Greetings from UCSF Fresno Family Medicine!

Another successful recruitment season is behind us! Results are in! Twelve new residents, the next generation of Family Medicine Physicians at UCSF Fresno have been selected! 100% Match this year. Be sure to check this issue of the SCOPE for further info on the program’s newest Valley Family Docs.

Once again, UCSF Fresno is making waves at the national level. This year we had a tremendous showing at the Society of Teachers of Family Medicine Conference in Orlando, with eight posters accepted for presenta-

Our Third Year residents took the ABFM Certification Examination last month, and with this big hurdle behind them, we’re on the home stretch of the academic year and are looking forward to Graduation. Exam results were released recently and we had a 100% pass rate! Congratulations to everyone!

Our dedication to meet the health care needs of the community remains firm. We are starting our plans for the third iteration of our advocacy and leadership curriculum that concentrate preparing our third year resident physicians to assume leadership roles and participate in organized advocacy on behalf of patients targeting the health care issues of our community. In addition, UCSF Fresno Family Medicine was recognized for its great work in continuing to train graduates to meet the health care needs of California and the Central Valley by OSHPD, with grants awarded through the Song Brown commission for residency education and support for work aimed at meeting the exceptional needs of domestic abuse victims.

We are on FaceBook! Check it out online. UCSF Fresno Family & Community Medicine

We are making a concerted effort to develop an active alumni group that can meet at national meetings, stay in touch and keep involved in program events. Thank you for helping us better prepare residents for the real world of family medicine. Any suggestions? Let us know! Please e-mail Lois Ceja at lceja@fresno.ucsf.edu to update your contact information so we can keep you informed!
Congratulations to Mario Martinez and Shruti Joseph for receiving the Steven Thompson Loan Repayment Scholarship

“We are extremely thankful to have received the Steven Thompson Loan Repayment Scholarship this year which is an award for primary care physicians who provide health care for underserved populations such as ours in Fresno County. Having always been committed to providing healthcare in medically underserved areas, this award is critical in our sustainability to do so. As it’s no secret that physicians accrue a large amount of debt in pursuing our passions, this award helps us alleviate some of that burden. As we have both come from health professional shortage areas, we have seen the effects on our communities’ first-hand. Our roots have stemmed our desire to serve these communities, and having done our residency training at UCSF Fresno we are fully committed to serve and give back to our community. We again are grateful for this award and for the opportunity to continue serving the patients of the Central Valley.”

Sincerely,

Dr. Martinez and Dr. Joseph

Lydia Rodriguez, MD is new HPM Faculty

Lidia Rodriguez Carranza joined the faculty for the Hospice and Palliative Medicine fellowship in April 2015. She is board certified in Internal Medicine, Geriatrics and Hospice & Palliative Medicine. Before coming to Fresno Dr. Rodriguez-Carranza was Clinical Director of Geriatric Services at Golden Valley Health Centers. She also precepted University of the Pacific and UC Davis students. Dr. Rodriguez-Carranza did her residency training at Harrisburg Hospital in Pennsylvania and completed a one-year fellowship in Geriatrics at the University of Pittsburgh. Born and raised in Peru Dr. Rodriguez-Carranza is fluent in both Spanish and English. She enjoys outdoor activities: hiking, sightseeing, rafting and exercising. She also enjoys traveling and listening to music.

It’s a Boy!

Join us in welcoming the newest member of FAMILY MEDICINE faculty...

Owen Alexander Levil Born on April 24, 2015, he weighed 7 lbs. 4 oz.

Congratulations to Dr. and Mrs. Blodgett on the birth of their first grandson, Owen!
Is an IUD safe and/or feasible for a patient to self-remove without seeking medical attention?

Evidence-Based Answer
In regards to safety, there is expert opinion that self-removal has little health risk to a woman. In terms of feasibility, a singular study exists stating that while many women are interested in the concept of IUD self-removal, there is a 20% success rate of self-removal.


This study was an observational case-control study (published 2014) with a sample size of 326 women. The main objective of the study was to assess the proportion of women willing to attempt IUD self-removal and determine rates of successful IUD self-removal. Attitudes toward IUDs were assessed after participants became aware of and/or attempted self-removal.

