is making her sleepy and she still has pain. She’s been trying to do her exercises, think positively, and use the ice/heat and massage. She also got some muscle rub.

Question
- Which of the following is the best course of action?
  - A) Continue with plan explaining it takes time to see improvement
  - B) Add diazepam for muscle pain
  - C) Check a urine drug screen
  - D) Start extended-release opioid medication
  - E) Something else

Case continued
- Patient returned for follow-up 2 weeks later. In that time she did not have to take additional sick days. She was taking ~1-3 pills per day. Her sleep had improved. She attended her healthy spine appointment & was taught additional exercises.
- Epilogue: Patient continued on opioid for ~3 months, taking less over time and with no concerning behaviors. Patient had also been doing basic fertility treatments and became pregnant, and stopped opioids completely.
**Take Home Point**

- Think of the four quadrants when developing treatment options with your patients. Cultivate their resilience & strength.
- Opioids may still be required for patients that have failed multi-modal therapy and who do not have active substance use or mental health disorders.

- Also... Providers with DEA license must register for CURES 2.0 before July 1, 2016: [https://cures.doj.ca.gov](https://cures.doj.ca.gov)

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**Case 3**

- 56yo M with a history of depression, alcohol use, retinal detachment from prior trauma, DM, and obesity with low back pain. He described excruciating, severe pain, 10/10, in the center of his back, causing difficulty getting out of bed or walking normally. He was started on opioids for acute pain management (oxy-APAP 1-2 tabs q6hr PRN pain).
- He returned for follow-up appointments describing huge relief from the medication. He was very grateful for the care. 3 months later he was still requiring/requesting opioid prescriptions.
- Over the next 3 mos. he started to exhibit the following concerning behaviors:
  - Poor adherence to other parts of treatment plan
  - Poor PCP follow-up
  - Frustration about any discussion of non-opioid agents

---

**Case 3, continued**

- His provider monitored him closely:
  - Urine drug screens were appropriate
  - Prescription activity report showed no outside providers
  - He had no new ED visits or hospitalizations
- The patient’s functional status: disabled, lives alone (no partner), goes out for basic errands, periodically sees family
- He continues to describe excruciating pain.

---

**How would you manage this patient?**

- Discontinue chronic opioid therapy
- Re-discuss the contents of the patient-provider agreement and your treatment expectations of him
- Start morphine sulfate ER 15mg po BID + short-acting PRN agents
- Switch him to buprenorphine-naloxone
Question

- How would you manage this patient?
  - A) Discontinue chronic opioid therapy
  - B) Re-discuss the contents of the patient-provider agreement and your treatment expectations of him
  - C) Start morphine sulfate ER 15mg po BID + short-acting PRN agents
  - D) Switch him to buprenorphine-naloxone

Monitoring

- Patient-provider agreements
  - no evidence they decrease misuse. Useful to facilitate communication and set expectations.
  - Recommended by:
    - CDC Guidelines (2016)
    - Chronic Opioid Treatment Guidelines (APS, AAPM; 2009)
      - Informed Consent (strong rec, low-quality evidence)
      - Treatment agreements (weak rec, low-quality evidence)
        - Goals, expectations for follow-up and monitoring, indications for stopping treatment, etc.
    - State Medical Board of California: Guidelines for Rx Controlled Substances for Pain (Nov 2014)
  - Examples:

Assessment

- Risks
  - Alcohol use
  - Depression
  - Not attending appointments
  - Not participating in other forms of treatment
  - Not spending time with family

- Benefits
  - Patient report

Case Continued

- The provider had actually been very clear with the patient in signing the treatment agreement. She was worried about his depression and so wanted him to connect with the behavioral health and to attend physical therapy. Despite repeated attempts at outreach/reminders, he did not attend.

- The provider explained that opioids would be discontinued. The patient became angry and verbally abusive toward the provider.

- Epilogue: He was transferred to me ~4 weeks later. Pain & previous history not discussed. Getting treatment for his DM, alcohol use disorder and severe depression.
Depression & Pain

- Depression and pain often linked
  - Study of outpatients at university-based outpatient pain clinic (n=2104):
    - 55% with current opioid use → 43% depressed (v. 26%)
    - If depressed, prob of opioids didn’t depend on pain severity.
  - Outcomes in depressed patients
    - Mod-high negative affect groups in a RCT trial of opioid therapy: decreased benefit from opioid therapy

Take-home point

- Severely depressed or anxious patients often do poorly on chronic opioid therapy. They may be inadvertently using opioids to treat their anxiety/depression symptoms, and hence feel very upset when medication is discontinued.

Case 4

- JF is a 66yo M with hx of chronic low back pain (sciatica s/p epidural injections), BPH, depression, remote alcohol and dextromethorphan abuse referred to CSI committee by new PCP.
  - Meds:
    - Fentanyl 75mcg TD q 48hrs
    - Oxy-APAP 5-325 #180/month
    - temazepam 15mg q hs
    - Testosterone gel
    - Dextroamphetamine 10mg q day
  - MED = 225mg daily
All of the following are risks of long-term, high-dose chronic opioid therapy except:

A. sleep disordered breathing
B. Hypogonadism
C. unintentional overdose
D. Pneumonia
E. BPH
F. osteoporotic fracture

Question

All of the following are risks of long-term, high-dose chronic opioid therapy except:

- A) sleep disordered breathing
- B) hypogonadism
- C) unintentional overdose
- D) pneumonitis
- E) BPH
- F) osteoporotic fracture

Risks of High Dose

- Unintentional overdose (~0.7%/year 20-100MED) and re-exposure (91% w/ rx at 10mos. post OD)
- Secondary Hypogonadism (~50% of men)
  - Decrease bone mineral density & increase fracture risk
- Sleep-disordered breathing (60-70% of patients)
- Pneumonia in older adults (case-control)
- Others
  - Opioid-induced hyperalgesia?
  - Cardiac toxicity with methadone

Case 4

JF is a 66yo M with hx of chronic low back pain (sciatica s/p epidural injections), BPH, depression, remote alcohol and dextromethorphan abuse referred to CSI committee by new PCP.

Meds:
- Fentanyl 75mcg TD q 48hrs
- Oxy-APAP 5-325 #180/month
- temazepam 15mg hs
- Testosterone gel
- Dextroamphetamine 10mg q day
Approaches to High Dose

- Open conversations with patients about risks and benefits
  - BEST work-up?
- Offer naloxone, if possible
- Get feedback:
  - Pain specialist
  - Peer review (controlled substance review committees)
- If tapering, go slow & see person often (10% per week-month). Remember, we started the meds.

Case Continued

- Patient referred to CSI committee
- Open to tapering
- Recs provided to PCP

Summary

- Chronic pain is extremely common and severely debilitating for our patients.
- Applying the biopsychosocial model to chronic pain helps inform management.
- Treatment for pain should be multi-modal and include pharmacologic, physical, complementary and alternative, and cognitive and behavioral techniques.
- Chronic opioid therapy is commonly prescribed. Emphasis should always be on safety and weighing the risks and benefits of treatment.

Summary cont’d

- In patients with an active substance use or mental health disorder, these should be treated/stabilized prior to prescribing chronic opioid therapy.
- Be aware of the long-term risks associated with chronic opioid therapy.
- Keep in mind your patients are suffering every day. Empower them to do the best they can via their own strengths and resources.
Questions?

Resources

• Patients:
  ◆ Pain Toolkit:
    http://www.paintoolkit.org/downloads/Pain_Toolkit_patient_b
    ooklet_copy_Short_Versions.pdf
  ◆ Chronic Pain Facebook Groups
  ◆ YouTube videos to educate patients about pain:
    ◆ Chronic pain in 5 minutes:
      https://www.youtube.com/watch?v=C_3ph893crY
    ◆ Treatment options: https://vimeo.com/74825810

• Providers:
  ◆ Washington Agency Medical Directors Guidelines:
    http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpio
    idGuideline.pdf
  ◆ SFHP patient/provider resources:
    http://www.sfhp.org/providers/pain-management/resource-
    tools/

With permission from Peter Moore.
Diabetes and Obesity Care in Vulnerable Populations

Sarah Kim, MD
Assistant Clinical Professor
UCSF-SFGH

Disclosures

I have nothing to disclose

Objectives

To discuss the following:
1. Burden of diabetes and obesity in the underserved population
2. How we can improve the care of diabetes and obesity in the underserved population

“New diabetes cases, at long last, begin to fall…”

NY TIMES, Dec 1, 2015

http://www.cdc.gov/diabetes/statistics/incidence/fig1.htm

Decline in diabetes incidence only among whites
Diagnosis of Diabetes & Pre-diabetes

<table>
<thead>
<tr>
<th>Pre-Diabetes Criteria</th>
<th>Diabetes Criteria**</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c 5.7-6.4%*</td>
<td>≥ 6.5%*</td>
</tr>
<tr>
<td>Fasting Glucose 100-125 mg/dL</td>
<td>≥ 126 mg/dL</td>
</tr>
<tr>
<td>2 hour post 75g OGTT 140-199 mg/dL</td>
<td>≥ 200 mg/dL</td>
</tr>
<tr>
<td>Random glucose N/A</td>
<td>≥ 200 with symptoms of hyperglycemia</td>
</tr>
</tbody>
</table>

*HbA1c is inaccurate in presence of anemia or hemoglobinopathy
**unless unequivocally hyperglycemic, results should be confirmed with another or repeat test

2015 American Diabetes Association Screening Guidelines

1. Screen in everyone age ≥ 45
2. Screen if BMI ≥ 25 (≥ 23 in Asians) and 1+ present:
   - physical inactivity
   - first-degree relative with diabetes
   - high risk race/ethnicity (non-white)
   - woman with history of GDM or delivered baby >9 lb.
   - hypertension
   - HDL <35, TG >250
   - PCOS
   - pre-diabetes on lab testing
   - acanthosis nigricans
   - CVD

Diabetes Care 2016:39(s1):s1–s112
**Diabetes in Asian Americans**

- Filipinos: [Graph showing prevalence rates]
- Chinese: [Graph showing prevalence rates]
- Japanese: [Graph showing prevalence rates]
- Pacific Islanders: [Graph showing prevalence rates]
- South Asians: [Graph showing prevalence rates]
- Koreans: [Graph showing prevalence rates]
- Vietnamese: [Graph showing prevalence rates]

*Karter et al., Diabetes Care 36:574-579, 2013*

**Lower BMI in Asian with Diabetes**

<table>
<thead>
<tr>
<th></th>
<th>Asian Americans</th>
<th>Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity Prevalence</td>
<td>10.8%</td>
<td>34.9%</td>
</tr>
<tr>
<td>BMI of those who develop diabetes</td>
<td>23.9-26.6 kg/m²</td>
<td>26-28.3 kg/m²</td>
</tr>
</tbody>
</table>

*Diabetes Care 2015;38:150-158*

**Lower BMI, Higher Body Fat**

<table>
<thead>
<tr>
<th></th>
<th>Filipino</th>
<th>White</th>
<th>African American</th>
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<tbody>
<tr>
<td>BMI</td>
<td>25.5 kg/m²</td>
<td>26.0 kg/m²</td>
<td>29.7 kg/m²</td>
</tr>
<tr>
<td>Visceral Fat</td>
<td>69.1 cm³</td>
<td>62.3 cm³</td>
<td>57.5 cm³</td>
</tr>
</tbody>
</table>

*Obes Res. 2005 Aug;13(8):1458-65*

**Diabetes is Preventable**

- Asian Females: 22.5
- Asian Males: 23.4
- White Females: 23.9
- White Males: 23.1

- Body Fat: 31.6% for Asian Females, 21.4% for Asian Males, 30.1% for White Females, 19.3% for White Males

*Am J Clin Nutr 1994; 60:23-8*

*N Engl J Med 346:393-403, 2002*
**Diabetes Screening Question**

All the following people should be tested for Type 2 diabetes EXCEPT?

- A. 20 year-old white male with a BMI of 24
- B. 46 year-old white female with a BMI of 24
- C. 20 year-old Chinese-American male with a BMI of 24 and hypertension
- D. 30 year-old Mexican-American female with a BMI of 25 and polycystic ovarian syndrome

---

**Diabetes Control and Complications**

Hispanics and African Americans are more likely to have a high A1c and suffer from ESRD.

Blacks with diabetes are ~2x more likely than whites to be hospitalized for heart disease, stroke, DKA, amputation.

Blacks are 2x’s more likely to die from hyperglycemic crisis than whites.

---

**TREATMENT OF DIABETES IN UNDERSERVED POPULATIONS**

*Diabetes Care 22:403–408, 1999*

**Psychological Insulin Resistance (PIR)**

- Negative perceptions of insulin resulting in reluctance to initiate insulin treatment
- **Provider PIR** results in significant delay in starting insulin in a timely fashion
  - Average 3 year delay after A1c is > target on maximum tolerated oral therapy
- **Patient PIR** results in refusal to initiate insulin or omission of doses
- Low income, ethnic minorities have higher rates of PIR

*J. Gen Intern Med. 2007; 22(4):453-8*

---

**Psychological Insulin Resistance**

Among 708 individuals with diabetes, not yet on insulin, attending diabetes conferences

- >50% were either "unwilling" or "slightly willing" to take insulin if prescribed
  - Among unwilling: 35% of non-whites, 22% of whites, p<0.01

Top reasons

- Low self-efficacy
- Restrictive
- Insulin = personal failure
- Insulin myths (causes complications like blindness)

*Diabetes Care 22:403-408, 1999
South Med J. 2007 Aug;100(8):812-20*

---

**SF Health Network Diabetes Registry**

- White, 14%
- Black, 20%
- Hispanic, 29%
- Asian, 34%
- Other/Ethn, 2%
- Native Hawaiian/PI, 1%
- Native American/Esk, 0%
- Other/Unk, 2%

---

**Starting Insulin Flipbook**
Addressing common feelings about insulin

Do you feel like this?

Natural course of diabetes

How to...
SFGH Experience

“Insulin introduction Group” retrospective review
- 181 patients attended group from ’08-’12
- 92% of attendees practiced a mock insulin injection
- 54.7% started insulin after the group vs. 39.4% who didn’t attend (referred but didn’t show, n=92)
- A1c drop of 1.45% in attenders within 6 months
- For non-attenders who were prescribed insulin by provider dropped A1c by only 0.56% in same time frame

C Kuo, unpublished

Insulin Prescribing Tips

Consider insulin pens
- May alleviate needle phobia
- Less association with IV drug use
- Less breakable, easier to carry
- Easier to dose accurately (especially if problems with vision or dexterity)
- Remind patients that insulin need not be stored in the refrigerator while in use
- Skin need not be “sterilized” before injection

Insulin and Low Health Literacy

Insulin and Low Health Literacy

Nutrition Facts

<table>
<thead>
<tr>
<th>Carbs</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Bedtime</th>
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<tr>
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Tips for low literacy

Carbohydrate estimation (e.g., fist full), instead of actual counting
- Counting pen clicks instead of reading numbers
- Having a literate caretaker or family member pre-fill insulin syringes
- Dose in even numbers (pens) or fives, tens (syringes)
- Avoid complicated scales
Relative importance of insulin types

- **Bolus Insulin** (50% Total daily dose)
- **Basal Insulin** (50% Total daily dose)
- **Correctional**
- **Mealtime**
- **Basal**

Insulin Sparing Medications?

Typical scenario: "Patient maxed on metformin, sulfonylurea and cannot/will not take insulin"
Many other drugs available but consider:

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>A1c lowering</th>
<th>Cautions</th>
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</thead>
<tbody>
<tr>
<td>T2Ds</td>
<td>0.6-1.5%</td>
<td>Weight gain, edema, CHF, fractures</td>
</tr>
<tr>
<td>DPP-4 Inhibitors</td>
<td>0.5-0.8%</td>
<td>Pancreatitis risk?</td>
</tr>
<tr>
<td>GLP-1 Agonist (injection only)</td>
<td>0.6-1.5%</td>
<td>Nausea, vomiting, Pancreatitis risk?</td>
</tr>
<tr>
<td>SGLT-2 Inhibitor</td>
<td>1%</td>
<td>Orthostasis, yeast infections, fractures</td>
</tr>
</tbody>
</table>

Choosing Insulin Wisely

No difference in A1c lowering performance between different basal insulins (glargine, detemir, NPH, degludec)

BUT peakless basal insulin preferred (e.g., glargine) for patients with unpredictable eating schedules to avoid hypoglycemia

OBESITY TREATMENT
**Obesity Among Adults**

Racial/ethnic minorities:
- Suffer more from obesity related conditions (diabetes, hypertension, CVD)
- Are underrepresented in weight loss studies

---

**Obesity is tough to treat**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Weight loss</th>
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</thead>
<tbody>
<tr>
<td>MD Counseling</td>
<td>0.1-2.3 kg</td>
</tr>
<tr>
<td>MD + Medications</td>
<td>1.7-7.5 kg</td>
</tr>
<tr>
<td>Collaborative Care (ex., RD, telephone calls, meal replacements)</td>
<td>0.4-7.7 kg</td>
</tr>
<tr>
<td>Weight loss medications</td>
<td>Additional 3-10 kg</td>
</tr>
</tbody>
</table>

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**Overcoming challenges in low resource settings**

- Culturally relevant diet and exercise recommendations
- Use of community members as coaches
- Recognize the psychological/emotional elements of overeating
- Target low hanging fruit (e.g., sugar beverages)
- Use simple food/exercise tracking tools (e.g., picture based)
- Free resources (e.g., Overeaters Anon)

---

**References**

- Obes Rev. 2012 March; 13(3): 193-213
**Bariatric Surgery**

- Most effective weight loss intervention
- The limited studies that examine the effect of race on bariatric surgery suggest that weight loss is generally impressive among all races (20-70% weight loss)
- May be slightly less weight loss among racial minorities but resolution of co-morbidities appear not to be affected

*Diabetes Care 35:1951-1958, 2012*

**Acknowledgments**

- SFGH Diabetes Center for Vulnerable Populations
- Dr. Elizabeth Murphy
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- Deborah Heuerman, NP
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- Debbie Schlanger, RD, CDE

- Weight Management Clinic
- Dr. Diana Alba
- Patricia Trujillo, RD, CDE
- Sarah Longino, PhD
- Danielle Hamilton
What Can Geriatrics Teach Us About the Care of Vulnerable Patients?

Helen Kao MD
Associate Professor
Medical Director, UCSF Geriatrics Clinical Programs
UCSF March 11, 2016

Objectives

1. Define vulnerabilities prevalent among older adults
2. Describe the role of geriatrics in the care of complex and vulnerable patients
3. Identify lessons from geriatrics which improve health outcomes for vulnerable patients
Older adults in U.S.

- Older adult population is rapidly growing
- Adults who reach age 65 now have a life expectancy of ~19 more years
- 48% of older adults are economically vulnerable (income <2x supplemental poverty level)
- 46% of women 75+ live alone

US Administration on Aging 2014 data

Vulnerabilities among older adults

- High degree of chronic conditions
- Greater proportion of physical disabilities and cognitive impairment
- Require significant caregiving
- At risk for abuse, neglect, and being taken advantage of
- Carry large burden of informal caregiving


King DE et al. JAMA Internal Medicine, online Feb. 4, 2013


Need for care: a growing problem

- Most adults are unprepared for disability and caregiving needs as they age
- Many adults mistakenly assume that Medicare will take care of their social care needs should they lose their independence
- Medical-Legal movement to encourage inclusion of financial and long-term care planning in ACP counsel (prepare for *incapacity*, not just EOL)

Hooper S, Kao H Moving ACP Upstream. 10/6/2015

. . .50% everything else

For patients with the most complexity
- The best care is, at most, 50% medical. . . and 50% everything else
- Lessons to be learned from caregivers, nurses, social workers, psychotherapists, pharmacists, rehab specialists, and others
Lesson 1: Medical care is not the same as health care

- Families progressively or catastrophically thrown into caregiving role; need to know how to provide total bed care and wound care to a grown adult
- Contrast this to new parents flooded with information on how to care for their newborn
- Home Health can educate caregivers how to adapt environment and care to a dependent adult
- Geriatrics counsel can help families read signs and symptoms of changes in status which can be managed as outpatient and don’t warrant 911

Lesson 2: Help families help patients

- Geriatrics focuses on how someone functions and identifying mismatch between a patient’s functional impairments and what their home and caregivers can provide
- Understanding what environmental, device, and care adaptations can be made, and which interprofessional disciplines to call upon, can help families support vulnerable adults
Lesson 3: Med review is a window into a patient’s entire situation

- Polypharmacy; potential interactions or adverse effects
- Potentially inappropriate medications
- Health literacy
- Cognitive impairment
- Financial struggles
- Manual/swallowing difficulties
- Vision trouble
- Disorganized/inadequate care oversight
- Uncoordinated care amongst clinicians

Medication biopsy

- Amlodipine 2.5mg 4x/day
- Aspirin 325mg daily
- Gabapentin 100mg nightly
- Losartan 50mg daily
- Losartan-HCTZ 50/12.5mg daily
- Lupron injections every 3 months
- Meclizine 12.5mg as needed for dizziness
- Methyldopa 500mg 4x/day
- Rabeprazole (aciphex) 20mg daily
- Diazepam (valium) ?? As needed for anxiety, dizziness
Lesson 4: Less is more

- It is easy to write prescriptions
- But can take months to safely taper patients off meds they have become dependent on physiologically or simply bc they’ve taken something for decades and are afraid to stop
- Med regimens should not only address polypharmacy but match a patient’s prognosis, goals, cognitive and manual dexterity function, swallowing ability, etc.

