Caring for an Aging Population

Innovations in Geriatrics

About 10,000 Baby Boomers turn 65 every day, and the number of seniors is expected to top 70 million by 2030. To help meet the needs of an aging population, the UCSF Division of Geriatrics is pioneering ways to provide better care to older adults, discover better therapies, and educate the next generation of medical professionals, caregivers and community members.

“We are passionate about caring for older persons across the full spectrum of aging, and are proud to lead improvements in clinical care and public policy that enhance quality of life for older adults – ranging from the healthiest to the frailest seniors and their caregivers,” says Louise C. Walter, MD, chief of the Division of Geriatrics.

Managing the Continuum of Care Takes a Team

One of geriatricians’ most powerful tools for providing coordinated care in a fragmented health system is a team approach that integrates the complementary expertise of nurses, physical therapists, nutritionists, social workers and many others.

“What we’ve learned in geriatrics is that often a problem is not a result of one issue, but five or six,” says Christine Ritchie, MD, MSPH, the Harris Fishbon Distinguished Professor in Clinical Translational Research and Aging and director...
Pioneering Models of Better Care

We are on the cusp of huge changes in health care in the United States: implementation of the Affordable Care Act is underway, the fragmented, crisis-based approach to medical care is financially unsustainable, and our country’s population is rapidly aging.

Our current health care delivery system is woefully underprepared to address the complex needs of our elders. Yet the UCSF Department of Medicine is developing many creative models to successfully care for this growing population. As the cover story describes, our exceptional faculty in the Division of Geriatrics are developing programs, discovering knowledge and educating the next generation to provide seamless care for frail older adults. We also profile one of our outstanding alumni, Erwin Tan, MD, who is applying his geriatrics expertise to promote volunteerism among seniors on a national level.

UCSF is also at the forefront of palliative care – promoting the highest quality of life for all patients facing serious illness. As articles in this newsletter illustrate, we are bringing these invaluable services to a wider group of patients, and are teaching the communication skills that enable trainees to compassionately and effectively discuss a patient’s symptoms, fears and hopes.

Both palliative care and geriatrics employ a team approach and focus on the whole patient – a powerful contrast to much of today’s medical care, which too often treats each organ and disease in isolation. By talking with patients about what is most important to them and providing the right help at the right time, these teams can align care with each patient’s goals and values. This tailored approach optimizes patient health, can prevent unnecessary hospitalizations, and delivers better care at lower cost – a vital combination that addresses some of the key challenges we face today.

This newsletter also highlights innovations in quality and safety, as well as nephrologist Stephen Tomlanovich, MD, who has greatly improved outcomes and access to kidney transplantation at UCSF over the past three decades.

As several stories in this issue demonstrate, philanthropy is essential to all our endeavors. It provides the seed money that allows us to test out, evaluate and refine new ideas. It also allows us to move the national conversation forward by disseminating successful approaches and bringing them to scale. Private gifts catalyze sustainable change by providing startup funds that go on to leverage funds from the National Institutes of Health and many other sources. We are tremendously grateful for your support, and look forward to continuing our partnership with you.

Sincerely,

Talmadge E. King, Jr., MD
Chair, Department of Medicine
Julius R. Krevans Distinguished Professorship in Internal Medicine
**Mobilizing Senior Volunteers**

When you are working with frail, older adults, you gain an understanding of the law of unintended consequences,” says geriatrician Erwin Tan, MD. He directs Senior Corps, part of the federal Corporation for National and Community Service, which connects volunteers age 55 and older with service opportunities. “If you add a new medication, you have to look for new drug interactions. Now as a policymaker, I have to be aware that any time I create a new policy or regulation, there can also be unintended consequences.”

Tan (pronounced “Tawn”) completed his primary care internal medicine residency at San Francisco General Hospital (SFGH), then trained at the San Francisco Veterans Affairs Medical Center as a geriatrician and VA National Quality Scholars Fellow. He served on the SFGH faculty for two years before becoming a White House Fellow, then joined the Johns Hopkins faculty. He was a co-investigator of the Baltimore Experience Corps Study, a randomized controlled trial of the health benefits of participation in a volunteer program that places adults 60 and older in Baltimore City public schools as AmeriCorps members.