Relevance: Patients selected were English and Spanish-speaking women ages 18 years and older presenting for IUD removal at five family planning clinics in the US (St. Louis, New York, San Francisco, Philadelphia, Salt Lake City). No exclusion criteria were noted. An initial survey collected sociodemographic data, satisfaction with current IUD, and reason for IUD removal. The patient was offered the option to attempt self-removal. A clinician removed the IUD for patients who were unable to self-remove or declined to self-remove. A second survey was administered to collect information regarding IUD removal experience or why patients declined self-removal. A clinician measured IUD strings and noted type of IUD.

Validity: This was not a randomized controlled trial. Questions about validity included no randomization of women who underwent clinician removal versus self-removal. There was no data capturing how long IUD strings were from the external cervical at time of removal. It was unclear that groups were similar in stages of menstrual cycle and cervical positioning which can affect ease of removal.

Findings: The study found that a majority of participants (59%) were willing to attempt IUD self-removal. Among those who attempted, one in five was successful and took an average of 3.6 minutes. Women whose IUD strings were 7cm or longer (total length) were more likely to be capable of removing IUD themselves. A significant number of women who attempted self-removal and succeeded reported less pain compared to women who were not successful and/or had a clinician attempt the removal.

Based on the study findings, self-removal of IUD created a more positive and popular attitude regarding this highly effective contraception method. More research needs to be done in terms of patient safety.

Anjani Kolahi, February 2015

Does inhaled corticosteroid use prevent COPD hospital admission?

Evidence-Based Answer: Yes, inhaled corticosteroids in combination with a long-acting beta-agonist reduced hospitalizations for COPD when used in combination with tiotropium.


This was a randomized, double blind, placebo-controlled trial from October 2003 to January 2006. 449 patients with moderate or severe COPD were included in the study. Primary outcome measured was COPD exacerbation. Secondary outcome included hospitalization.

Relevance: The patients enrolled in this study had moderate or severe COPD and came from 27 academic medical centers in Canada. Patients were 35 years of age or older, had at least 1 COPD exacerbation that required treatment with systemic steroids or antibiotics within 12 months, 10-pack year smoking history, FEV1/FVC less than 0.70 and post-bronchodilator FEV1 less than 65% of predicted.

Excluded were those with asthma diagnosed before 40 years old, CHF, receiving oral prednisone, or with sensitivity/intolerance to tiotropium, salmeterol, or fluticasone-salmeterol.

Primary outcome was the proportion in each group that experienced a COPD exacerbation within 52 weeks of randomization. Secondary outcomes measures included number of hospitalizations for COPD.

Validity: Groups were similar gender, age, had significant obstructive disease, and were smokers. Both the participants and investigators were blinded at time of randomization. The final analysis was conducted on an intention to treat basis. 74 patients dropped out of the tiotropium + placebo, 64 tiotropium + salmeterol groups, 37 dropped out of the tiotropium + fluticasone/salmeterol group and crossed over to open label ICS/LABA combination.

Findings: Patients treated with tiotropium + combination fluticasone-salmeterol had statistically significant fewer hospitalizations for COPD exacerbations compared to tiotropium + placebo. Incidence rate ratio was 0.53 (CI 0.33 – 0.86, p = 0.01).

Mario Espindola, February 2015
Does music therapy affect agitation in nursing home patients with dementia?

Evidence-Based Answer
Yes, individual music therapy can significantly decrease agitation disruptiveness in nursing home patients with dementia.


This was a two-armed, crossover, exploratory, randomized controlled study. There were 42 participants in this study recruited between Fall 2010 to Fall 2011. The main objective of the study was to examine the effect that music therapy had on agitation in nursing home residents with moderate to severe dementia. This study was published in 2013.

Relevance: The patients in this study all had moderate/severe dementia or Alzheimer’s disease and symptoms of agitation, who came from 14 different nursing home facilities in Europe (4 in Denmark and 10 in Norway). While their geographic location was different from my particular patient in question, their symptoms of agitation were alike. I choose this study because I have a nursing home patient who is chronically agitated, isolated and has very poor medication compliance. One day upon entering her room, I found her sitting in her room alone, in complete silence, staring at the wall. Her screening depression questionnaire was negative, therefore low risk. Providing my patient with biweekly music therapy, to listen to over a 6 week time is feasible.

Validity: This was a crossover study in which 42 patients were randomized to standard care or music therapy to start. Each participant participated in both the music intervention group as well as the standard care. Therefore, groups were identical at the start. The nursing homes contributed to the study by allowing time for proxy interviews, which were carried out by phone with a researcher who was blinded to the treatment. The proxy respondent rated the outcome measures. Patients were not blinded. All participants were accounted for at the end of the study.