Dementia care

- 1 in 9 adults age 65+, and ~1 in 3 age 85+ have dementia
- Prospective studies have found low SES associated with incidence of dementia
- Dementia is leading cause of institutionalization for vulnerable and low-income older adults

Alzheimers Association Facts and Figures 2015
Yaffe K et al. BMJ 2013;347:f7051
Agitation?

• Describing someone with dementia as agitated does not help identify or solve the neuropsychiatric symptom (NPS)
• “agitated” is as non-specific to a geriatrician as “rash” is to a dermatologist
• Describe the NPS, determine if there are triggers, and whether it is tolerable behavior or at risk of causing harm

Describing behaviors

Examples:
• Easily upset
• Repetitive questions
• Arguing or complaining
• Hoarding
• Pacing
• Inappropriate screaming, crying, sounds
• Rejection of care
• Leaving home
Types of neuropsychiatric sx

- Apathy, depression, or dysphoria
- Delusions (distressing beliefs)
- Hallucinations (visual, auditory, tactile)
- Aggression/violent outbursts
- Anxiety, worry, shadowing
- Wandering, rummaging (repetitive activity)
- Disinhibition (social or sexual behavior)
- Night behaviors (waking and getting up)
- Irritability or lability

Lesson 5: Sometimes what needs treatment isn’t the patient

- Though we always try to keep someone in their own home, sometimes this isn’t the best option (whether due to inadequate care, abuse/neglect, triggering risky behaviors)
- Adult day programs, changing caregivers, or changing the environment and moving to a different family home or facility, can minimize or extinguish NPS
Examples of modifications

For 84yo hispanic woman with dementia and violent aggression (throwing knives)
- Take her for walks to calm her
- Provide her a plant she can take care of
- Provide her “own dishes” to do “housework” to help her feel at home
- Change her roommate (to one who was minimally verbal to avoid irritating her)
- Provide Spanish-language magazines
- Be in her reality

Antipsychotic Epidemic

- 1 in 3 nursing home residents and 1 in 7 community-dwelling adults with dementia are prescribed antipsychotics
- 41% of nursing home veterans who were given antipsychotics had NO evidence-based indication

Gellad et al. Med Care 2012
GAO Antipsychotic Drugs and Older Adults 2012
CATIE-AD: antipsychotic v placebo

- CATIE-AD RCT study: 421 outpatients
- Risperdal, quetiapine, olanzapine, placebo*
- Ave tx length 7 wks (due to adverse effects)
- Risperdal (1mg) > olanz (5mg) > quet (mg50) for paranoia/hostility/aggression/mistrust, psychosis
- No change in function or care needs
- Olanz worse→ withdrawn depression, ADL function


Risks of Antipsychotics

- 1.5-1.7x increased risk of mortality
- 2-3x increased stroke risk
- CV and metabolic effects (obesity, glucose)
- Extrapyramidal symptoms
- Worsening cognition
- Falls
- Hospitalizations

Translating risk

- NNH – risk of death occurs as early as <6mo

Determine what underlies behavior

We wouldn’t medicate a colicky child, so don’t medicate an adult w dementia without first identifying whether there is discomfort or a need they are unable to communicate:

<table>
<thead>
<tr>
<th>Pain</th>
<th>Depression / Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot or cold</td>
<td>Overstimulation</td>
</tr>
<tr>
<td>Hunger or thirst</td>
<td>Loneliness / isolation</td>
</tr>
<tr>
<td>Toileting needs</td>
<td>Feeling threatened</td>
</tr>
</tbody>
</table>

Cohen-Mansfield and Werner 1999; Meares and Draper 1999; Hallberg et al 1993
Lesson 6: There are many ways in medicine to “save a life”

- There is “saving life” and there is saving *quality of life*
- Dementia patients are susceptible to iatrogenic harm from polypharmacy
- Medication adverse effects can lead to inappropriate/premature hospice referrals


Lesson 7: Change behavior to fix behavior

- Labs, xrays, tests are rarely useful in managing dementia neuropsychiatric behaviors
- Identifying ways in which a caregiver interacts/communicates with a dementia patient suboptimally can help you intervene/counsel/educate to improve a ‘problem behavior’ more than prescriptions
Lessons from Geriatrics

1. Medical care is not the same as health care
2. Help families help patients
3. Med review is a window into a patient’s entire situation
4. Less is more
5. Sometimes what needs treatment isn’t the patient
6. There are many ways in medicine to “save a life”
7. Change behavior to fix behavior

Helen.kao@ucsf.edu
CKD/ESRD care among vulnerable populations

Delphine Tuot, MDCM, MAS
Assistant Professor of Medicine

Disclosures

I have nothing to disclose

Objectives

- Recognize disparities related to kidney health
- Learn about early CKD management strategies that may be of particular importance in this patient population
- Appreciate that poor CKD awareness may contribute to suboptimal risk factor modification among vulnerable patients
- Learn strategies to alleviate the impact of homelessness on CKD/ESRD care

Case: Ms. S

- 50yo AA woman
- PmHx: hypertension
- Meds: chlorthalidone 25mg daily
- PE: 125/75 mmHg, 80 bpm

Older brother just initiated dialysis at age 58. She asks about her risk for dialysis.

- Is she at risk for CKD?
- Does she have CKD?
**What is CKD? Why should you care?**

- 11.5% adult population
- 23 million adults
- Low eGFR is associated with high mortality and CV morbidity

Setting: KP of Northern California

---

**Prognosis of CKD progression to ESRD by eGFR and albuminuria categories.**

<table>
<thead>
<tr>
<th>eGFR categories (ml/min/1.73m²)</th>
<th>albuminuria categories (mg/g)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;60</td>
<td>Normal 0.0-0.3</td>
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<tr>
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<td>690-709</td>
<td>Normal 0.0-0.3</td>
</tr>
<tr>
<td>710-729</td>
<td>Normal 0.0-0.3</td>
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<tr>
<td>730-749</td>
<td>Normal 0.0-0.3</td>
</tr>
<tr>
<td>750-769</td>
<td>Normal 0.0-0.3</td>
</tr>
<tr>
<td>770-789</td>
<td>Normal 0.0-0.3</td>
</tr>
<tr>
<td>790-809</td>
<td>Normal 0.0-0.3</td>
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<tr>
<td>810-829</td>
<td>Normal 0.0-0.3</td>
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<tr>
<td>830-849</td>
<td>Normal 0.0-0.3</td>
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<td>850-869</td>
<td>Normal 0.0-0.3</td>
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<td>870-889</td>
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<td>890-909</td>
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<tr>
<td>910-929</td>
<td>Normal 0.0-0.3</td>
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<td>930-949</td>
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<tr>
<td>950-969</td>
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<tr>
<td>970-989</td>
<td>Normal 0.0-0.3</td>
</tr>
<tr>
<td>990-1000</td>
<td>Normal 0.0-0.3</td>
</tr>
</tbody>
</table>

---

**For every level of eGFR, higher albuminuria confers higher mortality risk.**


---

**CKD prevalence: racial/ethnic disparities**

- Study population: NHANES adult participants, 1988-2012

---

**USRDS Data Report, 2015**
**CKD prevalence: racial/ethnic disparities**
- Study population: NHANES adult participants, 1998-2012

<table>
<thead>
<tr>
<th>Age</th>
<th>All CKD eGFR &lt;60ml/min/1.73m²</th>
<th>ACR &gt;30mg/g</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-39</td>
<td>5.1</td>
<td>0.7</td>
</tr>
<tr>
<td>40-59</td>
<td>8.4</td>
<td>0.9</td>
</tr>
<tr>
<td>60+</td>
<td>10.2</td>
<td>10.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD prevalence: SES disparities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Setting: community adults from 12 representative census tracts in Baltimore; equal numbers by sex, race, SES (high/low)
- Low SES: < 125% federal poverty level

**ESRD incidence: race/ethnic disparities**
- ESRD is nearly 3x greater among African Americans

**ESRD mortality: SES disparities**
- Setting: 11,027 young adults initiating dialysis in US, 2006-2009
- Predictor: Neighborhood SES (>20% residents below FPL)
- Outcome: probability of survival

- Blacks have poor survival
- Low SES: Blacks vs Whites: aHR for mortality = 1.52 (1.28-1.85)
- High SES: Blacks vs Whites: aHR for mortality = 1.26 (1.07-1.48)
CKD disparities: plausible mechanisms

- Traditional biological risk factors
  - DM/HTN, obesity
  - Genetics
- Non-traditional biologic risk factors
  - Co-morbid diseases (HIV, HCV)
  - Depression, substance abuse
  - Periodontal disease
- Social determinants of health
  - Poor patient CKD awareness/health related behaviors
  - Mistrust of medical system
  - Homelessness
- Health system barriers
  - Poor access to care (insurance issues, fragmented care)
  - Communication barriers
  - Low PCP self-efficacy for managing CKD

System

Patient

Provider

Paradigm shift: early detection of CKD

- Strong risk factors for CKD morbidity/mortality
  - Diabetes (presence and glycemic control)
  - HTN (presence and control)
  - Family history of ESRD
  - Low socioeconomic status
  - Racial/ethnic minorities

Screening for CKD

2013 ACP recommendation #1:
No screening for CKD in asymptomatic adults without risk factors of CKD.
Grade: weak recommendation, low quality evidence


Case: Ms. S

50yo AA woman  
PmHx: hypertension  
mMeds: chlorthalidone 25mg daily  
PE: 125/75 mmHg, 80 bpm  
Labs:  
- Cr=0.7 mg/dl; eGFRaa: >60 ml/min/1.73 m²  
- UACR: 800mg/g  
You start AceInh (i.e., Benazepril 10mg daily)  
Now what?

Titration of ACEi/ARB?

2013 ACP recommendation #2:  
No testing for proteinuria in adults with or without diabetes  
who are currently on an ACEi/ARB.  
Grade: weak recommendation, low quality evidence  
Predictor: UACR  
Outcome: mortality  
**Higher UACR is associated with greater mortality, independent of demographics, co-morbidities, eGFR, ACEi/ARB use.

Titration of ACEi/ARB?

Setting: China, ROAD trial  
Study population: 360 non-diabetic patients with avg sCr of 2.7 mg/dl  
Intervention: titration of ACEi/ARB vs. standard dose  
Titration of ACEi/ARB in pts with moderate CKD was associated with decreased composite endpoint of ESRD, doubling sCr, mortality, independent of BP control.

Summary thus far...

CKD is common  
Socioeconomic and racial/ethnic disparities exist  
eGFR and albuminuria are both important  
Early detection in primary care is key  
Strongly consider screening for CKD in vulnerable populations  
Potential role for titration of ACEi/ARB to achieve maximum albuminuria suppression
Other CKD management strategies

- Aggressive BP control (target still not clear)
  - < 130/80 mmHg if proteinuria
  - < 140/90 mmHg without proteinuria
- Glycemic control
- Statin for CV risk reduction
- Lifestyle modifications
- Consult Nephrology
  - eGFR < 30 ml/min
  - etiology of CKD is not clear
  - Rapid CKD progression (loss of 5 ml/min/year)

CKD disparities: plausible mechanisms

- Traditional biological risk factors
  - DM/HTN, obesity
  - Genetics
- Non-traditional biologic risk factors
  - Co-morbid diseases (HIV, HCV)
  - Depression, substance abuse
  - Periodontal disease
- Social determinants of health
  - Low patient/health awareness
  - Mistrust of medical system
  - Homelessness
- Health system barriers
  - Poor access to care (insurance issues, fragmented care)
  - Communication barriers
- Low provider self-efficacy for managing CKD and competing priorities

Patient Awareness of CKD is low

National estimate of CKD awareness = 6.0%

Study population: 2292 NHANES participants with CKD; 1999-2004.

... even among individuals with clinical markers of CKD

Clinical markers
- Anemia
- Hyperkalemia
- Hyperphosphatemia
- Albuminuria
- Acidosis
- Elevated BUN
- Uncontrolled HTN

P for linear trend = 0.08
Competing priorities and discomfort talking about CKD may contribute to poor awareness

- Setting: 15 low-income primary care clinics in/near Baltimore
- Study population: 236 patients with or at risk for CKD, largely AA

Topics of conversation (% of visits)

- CKD: 26% (n=66)
- Diabetes: 60% (n=140)
- Hypertension: 9% (n=11)
- Adherence: 80% (n=181)

How should we describe CKD?

Study population: 220 English and Spanish speaking patients with chronic diseases in safety-net primary care; 50% limited health literacy

- Weak of failing kidney: 33.2%
- Kidney Disease: 27.7%
- Kidney Problem: 40.1%
- Kidney Damage: 26.4%
- Protein in the urine: 39.8%
- Hypertension: 70.8%
- Hydration: 90.1%
- Diabetes: 91.8%

25% pts with CKD/ESRD have limited health literacy
Greater mortality among ESRD pts with low health literacy

- “Kidney Problem” resonates well
- “Protein in the urine”
  Introduce within context of HTN/DM to encourage risk modification
  Pre-empt negative reactions

"Most people live normal lives with little kidney function. You are not near that point, but we need to work together to keep your kidneys as healthy as possible and prevent them from losing too much protein in the urine."
CKD disparities: plausible mechanisms

- Traditional biological risk factors
  - DM/HTN, obesity
  - Genetics
- Non-traditional biologic risk factors
  - Co-morbid diseases (HIV, HCV)
  - Depression, substance abuse
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- Social determinants of health
  - Poor patient CKD awareness/health related behaviors
  - Mistrust of medical system

Health system barriers
- Poor access to care (insurance issues, fragmented care)
- Communication barriers
- Low provider self-efficacy for managing CKD and competing priorities

Homelessness is a risk factor for ESRD/death among those with CKD

- Crude HR: 1.8 (1.49–2.22)
- Adjusted HR: 1.28

Among homeless populations, ESRD is associated with increased mortality

Table 6. Risk Factors Associated With Death in Homeless Adults in Multivariate Analyses

Table 6. Risk Factors Associated With Death in Homeless Adults in Multivariate Analyses

<table>
<thead>
<tr>
<th>Variable</th>
<th>Case Patients, No. (%)</th>
<th>Controls, No. (%)</th>
<th>Odds Ratio (99% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infection, AIDS</td>
<td>65 (12)</td>
<td>5 (1)</td>
<td>55.8 (14.6–216.9)</td>
</tr>
<tr>
<td>HIV infection, symptomatic</td>
<td>44 (4)</td>
<td>6 (1)</td>
<td>17.7 (3.2–98.9)</td>
</tr>
<tr>
<td>HIV infection, asymptomatic</td>
<td>20 (4)</td>
<td>9 (2)</td>
<td>4.1 (1.5–11.2)</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>13 (2)</td>
<td>2 (0)</td>
<td>16.0 (3.1–88.9)</td>
</tr>
<tr>
<td>Diabetic hypertonia, or infection</td>
<td>21 (4)</td>
<td>4 (0)</td>
<td>8.9 (1.1–68.3)</td>
</tr>
<tr>
<td>Liver disease</td>
<td>31 (6)</td>
<td>5 (1)</td>
<td>3.9 (1.2–11.5)</td>
</tr>
<tr>
<td>Asthma</td>
<td>29 (5)</td>
<td>6 (1)</td>
<td>3.3 (1.1–9.4)</td>
</tr>
<tr>
<td>Seizures</td>
<td>133 (24)</td>
<td>71 (13)</td>
<td>1.7 (1.1-2.6)</td>
</tr>
<tr>
<td>Fracture</td>
<td>163 (29)</td>
<td>117 (21)</td>
<td>1.5 (1.0–2.3)</td>
</tr>
<tr>
<td>Injection drug use</td>
<td>208 (37)</td>
<td>98 (18)</td>
<td>1.5 (1.0–2.3)</td>
</tr>
<tr>
<td>Alcohol dependence or abuse</td>
<td>425 (68)</td>
<td>259 (46)</td>
<td>1.5 (1.0–2.3)</td>
</tr>
<tr>
<td>Non-English in 이렇다</td>
<td>14 (2)</td>
<td>50 (9)</td>
<td>0.4 (0.2–0.8)</td>
</tr>
<tr>
<td>Female</td>
<td>80 (14)</td>
<td>159 (23)</td>
<td>0.7 (0.5–1.1)</td>
</tr>
<tr>
<td>Black</td>
<td>169 (30)</td>
<td>177 (22)</td>
<td>0.9 (0.6–1.2)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>45 (8)</td>
<td>66 (12)</td>
<td>0.6 (0.3–1.1)</td>
</tr>
<tr>
<td>White</td>
<td>142 (25)</td>
<td>152 (22)</td>
<td>0.7 (0.5–1.1)</td>
</tr>
</tbody>
</table>


Strategies to improve kidney care among homeless patients

- Refer patients to nephrology early
- Advocate for permanent (AVF/AVG) access placement
  - Medication adherence
    - Daily dosing; long-acting medications
    - Pharmacy that delivers medi-sets to dialysis unit
    - Partnering with Methadone dosing programs
  - Dialysis adherence
    - Late shift if needed for odd jobs
    - Early shift if needed for shelter beds
  - Transportation
  - Case management programs
Homelessness is a risk factor for late nephrology referrals

Population: 460 patients who initiated dialysis at Grady hospital, 1999–2002

- Early referral: >3 mo
- Late referral: 1-3 mo
- Ultra-late referral: <1 mo

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ER</th>
<th>LR</th>
<th>ULR</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism (%)</td>
<td>10</td>
<td>14</td>
<td>34</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Substance abuse (%)</td>
<td>6</td>
<td>10</td>
<td>37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Unemployment/homelessness (%)</td>
<td>4</td>
<td>5</td>
<td>28</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Education (%)
- Primary school: 17 23 60 Not significant
- High school: 17 38 45 Not significant
- College: 31 23 46 Not significant

Strategies to improve kidney care among homeless patients

- Refer patients to nephrology early
- Advocate for permanent (AVF/AVG) access placement
- Medication adherence
  - Daily dosing; long-acting medications
  - Pharmacy that delivers medi-sets to dialysis unit
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- Dialysis adherence
  - Late shift if needed for odd jobs
  - Early shift if needed for shelter beds
  - Transportation
- Case management programs

Take home points

CKD is common, defined by eGFR and albuminuria
Socioeconomic disparities exist with respect to CKD/ESRD outcomes
Patient, provider, system-level factors contribute to these suboptimal outcomes
Small changes in practice can make a difference
- Screen among high-risk populations (low SES)
- Discuss CKD during visits
- Coordinate with care management programs to refer homeless patients to nephrology early and optimize care delivery for ESRD patients

Thank You
Delphine.Tuot@ucsf.edu
Update on Hepatitis C
Focus on Underserved & Vulnerable populations

Annie Luetkemeyer, MD
Division of HIV, ID & Global Medicine
San Francisco General Hospital

Disclosures
I have received research grant support to UCSF related to HCV from the following:
• Abbvie
• Bristol Myers Squibb (BMS)
• Gilead
• Pfizer
• Merck
• ACTG (NIH)

Objectives
• Impact of HCV on vulnerable and underserved populations
• Evidence supporting benefit of HCV cure
• Preparing for HCV treatment
• Overview of the HCV arsenal
• Focus on effective care delivery in marginalized populations

Resources
• http://www.hcvguidelines.org
  • Management guidelines from IDSA and AASLD
• http://www.hep-druginteractions.org
  • Free downloadable app
• http://www.hepatitis.va.gov/provider/index.asp
• Great patient information

American Association for the Study of Liver Diseases
Infectious Diseases Society of America
HCV: Quinessential disease of vulnerable populations

- NHANES estimate of 2.7 million in US with HCV viremia
- May be a gross underestimate due to exclusion of underserved populations: true estimate > 4.6 million
- Disproportionate impact on vulnerable populations
  - US HIV infected: ≈ 25-30% coinfection
  - Current/former injection drug users: ≈ 50-90% depending on population
  - Homeless: ≈7.5-50%

Incarcerated populations

- Substantial reservoir of HCV infection
- Limited to no access to HCV treatment

HCV Cascade of Care 2000-2013

Most important first step: Ensure our patients are tested (and retested!)

Our patient

- 42 yo man, HCV Ab+, establishing care with you
- PMH: depression
- Meds: Paxil, Methadone maintenance x 3 years
- Social history
  - Prior IDU heroin, none currently
  - Uses methamphetamines several times a month- usually smoked, occasionally IDU
  - Alcohol- few beers/day, binge drinks on occasion
  - Sexually active with men, condoms use inconsistent
  - Lives in a single room occupancy hotel x past 3 months
  - On disability
**HCV Ab+: next steps**

- Confirm viremia with HCV RNA
- Screen and vaccinate if indicated for HAV & HBV
- Reduce alcohol consumption
- Reduce forward transmission risk
  - Drug use – avoid sharing needles or nasal straws
  - Sexual counseling: MSM or HIV infected partner
  - Household precautions: no shared toothbrushes or razor
- Fibrosis Assessment: serologic markers (ex: APRI, Fibrotest) and/or imaging
  - Impacts decision to screen for HCC and varices
  - Affects treatment response, choice of therapy, and treatment initiation timeline
- HCV Genotype

**Case #1 continued**

- HCV RNA: 3 million IU/ml
- Genotype 1a
  - AST 35/ALT 33, Alb 3.9, INR 1.1, Platelets 210
- HIV Ab negative
- APRI = 0.4 (suggests non-cirrhotic)
- HAV Immune
- Hep B S Ab neg, S Ag neg, Core Ab Neg
- Ultrasound: no evidence of cirrhosis

**Genotypes 1-6**

- Can impact disease progression
  - Genotype 3: associated with steatohepatitis
- Impacts selection and response to therapy
  - Easiest to Cure: $2>4\geq 1 \geq (1b>1a)>\text{cirrhotic GT3}$
- Genotype 1: most common in US (70%)
  - $\approx 70\%$ 1a

Would you offer HCV treatment to this marginally housed non-cirrhotic patient, with active substance use?