During residency, Tan was impressed by geriatrics’ team approach to the whole patient. He remembers observing a team meeting during his first day of training at On Lok, a community organization serving seniors. “The bus driver’s supervisor said, ‘Ms. So-and-So was a little slow on the steps the other day,’” he recalls. “The nurse said, ‘Bring her on in.’ It was remarkable that everyone’s opinion counted at the table – including the bus driver’s.”

Tan’s training at UCSF helped him learn how to evaluate diagnostic tests, facilitate difficult conversations with patients and their families, and use national data sets like the Health and Retirement Study as a comparison group when conducting research about seniors. During fellowship training, he also joined the board of Conard House, an organization serving people with mental illness. “It was extremely valuable to understand the needs, restrictions and stakeholders of a community nonprofit,” he says. “They have a tremendous amount of agility and community trust, but are often run on a shoestring budget.”

### Seniors as a Resource

Tan now applies his expertise as a geriatrician to his role as a federal grantmaker. Senior Corps has several programs connecting seniors with service opportunities ranging from tutoring children to assisting with national disaster recovery efforts. Senior Corps’ programs have about $200 million in federal investment, with some 1,200 Senior Corps grantees nationwide.

As some of Tan’s own research has suggested, volunteers often experience benefits themselves. “Sometimes school chairs are a little low, so seniors have to practice getting up from them, which strengthens their quadriceps,” says Tan. “If you stumble, the quadriceps can prevent you from landing with a high impact. Mental activity may be helpful as well – and trying to teach a child to read is an all-consuming cognitive experience. Most importantly, there is evidence to suggest that social isolation as a chronic condition is an independent risk factor for death and poor health outcomes. But if you promise a child that you are going to be there, you are more likely to get up off the couch and go to school.”

“Erwin has done amazing things,” says Kenneth Covinsky, Edmund G. Brown, Sr. Distinguished Professor in Geriatrics. “He’s done a lot of traditional research, but is also leading this incredible national public service program. We often think of volunteering as a one-way street, but Erwin has been really innovative in evaluating how it can also help the volunteer – because social engagement is really important as you get older. We’re really excited and proud of his work.”

Under Tan’s leadership, Senior Corps also instituted the first-ever competitive grant renewals for one of its programs, and created performance measures across the board. “As a physician, you learn the importance of data that you can trust,” says Tan. “By 2030, one out of every five Americans will be age 65 or older, and I want Senior Corps to be an evidence-based program that is well-run and ready for expansion when the need arises.”

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“By 2030, one out of every five Americans will be age 65 or older, and I want Senior Corps to be an evidence-based program that is well-run and ready for expansion when the need arises. The Boomer generation represents the best-educated, wealthiest population to cross over that traditional age of retirement. You’re talking about an immense amount of human capital that has the potential to be mobilized into community impact through national service.”
Caring for an Aging Population

Innovations in Geriatrics

Continued from front page

of the UCSF Program for the Aging Century (please see story on the back page). “When you address these multiple issues all at the same time, you’re much more likely to improve someone’s outcome than if you only address one. With a patient who falls, if you adjust their medications, engage them in strengthening exercises from a physical therapist and address home safety issues, that’s going to be much more effective than if one person says, ‘Do X.’”

While the challenges are immense, this is a time of unprecedented opportunity. Many groundbreaking geriatrics programs started at the San Francisco Veterans Affairs Medical Center (SFVAMC), which has been closely affiliated with the UCSF School of Medicine for more than 35 years. Because the SFVAMC is responsible for patients whether they are hospitalized, in a nursing home or living at home, it has developed many programs to keep them as healthy as possible across every care setting.

Similarly, under health care reform, the country is moving to more integrated models of care, and the Centers for Medicare and Medicaid Services is beginning to hold institutions financially accountable for patients’ outcomes.

As organizations become responsible for the continuum of care, geriatrics can serve as a national model for how to best provide this care,” says Ritchie. For example, UCSF is piloting programs that send a team of doctors, nurses and other health care professionals to the frailest patients’ homes, providing care before conditions become urgent. “Our analysis shows that hospitalization rates decline substantially when patients are enrolled in our Housecalls program, generating substantial cost savings and providing better care,” says Ritchie. “Patients are happier, they actually do better, and they need less of some of the things that are the most costly. It’s the right care at the right place, at the right time.”