Findings: P-values were from paired t-tests. There was an increase in agitation disruptiveness during standard care and a decrease during music therapy. This difference was statistically significant (p=0.027). In addition, there was a decrease in the quality of life during the standard care, whereas there was an increase during music therapy, however this difference was not statistically significant (p=0.439). Increases in psychiatric medications occurred more often in standard care compared to music therapy. The study showed that by 6 weeks of individualized music therapy, agitation disruptiveness scores in persons with dementia, was improved compared to standard care alone.

Rashell Reynoso-Garza, April 2015

Which is better for acute pulmonary embolism, LMWH or UFH?

Evidence-Based Answer
LMWH appears to be as effective and safe as IV unfractionated heparin for the initial treatment of nonmassive pulmonary embolism


Multicenter, randomized, unblinded trial, sample size of 612 patients, publication date 1997.

Objective: Comparison of Unfractionated Heparin (UFH) vs. Low Molecular Weight Heparin (LMWH) for initial treatment of pulmonary embolism

Relevance: Conducted at 57 centers in France, Belgium, and Switzerland. Inclusion criteria: 18 years or older with pulmonary embolism (PE) confirmed by pulmonary angiography or ventilation-perfusion lung scan. Exclusion criteria: Massive PE requiring thrombolytic therapy or pulmonary embolectomy; active bleeding or disorders contraindicating anticoagulant therapy; if they had received anticoagulant therapy at a therapeutic dose for more than 24 hours before entering the study (the receipt of such therapy for 24 hours or less before randomization was permitted); if life expectancy was less than three months; if they had severe hepatic or renal failure; if non-compliance was likely; or if they were pregnant. Outcomes measured: Primary end points: death, recurrent PE, or major bleeding.

Validity: Treatment question: 612 patients, 308 randomly assigned to UFH, and 304 to LMWH. Groups were similar at start; it was an intention to treat study, and groups were treated equally throughout the study. Potential Bias: Study was not blinded but consecutive patients were included, all suspected recurrences of PE had to be confirmed by objective tests, and an independent committee assessed all critical events. Power analysis was not done and the sample size may have been too small to support the findings.

Findings: This study concluded there was no statistical difference between the two treatments. Deaths at 90 days: 4.5% in UFH group and 3.9% in LMWH. 95% Confidence Interval: -2.6 to 3.8. Recurrent Embolism: 1.9% in UFH, and 1.6 % in LMWH. 95% Confidence Interval: -1.8 to 2.4. Major Bleeding: 2.6% in UFH, and 2.0% in LMWH. 95% Confidence Interval: -1.8 to 3.0.

Bobby Aulakh, April 2015
Which is more effective in treating myofascial pain trigger point injection with lidocaine, lidocaine with steroids, or dry needling?

Evidence-Based Answer
The use of lidocaine and lidocaine plus corticoid can be used successfully for myofascial pain and headaches.


This study was a randomized clinical trial to compare trigger point injections using lidocaine with corticoid or lidocaine alone, compared to dry-needling for the management of local pain and associated headaches. A sample size of 45 patients (40 females and 5 males), with myofascial pain and headaches, was involved in this study, published in 2008.

Relevance: The patients enrolled in this study were between the ages of 18 and 65 years old, with myofascial pain and moderate to severe headache, present for at least six months, and at least one uni- or bilateral trigger point in the orofacial (masseter, temporalis) or cervical region (occiput, trapezius) sensitive to palpation.

Exclusion criteria: Patients with arterial hypertension, diabetes, hypoglycemia, blood dyscrasias, tumors, lupus, fibromyalgia, rheumatoid arthritis, allergy to the solutions and use of anti-coagulants.

Outcome was based on (1) modified Symptom Severity Index (SSI), (2) palpation of the trigger point, (3) pain diary assessing daily pain, and (4) pain questionnaire recording alleviation time of local sensitivity at injection site and headache.

Validity: The study did not evaluate whether symptoms persisted after the injection or whether referred pain from the trigger points was no longer present. The study was limited to three injection points which may limit the reproduction of the orofacial area. The study groups were compared, there were no significant differences in any of the injected points at any of the times assessed. All groups studied showed a lessened need for drugs to alleviate their symptoms. The association between lidocaine and corticoid showed less post-injection discomfort with relief of local symptoms a few days after application. The study did not indicate if there were any side effects from getting the different solutions.