A. No, I would not treat until evidence of advanced fibrosis or frank cirrhosis as no benefit
B. No, I am worried about reinfection via MSM route
C. Yes, I would pursue treatment now if he is motivated to be treated
D. Yes, but only after he demonstrates 6 months of sobriety
Whom to treat

Recommendations for Testing, Managing, and Treating Hepatitis C

Goal of Treatment
- The goal of treatment of HCV-infected persons is to reduce all-cause mortality and liver-related health adverse consequences, including end-stage liver disease and hepatocellular carcinoma, by the achievement of virologic cure as evidenced by a sustained virologic response.
Rating: Class I, Level A

Recommendations for When and Whom to Initiate Treatment
- Treatment is recommended for all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy. Patients with short life expectancies owing to liver disease should be managed in consultation with an expert.
Rating: Class I, Level A

www.hcvguidelines.org

Hepatic Benefits of HCV cure

- Reduce hepatic decompensation, liver transplant and HCC
- Avert MORE liver disease complication in those with LESS fibrosis

Non-Hepatic Benefits of HCV Cure

HCV is a systemic, inflammatory viral infection associated with non-hepatic complications
- Renal disease (Chen 2014)
- Lymphoproliferative disease (Hem 2014)
- Insulin resistance
- Vascular disease (CAD & CVA) (Hem 2014)
- Cognitive impairment
- Bone Disease & Fracture (Le Ra 2014)
- Skin disease including porphyria cutanea tarda

HCV cure reduces all cause mortality, including non-hepatic, as well as these co-morbidities

HCV treatment as prevention

- Base Case:
  - Risk based & Baby boomer screening
  - Treatment ramps up

- Ideal
  - Universal Screening
  - Treatment capacity unlimited

Figure 2: Estimated prevalence of cases of chronic HCV infection in the United States from 2001 to 2050 under different simulation scenarios.

Kabiri AIM 2014 Aug 5;161(3):170-80

AASLD 2014 Abstract # 1751
What about active drug use?

- C-Edge CO-STAR; HCV-infected patients stable on methadone or buprenorphine \( \geq 3 \) months and kept at least 80% of scheduled appointments
- 12 weeks of HCV treatment (one pill daily)

Despite substantial drug use during treatment, 96.5% of patients missed \( \leq 3 \) doses during 12 weeks.

What about alcohol?

- Alcohol and HCV are negatively synergistic
- Data support successful interferon-based HCV treatment in active drinkers
- Benefit of HCV cure despite continued alcohol in most patients (Russell 2012, Costenin 2013)
- Successful HCV cure can be a springboard for other positive health changes.

**Take-home:** Counsel regarding alcohol reduction but don’t withhold treatment due to alcohol use alone.

What about the COST??!

- Current oral medications remain extraordinarily expensive
- Despite the cost, many models find universal HCV treatment cost effective
- **Cost effective ≠ cheap**
  - If 50% of US HCV+ treated at base price = **$53 billion**

Drug procurement

- Limited access to expensive HCV drugs has impacted direct acting agents (DAAs)
- 2014-15 analysis, 4 states, 2350 HCV patients
  - 16% denied
  - Medi-caid: 46% denied
- Progress toward improved access
  - Medi-Cal 7/15: Removed restrictions limiting treatment to those with advanced fibrosis
  - HIV+. Women childbearing age, IDU, MSM
  - Worldwide: scale up of generic production
  - Continued advocacy for lower pricing
Highest Priority for HCV therapy

**HIGHEST PRIORITY**
- Advanced Fibrosis (F3) or compensated cirrhosis (F4)
- Cryoglobulinemia with end organ manifestations
- Renal complications of HCV infection

**HIGH PRIORITY**
- Fibrosis (F2)
- HIV Coinfection
- HBV Coinfection
- Other liver disease (e.g. NASH)
- Debilitating Fatigue
- Diabetes
- Porphyria cutanea Tarda
- HIGH HCV Transmission Risk (includes MSM, IDU)

Optimizing chances of success

- Counsel about new reality of HCV treatment
- Predictors of success
  - Strong motivation to be treated
  - Attendance of appointments
  - Evidence of adherence to other medication regimens
    - Methadone maintenance
    - HTN or DM2- at goal for treatment?
    - If HIV infected: HIV RNA suppression
- Anticipate and troubleshoot barriers
  - Changing housing, rehab plans, immigration status

Direct Acting Agents (DAA)

<table>
<thead>
<tr>
<th>Protease inhibitors</th>
<th>NS5b Inhibitors</th>
<th>NS5a Inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target viral protease</td>
<td>Target viral RNA polymerase</td>
<td>Target viral assembly and release</td>
</tr>
<tr>
<td>“previr”</td>
<td>“-buvir”</td>
<td>“-asvir”</td>
</tr>
<tr>
<td>Simeprevir</td>
<td>Sofosbuvir</td>
<td>Ledipasvir</td>
</tr>
<tr>
<td>Paritaprevir</td>
<td>NS5b Nucleotide</td>
<td>Ombitasvir</td>
</tr>
<tr>
<td>Grazoprevir</td>
<td>NS5b Non-nucleotide</td>
<td>Daclatasvir</td>
</tr>
</tbody>
</table>

“P”= Previr

“B”= Buvir

“A”= Asvir

>90-95% cure rate for most patients
Current DAA combinations

- NS5b Nucleotide based therapy
  NS5b Nuke Backbone + One drug from 2nd class
  - Sofosbuvir + Ribavirin
  - NS5a
  - Protease inhibitor

- Triple therapy without a NS5b Nuke
  - NS5a + NS5b Non-Nuke
  - NS5a
  - Protease inhibitor

- HCV protease inhibitor + NS5a
  - Protease inhibitor + NS5a

Current DAA combinations

- NS5b Nucleotide based therapy
  NS5b Nuke Backbone + One drug from 2nd class
  - Sofosbuvir + Ledipasivir
  - NS5a
  - Protease inhibitor

- Triple therapy without a NS5b Nuke
  - NS5a + NS5b Non-Nuke
  - NS5a
  - Protease inhibitor

- HCV protease inhibitor + NS5a
  - Protease inhibitor + NS5a

Current DAA combinations

- NS5b Nucleotide based therapy
  NS5b Nuke Backbone + One drug from 2nd class
  - Sofosbuvir + Daclatasvir
  - NS5a
  - Protease inhibitor

- Triple therapy without a NS5b Nuke
  - NS5a + NS5b Non-Nuke
  - NS5a
  - Protease inhibitor

- HCV protease inhibitor + NS5a
  - Protease inhibitor + NS5a

Current DAA combinations

- NS5b Nucleotide based therapy
  NS5b Nuke Backbone + One drug from 2nd class
  - Sofosbuvir + Simeprevir
  - NS5a
  - Protease inhibitor

- Triple therapy without a NS5b Nuke
  - NS5a + NS5b Non-Nuke
  - NS5a
  - Protease inhibitor

- HCV protease inhibitor + NS5a
  - Protease inhibitor + NS5a
Current DAA combinations

- **NS5b Nucleotide based therapy**
  - NS5b Nuke Backbone
  - One drug from 2nd class
    - Sofosbuvir + Ribavirin

- **Triple therapy without a NS5b Nuke**
  - NS5a + NS5b Non-Nuke + Protease inhibitor

- **HCV protease inhibitor + NS5a**
  - Protease inhibitor + NS5a

Options for our patient

- **Genotype 1a, non-cirrhotic, treatment naive**

<table>
<thead>
<tr>
<th>Regimens</th>
<th>Dose</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ledipasvir/Sofosbuvir</td>
<td>One FDC pill daily</td>
<td>x12 weeks (8 weeks if HCV RNA &lt; 6 million IU/ml)</td>
</tr>
<tr>
<td>PTV/RTV/OBV + DSV + RBV (&quot;PrOD&quot;)</td>
<td>One FDC pill + one BID pill + weight based ribavirin BID (4-6 pills day)</td>
<td>x12 weeks</td>
</tr>
<tr>
<td>Elbasvir/Grazoprevir</td>
<td>One FDC pill daily*</td>
<td>x 12 weeks (16 weeks +RBV if resistance)</td>
</tr>
</tbody>
</table>

*NS5a resistance testing required for GT1a

FDC= fixed dose combination
Tools

- Co-administration via methadone clinic
- Use of navigators / peer support
- Adherence coaching/check-in
  - Pharmacy
  - Clinic staff
  - Text messaging
  - Support groups
- Clinical trials
  - Monetary incentives
  - Structured monitoring

Back to our patient

- Insurance approves LDV/SOF x 8 weeks (HCV RNA < 6 million)
- You work with his methadone counselor to co-administer his HCV treatment with methadone
- Your pharmacist checks in with him every 2 weeks regarding adherence
- Week 4 lab check:
  - HCV RNA at week 4 is < limit of detection, LFTs have normalized
- 12 weeks after completing treatment, HCV RNA is undetectable -> Cured!

After the cure...

- HCV Ab may remain positive for life
  - Future HCV screening will need to be HCV RNA
- Counsel about Reinfection
  - Drug use: shared needles, works, straws used for snorting
  - Sexual contact through men having sex with men (MSM): risk highest in HIV+ men but occurs in HIV-
- If cirrhotic, continue to screen for hepatocellular carcinoma with q 6-12 month imaging

Conclusions

- We have to tools to cure HCV in the majority of HCV patients, including those with most complex disease
- HCV treatment is well tolerated and relatively straightforward for most patients
- Vulnerable populations can benefit enormously from HCV cure and many can successfully attain and complete therapy, despite substance use & other barriers
- In order realize the tremendous potential of HCV DAAs, we will need providers to identify HCV and discuss treatment readiness as well as large cadre of HCV treaters, including primary care based treatment
Thank you!

- University of Liverpool HCV Drug interaction database: [http://www.hep-druginteractions.org](http://www.hep-druginteractions.org)
- Patient education resource

---

Backup slides

### Treatment Considerations

<table>
<thead>
<tr>
<th></th>
<th>LDV/SOF</th>
<th>P/r/O/D+ RBV (1a)</th>
<th>P/r/O/D 1b</th>
<th>EBR/GZP</th>
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<tr>
<td>Pill Burden</td>
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<td>10</td>
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<tr>
<td>Cost**</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
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<td>Drug Interactions</td>
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<td>Adverse Events</td>
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<td>Resistance Risk</td>
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<td>Efficacy</td>
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<td>Limits in special populations (CKD-ESRD and severe liver disease)</td>
<td>CrCl &gt; 30 only</td>
<td>Caution in Cirrhosis</td>
<td>Can give in ESRD</td>
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<tr>
<td>Need for Ribavirin</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>1a, if NS5a resistance</td>
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*Interaction with acid suppressing medications
**Wholesale acquisition cost

Adapted from S.Naggie
Care of People with Severe Mental Illness

March 11, 2016

Medical Care of Vulnerable and Underserved Populations

Westin St. Francis Hotel, San Francisco, CA

Overview

• Clinical Case
• Define SMI
• Review of the literature on medical co-morbidities among people with SMI, with a focus on metabolic abnormalities
  – Prevalence
  – Screening
  – Treatment
• Discussion of what you can do to improve the care of people with SMI

Learning objectives

• Be aware of the early mortality rates among people with severe mental illness (SMI)
• Understand the low prevalence of screening of medical disorders among people with SMI
• Understand the low prevalence of treatment of medical disorders among people with SMI

Disclosures

• NIMH K23 Career Development Grant (2012-present)
• UCSF Hellman Family Award for Early Career Faculty (2013-present)
• UCSF RAP Grant for Underrepresented Minority Faculty (2011-2013)
• Past support: NARSAD; APIRE/Lilly; APIRE/Janssen
Clinical Case

Severe mental illness (SMI)

- SMI includes a range of DSM-IV psychiatric disorders that result in severe impairment in functioning (e.g., schizophrenia, schizoaffective disorder, bipolar disorder).
- In 2014, there were 9.8 million adults living with SMI in the US (4.2% of the US population)
- People with SMI utilize community mental health clinics significantly more often than primary care

Audience Participation

- What is your differential diagnosis?
- What do you think is the most likely diagnosis?
- What would you do?

The Institute of Medicine and the Surgeon General recognize significant health disparities for people with mental illness

SAMHSA, Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. 2015
Druss et al., Psychiatry Services 59(6):617-20, 2008

US DHHS (1999); Mental Health: A Report of the Surgeon General; IOM (2006) Improving the Quality of Health Care for Mental and Substance-Use Conditions
People with severe mental illness die 25 years earlier than the general population

Colton et al., Preventative Chronic Disease 3(2):A42, 2006
Olfson et al., JAMA Psychiatry, 72(9):1172-81, 2015
(A longitudinal study of >1M adults with schizophrenia found they were 3.5x more likely to die in the 1st year)

Audience Participation

- What is the primary cause of death among people with SMI?
  - Cardiovascular disease

Prevalence of medical comorbidities among people with SMI

- **Metabolic Syndrome ~41%**
  - 2x general population (CATIE 41%; NHANES 24%)
- **Diabetes ~15%**
  - 2x general population
- **HIV 6%**
  - 10x higher than general US population (0.5%)
  - Huge range (3-23%)
- **Hepatitis C 17%**
  - 17x greater than the general population (1%)

Odom et al., BMC Psychiatry 9:94, 2009

Special Populations to Consider regarding metabolic risk

- **Children and adolescents**
  - Obesity & Diabetes
- **Women**
  - Metabolic syndrome
- **African Americans**
  - Obesity & Metabolic Syndrome
- **Latinos**
  - Obesity & Metabolic Syndrome

Cornell et al., JAMA Psychiatry 71(12):1300-06, 2014
Dilling et al., JAMA Psychiatry, Jan 20, 2016
Schneiderman et al., Pharmacotherapy 29(8):975-87, 2009
Krakowski et al., Schizophrenia Research 110(1-3):95-102, 2009
Mangone et al., Community Ment Health J 48(2):195-6, 2012
Audience participation

- Why do so many people with SMI have so many medical co-morbidities?
  - Antipsychotic medications ➔ Remember the case!
  - Health behaviors
    - Tobacco use
    - Substance use
    - Poor diet & lack of physical activity
    - High-risk sexual activity
  - Social determinants of health
  - Quality of health care

Druss et al., Am J Psychiatry 171(3):380-8, 2014
Newcomer et al., JAMA 296(15):1794-6, 2007

ADA/APA monitoring guidelines for patients on SGAs

| TABLE | Recommendations for Metabolic Monitoring in Patients Receiving Atypical Antipsychotics
<table>
<thead>
<tr>
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<td>Weight (BMI)</td>
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<td>Blood pressure</td>
<td>X</td>
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<tr>
<td>Fasting plasma glucose</td>
<td>X</td>
</tr>
<tr>
<td>Fasting lipid profile</td>
<td>X</td>
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</tbody>
</table>

*More frequent assessments may be warranted based on clinical status. BMI—body mass index.

Health Behaviors: Tobacco & Substance Abuse

- Tobacco
  - 31-41% of all cigarettes smoked in the US are consumed by people with mental illness
  - 44-64% of people with SMI smoke

- Substance Abuse
  - 50% of people with mental illness use drugs or alcohol
  - Misuse of substances can lead to poor self-care, decreased adherence, risky sexual behavior

Buckley PF. J Clin Psychiatry 67(Suppl7):5-9
Health Behaviors:

Exercise & Diet

- **Exercise**
  - People with SMI engage in less physical activity than the general public
  - Strong association between social isolation and inactivity
  - Psychiatric disorders & medications cause sedation
- **Diet**
  - Socioeconomic disadvantage leads to poor diet and contributes to elevated rates of obesity
  - Food insecurity (71% among people with SMI vs 46% in a safety net population vs 12% in general population)

Mangurian et al., Psych Services 64(9):931-2, 2013.

Other causes of excess morbidity and mortality

- **Social determinants of health**
  - Economic and social conditions that influence health status (e.g., SES, psychological stress, early childhood development, social exclusion, unemployment, lack of social support networks, availability of healthy food, and safe transportation)
- **Quality of health care**
  - People with SMI receive lower quality of medical care
  - Focus of the remainder of the talk on this lack of screening and treatment of CVD


Health Behaviors:

High Risk Sexual Activity

- Although a lower percentage of people with SMI engage in sex, those that do display high-risk behaviors
  - ~60% do not use condoms
  - ~50% with multiple sex partners in the prior year
  - ~30% traded sex for money or goods
- 12% of sexually active people with schizophrenia had partners with risky behaviors (HIV, IVDU or blood transfusions)


Screening for medical co-morbidities among people with SMI

Mangurian et al., Psych Services 64(9):931-2, 2013.
### ADA/APA monitoring guidelines for patients on SGAs

**TABLE**

<table>
<thead>
<tr>
<th>Recommendations for Metabolic Monitoring in Patients Receiving Atypical Antipsychotic Agents*</th>
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<td>Fasting plasma glucose</td>
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<tr>
<td>Fasting lipid profile</td>
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</tbody>
</table>

*Note: Frequent assessments may be warranted based on clinical status. BMI = body mass index.

### Impact of the ADA Consensus Statement on Metabolic Screening


**Additional findings**

- **HIV**
  - Only 7% are tested (3,817/57,170) despite a 6% prevalence (0.5% in the general population)

- **Hep C**
  - Only 4.7% (2,674/57,170) are tested (12.7% in the general population), despite a 17% prevalence (1% in the general population)

- **Breast Cancer**
  - Only 23.2% (5,352/23,087) get mammograms (43% in general population)

---

**Low diabetes screening among people with SMI in California**

- Only 30% (15,315/50,915) of people were screened for DM, despite guidelines in place 10 years ago.
- The strongest correlate of diabetes screening was having at least one primary care medical care visit (36% vs 20%; PR 1.80, 95%CI 1.62-2.00, p<0.0005)
- Young adults (18-27) were less likely to be screened than any other category of older adults with SMI. ✉️ Remember the clinical case! ✉️

**Mangurian et al., JAMA Internal Medicine, 175(12):1977-9, 2015**
Multiple barriers impede metabolic screening of this population

- **Patient factors**
  - Amotivation, cognitive difficulties, or paranoia can make fasting labs or attending primary care appointments challenging

- **Provider factors**
  - Psychiatrists may believe guidelines go beyond their scope of practice.
  - Primary care physicians lack knowledge and comfort dealing with people with SMI.

- **Systemic factors**
  - Separation between medical and mental health care (geographically, financially, organizationally, culturally)
  - Difficulties coordinating care

Treatment for medical co-morbidities among people with SMI

Even if screened, treatment rates are low

- Less likely to receive treatment for dyslipidemia, hyperglycemia, and hypertension
- Less likely to receive angioplasty or CABG
- Less likely to receive drug therapies of proven benefit (thrombolytics, aspirin, beta-blockers, ACE inhibitors) post-myocardial infarction
- More likely to have premature mortality post-myocardial infarction

Prevention Opportunities Missed: Low Rates of Treatment for Metabolic Disorders in Schizophrenia in CATIE

*Non-white women had lower rates of treatment than their male counterparts*
Will people with SMI accept treatment?

• People with SMI appear receptive to treatment of metabolic disorders when options are made available.
  – A VA study found that adherence to oral hypoglycemic medications was better among diabetes patients with schizophrenia (N=11,454) than diabetes patients without this diagnosis (N=10,560) (57% vs 48%, p<0.001)
  – People with schizophrenia attend weight loss programs if these are provided to them, although whether attendance rates are comparable to those without SMI has not be directly studied.

What can you do to help your patients with SMI?

Medical providers should...

• Screen people with SMI for medical co-morbidities
  – Consider people with SMI in your risk stratification when deciding whether to screening for medical co-morbidities
  – ADA/APA guidelines recommend annual screening (BMI, blood pressure, lipids, A1c)
    - Remember young adults!
  – Annual screening for HIV & Hep C b/c of high risk
  – Don’t forget women’s health (mammograms and pap smears)

• Treat medical conditions

• Recognize modifiable risk factors:
  – Facilitate smoking cessation
  – Recommend substance abuse treatment
  – Recommend feasible diet and exercise plans
  – Encourage safe sex practices

What about switching medications?

• Prior systematic reviews did not recommend switching antipsychotic medications because of lack of evidence
• A recent literature review found that switching was beneficial and did not result in decompensation
• For primary care providers considering making this switch, I recommend:
  – Comparing metabolic side effect profiles
  – Close consultation with a psychiatrist, and
  – Close monitoring of psychiatric symptoms during this taper and/or cross titration.
Take home point

When you see someone with SMI, add 25 years to their age and then do your risk stratification.

Summary

- People with SMI die 25 years earlier than the general population, often from CVD
  - This is a major health disparity
- People with SMI are less likely to receive screening for medical conditions.
- Even if medical conditions are identified, people with SMI are unlikely to receive treatment.
- **YOU can do something:**
  - Screen
  - Treat
  - Advocate for systemic solutions, like integration of care

Maintenance of Certification

- **QUESTION:** Per the American Diabetes Association recommendations (2004), how often should people taking antipsychotic medications—regardless of age—be screened for diabetes?