The UCSF Division of Geriatrics and the Program for the Aging Century are developing many novel pilots to improve patient care, increase the evidence in support of the care provided and better educate health care providers to care for our aging society.

Clinical Innovation: ‘50% Medical, 50% Everything Else’

“I often tell our trainees that geriatric care is 50 percent medical and 50 percent everything else,” says Helen Kao, MD, medical director of UCSF Geriatrics Clinical Programs. Those other factors can include family support, mental health and socio-economic status. “A medicine-predominant practice will only get you so far,” she says. “Having strong relationships with the community is a direction for the future.” Some of these partnerships include:

UCSF Center for Geriatric Care: In 2013, the UCSF Lakeside Senior Medical Center relocated to the new Institute on Aging (IOA) facility in the Richmond District of San Francisco, renaming it the Center for Geriatric Care. “We were very excited about combining the best of geriatric medicine at UCSF with the Institute on Aging’s incredibly strong reputation in community-based social services,” says Kao.

She and two other physicians provide primary care to elders; the facility’s shared location with IOA makes it easier to connect patients with an array of support services. For example, Kao treated an elderly couple with dementia that was socially isolated. “They could literally walk around the corner from the clinic and down the hall to look at the adult day health center and meet the staff,” says Kao. In addition to UCSF’s own onsite geriatric nurse practitioner and social worker, she connects patients with IOA’s mental health professionals and case managers, as well as services like the Friendship Line, a telephone-based crisis intervention center that also provides medication reminders and check-in calls.

“Places like Google have people in communal settings where they can share ideas,” says Kao. “Frankly, the same thing has to happen in..."
Many seniors, To provide extra Kao and her HOUSECALLS hospitalization rate. The program is funded almost entirely through philanthropic support, and many patients remain on the waitlist.

patients and their caregivers about how to manage health conditions. UCSF Housecall patients have one-third the average Medicare program. On a typical day, Kao checks patients’ blood pressure, performs physical exams, adjusts medications and talks with Helen Kao, MD (above), and a team of colleagues provide care to 160 homebound older adults through the UCSF Housecalls program. UC Hastings faculty that brings law students into the clinic and on home visits. Trainees learn about medical and legal issues facing elders, and provide legal service. “There is a medical definition of cognitive impairment, and then there’s a legal definition,” says Kao. “That is eye-opening for law students.” With training, law students then help patients draft legal documents.

Kao hopes to expand the program to other learners from UCSF’s health professions schools. “There are so many legal determinants of health that medical trainees often don’t think about when they’re seeing the patient in clinic,” she says. “We have one of the few medical-legal partnerships for seniors in the country, and hopefully it’s something we can grow.”

UCSF UC Hastings Medical Legal Partnership for Seniors: Many seniors need help drafting an advance care directive or a will, but can’t afford to hire an attorney. Kao and Carolyn Welty, MD, co-founded a program in 2011 with UC Hastings faculty to bring law students into the clinic and on home visits. Trainees learn about medical and legal issues facing elders, and provide legal service. “There is a medical definition of cognitive impairment, and then there’s a legal definition,” says Kao. “That is eye-opening for law students.” With training, law students then help patients draft legal documents.

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UC Care at Home: Kao and her team run several programs for homebound older adults. “We go to great lengths to keep patients safe and provide all of their care in the home,” says Kao. “We ultimately want all our clinical programs to be a seamless panel of services that help patients wherever they land.”

The UCSF Housecalls program recently expanded from 100 to 160 patients, although many more remain on the waitlist. Many patients cannot walk or even get out of bed; others are housebound due to psychiatric or cognitive impairment. Kao and her colleagues Rebecca Conant, MD, Josette Rivera, MD, Carla Perissinotto, MD, MHS and Courtney Gordon, DNP, perform physical exams, adjust medications, draw blood for labs, and manage acute and chronic illness. “Our Housecall patients have one-third the average Medicare hospitalization rate,” says Kao. “That is remarkable, if you think about their level of frailty.” The need for these services far exceeds current capacity.