Ashlynn Gordon, April 2015

Are the use of antihistamines, such as Benadryl, safe in the pediatric population?

Evidence-Based Answer
This question has not been directly answered, however through these articles I can infer that Benadryl can be safely administered if given in proper doses and for a therapeutic intent.


The 2009 study was a retrospective review of deaths of children related to 8 active ingredients in cold medications. The 2006 study was a randomized, double-blind controlled study to see if infants slept better when given diphenhydramine.

Relevance: The patients enrolled in this study were between the ages of 18 and 65 years old, with myofascial pain and moderate to severe headache, present for at least six months, and at least one uni- or bilateral trigger point in the orofacial (masseter, temporalis) or cervical region (occiput, trapezius) sensitive to palpation.

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Jasmine Garcha, May 2015
What is the efficacy of varenicline compared with nicotine replacement therapy for smoking cessation?

Evidence-Based Answer

Varenicline in combination with nicotine replacement therapy (NRT) was more effective than varenicline alone for smoking cessation.


This study was a randomized, blinded, placebo-controlled clinical trial that was conducted in 7 centers in South Africa (published in 2014). The goal of this study was to assess the efficacy and safety of varenicline and a nicotine patch vs. varenicline by itself in smoking cessation.

Relevance: Participants were 18 to 75 years old who sought assistance in smoking cessation. Inclusion criteria included those who smoked >10 cigarettes/day with no period of abstinence >3 months in past year. The study used standardized testing including Fagerstrom Test for Nicotine Dependence, Nicotine Use Inventory (NUI), measurement of exhaled CO, and Wisconsin Scale for Withdrawal Symptoms. The intervention is feasible in our clinics but the race and spectrum of disease of the participants may not be applicable.

Validity: Groups were similar in age, gender, BMI, Fagerstrom score, and smoking history (yrs smoked, cigs/day, pack-ys, previous quit attempts). A placebo patch vs. nicotine patch was used and both investigators and participants were blinded. The study had close follow-up for up to a total of 6 months. All 446 participants were included in the ITT analysis. Participants who discontinued the study or were lost to follow-up were considered smokers and those who missed a visit were considered to be smokers at that point. Descriptive statistics and X2 or Fisher exact tests as well as t-tests were used in per-protocol and intention-to-treat analyses.

Findings: Those who received nicotine patch and varenicline were more likely to have continuous abstinence at 12 wks (55.4% vs 40.9%, p = 0.007) and 24 wks (49.0% vs 32.6%, p = 0.004) and point prevalence abstinence at 24 wks (65.1% vs 46.7%, p = 0.002) than those who received placebo patch and varenicline. The NNT to achieve 1 more successful attempt at smoking cessation was 7 (95% CI, 5-20) at 12wks and 7 (95% CI, 4-14) at 24wks. Based on ITT analysis of the primary end point, continuous abstinence at 12 wks was 44.6% (95% CI, 38.0-51.4%) for nicotine patch vs. 31.3% (95% CI, 25.3-37.8%) for placebo patch group; OR 1.77 and p = 0.004.

Rashell Reynoso-Garza, April 2015
**Assessing competency with interpreters. Six years of experience using the OSCE**

Ivan Gomez, MD, Susan Hughes, MS, and Judy Ikawa, MS

Purpose: The correct use of interpreters is a vital skill in the provision of culturally competent care. It can be a challenge to teach and assess this skill in residency. We evaluated resident performance using objective structured clinical exercises (OSCE) in psychosocial scenarios with and without an interpreter over three years of residency training.

Methods: In 2009, an educational series including cultural decision making and interpreter use was added to a new cultural competency curriculum. An objective structured clinical exercise (OSCE) was organized once a year during residency. Residents completed two standardized patient cases including one that required the use of an interpreter. Cases covered various challenging psychosocial issues (i.e., domestic violence, unwanted pregnancy, HIV disclosure, among others) focusing on interview skills. Faculty observers assessed resident performance using case-specific measures based on ACGME core competencies. Measures were evaluated using a scale of 1 to 5 (1=not done; 5=outstanding). For interpreter cases, faculty also assessed appropriate interpreter use.