- **ANSWER:** Annually when on maintenance medications. More frequently if initiating these medications. This applies to all ages, including young adults.

Thank you!

Please feel free to contact me with questions (christina.mangurian@ucsf.edu)
High Quality Care Transitions for Vulnerable Patients

L. Elizabeth Goldman, MD, MCR
Associate Professor of Medicine

Objective

Understand how care transitions affect vulnerable patients

Review the evidence for care transition interventions

Identify best practices to implement TODAY

“Care Transitions are a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location.”

Eric Coleman’s Definition of Care Transitions

Disclosures

I have no disclosures.
**Case: Can we prevent readmission?**

89 year old Spanish-speaking woman h/o CHF, atrial fibrillation, diabetes

Recently hospitalized for delirium in the context of a urinary tract infection & volume overload

**Question**

- What evidence based strategies can prevent hospital readmissions?

**Poor Care Transitions Affect Patients**

- High rates of medical errors
- Serious unmet needs
- Poor satisfaction with care
- High rates of preventable readmissions

**Vulnerable Patients at Higher Risk of Poor Outcomes**

- Multiple comorbidities
- Severe mental illness
- Homeless
- Substance use
- Medicaid insurance
- Functional impairment
Human and Financial Costs

3/12/2016

What works?

Many strategies...

What works: multidimensional

Naylor Transitional Care Model
- Advanced Practice Nurses
  - Home visits and phone calls for 6 weeks
  - English speaking >65 years old

Coleman Care Transitions Intervention (CTI)
- RN Transitional Care Coach
  - Home visit by RN and follow-up phone calls over 4 weeks
  - Medication self-management, patient centered health record, PCP and specialist follow-up, red flags
  - English-speaking >65 years old

Hansen, 2011; Naylor, 1999; Coleman, 2006
Let’s apply to safety net

- SHHE Project: Support for Hospital to Home for Elderly at a public safety-net hospital
  - Nurse-led language concordant in-hospital educational intervention with follow-up phone calls 3 and 7 days after discharge by Nurse Practitioner/Physician Assistant
  - English, Spanish, Chinese-speaking patients over 55

Goldman, 2014

SHHE PROJECT

- No reduction in readmissions and ED visits!
- Conclusion: Hospital-based intervention not sufficient in our patient population

Goldman, 2014

Collaboration is key!

- Collaborate with cross-setting partners
- Enhanced services for high-risk patients

Boutwell, 2014

What can we do for Ms. J?

Guide for Hospitals to Prevent Medicaid Readmissions

Boutwell, 2014
**Post-discharge follow-up calls**

Calls by primary care personnel showed increased engagement in primary care

*Mistiaen, 2006; Crocker, 2012*

---

**Early in-person follow-up**

Early follow-up in primary care associated with lower rates of readmission in surgical and medical patients.

- ‘Early’ not standardized
  - 7 days?

*Brooke, 2014; Hernandez, 2010*

---

**Medication Reconciliation**

Not effective in isolation

Inpatient pharmacist reduced ER visits and re-hospitalizations within 30 days of discharge

- Timeframe
- Roles & responsibilities
- High risk medications

*Kwan, 2013; Mekonnen, 2016*

---

**CHF: High Risk Condition**

Multidisciplinary HF clinic visits or home visits reduced both all-cause readmissions and mortality

- Self-management education delivered *in person*
- Early post-discharge contact
- A point of post-discharge contact
- Ability to *individually tailor* the intervention.

*Feltner, 2014*
**Cross-Setting Partnerships**

- Discharge summaries not complete
- Communicate with inpatient, ED, behavioral health & social services
- Take time to build partnerships for complex patients

*Kripalani, 2007; Nguyen, 2014; Boutwell, 2015;*

**Can we predict?**

- No perfect risk-stratification tool to predict who will be readmitted

*Kansagara, 2011*

**What about Mr. Z.?**

- 46 year old English-speaking man ETOH use disorder, cirrhosis is homeless living under a bridge
- Recent admission for ETOH withdrawal and volume overload.
  - Street outreach & engagement if not engaged in primary care

**Summary**

- Comprehensive multidimensional programs best
- Follow-up calls to increase primary care attendance
- Early primary care follow-up
- Medicine reconciliation
- Cross setting communication & collaboration
- Intensive programs for high risk individuals
Addressing Disparities in Abortion & Contraception

Karen R Meckstroth, MD, MPH
Clinical Professor, Obstetrics, Gynecology & R.S.
Director, UCSF Women’s Options Center
&
Beth Harleman, MD
Professor of Medicine and
Obstetrics, Gynecology and R. S.

Disclosures
We have no disclosures relevant to this talk

Acknowledgements

to Andrea Jackson, MD
and
Christine Dehlendorf, MD, MAS
for their research and slides

Objectives

At the end of this talk, you will be able to:

- Help poor women navigate care for undesired pregnancies
- Choose safe methods of contraception in women with medical illness
- Utilize a shared decision-making model for contraceptive counseling

Disparities for Women

- Less social and economic power
- Lower income for similar work
- Shoulder higher burden of unpaid and hidden work
- Receive less preventative care for CVD
- Higher rates of depression
- Higher risk of being uninsured
- Since women’s care often split (reproductive and primary), higher risk of inadequate care.
Case

- Young woman, post-partum
- My desire: to give her "highly effective" contraception

Why I'm motivated...

Blacks & Hispanics have high rates of unintended pregnancy

Finer, LB. AJPH 2014

Unintended Pregnancy with Patch-Pill-Ring vs. LARC

Finer, LB. AJPH 2014
Abortion rates mirror unintended pregnancy rates for ethnicity & SES

83% of abortions occur in women < 300% of FPL

Poor women are overrepresented among abortion patients

Abortion stigma

“A negative attribute ascribed to women who seek to terminate a pregnancy that ‘marks’ them as inferior to ideals of womanhood”

Women who have abortions are often regarded as:
- Selfish
- Promiscuous
- Irresponsible
- Heartless
- Abnormal

Women hide abortion


Kumar et al 2009; Norris et al. 2011
Restrictive abortion laws disproportionately affect poor women

- Travel, childcare, time off work
- Poor girls more likely to live with one or neither parent
- Public facilities affected by restrictive laws
- Religious facilities often in poor communities
- Default enrollment

Dramatic increase in U.S. abortion restrictions

Legal status does not predict incidence worldwide

Restrictive U.S. abortion laws

- Physician-only
- Hospital-only after certain gestation
- Facilities restrictions (TRAP laws)
- Funding restrictions
- No private insurance coverage
- Parental involvement
- Waiting periods (24-72 hrs)
- State-mandated counseling of false info
- Ultrasound viewing or listen to heart

WHO 2014 & Lancet 2012

Guttmacher Feb 2016
The Hyde Amendment
- Bans federal funding of abortion
- Only 17 states use state funds to pay for abortions for women with Medicaid

Effects of funding restrictions
Evidence supports:
- Decreased rate of abortions
- Delay in access to abortion
- Fewer abortion providers
- Higher costs to gov’t social programs

Studies suggest:
- Rates of illegal abortions
- Abortion complication rates
- Pregnancy complications (PTD, low BWt)
- Child abuse rates
- Suicide rates

Henshaw et al. Restrictions on Medicaid Funding for Abortions: Guttmacher Jun 2009

Reasons for delay in 2nd-trimester patients
- Didn’t suspect pregnancy: 34%*
- In denial about being pregnant: 21%*
- Difficulty in getting to our clinic: 63%*
- Initially referred to other clinic(s): 47%*
- Difficulty figuring out where to go: 20%*
- Difficulty with Medi-Cal, money, insurance: 20%*
- Emotional factors: 51%*
- Unsure of decision: 30%*
- Afraid: 35%
- Unsupportive partner: 19%

*statistically significant vs. early abortion patients, p<0.05

Drey E et al, Ob Gyn, 2006

Medi-Cal (mis)information
Calls to 30 county social services in CA:
- <21yo woman wants Medi-Cal for pregnancy
- 17% not in service or unanswered
- Frequent incorrect info:
  - 53%: Must bring ID and citizenship docs
  - 23%: Parents have to be involved
  - 17% mentioned Minor Consent for Sensitive Services
**Case**

- Young woman, post-partum
- My desire: to give her “highly effective” contraception
- Her concern: autonomy

**Contraception for Underserved Women**

- Safe prescribing for women with medical illness
- Shared decision-making
Low income women and women of color have higher illness burden

Higher rates of chronic diseases:
- HTN
- DM
- Obesity

Many chronic diseases:
- Worsen in pregnancy
- Have potentially teratogenic effects
- Treated using potentially teratogenic meds

PCP’s underestimate risk of unintended pregnancy

- Underestimate risks:
  - prevalence of unintended pregnancy by 23%
  - risk of pregnancy with no contraception by 35%
- Underestimate failure rates:
  - 85% underestimate failure rate of OCP’s
  - 62% for condoms
  - 16% for injectables

Parisi Contraception 2012

Contraception in women with medical illness

- Don’t forget!
- Weigh risk of pregnancy against risk of method
- Use a resource:
  - Rates methods for medical conditions
    - 1=no restriction; 4=unacceptable risk
- Search for “CDC MEC”
- Available as an App

CDC MEC for CV disease

<table>
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<th>Prog Implant</th>
<th>DMP A</th>
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</table>
Why do underserved women have higher rates of unintended pregnancy?

Black and Latinas disproportionately use lower efficacy methods

Reproductive abuse in the US
- American Eugenics movement, 1907-1960
- >100,000 sterilized
- >30 states
- California 60,000
- Norplant, 1990s
- Government aid
- Target racial/ethnic minorities

Reproductive abuse in the US
- 2006-2010, California prisons
- 150 female inmates

150 sterilizations between 2006–2010
Women of color have concern about contraceptive methods

- Focus groups of black participants\(^1\)
  - Changes in menstrual cycle is evidence of reproductive harm

- Majority of long-acting reversible contraception has this side-effect

Clark, Contraception 2006

Women of color have concern about reproductive harm

- Cross-sectional telephone national survey of Black Americans, reproductive age\(^1\)
  - "Poor and minority women are sometimes forced to be sterilized..."
  - "Medical and public health institutions use poor and minority people as guinea pigs..."

- Survey black parishioners, 35 churches in Louisiana\(^2\)
  - Believe family planning programs are a form of genocide


Contraceptive features preferred by patient race/ethnicity

- 1700 women, 13 clinics, nation-wide
- Black, Latina, White, Asian Pacific Islander
- Surveyed during family planning encounter

Examples:
- Stopping use of the method (return to fertility)*
- Ease of use
- Getting the method (cost, clinic visit)
- Side effects or health concerns
- Efficacy
- Control and privacy*

Jackson, AV unpublished data

Are women of color counseled differently?

- More dissatisfied with their family planning provider, many report racial discrimination

- More likely to report being pressured to:
  - Use birth control
  - Limit their family size

Forrest, Fam Plan Perspect 1999, Thorburn Womens Health 2005
Are women of color counseled differently?

Providers more likely to:
- agree to sterilize minority and poor women
- recommend the IUD to women of color and poor women

Harrison Obsetrics and Gyn 1988, Dehlendorf AJOG 2010

Why are women of color counseled differently?
- Statistical discrimination
  - Use of group averages
- Stereotyping
  - Fixed and oversimplified image or idea
  - Not necessarily negative
  - How we organize our complex world
  - History of racism makes racial and ethnic stereotyping impossible to avoid

Implicit bias in family planning

- Young woman, post-partum
- My desire to give her “highly effective” contraception
- Her concern: autonomy
- Did I not trust her?

Implicit bias can contribute to family planning disparities

Differential pressure to control fertility can:
- Increase mistrust between patient & provider
- resistance from patient
- greater tendency to discontinue methods
- health disparities
Contraceptive decision making

- Consumerist Counseling
  - Promote patient autonomy
- Directive Counseling
  - Increase use of highly effective methods

Shared Decision Making

Quality decision based on patient preferences

Does quality contraceptive counseling matter?

- Counseling influences method selection
- Quality of care associated with use of contraception and satisfaction
- Client-centered care is the right thing to do


Shared decision making in contraceptive counseling

- Elicit her preferences
  - "What’s important to you in a contraceptive method?"
  - "For some women, having a method that is easy to start or stop is important, and for others, having a method that’s totally private matters most. What kinds of things matter to you?"

- Ask clarifying questions
  - "There are methods you take once a day, once a week, once a month, or even less often than that. Is that something you have a strong feeling about?"

- Use natural frequencies when explaining efficacy
  - "9 out of 100 women get pregnant after a year on the Pill; less than 1 in 100 get pregnant with an IUD"

- Visual aids, websites
  - www.bedsider.org

- Shared decision making is an iterative process
The 2/3 of women using consistent contraception have 5% of U.S. abortions

Summary – What can we do?

- Make time for contraceptive counseling
- Use CDC MEC resource
- Ask:
  - “Do you want to become pregnant in the next year?”
  - “What is important to YOU in your contraceptive method?”
- Support Reproductive Justice

Summary – What can we do?

- Let patients know they can come to you for an unplanned pregnancy
- Do your part to reduce abortion stigma

Summary – What can we do?

- Help women who desire abortion navigate access

- Ryan Programs (85 academic med centers)
- NAF
- National Network of Abortion Funds
- Access Women's Health (Nor Cal)
Which of the following are important considerations to inform a shared decision-making approach to contraception counseling?

A. LARC methods are low risk and significantly more effective and should be recommended first for contraception.
B. Women know what they want and are more likely to use the first method they mention.
C. Efficacy is not the top priority for all women.
D. Women of color report coercion in family planning counseling at high rates.
Medical Care of Vulnerable and Underserved Populations: Advanced Cases in Anxiety and Depression

Lisa Ochoa-Frongia, MD
Christina Mangurian, MD, MAS
L. Elizabeth Goldman, MD, MCR
Margo Pumar, MD

Disclosures
The speakers have no disclosures.

Overview of Workshop
Objectives
- Understand challenges in diagnosing and treating anxiety and depression in underserved and vulnerable populations
- Review best practices
- Learn how to differentiate between different anxiety disorders
- Review management of treatment refractory depression

Objectives
- Review challenges in underserved populations
- Split into small groups to discuss cases
- Groups come together to review cases
- Audience questions
- Conclusions
What best describes your training?

A. Resident  
B. Nurse Practitioner  
C. Physician’s Assistant  
D. General Internist or Family Practitioner  
E. Psychiatrist  
F. Allied Health Professional

Challenges in Underserved and Vulnerable Populations

Contributors to anxiety, depression

- Homelessness
- Poverty
- Medical complexity
- Health disparities
- Immigrants
- Unemployment
- Trauma history
- Uninsured

Standard treatment PLUS services

Case 1: Mr. M

ID/CC: 32 year-old Spanish-speaking man presenting to primary care with anxiety.

- HPI: Patient reports significant anxiety. At times so distressed by his symptoms that he thinks he might be better off dead. Numerous recent visits to the ER for chest pain, anxiety, negative cardiac workup. Recent heavy alcohol use and some recreational cocaine use in past.
- PMH: GERD

Medications: Started paroxetine 20 mg two weeks ago, but does not want to continue since making him sleepy during day, not helping anxiety.

Family history: father w/ anxiety, depression. No history of suicide attempts in family.

Social history: Moved from Mexico 2 years ago, lives with father. Works in construction.
**Case 1: Questions**

- What is your behavioral differential diagnosis for Mr. M’s anxiety?
- What instruments, testing, or additional questions could help you clarify his diagnosis?

**Case 1: Questions**

- After being given additional information by your facilitator, what are your treatment recommendations for Mr. M?
- How would your treatment differ if he had a history of trauma?
- Are you concerned about suicide risk? How do you assess this?

**Anti-depressants and Sedation**

Different patients have different responses
- Paroxetine generally most sedating SSRI
- Mirtazapine, Trazodone also very sedating, often used for insomnia
- Citalopram, escitalopram less sedating/neutral
- Fluoxetine more activating
- SNRIs (venlafaxine), bupropion more activating

**Suicide Risk Assessment**

Patients who died by suicide were over twice as likely to have PCP visit in month preceding death compared to psychiatrist (45% vs 20%)

SAFE-T: Suicide Assessment Five-step Evaluation and Triage
**Suicide Risk Assessment: SAFE-T**

- Screen for symptoms/episodes of mania, trauma history
- Consider sedating vs. activating SSRI/SNRI
- Assess suicide risk in patients with SI
- SSRIS for anxiety: “start low and go slow”
- Adjunctive medications to “bridge” patient to SSRI effect: propranolol, hydroxyzine, BZDs

---

**Case 1 Teaching Points**

- Prior to initiating SSRI/SNRI, screen for symptoms/episodes of mania, trauma history
- Consider sedating vs. activating SSRI/SNRI
- Assess suicide risk in patients with SI
- SSRIS for anxiety: “start low and go slow”
- Adjunctive medications to “bridge” patient to SSRI effect: propranolol, hydroxyzine, BZDs

---

**Case 1 Teaching Points Continued**

- Titrate to maximum SSRI dose as tolerated/until symptoms remit
- Track patient symptoms with a validated tool
- Switch to a different SSRI if no response to first at maximal dose by 6-8 weeks
- Treat minimum 6-8 months after sx remit
- When stopping anti-depressants, taper

---

**Case 2: Mrs. D**

- **ID/CC:** 70 year-old woman with depression, MMP. Mrs. D’s depression worsening, very low motivation. Has gained 9 pounds since last visit and back pain worsening. PHQ-9 score is 20. Stopped seeing therapist.
- **PMH:** CAD, DM-2, HTN, obesity and chronic low back pain w/sciatica.
Case 2: Mrs. D

- **Medications:** sertraline 200mg, aspirin, benazepril, carvedilol, atorvastatin, metformin, glipizide, gabapentin, acetaminophen

- Previously on citalopram for 3 years, stopped working, switched to escitalopram which failed, now on sertraline x 1 year.

- **Social history:** widowed, lives alone, facing eviction

Case 2: Questions

- What is the most likely diagnosis of Mrs. D? Why?
- What would you do to treat her? Why?
- If you decide to cross-taper her to venlafaxine, how would you do this?

Case 2 Teaching Points

- Definition of treatment-resistant depression: MDD not responding to at least two appropriate courses of antidepressants

- Algorithm for treatment-resistant depression: STAR-D

- If PCP comfortable with treating resistant depression, follow algorithm, otherwise refer

Simplified STAR*D Algorithm for Treatment of Depression

1. **SSRI**
   - Switch OR
   - Cont. and Augment: Buspar, Bupropion, CBT

2. **SNRI**
   - Switch OR
   - Cont. and Augment: Buspar, Bupropion, CBT

3. **Bupropion**
   - Switch to Mirtazapine, TCA OR
   - Augment: SGA (Abilify, Seroquel), T3, Lithium, Stimulant

- Based on STAR-D, 2008.
- Each of these with an 8 week trial at an adequate/tolerated dose.
- Bupropion, venlafaxine should be prescribed in sustained/extended release.
**Case 2 Teaching Points Continued**

- Be aware of other conditions: choose medications that might “kill two birds with one stone.”
- Depression or anxiety with chronic pain: TCAs, SNRIs
- Gabapentin and pregabalin also w/anxiolytic effects
- Anxiety + psychosis: quetiapine has some evidence for off-label use
- Depression or anxiety with insomnia: mirtazapine

**When To Refer to Psychiatry**

- When diagnosis is not clear
- Serious mental illness
- Depression with psychotic features
- When medications indicated are beyond PCP’s scope of practice (mood stabilizers, antipsychotics)

**Summary: Advanced Cases in Anxiety and Depression**

- Importance of screening patients for anxiety, depression, using validated tools
- Keep in mind evidence-based algorithms
- Follow best practices in medication prescribing
- Advocate for increased integration of behavioral health
- Ensure providers in your clinic understand how to refer to behavioral health providers

**Questions?**
Optimizing Care for Patients with Limited Literacy & English Proficiency

Dean Schillinger MD, Alicia Fernandez MD
UCSF Professors of Medicine
Division of General Internal Medicine
UCSF Center for Vulnerable Populations @ SF General Hospital

DISCLOSURES
While we both are conflicted, we have no conflicts of interest and nothing to disclose

Objectives
- To review the evidence that limited health literacy and limited English proficiency (LEP) have untoward health consequences
- To describe how these barriers affect clinical communication
- To provide a brief set of actionable strategies to optimize care for patients with limited health literacy and LEP

Common Social Vulnerabilities
- Violence
- Uninsured
- Literacy and Language
- Neglect
- Economic hardship/food insecurity
- Race/ethnic discordance, discrimination
- Addiction
- Brain disorders, e.g. depression, dementia
- Immigrant
- Legal status
- Isolation/Informal caregiving burden
- Transportation problems
- Illness Model
- Ears and Eyes
- Shelter

Schillinger 2007
What is Health Literacy?