Geriatricians often function as detectives, interpreting nonverbal clues to address underlying problems. “Many patients with dementia can’t tell us that this hurts, or that itches,” says Kao. “The immense advantage of seeing a patient in their home environment is witnessing what is happening.”

For example, a patient who throws his food may have difficulty chewing; meals that are easier to eat could resolve the issue. A patient who yells may be less agitated if people approach her from the front rather than from behind. “Oftentimes, the reflex is to give antipsychotics or calming medications,” says Kao. “We try very hard to identify what might be triggering a patient’s behavior, and come up with creative solutions to keep patients calmer and safer.”

Bridges, a geriatric transitional care program which was piloted with heart failure patients, now supports other complex patients through home visits designed to prevent unnecessary hospitalizations and maximize quality of life. Under the leadership of Brook Calton, MD, the Division of Geriatrics is also building a home-based palliative care service within Bridges to support seriously ill patients who are too sick to come to clinic, yet need symptom management and psychosocial support.

The Division of Geriatrics is partnering with many others to pilot the UCSF Care Support Program, bringing together a team of nurse practitioners, social workers, a psychologist, geriatrician and pharmacist to provide intensive case management in patients’ homes for those struggling to manage chronic illness. “There is a lot of face time, phone time, care coordination, and interaction with primary care doctors, specialists and patients,” says Kao.

“These are time- and labor-intensive types of care,” says Kao. “But for a subset of patients who are chronically ill, or so frail that sending them to the clinic requires a whole army of people, we may be able to provide better and more cost-efficient care – and make the patient and family happier. We hope to expand what we are able to offer.”

GeriConsults: To provide extra support for the many older patients at San Francisco General Hospital (SFGH), Edgar Pierluissi, MD, and geriatrics fellow Anna Chodos, MD, established a computer-based consultation service allowing primary care physicians to receive guidance from geriatricians. For more complex issues, SFGH recently established a geriatrics clinic open on Saturdays.
Brie Williams, MD, MS (above), with colleagues from the NorCal Geriatrics Education Center, has developed and delivered targeted geriatrics trainings for diverse professionals working in the criminal justice system, including jail health and social services providers, lawyers, probation professionals, and law enforcement. Here, she and her team guide a group of San Francisco Police Officers in hands-on learning activities that simulate common age-related changes in vision, hearing, and function while participants perform basic daily activities like sorting medications, buttoning shirts, and walking with a cane.

In 2013, UCSF became one of only 13 sites nationally to be designated as a Claude D. Pepper Older American Independence Center, funded by the National Institute on Aging. Directed by Covinsky, the Center supports research about preventing and managing disability in older people, particularly those who are medically or socially vulnerable, and bolsters the Division’s already robust research program.

A few examples of the Division’s research projects include:

**Advance care planning:** Rebecca Sudore, MD, created a website (prepareforyourcare.org) that walks users through the process of creating advance care directives using clear, simple language and videos with trained actors.

**Diabetic seniors:** Sei Lee, MD, MAS, has shown that a “less is more” approach is effective for elders with diabetes and multiple other conditions. Rather than focusing on perfect blood sugar control, such patients benefit more from a combination of reasonable control and increased focus on quality of life.

**Seniors and law enforcement:** Brie Williams, MD, studies the intersection of geriatrics and the legal system. She is developing methods to screen for functional and cognitive problems in prison inmates, and training police officers and 911 dispatchers to identify age-related conditions, such as dementia and hearing loss, which can affect older adults’ safety.

“Geriatricians can’t do it all alone,” says Covinsky. “We also have a big interest in supporting people in other disciplines who are improving care and outcomes of older people.”

A few examples include:

**Surgical outcomes:** Colorectal surgeon Emily Finlayson, MD, MS, is investigating how to improve surgical outcomes among frail elders.

**Quality of life:** Alexander Smith, MD, MPH, has shown that good quality of life is possible in older subjects, even with severe disability that requires caregiving assistance. Respecting elders’ dignity and helping them maintain social connections are crucial.

**Preventing rehospitalizations:** Hospitalist Ryan Greysen, MD, found that functional and cognitive impairment and social vulnerabilities contribute to rehospitalization of discharged seniors. He is developing ways to use mobile devices and social media to improve transitions of care.