Results: Twenty residents had three complete years of data. Twenty-three of 77 interns noted limited or no experience with interpreters prior to the exercise. Competencies in interpreter cases averaged 3.46, 3.61, and 3.75 over the duration of residency training. Competencies in non-interpreter cases averaged 3.28, 3.58, and 3.51, and appropriate interpreter use averaged 3.63, 3.83, and 3.78.

Conclusion: Over the course of training, competency scores in interpreter and non-interpreter cases improved during the first year as well as interpreter use scores. Non-interpreter competency and interpreter use leveled off in the third year, possibly indicating that the appropriate skill set was acquired during the first year of training. Competency in interpreter cases however, continued to increase during the third year, which could suggest skills continue to improve with ongoing experience with this population. The residency program will consider re-structured the evaluation of competencies addressed by this curriculum in the context of the Family Medicine Milestones in future evaluations.
Training residents to be teachers using objective structured teaching exercises (OSTE)

Ivan Gomez, MD, Alex Sherriffs, MD, Judy Ikawa, MS, and Susan Hughes, MS

**Purpose:** A curriculum was designed to help senior residents improve teaching skills using objective structured teaching exercises (OSTE).

**Methods:** Two OSTE scenarios were developed to address problem learners and difficult teaching. Thirty-three residents participated as both a teacher and a peer observer. Residents received individual immediate feedback and group debriefing. Later, relevant video excerpts were reviewed during small group reflection sessions using a faculty facilitator. Resident scores and feedback were collected to assess the success of the program.

**Results:** Observations scored 1-5 on 18 teaching skill measures. To date, residents scored an average of 4.5/5 from standardized learners, and 4.6/5 from peer observers. Resident feedback following the experience was positive.

**Conclusions:** This curriculum was a useful mechanism to improve teaching skills in a safe environment.

Perceptions of health care providers in LGBT and non-LGBT patient populations

Benjamin Huang, Arthur Chyan, Scott Reichelderfer, Liana Milanes, Ivan Gomez, Judy Ikawa, Susan Hughes

**Purpose:** Health care disparities among lesbian, gay, bisexual, and transgender (LGBT) patients exist due to a number of factors ranging from provider training and exposure to the effects of social stigma. Literature demonstrates that health care providers often feel they are impartial and give each patient the same level of care, though evidence shows otherwise. We are surveying LGBT and non-LGBT patients regarding perceptions of their primary care providers. These perceptions will help determine patient-physician comfort level, including sharing sexual orientation and sexual history with their primary care physician.

**Methods:** This is a cross-sectional study using an anonymous online health care survey. Flyers with links to the survey are being posted at health clinics and LGBT and non-LGBT support group sites. Adult participants access the English- or Spanish-language survey and rate how comfortable they feel sharing their sexual background with their primary care physician. The data is being collected from November 2014 through March 2015 and will be analyzed to compare LGBT to non-LGBT responses using a chi-squared test.

**Results:** After 6 weeks, a total of 56 respondents have participated in the survey. About 94% of the respondents were 18-34 years old, residing mostly in California (29%) or New York (32%). The largest ethnicity to respond was white (79%), primarily male (86%), and identified their sexual orientation as gay, lesbian, or bisexual (70%). A majority of respondents had private insurance (84%), while 9% had no insurance. Most people felt comfortable to very comfortable sharing sexual history (70%), rated sexual orientation as not affecting the quality of medical treatment received (78%), and their doctor's attitude toward sexual orientation as important to very important (60%). Currently, 71% of respondents have a primary care doctor and 21% previously had a primary care doctor. Of these respondents, 87% are satisfied or very satisfied with their doctor. No comparisons between groups have been made yet.

**Conclusions:** The young urban adults who have participated appear to be comfortable discussing sexual health with their primary care doctors, but more responses are needed to ensure that survey results reflect the LGBT and non-LGBT patient populations. The research findings will allow us to better understand what sexual health care differences there may be between the LGBT and non-LGBT communities.
Resident Learning in Family Planning Health Policy

Anjani Kolahi, MD; Susan Hughes, MS; Ivan Gomez, MD

Purpose: A family planning curriculum in residency has a role beyond medical and technical skill training; it can provide residents insight into how reproductive health policy impacts health care, even without formal policy instruction. Our study will examine if introducing a family planning curriculum focused on medical training will also increase residents' knowledge and attitudes toward family planning health policy.