- "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make [informed] health decisions."
- 3 domains: oral (speaking, listening); written (reading, writing); numerical (quantitative)
- Web? Patient portals?
- Capacity/Preparedness ↔ Demand Mismatch

1st National Assessment of Health Literacy  n=19,714

- **Below Basic**: Circle date on doctor’s appointment slip
- **Basic**: Give 2 reasons a person with no symptoms should get tested for cancer based on a clearly written pamphlet
- **Intermediate**: Determine what time to take Rx medicine based on label
- **Proficient**: Calculate employee share of health insurance costs using table

1st Health Literacy Assessment  n=19,000 U.S. Adults

- 53% Intermediate
- 14% Basic
- 12% Proficient
- 22% Hispanic
- Average
- Medicare

Patients with Diabetes and Low Literacy Less Likely to Know Correct Management

- **Need to Know**: symptoms of low blood sugar (hypoglycemia)
- **Need to Do**: correct action for hypoglycemic symptoms


Williams et al., Archive of Internal Medicine, 1998
Health Literacy is Associated with Glycemic Control, N=408

- Adjusted OR=0.57, p=0.05
- Adjusted OR=2.03, p=0.02

<table>
<thead>
<tr>
<th>1st Quartile</th>
<th>4th Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Tight Control: HbA1c≤7.2%)</td>
<td>(Poor Control: HbA1c&gt;9.5%)</td>
</tr>
</tbody>
</table>

Lower health literacy is associated with diabetes complications (N=408)

<table>
<thead>
<tr>
<th>Complication</th>
<th>n”</th>
<th>AOR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinopathy</td>
<td>111</td>
<td>2.33</td>
<td>(1.19-4.57)</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>62</td>
<td>1.71</td>
<td>(0.75-3.90)</td>
</tr>
<tr>
<td>Lower Extremity Amputation</td>
<td>27</td>
<td>2.48</td>
<td>(0.74-8.34)</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>46</td>
<td>2.71</td>
<td>(1.06-6.97)</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>93</td>
<td>1.73</td>
<td>(0.83-3.60)</td>
</tr>
</tbody>
</table>

Diabetes Patients with Limited Health Literacy Experience Poorer Quality Communication, N=408

- OR=3.2;p<0.01
- OR=3.3;p=0.02
- OR=2.4;p=0.02
- OR=1.9;p=0.04

My Doctor said “Only 1 glass of alcohol a day. I can live with that.”

“The problem with communication is the assumption that it has occurred.”

-GB Shaw

“The problem with communication is the assumption that it has occurred.”

-GB Shaw
**Conceptual framework:**

4 basic functions of communication in outpatient care

- Disease state
- Barriers
- Diagnosis
- Treatment plan

**Communication Characteristics**

- **Clinician-patient concordance**
- Clinical decision-making
- Health outcomes
- Treatment adherence

**Communication Characteristics**

- **Clinician-patient concordance**
  - Elicitation
  - Explanation

**Recommendation #1: Eliminate Jargon**
(Use “Living Room Language”)

- GLUCOMETER
- HEMOGLOBIN A1c
- DIALYSIS
- ANGINA
- RISK FACTORS
- CREATININE

**Jargon Terms**

- ...unclarified
  - Glucometer
  - Immunizations
  - Weight is stable
  - Microvascular complication
  - System of nerves
  - HbA1c
  - EKG abnormalities
  - Dialysis
  - Wide Range
  - Risk factors
  - Kidney function
  - Interact

- ...clarified
  - Angina
  - Microalbuminuria
  - Ophthalmology
  - Genetic
  - Creatinine
  - Symptoms

**Function of Physician Jargon in Outpatient Visit**

- Assess Symptoms 10%
- Deliver Test Results 24%
- Provide Recommendations 37%
- Provide Health Education 29%

- n = 60
- jpm = 0.4

*Castro, Schillinger AJHB 2007*
Dialysis “Do you know what the number one cause for people in this country being on dialysis is? Diabetes”

<table>
<thead>
<tr>
<th>Would you please tell me in your own words what dialysis means?</th>
<th>In your own words, what do you think the doctor was trying to tell the patient?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Check something every day.”</td>
<td>“Sugar is too high.”</td>
</tr>
<tr>
<td>“What? Is that about your toes?”</td>
<td>“I can’t say it.”</td>
</tr>
<tr>
<td>“It means that your diabetes is going worse that you have to exercise to make diabetes.”</td>
<td>“Means that more people are getting diabetes.”</td>
</tr>
<tr>
<td>“You got to get on machine to pump...redo blood to come up to par.”</td>
<td>“That the sugar was not...hmm.”</td>
</tr>
<tr>
<td>“...regarding kidney.”</td>
<td>“Diabetes is one cause of kidney problems.”</td>
</tr>
<tr>
<td>“That is a warning...about the kidney...my doctor told me about those side effects of the diabetes.”</td>
<td>“About dialysis...because they are warning us, they are telling me about the complications...that if I’m having problems in my kidney, I’m going to have dialysis.”</td>
</tr>
<tr>
<td>“It’s a way to clean blood get off toxins out the blood.”</td>
<td>“That you need to be on dialysis to cleanse blood or gonna die.”</td>
</tr>
</tbody>
</table>

Recommendation #2: Assess comprehension with the “teach-back” method aka “Closing the Loop”

- In this interactive technique, the clinician prioritizes amongst the information exchange and explicitly asks the patient to “teach-back” what he/she has recalled and understood on those high-priority domains.

- Similarly, clinicians can use the strategy to assess patient’s perceptions of the information or advice given.

- The technique can be used toward the end of a visit or during the course of the visit, so as to tailor communication earlier.

We Rarely “Close the Loop” -- But It’s Good When We Do

- Physicians assessed recall or comprehension for 15/124 new concepts (12%)
- When new concepts included patient assessment, patient provided incorrect response half the time (7/15 = 47%)
- Visits using interactive communication loop not longer (20 min vs. 22 min)
- Application of loop associated with better HbA1c (AOR 9.0, p = .02)

Schillinger Arch Int Med 2003
Recommendation #2: Assess comprehension by using the “teach-back” method

- In this interactive technique, the clinician prioritizes amongst the information exchange and explicitly asks patients to “teach-back” what he/she has recalled and understood in high-priority domains.
- Similarly, clinicians can use the strategy to assess patient’s perceptions of the information or advice given.
- The technique can be used toward the end of a visit or during the course of the visit, so as to tailor communication earlier.

How to use “Teach Back”? Example 1 (medication change):

- Doctor (to patient): “I want to make sure I did a good job explaining your heart medications, because this can sometimes be confusing. Can you tell me what changes we decided to make and how you NOW will take the medications?”

- Note especially how the physician places the onus of any possible miscommunication on himself/herself. In other words, the “teach-back” task is conveyed not as a test of the patient, but of how well the physician explained the concept.

How Not To… Example #2: Taking the Easy Way Out

- Doctor (to patient): “Do you understand what we just talked about?” or “Do you understand the plan regarding your blood pressure medications?” “Did that make sense?”

- These routine queries, which do not require explicit articulation of recall, comprehension, or perceptions on the part of the patient, will universally be met with an uninformative (and possible falsely re-assuring) “Yes, doctor”.

Recommendation #3: Employ well-tested visual aids

http://diabetes.acponline.org/patient/index.html
Carb Counting Vs. Plate Method?

Rothman 2010

Plate Model > Carb Counting > Usual Care in lowering HbA1c, especially for low numeracy

Rothman et al 2010

Recommendation #4: Use Accessible Technology

The future is already here, it's just not evenly distributed

Rothman 2010

IDEALL PROJECT

Randomize 339 Patients with HbA1c >8.0%

- 6-10 Patients
- Health Educator
- Primary Care Physician

Weekly Interactive Technology
- Usual Care
- Monthly Group Medical Visits

Nurse Care Manager
- Primary Care Physician
- English Speaking Group
- Spanish Speaking Group
- Cantonese Speaking Group

Follow-Up Questionnaires (Patient-Centered Outcomes, Functional Status, Glycemic Control, Blood Pressure)
Key Findings of IDEALL Program
Estimating Public Health “Reach” of Programs

<table>
<thead>
<tr>
<th>Composite reach product</th>
<th>ATSM</th>
<th>GMV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>22.1</td>
<td>4.8</td>
</tr>
<tr>
<td>English</td>
<td>20.0</td>
<td>6.4</td>
</tr>
<tr>
<td>Chinese</td>
<td>22.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Spanish</td>
<td>24.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Adequate Literacy</td>
<td>15.6</td>
<td>7.6</td>
</tr>
<tr>
<td>Limited Literacy</td>
<td>28.0</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Schillinger Health Ed and Behavior 2007

Results: ATSM superior in Improving Quality of Life

<table>
<thead>
<tr>
<th>Rate ratio 0.5 vs UC, 0.35 vs GMV</th>
<th>OR 0.37 vs UC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>*P&lt;.05</td>
</tr>
</tbody>
</table>

Adequate Literacy: 15.6 vs GMV, 28.0 vs UC

Limited Literacy: 24.3 vs GMV, 28.0 vs UC

Language Barriers in Health Care

Resources

- AHRQ Health Literacy 2016 Toolkit:
Case: LEP patient with diabetes

You are scheduled to see Ana Jimenez, a 53 y old Mexican-American woman with diabetes. Pre-rounding, you note that her A1c=9.2, LDL=104, other labs WNL. The transfer note reads “Spanish speaking only, brings daughter”.

- You speak “un poquito” and, depending on circumstances, you “get by” with your skills.
- Is there an evidence base to guide your approach to communicating with Ms. Jimenez?

Learning Objectives

- Review growth of LEP population
- Highlight recent evidence on language barriers and DM outcomes
  - Glycemic control
  - Lipid, blood pressure control
  - Patient centered outcomes: trust, respect, satisfaction
- Review practical recommendations for improving communication with LEP patients

Growth of US Linguistic Diversity

NYT, 4/21/15
Defining Limited English Proficiency

US Census: “How well do you speak English: very well, well, not well, not at all”
- 1 in 5 (20%) speak non English language at home
- 45% are LEP: English less than “very well”
- 25% are LEP: English “not well” or “not at all”
- Spanish: 62%
- Chinese: 4%
- Many Asian and European languages under 1-2%

Back to our patient...

- You wonder if Ms. Gonzalez’ poor diabetes control is related to the fact that she has a language barrier with her clinician. But then again, she has lots of issues: poor, low educational level in Spanish, lots of competing demands, and she has always been reluctant to take medications.

- Does the language barrier really matter? And, if so, how can it best be overcome.
**DISTANCE: Diabetes Study of Northern California**

- Data from KPNC: uniform access to care, financial barriers to medication are controlled, interpreters available.
- DISTANCE: survey study of 20,000 patients, conducted in 5 languages including English and Spanish. (PI: Andy Karter, Dean Schillinger)
- Clinical data abstracted from electronic records

### Characteristics of 252 Latino Patients with Diabetes and LEP by Physician-patient Language Concordance

<table>
<thead>
<tr>
<th></th>
<th>LEP-LC (n=137)</th>
<th>LEP-LD (n=115)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>57.5 (11.5)</td>
<td>56.0 (10.5)</td>
<td>0.29</td>
</tr>
<tr>
<td>Women, n (%)</td>
<td>85 (62.0)</td>
<td>77 (67.0)</td>
<td>0.42</td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School</td>
<td>100 (73.0)</td>
<td>81 (70.4)</td>
<td>0.68</td>
</tr>
<tr>
<td>High School or above</td>
<td>33 (24.1)</td>
<td>32 (27.8)</td>
<td></td>
</tr>
<tr>
<td>Annual household income, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;= $34,999</td>
<td>88 (64.2)</td>
<td>67 (58.3)</td>
<td>0.08</td>
</tr>
<tr>
<td>&gt; $35,000</td>
<td>37 (27.0)</td>
<td>27 (23.5)</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>12 (8.9)</td>
<td>21 (18.2)</td>
<td></td>
</tr>
<tr>
<td>DM duration, mean (SD)</td>
<td>9.8 (6.4)</td>
<td>10.3 (10.0)</td>
<td>0.80</td>
</tr>
<tr>
<td>Comorbidity Score (2005), mean (SD)</td>
<td>3.7 (3.4)</td>
<td>4.3 (5.2)</td>
<td>0.29</td>
</tr>
<tr>
<td>Continuous Pharmacy Benefits, n (%)</td>
<td>113 (82.5)</td>
<td>104 (90.4)</td>
<td>0.07</td>
</tr>
</tbody>
</table>

**Abbreviations:** LEP: Limited English Proficient; LEP-LC: LEP with language concordant physician; LEP-LD: LEP with language discordant physician

### Characteristics of 3193 Latino Patients with Diabetes by English Language Ability

<table>
<thead>
<tr>
<th></th>
<th>English Latinos (n=2683)</th>
<th>LEP Latinos (n=510)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>57.3 (10.8)</td>
<td>56.9 (10.8)</td>
<td>0.43</td>
</tr>
<tr>
<td>Women, n (%)</td>
<td>1338 (49.9)</td>
<td>346 (63.9)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School</td>
<td>741 (27.6)</td>
<td>256 (69.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High School or above</td>
<td>1864 (68.5)</td>
<td>148 (29.0)</td>
<td></td>
</tr>
<tr>
<td>Annual household income, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;= $34,999</td>
<td>898 (33.5)</td>
<td>296 (58.0)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>&gt; $35,000</td>
<td>1505 (56.1)</td>
<td>119 (23.3)</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>280 (10.8)</td>
<td>95 (18.6)</td>
<td></td>
</tr>
<tr>
<td>DM duration, mean (SD)</td>
<td>9.5 (6.2)</td>
<td>9.5 (6.0)</td>
<td>0.97</td>
</tr>
<tr>
<td>Comorbidity Score (2005), mean (SD)</td>
<td>4.4 (4.7)</td>
<td>4.0 (4.2)</td>
<td>0.06</td>
</tr>
<tr>
<td>Continuous Pharmacy Benefits, n (%)</td>
<td>2533 (94.4)</td>
<td>438 (85.9)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**Abbreviations:** LEP: Limited English Proficient; LEP-LC: LEP with language concordant physician; LEP-LD: LEP with language discordant physician

### Poor Glycemic Control (A1c≥9%) by Race, Language, and PCP Language

<table>
<thead>
<tr>
<th></th>
<th>White English Speakers n=3545</th>
<th>Latino English Speakers n=2683</th>
<th>All LEP n=510</th>
<th>Among LEP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1c, mean (SD)</strong></td>
<td>7.2 (1.4)</td>
<td>7.65 (1.71)*</td>
<td>7.81 (1.85)</td>
<td>7.58 (1.62)</td>
</tr>
<tr>
<td><strong>Poor Glycemic Control %</strong></td>
<td>10.0</td>
<td>18.0*</td>
<td>21.4**</td>
<td>16.1</td>
</tr>
</tbody>
</table>

**Abbreviations:** PCP: Primary Care Physician; * Latino English vs. White; **All LEP vs Latino English; LEP: Limited English Proficient; LEP-LC: LEP with language concordant PCP; LEP-LD: LEP with language discordant PCP
**Language and Glycemic Control**

- LEP slightly more likely to have poor glycemic control than Latino English-speakers.

- Yet differed greatly by the Spanish skills of their PCP.
  - LEP patients with Spanish speaking PCP have similar rates of poor glycemic control as Latino English speaking patients.
  - LEP patients with language discordant PCP are about twice as likely to have poor glycemic control than LEP with Spanish speaking PCPs.


---

**Poor Lipid and Blood Pressure Control among Patients with Diabetes by Ethnicity, English Language Proficiency, and Patient–Physician Language Concordance**

<table>
<thead>
<tr>
<th>Ethnicity and English Language Proficiency</th>
<th>Among Latino LEP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White*</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Total</td>
<td>n=3896</td>
</tr>
<tr>
<td>LDL &gt; 100, %</td>
<td>33.8*</td>
</tr>
<tr>
<td>SBP &gt; 140, %</td>
<td>21.7</td>
</tr>
</tbody>
</table>

* $p \leq 0.05$ for comparisons between white patients and Latino English-speaking patients.

/uni2C61 $p \leq 0.05$ for comparisons between Latino English-speaking patients and Latino-LEP patients.

---

**Recommendation #5:**

- Switch patients with LEP and chronic disease to a language concordant clinician if chronic disease control is poor.

**Recommendation #6: Test your language skills**

- Two ways to test: self-report and objective.
- How well do you speak (language)?
  - Not at all/poor/fair/very good/excellent
- Patients agreed that docs spoke Spanish or not when self report was at either end of scale.
- Agreement with patient report of MD skills when "fair" : 50%
- New study: How confident are you in conducting medication reconciliation or sensitive discussion: highly.

Rosenthal/Fernandez, *JIMH*2011
Language Barriers and Patient – MD Relationship

- Multiple studies have shown less patient satisfaction and lower patient comprehension in language discordant care, even when professional interpreters are involved.

<table>
<thead>
<tr>
<th>Interpreter System A</th>
<th>Interpreter System B</th>
<th>Language Concordant MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understood MD explanation</td>
<td>35% 39% 59%</td>
<td></td>
</tr>
<tr>
<td>Understood instructions</td>
<td>33% 38% 63%</td>
<td></td>
</tr>
</tbody>
</table>

Suboptimal Communication By LEP and Language Concordance

<table>
<thead>
<tr>
<th></th>
<th>English-proficient N=8116</th>
<th>LEP N=522</th>
<th>P value</th>
<th>LEP-LC N=210</th>
<th>LEP-LD N=153</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of trust in MD</td>
<td>26% 25%</td>
<td>0.37</td>
<td>16%</td>
<td>35%</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>Treated poorly because language</td>
<td>2% 12%</td>
<td>&lt;0.001</td>
<td>9%</td>
<td>20%</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>MD not showing respect</td>
<td>28% 30%</td>
<td>0.31</td>
<td>29%</td>
<td>39%</td>
<td>0.04</td>
<td></td>
</tr>
<tr>
<td>MD not listening</td>
<td>33% 28%</td>
<td>0.02</td>
<td>26%</td>
<td>32%</td>
<td>0.24</td>
<td></td>
</tr>
</tbody>
</table>

Language Barriers and Patient Centered Measures

- Language barriers are associated with:
  - less trust
  - less comprehension
  - worse patient satisfaction

Overcoming Language Barriers

- Evidence for Professional Interpreters
  - Analysis of audiotapes show fewer errors
  - Increased patient satisfaction over ad hoc or no interpreters
  - Increased satisfaction for clinicians

- Certification and supply problem
- Underuse of interpreters by clinicians
- Patient centered interpreter mediated encounters
San Francisco General Hospital

Level 1 Trauma Center for SF County Hospital/UCSF Physicians
Uninsured and publically insured patients
2nd most ethnically diverse Medical Center in US
140 languages spoken per month
Professional interpreter available in 40 languages
60 languages on contract

Recommendation # 7: Use Professional interpreters

- Multiple studies showing better communication and higher patient satisfaction with professional interpreters (vs ad hoc, or family)
- Far fewer errors
- Studies also show higher clinician satisfaction
- Physicians who got training in use of professional interpreters were more satisfied (Karliner, JIGM 2004)

Recommendation # 8: Technology Raises Rate of Interpreter Use

<table>
<thead>
<tr>
<th>Procedure Note Documenting IC discussion, n (%)</th>
<th>LEP (n=74) %</th>
<th>English (n=74) %</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Form - any language, n (%)</td>
<td>70%</td>
<td>85%</td>
<td>0.03</td>
</tr>
<tr>
<td>Consent Form - pt’s language n (%)</td>
<td>22%</td>
<td>85%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Fully Documented Informed Consent n (%)</td>
<td>28%</td>
<td>53%</td>
<td>0.003</td>
</tr>
</tbody>
</table>

Documentation of Informed Consent for Invasive Procedures

Schenker-Fernandez, 2007
**Interpreter Use**

- MD underuse is common
- Quality is uncertain
- Technology may help
- Payment is problematic

Patient centeredness suffers: audiotape studies
Indicate that patients speak less and have values elicited less in interpreter mediated interactions

**Recommendation # 8: Elicit patient viewpoint**

“What do you think might be causing the problem?”

“What worries or concerns you most about this problem?”

“What have you done to treat this illness so far?”

How were you hoping I could help you most?


**Answer to MOC question**

- The following strategy NOT an evidnced-based method to imprve communication with patients who have limited health literacy and limited English proficiency (LEP) have untoward health consequences:
  - Speak LOUDER

**Conclusions**

- Limited health literacy and limited English proficiency (LEP) are very common in healthcare and often result in untoward health consequences
- These barriers affect clinical communication in ways that can be remediable
- There are a set of actionable strategies that clinicians should employ to optimize care for patients with limited health literacy and LEP
  - Avoid jargon
  - Use the teach-back method, elicit patients’ perspectives
  - Use well-tested visual aids
  - Use accessible technology
  - Test your own language skills
  - Switch patients to language concordant provider when feasible
  - Always use professional interpreters
Caring for Older Homeless Adults

Margot Kushel, MD
Professor of Medicine
UCSF/ZSFG

Objectives

- Define homelessness
- Review demographics of aging homeless and at-risk population
- Review risk factors for homelessness
- Discuss approaches to improve medical care of homeless older adults

Which of the following older adults would you screen for homelessness?

A. 52 year old man with chronic alcohol use disorder
B. 86 year old Spanish speaking woman with severe depression, born in Mexico, accompanied by her 62 year old daughter
C. 73 year old woman, retired former skilled tradesperson; no SU or MH history
D. 56 year old man, African-American, 20 year past h/o incarceration, on opioid replacement therapy

What is the Problem?

- Homeless population is aging
- Median age of single homeless population now over 50
- Homeless adults have health problems similar to those 15-20 years older
- Considered “older” by age 50

5/12/2016

Hahn et al JGIM 2006
Culhane ASAP 2013
Brown et al JGIM 2012
Dewoskin et al Gerontologist 2016
Definition of Homelessness

- Lacks fixed, regular night time residence (includes emergency shelter)
- Imminently lose their nighttime residence (within 14 days)
- Fleeing, or attempting to flee, interpersonal violence, stalking, sexual violence
- (Expanded definition for children/youth)
  - Homeless Emergency Assistance and Rapid Transition to Housing Act 2009 (HEARTH ACT)

Homelessness is state and not trait

- Older age at onset of homeless associated with increased risk of chronic homelessness
- Chronic homelessness
  - Homeless person with a disability AND
  - Homeless for >12 months OR
  - Four or more times in prior 3 years, totaling >12 months
- Most people who become homeless do not become chronically homeless, but older adults at higher risk
  - Chronic Homelessness Final Rule 2015

Living situations vary

- In safety net settings, many individuals may live with housing instability/informal arrangements
  - "couch surfing" w/o leases, guarantees
  - Garages/trailers
  - Overcrowded housing

And go back and forth between “homeless” and not “homeless”

Why do people become homeless in late life?

- Evictions
- Job loss
- Marital/relationship dissolution
- Death of spouse
- Death of elderly parent (with whom living)
- Death or job loss of roommate
- Health crisis
What factors heighten risk of homelessness in older adults?

- POVERTY
- African-American
- Native American
- LGBTI
- History of incarceration
- Mental health or substance use problems
- Adverse childhood experiences
- Social isolation
- Immigrant communities

Why is homeless population aging?

- People born in latter half of baby-boom (1954-1964) have had lifetime elevated risk of homelessness
- Among homeless people aged 50 and older, 43% never homeless prior to age 50
- Nationwide 1/3 renters aged 50+ are “housing cost burdened” paying >30% household income in rent
  - Increasing numbers “severely cost burdened” paying >50% in rent
  - Worse in high cost areas
    - Hawaii and California with highest housing costs nationwide

Homelessness and Health

- Homelessness associated with poor health outcomes, likely causal
- Homelessness associated with underuse of non-ED ambulatory care, increased use of acute care (ED use and hospitalization)
- Associated with poor quality of life and increased mortality

Older Homeless Adults

- Leading cause of death cardiovascular and cancer
  - 15-20 years earlier than general population
- High prevalence of geriatric conditions
  - 20 years earlier than general population
- Increased likelihood of progression to skilled nursing facility (SNF)
- Concerned about mortality, but few discussed advance care planning (ACP) with healthcare providers
What is role of healthcare providers/teams in safety net settings?

- Screen for risk of homelessness and homelessness
- Refer at-risk for prevention efforts
- Adapt care for those who are homeless
  - Collect multiple contacts
  - Consider loosening targets to avoid iatrogenesis
  - Screen (and treat/refer) for mental health and substance use problems, geriatric conditions
- Advance care planning/End of Life issues
- Know local resources and refer
  - Permanent Supportive Housing
  - Medical Respite
  - Rapid Rehousing

No validated screening tool for homelessness or risk of homelessness

Screen for homelessness

- Recommend against using “Are you homeless?”
- Normalize homelessness “Many of our patients are finding it difficult to have a regular place to stay.”
- Ask: Have you been without a regular place to stay in the past month? Have you stayed in a shelter/outdoors/car?
- If staying with friends/family ask:
  - Can you stay there as long as you would like? Do you stay the same place every day?

Screen for risk of homelessness

- Do you have difficulty paying rent, mortgage or utilities?
- Have you fallen behind in your rent?
- What proportion of your total household income is going towards housing? (>50% high risk)
- Are you worried you will be evicted/asked to leave?
- Are you worried that someone else who helps you pay for your rent won’t be able to pay?
- Is your name on the lease?
Screen for risk of homelessness

- Be aware of high risk periods
  - Death of household member
  - Job loss (patient or household member)
  - Illness/injury (patient or household member)

Why ask?

- Even if you can’t “do anything,” it will help you understand your patient and build trust
  - Be aware of stigma and stigmatizing language
- Refer to appropriate programs
  - Recognize that not all will want to go to shelter settings even if available
  - Most shelters require residents to leave during day
- Gather contact information
  - Where do you stay
  - Is there anyone who may be in touch with you?
  - Is there any place you attend regularly where I could leave messages? (church, senior center, food program)

Key referrals for those at-risk of losing housing

- Homelessness/eviction prevention
  - Short and medium term rental subsidies, utility deposits and payments, legal services
  - Case management
  - Housing search and placement
  - Credit repair
- Legal resources
  - Seniors and people with disabilities may have extra protections beyond general tenancy protections

Code it!

- Housing Circumstance Affecting Care Z59.9
- Homelessness Z59.0
Avoid Iatrogenesis

- High fall risk and lack of regular access to food
  - Consider loosening control of blood pressure, diabetes
- Lack of toileting, bathing and cooking facilities
  - Diuretics, medications that cause diarrhea
  - Feet and skin care
  - Avoid medications that require refrigeration
- If use opioids: Small quantities with frequent refills and NALOXONE
  - Prior to sending screening tests, ask
  - Do you have follow-up for abnormal results?
  - Will patient be able to do follow-up test (i.e. FIT® colonoscopy)

Mental Health and Substance Use Problems

- High prevalence of mental health and substance use problems
  - Screen for
    - Depression, post traumatic stress disorder
    - PHQ 9 or Geriatric Depression Screening Tool
    - Primary Care PTSD Screener
    - Alcohol and Substance Use Disorder
    - AUDIT and ASSIST
    - Tobacco use
    - 5As (Ask, Advice, Assess, Assist, Arrange)

Geriatric Conditions

- Cognitive Impairment
- ADL and IADL impairments
- Mobility impairments, Falls
- Urinary incontinence
- Depression
- Vision and hearing impairments

Geriatric Conditions

- Common
- Severe
- Onset much earlier than general population
Screen, starting at 50

- Cognitive Impairment
  - Mini Cog, MOCA
- ADL and IADL impairments
  - Katz ADL, BIFS (adapted IADL)
- Mobility impairments/Falls
  - Do you have difficulty walking across a room?
  - Have you fallen in the prior six months?
  - Timed Get Up and Go Test
- Urinary Incontinence
  - Screen, recognize role of environment!
- Hearing and vision

Life threatening conditions and mortality

- Homeless adults are worried about dying
- High prevalence of personal experience of death
  - Close family member, witnessing death
- Worries include:
  - No one will find them
  - Wishes won’t be followed
  - Won’t be remembered or memorialized
  - Concerns about what will happen to their bodies after death
  
  Song JGIM 2007

Advance Care Planning and End of Life Care

- Don’t assume estrangement from family, but if patient expresses reluctance or resistance, respect that
- Homeless individuals can be engaged in ACP
  - Issues include documentation and communication of wishes
  - Make effort to do and to be thoughtful about how decisions relayed to treating facilities
  - Recognize that “home hospice” is not option if someone is living on streets
  - Consider: Respite Care, PSH, hospice within SNF

Know Key Interventions

- Housing First Permanent Supportive Housing
- Medical Respite
- Rapid Rehousing
Housing First Permanent Supportive Housing

- Subsidized housing with on-site or closely linked supportive services
- Low barrier to entry: no requirements of sobriety or adherence to mental health plans prior to housing
- Tenant has tenancy rights
- For veterans, called HUD-VASH
  - [https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf](https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf)

Medical Respite

- Acute and post-acute care for homeless individuals too ill to be on street, but not meeting requirement for hospitalization
- Variety of settings
  - Shelters, freestanding facilities, SNF, transitional housing
  - National Health Care for the Homeless Council
  - [https://www.nhchc.org/resources/clinical/medical-respite/](https://www.nhchc.org/resources/clinical/medical-respite/)

Rapid Rehousing

- For people who meet Federal criteria for homelessness
- Temporary financial assistance and services to return people experiencing homelessness to permanent housing
  - [http://www.endhomelessness.org/pages/rapid-re-housing](http://www.endhomelessness.org/pages/rapid-re-housing)

Summary

- Median age of homeless population is increasing
  - Median age >50
  - Almost half of older homeless newly homeless in older age
- Screen and refer to services for both homelessness and risk of homelessness
  - Think about homelessness risk and refer for prevention efforts!
- Homelessness associated with poor health outcomes
  - Adapt care as appropriate
    - Collect contacts
    - Loosen targets
    - Consider medication side effect profile
    - Think before sending screening tests!
Summary

- Mental health, substance use problems and geriatric conditions prevalent and start early
- Screen for them and treat as possible
- Address concerns about dying, end of life care
  - Discuss fears openly
  - Engage in advance care planning
  - Recognize challenging in EOL care
- Know key interventions
  - Housing First Permanent Supportive Housing
  - Medical Respite
  - Rapid Rehousing
Care of the Patient with History of Incarceration

Shira Shavit, MD
Executive Director, Transitions Clinic Network
Associate Clinical Professor
Dept. Family and Community Medicine
University of California, San Francisco

Caring for a Patient with a History Incarceration:

Objectives
• Review demographics of mass incarceration
• Describe health status of returning prisoners
• Review health impacts of incarceration
• Review approach to healthcare for recently released prisoners

Case
Mr. Jones a 67 year old man with type 2 DM, HTN, hyperlipidemia, HCV, chronic low back pain, major depression and a history of heroin addiction.

Released from prison 1 week ago after 23 years of incarceration.

Staying in halfway house for another 3 weeks. From Los Angeles, but lost contact with all family members during incarceration.

Was not released with any medications. Takes 7 different pills, but unsure of the names/dosages except for the morphine “30’s” he gets for his low back pain.

Disclosures
I have nothing to disclose.
Case

Did I mention...

Mr. Jones arrived 45 minutes late to his appointment because he got lost on the way to the clinic.

And....

He had to get off the bus once it got crowded, because he started having a panic attack.

And...

You only have a 15 minute appointment scheduled for him and 3 patients are waiting.

Case

What is the likelihood of a primary care provider encountering a patient like Mr. Jones in their clinical practice?

A. Unlikely, since most prisoners like Mr. Jones will never be released back to the community
B. Unlikely, since most returning prisoners do not have health insurance and cannot access care.
C. Unlikely, since most clinics have a 15 minute late policy
D. Unlikely, (I hope) because thinking about seeing a patient like this is stressing me out.

Jail vs. Prison

<table>
<thead>
<tr>
<th>Jail</th>
<th>Innocent until proven guilty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Awaiting trial</td>
</tr>
<tr>
<td></td>
<td>Short(er) terms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prison</th>
<th>After trial and sentencing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parole violation</td>
</tr>
</tbody>
</table>

Incarceration in the U.S.

- ~ 2.2 million people in prisons and jails
- More than one in every 100 adults is now incarcerated
- 1 in 37 adults have been incarcerated
- 1 in 36 under some form of correctional supervision

Incarceration In The US

1974-2001: number incarcerated for the first time *tripled*
Prisons in California

1852 - San Quentin State Prison (SQ)
1880 - Folsom State Prison (FOL)
1933 - California Correctional Institution -- Women (Closed) (CCI)

World War II

- 1941 - California Institution for Men (CIM)
- 1946 - Correctional Training Facility (CTF)
- 1953 - Deuel Vocational Institution (DVI)
- 1952 - California Institution for Women (CIW)
- 1955 - California Medical Facility (CMF)
- 1954 - California Men's Colony (CMC)

Vietnam War

- 1961 - West-California Men's Colony (CMC)
- 1984 - California State Prison Solano (SOL)
- 1986 - California State Prison, Sacramento (SAC)
- 1987 - Avenal State Prison (ASP)
- 1987 - Mule Creek State Prison (MCSP)
- 1990 - Central California Women's Facility (CCWF)
- 1990 - Waco State Prison (WSP)
- 1992 - Calipatria State Prison (CAL)
- 1993 - California Substance Abuse Treatment Facility (SATF)
Prisons in California

Incarceration in the U.S.

Lifetime chance of incarceration

- Black males 1 in 3
- Latino males 1 in 6
- White males 1 in 17

Prison Industry: US Expenditures

1987: $10.6 billion
2007: $44 billion

States in the U.S. are spending more and more on inmates who are less and less a threat to public safety

Case

Mr. Jones was incarcerated in state prison. Which of the following statement about the prevalence of behavioral health conditions in people with a history of incarceration is true?

A. More than 80% of state prisoners meet the criteria of having either a mental or substance use issue.
B. 82% of jail inmates meet the criteria for having either a mental or substance use issue.
C. 72% of federal inmates meet the criteria for having either a mental or substance use issue.
D. All of the above.
Behavioral Health

- 2/3 population substance users; 22% receive treatment inside
- >50% mentally ill; ½ treated inside

Chronic Diseases

Higher prevalence than general population:
- Hypertension
- Asthma
- Arthritis
- Cervical Cancer
- Hepatitis

Infectious Diseases

- Increased prevalence: Hepatitis, HIV, STIs, TB
- HIV 3x prevalence general population
- HCV prevalence approaching 40%
- ¼ of those with HIV infection pass through a US correctional facility each year

High Risk Behaviors and Exposures

- Unprotected sexual activity
- IV drug use
- Tattooing
- Violence
- Sexual Assault
- Solitary Confinement
- Infections (MRSA, Influenza, Coccidiomycosis)
- Disruption of family/social network
Case

Mr. Jones a 67 year old man with type 2 DM, HTN, hyperlipidemia, HCV, chronic low back pain, major depression and a history of heroin addiction.

- Recently released from prison
- Marginally housed and at risk for homelessness
- No social support
- No medications
- Low health literacy
- Currently experiencing PTSD sx

What is the most likely cause of death for Mr. Jones in the first 2 weeks post-release?

A. Exposure to the elements if he becomes homeless.
B. Complications of his diabetes
C. Drug overdose
D. Violence related to his past crime

Health Risks Following Release

Chronic medical conditions, HIV and substance use
Incarceration

Hospitalization
Community
Death

The leading causes of death:
1. Drug overdose
2. Cardiovascular disease
3. Homicide
4. Suicide
5. Cancer

Health-related Reentry Challenges

- No discharge planning and short supply of medications
- No health insurance/lapse in Medicaid and Medicare B
- Additional barriers to meeting basic needs (social determinants of health)

Collateral Consequences of Incarceration

- **Employment**: Unable to apply for certain jobs, conviction barriers to employment
- **Public Assistance**: Prohibited from collecting food stamps, WIC, Pell grants, federal student aid
- **Housing**: Prohibited from section 8 housing, restrictions on distance from schools/parks
- **Voter disenfranchisement**: 1 of 13 African Americans (7.7%) is disenfranchised, compared to 1.8 percent of non-African Americans.¹

http://www.abacollateralconsequences.org/map/

¹ Subramanian et al, Relief in Sight? States Rethink the Collateral Consequences of Criminal Conviction, 2009-2014. Vera Institute of Justice, DECEMBER 2014

Case

Mr. Jones a 67 year old man with type 2 DM, HTN, hyperlipidemia, HCV, chronic low back pain, major depression and a history of heroin addiction.

- Recently released from prison
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- No social support
- No medications
- Low health literacy
- Currently experiencing PTSD sx

Barriers to Care Engagement
Transitional Care: Continuity of Care

Continuity of Care:
- Ensures access to medical records
- Enhances continuity
- A voids inappropriate healthcare utilization
- Reduces risk

Medical Home

Shifting the Paradigm

Patient Centered Care for Returning Prisoners

- Culturally competent primary care teams.
- Patient centered services; i.e. access to primary care within 2 weeks of release (starting in prison), behavioral health integration, re-entry support.
- Partnerships with existing community organizations that serve formerly incarcerated individuals to address social determinants of health.
- Multidisciplinary team including certified community health worker (CHW) with past history of incarceration to assist with patient engagement, navigation, care management, and chronic disease self-management support.
What can a provider do during a clinic visit?

- Past Medical History
- Mental health History
  - Diagnoses, symptoms, medications, hospitalizations
- Social history
  - Social determinants of health: housing, food security, family support/reunification, education, substance use, relapse prevention, harm reduction, health literacy
- Incarceration History

Incarceration History

- Duration of incarceration
- Location
- Number of times incarcerated
- Date released
- Solitary confinement
- High risk behaviors (tattoos, sexual activity, IVDU)
- Community supervision
- Crime--- To ask or not ask?

Case

You sit down with Mr. Jones to get his medical history and he shares that he is very happy to be out in the community. He tells you that he never thought he would get out of prison in his lifetime after the terrible crime he committed. Do you ask Mr. Jones what was his crime?

A. Yes, you are curious and because he brought it up it is appropriate to ask.

B. No, never. You are trying to build trust with the patient and asking about his crime will immediately alienate him.

C. No, the information is not medically relevant, especially since the crime was over 20 years ago.

D. Yes, always because it might be relevant to addressing his health and re-entry needs.
Summary

- Prison populations in US have increased dramatically leading to mass incarceration.
- Prisoners have higher burdens of mental illness, infectious diseases, substance use disorders and other chronic diseases
- Risks of release include mortality, hospitalization, discontinuity of medical care, including medications
- Community providers can play an important role

Contact Information

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www.transitionsclinic.org
Follow Us on twitter: @_Transitions
Updates on the care of people with addictions
Diana Coffa, MD
Residency Program Director
UCSF Family and Community Medicine

Disclosures
I have nothing to disclose

Objectives
- Explore how definitions and language around addiction impact stigma and treatment
- Describe the SBIRT model
- Identify and discuss medications that can be used in primary care to treat addiction

New issues in defining addiction
- New DSM 5 criteria
- Language of substance use
- Popular perceptions of addiction

DSM 5
- Remove terms *abuse* and *dependence*
- Replace with spectrum of Substance Use Disorder (SUD)
- Craving added as a criterion
- Problems with law enforcement removed

DSM 5 criteria for Substance Use Disorder

- 2-3 Mild, 4-5 Moderate, >5 Severe

<table>
<thead>
<tr>
<th>Roles</th>
<th>Risk</th>
<th>Relationship</th>
<th>Compulsion</th>
<th>Control</th>
<th>Consequence</th>
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<tbody>
<tr>
<td>Recurrent use resulting in <strong>failure to fulfill major roles or obligations</strong> at work, home, or school</td>
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<td>Recurrent use in <strong>hazardous situations</strong></td>
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<tr>
<td>Recurrent continued use despite <strong>social or interpersonal problems</strong> caused or exacerbated by drugs</td>
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<tr>
<td><strong>Tolerance</strong></td>
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<td><strong>Withdrawal</strong></td>
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<tr>
<td><strong>Cravings</strong></td>
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<tr>
<td><strong>A great deal of time</strong> getting or using the substance, or recovering from use</td>
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<tr>
<td>Use of <strong>more than intended</strong> or for longer than intended</td>
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<tr>
<td>Persistent <strong>desire or efforts to cut down</strong></td>
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<tr>
<td>Important <strong>activities given up</strong> or reduced due to substance use</td>
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<tr>
<td>Continued use despite knowledge of <strong>physical or psychological problems</strong></td>
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</tbody>
</table>

Stigma in underserved populations
- Addiction treatment is often limited by
  - Shame
  - Low sense of self-efficacy
  - History of failure and fear of recurrent failure
  - Moralistic undertones

<table>
<thead>
<tr>
<th>Stigma inducing</th>
<th>Stigma mitigating</th>
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<tbody>
<tr>
<td>Addict, Abuser,</td>
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<tr>
<td>Junkie, Tweaker</td>
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<td>Abuse</td>
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<td>Clean, Dirty</td>
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<td>Habit</td>
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<td>Replacement or</td>
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<td>Substitution therapy</td>
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<td>User</td>
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<td>IVDU</td>
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<td></td>
<td>Stigma inducing</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>Addict, Abuser, Junkie, Tweaker</td>
<td>Person with addiction Person in active addiction Person with substance use disorder</td>
</tr>
<tr>
<td>Abuse</td>
<td>Use disorder Harmful use, risky use</td>
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<tr>
<td>Clean, Dirty</td>
<td>Harmful use, risky use</td>
</tr>
<tr>
<td>Habit</td>
<td>Negative, positive, discordant</td>
</tr>
<tr>
<td>Replacement or Substitution therapy</td>
<td>Addiction, substance use disorder</td>
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<tr>
<td>User</td>
<td></td>
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<tr>
<td>IVDU</td>
<td></td>
</tr>
<tr>
<td>PSA</td>
<td></td>
</tr>
<tr>
<td><strong>Stigma inducing</strong></td>
<td><strong>Stigma minimizing</strong></td>
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<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
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<tr>
<td>Addict, Abuser, Junkie, Tweaker</td>
<td>Person with addiction</td>
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<td></td>
<td>Person in active addiction</td>
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<td></td>
<td>Person with substance use disorder</td>
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<tr>
<td>Abuse</td>
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<td></td>
<td>Harmful use, risky use</td>
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<td>Negative, positive, discordant</td>
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<td>Habit</td>
<td>Addiction, substance use disorder</td>
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<tr>
<td>Replacement or Substitution therapy</td>
<td>Treatment</td>
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<td>Medication assisted treatment</td>
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<td>User</td>
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<td>IVDU</td>
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<tr>
<td>PSA</td>
<td></td>
</tr>
<tr>
<td>User</td>
<td>Person who uses...</td>
</tr>
<tr>
<td>IVDU PSA</td>
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</table>
Is Addiction a Disease?

Two "No" arguments
- It is a voluntary, hedonistic choice
- It is a socially mediated, politically mediated, culturally mediated, behaviorally mediated, environmentally mediated, complex phenomenon. It is not simply an organic brain disease.