Methods: This 2-year study uses a pretest/posttest to assess UCSF Fresno Family Medicine PGY2 and 3 resident knowledge and attitudes regarding family planning policy at the start and end of the academic year. The intervention is a new family planning curriculum that includes medical training using didactics, workshops, and clinical work at a family planning clinic. Learning methods include a lecture series, readings, clinical experiences, and reflective discussions. The pretest/posttest measures include 15 multiple choice or true/false knowledge questions and four attitude assessments on a continuous 10-centimeter scale (disagree to agree). Main outcomes will identify changes in resident health policy knowledge and attitudes, as well as the most effective learning method. Outcomes will be analyzed with paired t-tests. Proportions with 95% confidence intervals will be used to determine methods residents felt were effective in learning reproductive health policy.

Results: Initial results reflect resident knowledge prior to the introduction of the family planning curriculum. Residents averaged 8.4 correct responses on the knowledge-based questions. Fifty percent of residents were able to correctly identify the percentage of unintended pregnancies in the United States, 27% could identify patient demographics for the majority of women seeking abortion, and 32% knew if CA law mandates a waiting period. Residents’ interest in learning about abortion policy averaged 8.85, and the level of importance for their residency program to include training in reproductive health policy averaged 9.06.

Conclusions: Preliminary data shows residents are unfamiliar with family planning health policy and express a strong interest in training in this field. If adding a medical curriculum in family planning results in a better understanding of reproductive health policy, future clinicians and their patients stand to benefit.

Does a Medroxyprogesterone Injection 24 to 72 Hours Postpartum Affect Breast-Feeding?

Mary McLain; Christina X. Chavez-Johnson, MD; Ivan Gomez, MD; Susan Hughes, MS; Liana Milanes; George Neves, MD

Purpose: There is a theoretical risk of decreased milk production in women who receive medroxyprogesterone injections postpartum. Our objective was to investigate if getting a medroxyprogesterone injection 24 to 72 hours after delivery to prevent pregnancy impacted breast-feeding.

Methods: This was a prospective study of postpartum women planning to breast-feed in one large urban hospital in California’s Central Valley. Participants were asked a few questions prior to hospital discharge, then asked about breast-feeding status at 4, 8, and 12 weeks postpartum. If a woman stopped breast-feeding, her participation ended. After all follow-up information was collected, the women’s charts were reviewed to determine medroxyprogesterone status. Chi-squared analysis was done.

Results: There were 186 participants. We were unable to reach 16% of participants for any follow-up; 2% withdrew from the study. Complete data were obtained for 62% of participants. A total of 168 charts (92%) have been reviewed for medroxyprogesterone status. Of those reviewed, 11.3% received the injection, and 88.7% did not. Of note: 13 of the 168 had medroxyprogesterone ordered but never received it. The rate of mothers still breast-feeding at 12 weeks postpartum was 15.8% if they received the injection and 22.8% if they did not receive the injection. This is a non-significant difference, P=.486. The overall study rate for mothers’ breast-feeding at 12 weeks was 24.7%.

Conclusions: Overall breast-feeding rates at 12 weeks were below the national average of 37.7%. Self-reported rates of breast-feeding at 12 weeks in a largely underserved population from California’s Central Valley exhibited a nonsignificant difference between those that received and those who did not receive medroxyprogesterone 24 to 72 hours postpartum.
Impact of Nutrition and Physical Activity Interventions on Knowledge and Growth in Sixth Grade Students*

Nitika Narinder Dhir, MD; Ji Young Park, MD; Arlin Marie Venturina, MD; Judy Ikawa, MS

Purpose: The Centers for Disease Control (CDC) reported that in the last 30 years, obesity had more than doubled in children and tripled in adolescents. The objective of this study was to investigate the impact of educational interventions on reported eating habits, physical activity, and growth in children.

Methods: The study took place in one sixth grade classroom at Yokomi Elementary School in Fresno, CA. A prospective study over the school year included three interventions performed at 4-month intervals. The interventions involved a 20-minute lecture on nutrition and physical activity, followed by 40 minutes of fun exercises. A pretest was given to each student to assess baseline knowledge and behavior before the first instructional session. Each student’s height and weight were measured to determine body mass index (BMI). Post-knowledge assessment and BMI measurements were done at later sessions.