Is Diabetes a Disease?
- Behaviorally mediated
- Environmentally mediated
- Socially mediated
- Politically mediated
- Culturally mediated
- Not just an organic pancreatic disease

Addiction is a complex disease
- Behaviorally mediated
- Socially mediated
- Politically mediated
- Environmentally mediated
- Culturally mediated
- Emotionally mediated
- Genetically mediated
- Pharmacologically mediated
- Organic brain disease
Addiction as an organic brain disease

- Disrupted voluntary behavioral control
- Supraphysiologic dopamine release at nucleus accumbens
  - Massive reward


Natural Reward Elevates Dopamine Levels

---

Effects of drugs on dopamine release

Addiction as an organic brain disease

- Disrupted voluntary behavioral control
- Supraphysiologic Dopamine release at nucleus accumbens
  - Massive reward
  - Increased salience
- Over time, diminished intrinsic dopamine release in limbic system
  - Baseline dysphoric state with decreased reward and salience from natural reward stimuli
- Diminished dopamine and glutamate release in frontal cortex
  - Decreased executive function, impulse control

Is it harmful to call addiction a disease?
- People with addiction sometimes describe the disease label as demoralizing or diminishing.
- "It makes it seem like a bigger deal than it is. It's just a habit that I need to quit. It's not like there's something wrong with me."
- Concern that it implies a permanent change that cannot be cured

Why is it useful to call addiction a disease?
- Reduces stigma
- Reduces blame and increases appropriate response to relapse
- Leads to the most effective treatments: medication assisted treatments

A compromise position
- Treat addiction like a disease
  Even if you don’t think it is one
  --Anna Lembke, MD

SBIRT Model of Care
- Screening
- Brief Intervention
- Referral to Treatment
Screening

- USPSTF Grade B recommendation: Annual Alcohol Screening and Brief Intervention for all adults
  - Same as mammograms

Single Question Screener

- How many times in the last year have you had 4 or more (5 for men) drinks in one day?
  - 82% sensitive, 79% specific

Single Question Drug Screener

- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
  - 100% sensitive, 73.5% specific for drug use disorder

If single question screen is positive

- Further assess quantity, consequences, and control
- Provide Brief Intervention appropriate to the level of use.
Referral to Treatment

- Residential Treatment
- Outpatient Treatment
  - High intensity
  - Moderate intensity
  - Low intensity
- Fellowship meetings
- Medication assisted therapy

Office Based Medication Assisted Therapy

- Opioid Use Disorders
- Alcohol Use Disorders

Medication Assisted Treatment for Opioids

- Methadone
  - Reduces
    - Death
    - HIV
    - Infections
    - Heroin and other opioid use
    - Criminal behavior
  - Cannot be prescribed for SUD in the primary care setting

Methadone

- Reduces
  - Death
  - HIV
  - Infections
  - Heroin and other opioid use
  - Criminal behavior
- Cannot be prescribed for SUD in the primary care setting

Medication Assisted Treatment for Opioids

- Buprenorphine
  - Lower retention than methadone
  - Fewer barriers to treatment
  - Fewer side effects
  - Lower mortality rates
  - Only MD’s can currently prescribe
    - Advocacy to expand to NP
  - Limited to 100 patients per MD
    - Likely raise cap soon

Ling et al. Drug and Alc Dep 2003

Mattick R et al. Cochrane Review 2009
 Updates on Buprenorphine

- Off label use of SL buprenorphine for chronic pain
  - May be a good first line opioid for high risk patients
  - Dose TID
  - Transdermal form is FDA approved for chronic pain
  - SL form only approved for OUD

Daitch et al. Pain Physician 2012
Malinoff et al. Am J Ther. 2005

 Updates on Buprenorphine

- Increasing interest in home inductions
  - Dominant model for induction in Europe

 Naltrexone

- Oral Naltrexone
  - Effective in unusually externally motivated patients

- Injectable Naltrexone
  - May be more effective
  - Low retention rate
  - High risk of overdose
Alcohol use disorder

**Withdrawal management**
- Benzodiazepines
- Gabapentin

**Maintenance**
- Naltrexone 25mg–150mg/d
  - Return to any EtOH: 5–40% reduction, NNT 20
  - Return to heavy drinking: 20–35% reduction
  - Can be used PRN before planned drinking events
  - Injectable depo form less well studied but may increase retention in treatment

- Acamprosate 666mg TID
  - Consistently effective in European trials
  - No effect in two large US studies
  - Similar side effect profile to naltrexone
  - Avoid in severe liver disease or severe renal disease

- Disulfiram 250mg–500mg/d
  - Low retention, poor studies
  - Monitor LFTs, neuropathy and vision changes

---


Summary

- The words we use matter
- We should treat addiction like a disease
  - That may be curable
  - And is definitely treatable
- Screen everyone
  - Provide brief interventions to people with risky use and SUDs
  - Provide referral to treatment for all SUDs
- You can prescribe medications to treat opioid or alcohol use disorders
Care of the Transgender Person

Barry Zevin MD
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San Francisco Department of Public Health
Assistant Clinical Professor of Medicine
UCSF School of Medicine
barry_zevin@sfdph.org
transgenderhealthservices@sfdph.org
www.sfdph.org/transgenderhealthservices

Learning Objectives

The participant will:
- Understand the prevalence and diversity of transgender, transsexual, and gender nonconforming people
- Be prepared to implement 3 practice adaptations needed in working with this population due to high levels of discrimination
- Gain knowledge and have access to resources to safely and successfully treat gender dysphoria

Disclosures

- Dr. Zevin is an employee of the San Francisco Department of Public Health
- There are no other relevant financial or personal relationships that could cause bias in this presentation
- No medications used as feminizing / masculinizing therapy for transgender patients are FDA approved for this indication
Prevalence

1:11,900 – 1:45,000 MTF
1:30,400 – 1:200,000 FTM

Conventional prevalence based on presentation to specialized centers
Prevalence

• 0.3% to 1.4% of the general population
  – Based on community surveys
  – % even higher if includes “ambivalent”
    gender identities
  – Numbers seen in healthcare settings rising

Two Question Method for Recording Sex and Gender in Health Records

What is your gender? - Check one that best describes your current gender identity.

- Male
- Female
- Trans male
- Trans female
- Not listed, please specify.
  [Survey forms would include options 1–5. Coding should also allow for options 6 and 7]
  – Declined/Not stated
  – Question not asked

What was your sex at birth? – Check one

- Male
- Female
  [Survey forms would include options 1–2. Coding should also allow options 3 and 4.]
  – Declined/Not stated
  – Question not asked

Female to male, FTM, F2M, trans man, transmasculine, masculine spectrum

He, him

Male to female, MTF, M2F, transwoman, transfeminine, feminine spectrum

She, her
Data from the National Transgender Discrimination Study—online responses were obtained from 6,456 self-identified transgender and gender non-conforming adults aged 18 and over.

• 97% reported harassment, mistreatment or discrimination at work.
• 55% had lost a job due to bias
• 53% report being verbally harassed or disrespected in public setting.
• 57% experienced rejection by their families.
• 11% evicted due to gender.

An ongoing crisis

• At least 21 transwomen killed this year, most are women of color
• Transgender people of color were 1.6 times more likely to experience physical violence when compared to other members in the LGBT community
Adverse Effects of Discrimination

- Nearly four times more likely to have a household income of less than $10,000/year compared to the general population.
- One-fifth (19%) reported experiencing homelessness.
- Almost half of the respondents (46%) reported being uncomfortable seeking police assistance.
- Discrimination was pervasive.
- People of color fare worse; African Americans most impacted in many dimensions.

Discrimination in Healthcare Settings

- 19%-26.7 of people refused medical care in the past. [NTDS; Lambda Legal]
- 51.9% are expecting to be refused Medical care. [Lambda Legal]
- 28% of people report harassment in medical setting. [Lambda Legal]
- 20.9% healthcare providers used harsh or abusive language. [Lambda Legal]
- 7.8% health care professionals were abusive or physically rough. [Lambda Legal]
- 2% of the NTDS study reported violence IN the doctor’s office.

Discrimination in Healthcare Settings

- Common Errors
  - Failure to use proper names and pronouns
  - Focus on gender when issue has nothing to do with gender status
  - Excess curiosity about a person’s gender and sex
  - Asking patients to educate providers
  - Using patients as teaching example
  - Breast, genital or rectal exams without considering patient’s past history of trauma or difficult relationship with that part of their anatomy

Adverse Effects of Discrimination on Health

- High rates of stress and trauma-related behavioral health problem
- High-risk behaviors and suicidality
- High risks of HIV infection and STDs
- Decreased rates of receiving recommended preventative care and care for medical conditions
Caring for the Trans Person part 1: addressing the results of discrimination

Adaptations in Care Pearls

- Using appropriate pronouns and language
  - Ask straightforwardly what patient prefers if unsure
  - Change chart names and gender and train front office staff
  - Avoid terms pre-op/post-op, confusing and assumes surgery is norm
- Acknowledge “years of isolation and struggle”
  - Daily stress of living in a stigmatized and marginalized status
  - Recognition of this in patient care has been reported to be more important than “transgender expertise” Lombardi 2001

Adaptations in Care Pearls

- Trauma Informed Approach
- Create Trans friendly setting by including relevant posters, magazines, etc.
- Unisex bathrooms are preferred solution to BR problems
  - If BR is gendered patients must be allowed to use BR they feel is appropriate to their identity

Adaptations in Care / Pearls

- in addition to a standard health history:
  - history of gender experience
  - prior hormone use
  - prior surgical history
  - sexual history
  - goals related to health and gender transition
Adaptations in Care / Pearls

• Preventative care / cancer screening based on anatomy
• Be mindful in physical exam of previous trauma and abuse
  – Avoid genital and rectal exams on 1st visit if possible

Caring for the Trans Person part 2: Transition related healthcare

Gender Dysphoria

• Diagnostic Terms
  – DSM5 - Gender dysphoria
  – ICD 10 – Transsexualism, other gender identity disorders, etc.
  – ICD 11 - Gender Incongruence???

Gender Dysphoria

• Practical Diagnosis and Informed Consent Standard
  – Patients will bring specific issues
  – “Dysphoria” is an understatement as emotions involved usually very intense
  – Initiating treatment in primary care setting based on informed consent is reasonable and shows good outcomes
### Gender Dysphoria: Hormone Therapy

- Rx initiated by prescribing MD
  - Based on clinical judgment
  - Lack of contraindications
  - Pt. capacity to give informed consent
  - Informed consent
  - Model patient education documentation forms are available: [https://www.sfdph.org/dph/comupg/oprograms/THS/ClinicalResources.asp](https://www.sfdph.org/dph/comupg/oprograms/THS/ClinicalResources.asp)

### Natural History of Gender Dysphoria

- Consequences of untreated gender dysphoria
  - Suicidality / suicide
  - Neglect of health and healthcare needs
  - Resorting to black market or unscrupulous MD's
    - Unmonitored hormone therapy with adverse effects
  - High risk sexual behavior
  - Substance use
  - HIV and other infectious diseases
  - Vulnerability to victimization
  - Attempts at self surgery or surgery by unscrupulous providers
    - Silicone and other injections "pumping parties"

### Transition

- Unique to each person based on their goals and situation, health, family, identity, etc.
  - Not everyone wants or needs hormones or surgery
  - Not the same starting or ending point for everyone
  - Can take many years
  - Move back and forth; not linear
  - Life forces person back / Opportunities help people forward
  - Developmental process unique to the individual

### Hormone Therapy

- **Feminizing Therapy**
  - Anti-androgen: In US usually Spironolactone
  - Estrogen: 17β-Estradiol (oral, sub-lingual, injectable, transdermal, etc) – many brand names
    - Estradiol is strongly preferred to Conjugated Equine Estrogen or ethinyl estradiol
- **Masculinizing Therapy**
  - Testosterone: injectable, patch, topical
Hormone Therapy: Dosing and Monitoring Guidelines

- UCSF CoE: http://transhealth.ucsf.edu/

Surgery

- Not every trans person wants or needs surgery
  - The terms “pre-op, post-op, non-op” are unhelpful
- Some trans individuals need surgery
  - Non-discrimination policies and health care reform are making surgery much more accessible in California and possibly across USA
  - Insurance coverage and access to these procedures is rapidly improving
  - Still numerous barriers and gaps

Surgeries

- Mastectomy w/ male chest construction
- Hysterectomy/salpingo-oophrectomy
- Vaginectomy/colpocleisis
- Metoidioplasty
- Phalloplasty with Penile Implant
- Scrotoplasty
- Urethral reconstruction
- Orchiectomy
- Penectomy
- Vaginoplasty
- Clitoroplasty
- Labiaplasty
- Feminizing mammoplasty
- facial feminization,
- tracheal shave,
- facial and body hair removal

Surgery

- Period before during and after surgery highly stressful and traumatizing to many patients
- Excellent patient education and preparation are keys to best outcomes
- Extensive resources and information available from SFDPH Transgender Health Services https://www.sfdph.org/dph/comupg/oprograms/THS/default2.asp
Transgender Care Across the Lifespan

10 things to know about feminizing hormone therapy

1. Decision to start, continue, or increase hormones must include benefits, risk of adverse effects, and risk related to what will happen if a person does not get it
2. More isn’t always better / less isn’t always better
3. Importance of smoking cessation
4. Psychological benefit may be more than physical changes
5. Hormone therapy cannot get rid of hair follicles

6. Estrogen is not toxic to the liver or kidneys with very rare exceptions
7. Counsel patients on fertility impairment and offer sperm banking to interested patients prior to starting therapy
8. Patches or shots may be the safest for many patients over 40 or with other health issues
9. Ask about sexual functioning and expectations about erections before start or change
10. Changes related to any particular hormone or dose may take 3 months or longer to be noticeable
10 things to know about masculinizing hormone therapy

1. Importance of smoking cessation
2. Facial / body hair growth, voice deepening may occur quickly even at low doses and is irreversible
3. Male pattern baldness may occur quickly and is irreversible
4. Almost everyone can be taught to self inject testosterone but everyone needs to be taught
5. Libido can increase and sexual attractions can change with start of testosterone (think adolescent boys)

6. If patients have mood swings on every 2 weeks injectable testosterone may be helped by changing to every week (at ½ dose) or patch or gel
7. Testosterone usually does not cause rage, aggression, or violence (even in high doses)
8. Counsel regarding loss of fertility and possibility of ova banking
9. Uterine bleeding after being on a stable testosterone dose requires a medical work up
10. Testosterone is not a reliable contraceptive and other methods are required if patients are having vaginal sex with cisgender men
10 things to know about surgery

1. Not everyone wants or needs surgery (banish the terms pre-op, post-op)
2. Decisions about surgery require a cooperative patient centered approach including patient, primary care, behavioral health, and surgeon
3. Vaginoplasty is a major procedure requiring several days hospitalization and extensive self care
4. Sexual functioning and orgasm are usually good after vaginoplasty but different than before
5. Phalloplasty is a major and very arduous procedure requiring multiple surgeries and prolonged recovery with a very high complication rate

6. Well controlled HIV infection and other well controlled chronic illness are not a contraindication to any surgeries
7. Testosterone or estrogen are required to prevent osteoporosis after surgery that removes the ovaries or testes
8. Counseling about fertility options should be given to every patient considering genital surgeries
9. Substance use disorders, mental health disorders, homelessness, cultural differences may create challenges but are not contraindications to surgery
10. Unrealistic Expectations are main barrier to good outcomes

Resources

- World Professional Association for Transgender Health http://www.wpath.org/
- SFDPH Transgender Health Services http://www.sfdph.org/transgenderhealthservices
- UCSF Center of Excellence for Transgender Health http://transhealth.ucsf.edu/
- Transline project- health.org/transline
- Vancouver Coastal Health transhealth.vch.ca

Thank you to my colleagues in the SFDPH Transgender Health Project, transgender community advocates and especially to our patients for teaching us and supporting us every day
Summary

• Every trans person can get accessible high quality healthcare if health care teams become educated
• High quality care for Trans people includes equal access to general healthcare, addressing the results of long term discrimination, and for some patients transition related medical services
• Many resources are now readily available
Telemedicine to Improve Care for the Underserved
March 11, 2016

George Su, MD
Medical Director of Telehealth,
San Francisco Department of Public Health
Associate Professor of Medicine, UCSF
San Francisco General Hospital

Disclosures
I have nothing to disclose

Objectives
1. Basic telemedicine modalities
2. Telemedicine delivery models
3. Design of telemedicine applications and care for the underserved
Definitions

- Telemedicine: use of medical information exchanged from one site to another via electronic communications to improve patients’ health status
- Telehealth: same as above, but not restricted to clinical services

Five “types” of telemedicine

- Referring provider  Specialist
- Patient  Provider
- Home monitoring
- Remote medical education
- Informational push

Telemedicine modalities

- Synchronous
  - Live video
- Asynchronous
  - “Store-and-forward”
Synchronous live

Asynchronous

Remote monitoring

Telemedicine models
- Rural (“traditional”)
- Urban
- “Delivery system” model
Telemedicine models

- "Traditional" vs. "Urban"

Hub site
Spoke/network member
Rural health grant recipients

Center for Applied Research and Environmental Systems
Office of Rural Health Policy, HRSA, 2011

"Hub and spoke"

"Spoke and hub"

Alaska Federal Health Care Access Network (AFHCAN)
Rural telemedicine

- Geographic barriers and access disparities
- Telehealth “carts”, video applications
- Higher workflow burden

Urban telemedicine

- Higher density of specialists
- Access to specialty services
- Health disparities and barriers to care
- Hub and spoke

Maxine Hall Health Center

South of Market Health Center

Haight Ashbury Free Clinic

SF AIDS Foundation

Black Coalition on AIDS
“Delivery system” model

• Urban telemedicine PLUS
• Design of telemedicine applications are contextualized to and aligned with system goals:
  – Quality care
  – Cost-effectiveness
  – Patient-centeredness

Delivery system model: design considerations

• “Partnership model”
• System-wide context and benefits
• Population health
• Chronic care management
• Patient-centered care principles

Annually:
110,000 inpatients
592,000 outpatients
33,000 mental health
3,300 trauma

Delivery system
Capitation
Financial resources
Primary care burden
Specialty access
Fixed workforce
Integrated care
The Partnership Model

Drivers:
- Reasons to partner

Facilitators:
- Supportive factors

Components:
- Joint activities and processes

Outcomes:
- How did we do?

Drivers determine outcomes

The Partnership Model

- Typically a primary care-specialty partnership
- Technologies must enhance these relationships

The Partnership Model: Telemedicine

Drivers:
- Access
- Inefficiencies
- Costs
- Satisfaction

Facilitators:
- Sponsors
- Incentives

Components:
- Technology
- Workflows

Outcomes:
- Better access
- Efficient care
- Lower costs
- Satisfaction

Drivers align with institutional priorities

Teledermatology

Toby Maurer, MD
Chief, Dermatology at SFGH
Facilitators:
- Prop 1D
- DSRIP

Components:
- Technology
- Workflows

Outcomes:
- System-wide spread/adoption

Drivers:
- Access
- Wait times
- Force multiplier

Components:
- Workflows
- EMR
- Telederm

Outcomes:
- Access

Teledermatology workflow

Reports and images

Consults vs. third next available appointment

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<tr>
<td>72</td>
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TNAA
- 72 days
- 65/month

Consults
- 16/month


### Diagnosis

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<tr>
<td>Atopic dermatitis, unspecified</td>
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</tr>
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<td>Nummular dermatitis</td>
<td>3</td>
</tr>
<tr>
<td>Vitiligo</td>
<td>3</td>
</tr>
<tr>
<td>Lichen simplex chronicus</td>
<td>2</td>
</tr>
<tr>
<td>Other prurigo</td>
<td>2</td>
</tr>
<tr>
<td>Alopecia areata, unspecified</td>
<td>2</td>
</tr>
<tr>
<td>Other rosacea</td>
<td>2</td>
</tr>
</tbody>
</table>
Home monitoring: positive airway pressure

George Su, MD
Medical Director
Eula Lewis RRT, CTTS
Outpatient Director, Respiratory Care Services
Program Director
Identify at-risk patients

Phone interrogation “POTS”

PAP Clinic

Enlist DME vendor(s)

Follow-up protocol

Day 30

Wireless patients

Day 60

Wireless patients

Home monitoring pilot: 30 day

Days with 4 hr/day use over 30 days (%)

Day 30

Day 60

“POTS”

Usual care
Patient-centered care for the underserved

- Welcoming environment, comfort, support
- Respect for patients’ values and expressed needs
- Patient empowerment or “activation”
- Socio-cultural competence
- Coordination and integration of care
- Access and navigation skills
- Community outreach

Silow-Carroll, et al., 2006

---

Which statement regarding the use of telemedicine in community health centers (CHCs) is correct?