Results: Of the 31 students that were part of the initial session, 27 students were present during the final session. There were more male (59%) than female students. At baseline, 48% of the students were considered to have a healthy BMI based on current CDC age charts; the number increased to 56% (P=.68). The pretest nutrition knowledge score was 13% and increased to 35% at follow-up (P=.13). Baseline exercise knowledge was 47% and increased to 83% (P=.01). Within the last 24 hours, 26% of the students met the recommended daily allowance for healthy foods, and there was a 44% decrease in reported consumption of unhealthy foods.

Conclusion: The educational intervention significantly increased students’ knowledge about exercise and showed a nonsignificant increase in healthy BMI. Getting students excited about learning how to be healthy can help motivate and engage students in eating healthy and modifying undesirable behavior.

*Also presented May 28, 2015 at the UCSF FCM Colloquium

Building wellness from the inside out

Melanie Southard; Liana Milanes; Ivan Gomez, MD; Betty Jarman, PhD

Recent studies have suggested that burnout in medicine begins to occur as early as the third year of medical school. Family physicians in particular are vulnerable to burnout as they are often practicing in settings with limited resources and increasing patient volumes. In our program we have a once a month resident support group in which all three classes come together. We decided to utilize some of this time to teach residents mindfulness and engage them in activities that promoted well being.
Impact of pain management consults on hospital teams at Community Regional Medical Center

Project Participants:

James Simmons  HPM Fellow 2014-15, UCSF Fresno
Tegest Hailu  HPM Fellow 2014-15, UCSF Fresno
Sue Yie  HPM Program Director, UCSF Fresno
Christine Swift  Palliative Care Manager CRMC
Susan Hughes  Research director, UCSF Fresno

Background/Objective: Pain has been described as the 5th vital sign. The palliative care team is often consulted to provide pain management for patients with terminal diagnoses. At our institution there is a perception that the teaching hospitalist teams take longer to request consults and implement recommendations after consultation compared to the private hospitalist teams. Our objective was to see if there are actually any differences when palliative care consultation are done.

Methods: A retrospective chart review of patients receiving a palliative care consult at Community Regional Medical Center from April 15, 2014 to August 31, 2014 was done. Data collected included: demographics, socioeconomic information, pain scores, days in hospital before pain consultation, and length of stay. Pain scores were averaged over four 24 hour time periods: at admission, 24 hours before consult, 24-48 hours after consult, and at discharge. Comparisons between the academic and non-academic groups to evaluate time to initial pain consult and length of stay were done using nonparametric Wilcoxon rank sum tests. Changes in pain scores were compared using t-tests.

Results/Analysis: 320 medical records were reviewed, resulting in 65 patients with pain management issues. 39 patients were on the academic service; private service. There were no significant differences found in length of stay, time to consult, or. There is a statistically significant different in pain management when the palliative team is involved.

Conclusions/Interpretations: No differences were found between academic and private hospital teams in pain control. However, we did find that pain control improved after palliative care specialists were involved.
On May 2, 2015 the residents enjoyed a beautiful afternoon at Kearney Park for the first Annual Spring Picnic. Bubbles and a bounce house (a boxing ring – how appropriate for a picnic on the day of the boxing match) were part of the fun. The BBQ’d meat, chicken and corn cooked by Sebouh, Adrian and Jose was superb and there was plenty of other food and drink to enjoy. It was a great day of camaraderie.
The academic year is quickly coming to an end. To some of us it couldn't come any faster. How many more weeks Mel? Boards have been taken and if I am not mistaken we all have jobs lined up after residency. Let's give Ji, Rachel, Derik, Anjani, Erica, and Jasmine fist bumps, high fives, gold stars, and pats on the back for staying in the Valley. Nitika is headed to Miami, Mel is going back to the North Bay, David to SoCal, and Ida and I to Mendocino County. Sadly for Anjani and I this is our last newsletter for the academic year as your chiefs. For Vanessa I am sure she will be glad it's our last ...just kidding, wink, wink. I want to thank you all for making my job very easy. It was a pleasure serving as your chief and I will miss you all as we move on to the next phase in our lives. I have made some lifelong friends here and I could not have asked for a better crew of residents to work alongside with. I want you to know that I care deeply about every one of you and I wish you the very best as you begin life as attending physicians, senior residents, and moving on from intern year. I also want to thank our UCSF/Fresno FCM office staff for all of their help. Without their assistance this ship would have sunk a long time ago!

—Mario Espindola

Mario has already written a brilliant blurb, please see his section and know I echo his sentiments. It has been a pleasure and an honor serving as your chief. Thank you all around for making this job so rewarding.

For my blurb piece, I'm torn because I want to save some thoughts for graduation. I figure I won't be able to get into too much trouble then since Dr. Hoang will also be speaking. ;) But for the first and second year class who might not be able to join us for the festivities, I will pass on a few words that helped me through residency. I can't cite the author, it's debatable, but I think it's important to remember that "decisions are made by those who show up." I found large undergrad and med school classes to be big and impersonal, but I think one of the beauties of our department is that it has the words family and community built into its title. This is the place to learn how to show up. Residency is very busy, but if you can manage to just peak your head in once in a while from the whirlwind of clinical life, I think each resident can leave their mark on this program. It was inspiring to see Dr. Dhir as an intern be trained as a lactation specialist, to see Dr. Chavez champion for an OB fellowship, to see Dr. Southard complete a longitudinal fellowship focusing on leadership and wellness, to record high numbers of research posters accepted into well-respected conferences such as STFM. I think the key is to show up. Go to the Peds meetings, go to CAFP events, go to resident council meetings, think about what you want and need to get out of your three years of time here. I think that self-reflection will make the block schedules much more exciting. Then you can start a countdown on your phone for how long you've got to soak it all up.

"It is a mistake to think you can solve any major problems just with potatoes." – Douglas Adams, Hitchhiker's Guide to the Galaxy.

Those are my (preachy) pearls to share. Something that worked for me.

Best of luck to my colleagues in their future endeavors. I feel very lucky to have been a part of such a great class.

—Anjani Kolahi
Message from the new 2015-2016 Family Medicine Chief Residents

Hola!

Thank you to all those who came out to our First Annual Spring Picnic. We hope the tradition of bubbles and bouncing will be carried forth for a long time. It was refreshing to be able to spend some time with the third years. It seems you were all taken hostage by the board exam. We are glad you survived! As the year slowly draws to a close, we urge (all in support group, in an email to the chiefs, anonymously in our mailboxes or the suggestion box) of you to reflect on what you felt worked and what didn’t and ask that you speak up.

For our PGY1s, don’t panic, we got your back. PGY2s it is time to step up and model the way as seniors. PGY3s: Please don’t leave us! We mean, thank you for being such great role models and raising the bar for Family Medicine.

Be kind and laugh together,

—Drs. Liana Milanes and Satjit Sanghera

Incoming Residents: Welcome the Family Medicine Class of 2018!

Gangandeep Aulakh, DO
Touro University

Nicole Constanz, MD
Georgetown University

Raj Dhah, DO
A.T. Still University in Arizona

Jenny Du, DO
Touro University

Ahn Le, MD
St. George’s University

Todd Macauley, DO
Lake Erie College of Osteopathic Medicine

Assad Malik, MD
Ross University

Theresa Day, MD
University of Arizona

Madeline Nguyen, DO
Touro University

Ebimoboere (Ebi) Okoro, MD
American University of the Caribbean

Laura Pierce, DO
Touro University

Nevkeet Toor, MD
Saba University, SOM
Our very talented Class of 2015 welcomed everyone to their party on Saturday evening, showing off their synchronized rhythmic dance moves to the beat of Bruno Mars “Uptown Funk!” The heat did not dissuade anyone from enjoying the celebration. Congratulations to Dr. Melanie Southard on receiving the Behavioral Science Award as well as the Resident Teacher of the Year. Dr. Southard was also the recipient of this year’s UCSF Fresno Leon S. Peters Award. This year the STFM Teacher of the Year went to our “funny guy”, Dr. David Hoang. Departing Chief, Dr. Anjani Kolahi was recognized for going above and beyond and adding an “Area of Concentration in Family Planning” to her residency education. Dr. Kolahi was also this year’s recipient of the Davin Youngclarke Scholarly award for her scholarly project. “Outstanding Resident of the Year” was awarded to our quiet, but dedicated social advocate for the underserved, and co-chief, Dr. Mario Espindola. This year’s graduates went out with a laudatory bang, proudly achieving 100% pass rate on their ABFM Board Exam! Way to go Class of 2015! This spunky team will be missed!
SAVE THE DATE

- FCM Objective Structured Clinical Exercise, July 9, 2015
- Resident Retreat, October 17 & 18, 2015, Wonder Valley, CA
- FCM Resident Objective Structured Teaching Exercise, November 12 and 19, 2015