A. Community health centers that provide telemedicine services are more likely to serve urban rather than rural communities.
B. The costs required to implement telemedicine in CHCs are low, and do not pose a significant barrier to adoption.
C. Telemedicine in CHCs increases access to specialty-level care and diagnostics, while maintaining a patient-centered focus and attention to needs of underserved communities.
D. Community health centers that provide telemedicine services have lower non-physician staff ratios than CHCs that do not offer telemedicine.
Provision of telemedicine by CHCs

- Increases access to specialty-level care and diagnostics, while maintaining a patient-centered focus
- Point-of-service specialty services leverages local expertise and resources


Telespirometry

George Su, MD
Medical Director
Eula Lewis RRT, CTTS
Outpatient Coordinator, Respiratory Care Services
Program Director

Telespirometry (pre- & post- comparison)

- Patient
- Data loops
- Virtual Coach

45% FAIL
23% Acceptable
32% Caution
16% FAIL
59% Acceptable
Community health center telemedicine - survey of 625 CHCs

- 147 (23.5%) one telemedicine service
- 82 (13.1%) ≥ 2 telemedicine services
- ≥ 2 telemedicine services vs. without:
  - 54.9% vs. 34.8% rural
  - 28.0% vs. 47.0% urban
  - 18.2% vs. 17.1% both
  - 5.2 vs. 3.5 mid-level providers (FTEs per 10,000 patients)
  - 25.9 vs. 23.2 other (FTEs per 10,000 patients)

Shin, et al., 2014

Telemedicine at community health centers

- Limited budgets, low debt tolerance, competing demands for funds
- Costs: technology, system upgrades, ongoing use, maintenance
- Alternative funding (grants, group purchasing, open source solutions)
- Medicare reimbursement: originating site is rural Health Professional Shortage Area (HPSA) located outside of a Metropolitan Statistical Area (MSA)

Gaylin, et al., 2011; Fortney, et al., 2013

Question

Which statement regarding the use of telemedicine in community health centers (CHCs) is correct?

a. Community health centers that provide telemedicine services are more likely to serve urban rather than rural communities. **FALSE**

b. The costs required to implement telemedicine in CHCs are low, and do not pose a significant barrier to adoption. **FALSE**

c. Telemedicine in CHCs increases access to specialty-level care and diagnostics, while maintaining a patient-centered focus and attention to needs of underserved communities. **CORRECT**

d. Community health centers that provide telemedicine services have lower non-physician staff ratios than CHCs that do not offer telemedicine. **FALSE**
TELE-MED Act of 2015

• Amends title XVIII of the Social Security Act to permit certain Medicare providers licensed in a State to provide telemedicine services to certain Medicare beneficiaries in a different State
• Expands pool of eligible consultants, but doesn’t address reimbursement gaps (particularly for non-rural setting)

Telemedicine to improve care for the underserved

• Rural “traditional” telemedicine—geographic disparities
• High potential to address disparities and barriers in urban settings
• Can leverage CHCs to promote patient-centered care
• Substrate for primary-specialty relationship (“partnership model”)
• “Delivery system” model requires multidimensional design
• Well-designed programs can align with health care reform principles
• Well-established value proposition (cost/benefit) for rural model
• Health outcomes/urban models need further evaluation
• Reimbursement remains barrier

Thank you!

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George Su, Medical Director of Telehealth, SFDPH
Bruce Occeña, Director of Telehealth, SFDPH
Advances in Palliative Care in Underserved Settings

Care of Vulnerable and Underserved Populations
March 12, 2016

Disclosures

We have no significant financial relationships to disclose

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  - Associate Clinical Professor of Medicine, UCSF

- Heather A. Harris, MD
  - Associate Medical Director, Supportive & Palliative Care Service, ZSFG
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Outline

- Define palliative care
- Recognize when to start palliative care
- Review advance care planning with vulnerable patients
- Review updates in documenting patients’ wishes

Outline

- Challenges
- Evidence
- Tools
- Recommendations
Clinical scenario

You are a hospitalist caring for a Mr. Chavez, a 45 year-old Spanish-speaking man with stage IV NSCLC, admitted with dyspnea and fatigue. While working up the cause of his symptoms, you suggest to the patient’s oncologist that you think that a palliative care consult would be appropriate. He says that Mr. Chavez is “not ready for palliative care” because he is young, and still wants to pursue chemotherapy.

Traditional model for serious illness

![Diagram of traditional model for serious illness]

Adapted from S Pantilat, PCLC 2005
What is palliative care?

“Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.”

Center to Advance Palliative Care, 2011

Relationship Between Hospice, Palliative Care, Pain Management, and Life-Prolonging Therapy

- Hospice Care is a specialized form of Palliative Care
- Hospice Care and Life-prolonging therapy usually do not overlap
- Palliative care includes specialized training in pain management, but typically does not manage chronic pain
**Integrated model for serious illness**

- **Curative care**: Focus on treatment with curative intent.
- **Palliative care**: Focus on symptom management and quality of life.
- **Hospice care**: Focus on end-of-life care.
- **Bereavement**: Support for the surviving family and friends.

**Effects of early palliative care**

- **Stage IV NSCLC**
  - Automatic outpatient palliative care referral
  - Standard care

- **Results**
  - Improved QOL
  - Less intensive end-of-life care
  - Less depression
  - Increased survival (~3mo)

*Temel et. al., 2010 NEJM*
Best practice: concurrent care

Do patients know what palliative care is?

Center to Advance Palliative Care, 2011
National Survey Results
Are vulnerable patients afraid of palliative care?

cuidados paliativos
姑息治療 Gǔxí zhíliáo
chăm sóc giảm nhệt
паллиативный уход
(palliativnyy ukhod)
pampakalma pag-aalaga
الرعاية التلطيفية
(alrrieayat altaltiffin)

Clinical bottom line

• Integrating palliative care earlier and providing it concurrently with disease-directed therapy leads to:
  – improved clinical outcomes
  – greater patient and caregiver satisfaction
  – lower costs of care
  – (prolonged survival)
How might you change your practice?

- Integrate palliative earlier
  - “Extra layer of support”
  - Focus on the reason for referral (e.g. symptom management)
- Resources
  - Chinese American Coalition for Compassionate Care
  - CSU Course focusing on cultural competence in caring for Latinos
  - Interpreters curriculum in palliative care

http://www.caccc-usa.org/
https://csupalliativecare.org/programs/latinos/

Clinical scenario, cont.

After introducing Mr. Chavez to the concept of palliative care, and reassuring the oncologist that receiving chemotherapy and palliative care are not mutually exclusive, there is agreement that he could benefit from palliative care. However, he’s about to be discharged from the hospital and you’re unsure of what resources are available in the community.
Growth of palliative care programs

• 67% of hospitals now report offering palliative care services
  – 90% of hospitals with 300+ beds
  – 59% of public hospitals
• Significant expansion in CA safety net hospitals
  – 2007: 4 hospitals (24%)
  – 2013: 17 hospitals (100%)

Expansion into the community

• Clinic-based services
  – Co-located or embedded
  – Stand alone
• Home-based services
  – Hospice & home health programs
  – Enhanced case management
• SNF-based services
• Telehealth

https://reportcard.capc.org/
Center to Advance Palliative Care, 2015
Community-based palliative care

- 2011 survey of California hospitals
  - Only 24 hospitals (7%) reported having outpatient palliative care services
    - Fewer pediatric palliative care programs (8 total)
- Unknown
  - National or safety net prevalence
  - Home - or SNF-based prevalence

Rabow, 2014 J Palliative Med

Tool for California

- County summaries
  - Inpatient and outpatient PC programs and sufficiency
  - Population and annual death volume
  - Compare with existing programs and their capacity

http://www.chcf.org/publications/2015/02/palliative-care-data
Landmark legislation for vulnerable patients

- Passed September 2014
- Based on success of pediatric pilot
- Requires the DHCS to “establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.”
- Await all-plan letter to managed Medi-Cal programs
  - Develop alternative payment models

Meeting the need

- Specialty Palliative Care
- Secondary Palliative Care
- Primary Palliative Care
Clinical bottom line

- Sub-specialty palliative care is not available equitably throughout the country
  - current move from inpatient to outpatient settings

- The vast majority of palliative care will be provided through primary palliative care

How might you change your practice?

- Continuing Education
  - CSU Institute for Palliative Care
  - Center to Advance Palliative Care
  - VitalTalk
  - ELNEC
  - Harvard: Center for Palliative Care
  - Palliative Care Masters Degree
    (U Colorado Denver)

- System Redesign
  - not just individuals, but systems change

http://www.chcf.org/publications/2015/08/weaving-palliative-care
Clinical scenario, cont.

You are seeing Mr. Chavez in the outpatient setting and want to address his end of life wishes. Whenever you try to bring up the topic, his body language changes and he says that “God will decide,” then changes the subject.

Advance Care Planning: Disparities for Vulnerable Patients

• Not many Americans have advance directives
  – Only 18-30% of general population
  – Lower among non-Whites, lower SES
• Systems not reliable in following directives
  – Missing/wrong 70% of the time even in Canada!
  – Black cancer pts far less likely than whites to have advance care preferences honored

Wilkinson, 2007 Rand Corp
Heyland, 2013 JAMA Int Med
Loggers, 2009 J Clin Onc
Barriers to advance care planning in the safety net

• Patient-level barriers
  – Perceive advance care planning (ACP) as irrelevant
  – Don’t understand or need help completing legal documents
  – Not enough time during visit
  – Poor relationship with family/friends, or don’t want to burden them
  – Personal barriers (e.g. too sad, too nervous)


Additional barriers

• Provider- and System-level barriers
  – Communication about end of life
  – Communication across cultures
  – Takes longer to communicate (e.g. patients with limited English proficiency)
  – Limited access to tools
  – Limited staffing
• Laws may make it harder for vulnerable pts to complete advance directives

Elliott, 2016 J Pain Sympt Mgmt
Castillo, 2011 Ann Int Med
Keys for changing experience with ACP:

• Redefine goals
  • Assess pt readiness
  • Help motivate *engagement* in *dialogue* with surrogates and provider *over time*
• Prioritize certain aspects of ACP
  • Identifying surrogate(s)
  • Clarifying broad wishes/goals

**Determining patient readiness**

• Prior engagement with ACP
  – Personal experience
  – Surrogacy or vicarious experiences
• Insight into health, function
• Clarification of personal values, wishes
• Discussions about values, wishes
  – With family/friends
  – With clinicians
ACP and motivational interviewing


Creative ways to activate patients

www.prepareforyourcare.org – English and Spanish
Creative ways to activate patients

ACP Decisions (www.acpdecisions.org)
• Evidence-based approach using videos to educate and motivate pts in ACP
• Large library of resources for pts, providers, including how-to guide, checklist
• Paid subscription

Serious Illness Conversation Guide

**CONVERSATION GUIDE**

**Understanding**

What is your understanding now of where you are with your illness?

**Information preferences**

How much information about what is likely to be ahead with your illness would you like from me?

**Prognosis**

Share prognosis, tailored to information preferences

**Goals**

If your health situation worsens, what are your most important goals?

**Patient/whishes**

What are your biggest fears and worries about the future with your health?

**Functions**

What abilities are so critical to your life that you can’t imagine living without them?

**Trade-offs**

If you become sicker, how much are you willing to go through for the possibility of gaining more time?

**Family**

How much does your family know about your priorities and wishes?

Bernacki, 2014 JAMA Int Med
Ariadne Labs
How might you change your practice?

• Change focus in ACP
  – Prioritize specific components
    • Identify surrogate(s)
    • Understanding broader wishes/values
  – Goal is to motivate engagement, dialogue

• Try out tools
  – Conversation guides
  – Patient activation

Discussion and documentation

• Communication recommendations
• New Decision Tools
• POLST/MOLST
Possible barriers to documenting preferences in safety net

- Patient-level
  - Mistrust
    - Concerns about legal documents
    - Concerns about limiting care
  - Literacy
- Systems-level
  - Documenting within large public health systems
  - Documenting across systems

Elliott, 2016 J Pain Sympt Mgmt
Castillo, 2011 Ann Int Med

Talking about treatment choices

- Who should be involved?
- Ask-Tell-Ask
- Communicating risk
  - Use absolute risk
  - Written and verbal info
  - Pictographs
- Talk to other patients (or see!) what treatment would be like

Fagerlin, 2011 J Natl Cancer Inst
POLST

• Can be controversial
• Which patients?
  – Limited prognosis (1-2 yrs)
  – Prefer some limitations on aggressive care
    • Code status
    • Hospitalization
    • Artificial nutrition
• Action step at end of ACP conversation, not main focus
POLST in Practice

- Use of translated versions
- CA: Recent changes
  - Wording in section B
  - NPs and PAs can now complete POLST
- Education available for providers
- POLST registries

How might you change your practice?

- Try a new communication technique
  - Verbal
  - Pictographs, video
  - Expand inventory of easy-to-read forms and information
- Use legal documents differently
  - OK to fill out just the components pt wants to complete
  - California POLST

capolst.org
Summary

- Increasing evidence of benefit for starting palliative care “early”
- Specialist palliative care is increasingly available, community is new frontier
- Growing number of tools to enhance palliative care skills and redesign systems to support primary palliative care in clinics
- Reframe your goals around advance care planning and try new tools to activate patients

Questions?
CME Question

PATIENTS receiving care in a safety net clinic report all of the following barriers to advance care planning EXCEPT:

a) Unable to complete forms without assistance
b) Not enough time to discuss with provider
c) Perception that advance care planning is irrelevant
d) Forms are not available in their preferred language
e) Relationship with potential surrogate is strained

References

• America’s Care of Serious Illness: 2015 State-by-State Report Card on Access to Palliative Care in our Nation’s Hospitals, report published by the Center to Advance Palliative Care, 2015.
References

- McInturff B and Harrington E, 2011 Public Opinion Research on Palliative Care, report by Public Opinion Strategies, commissioned by the Center to Advance Palliative Care, 2011 June.
Case Management for Socially and Medically Complex Patients

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Assistant Clinical Professor, UCSF

Disclosures
We have nothing to disclose

Objectives
- Describe interdisciplinary models of care for complex patients
- Review the characteristics of successful case management programs
- Review the skills necessary to partner with case managers in the care of complex patients

Case
Mr. W is a 62 year old man with CHF, CAD, homelessness, and cocaine use disorder with frequent ED visits and admissions for chest pain and shortness of breath in the setting of cocaine use and difficulty managing his medications.

He infrequently engages with care and is difficult to find between hospitalizations. He does not go to shelters or have a functioning cell phone.
**Problem**

- Five percent of patients account for 50% of healthcare costs.
- Often these pts are poor and have high rates of chronic disease, mental illness, and/or addiction.
- Multiple barriers to effective care: homelessness, low literacy, social isolation, language barriers, addiction, and mental illness.
- Barriers to health care result in high rates of ED visits and hospitalizations, driving high costs.

**Challenges: System**

- Poorly integrated medical, psychiatric, addiction and social services.
- Insufficient self management coaching leaves patients unable to manage their chronic conditions.
- Inadequate support with complicated medication regimens leads to medication errors and non-adherence.
- Lack of caregiver support and/or transportation support limits patients’ ability to follow-up.

**Challenges for providers**

- Providers are overwhelmed by the patient’s complex social situation.
- Providers do not feel competent to address complex care issues such as homelessness.
- Providers lack the skills to recognize and leverage patient strengths and resiliency factors.
- Overcoming language differences can feel impossible.
- Real or perceived cultural biases may impede effective alliances between patients and providers.

**Challenges for patients**

- Competing personal priorities (the search for food, housing, and safety) interfere with accessing medical care.
- Mental illness and/or substance use interfere with patients’ follow up.
- Lack of social support makes self-management challenging.
- Other issues –lack of trust, language, costs- are barriers to seeking care.
A Brief History of Case Management

1970s
- Case management for patients with severe mental illness

1980
- Medicare demonstration projects

1990s
- HMO-based nurse case management
- Homelessness focused case management
- Primary care-based complex care management
- Health Homes

2010s
- Primary care-based complex care management
- Health Homes

Craig, C; Eby, D; Whittington, J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. Institute for Healthcare Improvement, 2011.

Shared Characteristics of Effective Care Management Programs

- Systematic process for identifying high risk patients
- Comprehensive patient assessment on enrollment
- Interdisciplinary care plans
- Tracking progress of care plan goals
- Reduce barriers to care at the system, provider, and patient level
- Include face to face visits


Steps of Program Design

Choose your population and learn about its assets and needs
Develop and test out your enhanced care design
Revitalize patient engagement
Iteratively improve your enhanced care model to fit the assets and needs of your population
Strengthen partnerships within and outside of your organization

Learn to Operate Sustainably at Full Scale: 5 to 25 to 125 to ...

From Institute for Healthcare Improvement, Better Health at Lower Cost Collaborative
Variability in Program Design

- Duration of services
- Intensity of services
- Focus of services
- Availability
- Length and approach to engagement period
- Location of services
  - Clinic based
  - Free standing
  - Outreach/home-based

Successful Program Models: Primary care based – Ambulatory ICU

- Intensive primary care
- Efficient utilization of specialty services
- Employer based: Boeing, Stanford, Atlantic City Casino Workers Union
- Safety net: Hennepin County Medical Center, Denver Health


Redesigning Primary Care for Breakthrough in Health Insurance Affordability Model: The Ambulatory Intensive Caring Unit. August 2005, California Health Care Foundation

Successful Program Models: Primary care based – Wrap around

- Patients keep their PCP
- Interdisciplinary, usually nurse-led, team provides supportive services
  - San Francisco Health Network
    - Nurse-health coach dyad with MD and SW support
    - 50% fewer hospital days after enrollment
  - Cambridge Health Alliance
    - Nurse-SW dyad with MD support
    - 40% fewer hosp days; 30% lower cost

Successful Program Models: Health Plan Based

- Community Care of North Carolina
  - Face to face visits in hospital, home, primary care office
  - Focus on safe transitions in care, self management, medications
  - Nurse led with strong pharmacy component
  - Hospitalizations state-wide decreased 10.5%
  - Readmissions state-wide decreased 10.2%


SCHOOL OF MEDICINE * UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Successful Program Models: Community Based and Street Outreach

Emergency Department Case Management Program
- MSW based intensive case management program
- Wrap around medical services
- Linkage to housing, entitlements, primary care, mental health, substance abuse services
- Direct mental health and SUD counseling

Outcomes:
- Decrease in ED usage
- Decrease in hospitalizations (not statistically sig)
- Decrease in homelessness
- Decrease in problem drinking


Successful Program Models: Community Based and Street Outreach

Case Continued
After extensive street outreach efforts, Mr. W engaged with a case manager with the Emergency Department Case Management Program
- Engaged and learned self-management skills
- Started taking medications
- Though motivational interviewing by CM decided to enroll in residential treatment program
- On graduation from residential program linked to long-term housing

Best Practices for Collaborating with Members of the Case Management Team
- Understand the role/ scope of practice of various members of the team – ask for clarification if needed!
- Maintain active communication and collaboration
- Support each other and avoid opportunities for client splitting
- Recognize differences in language and approach between different disciplines on the team

Successful Program Models: Homeless Focused – Chicago
- Post hospitalization transitional housing with linkage to long term housing
- Housing-based MSW led case management
- Randomized controlled trial

Outcomes:
- 24% decrease in hospital days
- 29% decrease in emergency department visit

**Case Continued**

While in residential housing, Mr W relapsed. He had a strong relationship with his case manager and asked for help. Case manager re-linked with residential treatment program. He continued to use self-management skills. He remained out of the ED and hospital despite relapse. Recently graduated from residential treatment, reconnected with his family, is doing well in the community.

**Summary**

High users of care tend to have high rates of poverty, chronic disease, mental illness, and addiction.

- Interdisciplinary teams provide perspectives from multiple professions and reduce barriers to adequate care at the system, provider, and patient level.
- There is no one-size-fits-all approach; each program must be tailored to the local population.

**Which of the following is a core component of all case management programs for high-risk patients?**

A. Track patients’ hemoglobin A1cs
B. Perform home visits
C. Formulate interdisciplinary care plans
D. Link to psychiatric care

**Thank you!**

Kathy O'Brien and the EDCM team
SFHN Complex Care Management team

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A primary, chronic disease of brain reward, motivation, memory, and related circuitry

In a large urban metropolis, HIV seroconversion rates were 4x higher in persons using heroin compared to persons taking this medication (Hint: effective dose 80-100 mg/d)
“PWID”
not
IVDA, PSA, addict, clean…
because in fighting stigma,
language matters

The diagnosis of 188 new HIV cases in Indiana from injecting oxymorphone helped lift the ban on federal funding for these prevention programs

Yawning, sweating, restless, anxious, irritable, runny nose piloerection, tachycardia, dilated pupils, joint & muscle aches, tremor, GI upset

The only three FDA-approved pharmacotherapies for treating alcohol use disorder (No brand names, please!)
52-year old woman with known COPD and DJD found down in her SRO hotel with this reversible toxidrome of apnea, stupor, miosis

What is opioid intoxication (overdose)?

A directive, client-centered counseling style for eliciting behavior change by helping persons to explore and resolve ambivalence

What is motivational interviewing?

“Legal problems” removed and “craving” added to this set of 11 diagnostic criteria when revised in 2013

What are the DSM-5 Criteria for Substance Use Disorder?

Buprenorphine can be initiated in a clinic or by well-prepared patients in this private setting

What is home?
The antidote to the most common cause of poisoning deaths may be furnished by CA pharmacists without a prescription.

An effective behavioral treatment for stimulant use disorder based on the principle: *If a behavior is reinforced or rewarded, then it’s more likely to occur in the future.*

No more than 3 standard drinks per day and 7 drinks per week.

FDA approved to treat both alcohol and opioid use disorder as a monthly injection (No brand names, please!)
Not recommended for this 63-yo man with HCV and opioid use disorder in long-term remission on methadone. He wants a pill to help him cut down on his drinking.

Compared to BZD, its off-label use for medically supervised EtOH withdrawal is associated with less craving, anxiety, and sedation BUT contraindicated in persons with h/o DTs or sz.

At least 2 opioid analgesics NOT routinely detected on urine drug “opiate screen” immunoassays.

Off-label use for treating co-occurring PTSD and alcohol use disorder by modulating glutamatergic and GABAergic neurotransmitter systems.
27 cities outside of the U.S. operate these facilities that reduce disease, death, public drug use, discarded syringes, and increase entry into drug treatment.