Most research focuses on specific diseases, contributing to a piecemeal approach when caring for elders with multiple conditions. “A whole-person geriatric approach can help us provide both better and more cost-effective care,” says Covinsky. “Often what’s missing from medical research is the focus on functioning – is somebody having trouble walking? Can they care for themselves? We want to find out how we can treat them so they thrive in spite of the impairments of old age. Sometimes we can improve quality of life more by providing simple things like transportation so they can continue to go to church every Sunday, as opposed to getting an MRI scan.”
**Rebooting Medical Education**

The UCSF Division of Geriatrics has cultivated many leaders in the care of older adults, including more than 115 fellows in geriatrics and other health professions. For the last three years, it has also hosted the Bechtel Geriatrics Scholarship Award Summit – a national competition for residents to discuss their aging research with colleagues and mentors.

While UCSF is known for its excellence in training geriatricians, the need for expertise in caring for older adults goes far beyond this specialty. “There is less than one geriatrician for every 6,000 people over 65 in the United States,” says Louise C. Walter, MD, chief of the Division of Geriatrics. UCSF geriatricians are helping lead the way in training the next generation of providers.

Although teamwork is the heart of providing optimal care to older adults, traditional frameworks of medical education have left learners ill-equipped to practice in this model. Trainees are often taught in silos – physicians teaching medical students, with little longitudinal contact with learners and clinicians from other professions – and many programs still reward individual achievement rather than competence in working with colleagues as a team member.

“A myth in education is the idea if you are around someone from a different profession, then somehow you must be learning to work as a team – but it’s so much more than that,” says Anna Chang, MD. She leads a School of Medicine initiative funded by the Donald W. Reynolds Foundation to develop a comprehensive geriatrics curriculum that will prepare physicians to work effectively within interprofessional teams.

For example, first-year medical students could partner with pharmacy students to review the safety of lengthy medication lists in older adults admitted to hospitals and nursing homes. Second-year students would learn to develop care plans for older patients, integrating input from physical therapists and social workers. “We’re hoping to create high-functioning teams composed of learners from different professions, and have them learn by struggling through real clinical problems together,” says Chang.

She also helps lead the UCSF School of Medicine Bridges Curriculum, which recently received one of only 11 grants nationally from the American Medical Association to create 21st century physicians with skills to work collaboratively. Part of this ambitious reboot effort seeks to create opportunities for students to contribute authentically to patient care, challenging the traditional perspective that learning in the first two years of medical school is best done in classrooms.

“What if students could be prepared from day one to enter the clinic, hospital, nursing home or patients’ homes to help the clinical team improve patient outcomes?” says Chang. She recalls a medical student who learned health coaching skills, then used them to discuss strategies for weight loss with a clinic patient. “Months later, the patient came back and said, ‘Because of what that student discussed with me, I have made real progress towards my weight loss goals. Will you thank that student for me?’

“At UCSF, we are saying, let’s leverage all the creativity and passion that our students bring, and give them tools to learn as they help solve some of the most important questions in health care,” says Chang. “Geriatricians are well-poised to lead this kind of change. We have a philosophy and practice of working effectively in teams to take care of older adults facing complex problems that don’t have a single solution. We are bringing all that we’ve learned to problems that face both the health care system and medical education.”

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**Honoring Dr. Ephraim Engleman**

On March 10th, UCSF celebrated the renaming of the Rosalind Russell/Ephraim P. Engleman Rheumatology Research Center. At 103 years of age, Ephraim P. Engleman, MD, is UCSF’s longest tenured professor and has directed the Center since its founding. Over the years, the Center has raised more than $50 million for arthritis research at UCSF, helping it become one of the top arthritis research centers in the country and train more than 120 research fellows.
When I was in medical school, we learned about lots of diseases that can end your life, but we never learned how to take care of people who were dying,” says Steven Pantilat, MD, the Alan M. Kates and John M. Burnard Endowed Chair in Palliative Care.

As a resident, he cared for a young mother with advanced leukemia. His supervising attending physician kept performing interventions, but never discussed the possibility of death with her. She soon died. “We couldn’t cure her leukemia, but there was much we could have done,” says Pantilat. “No one asked if she wanted to write a letter to her daughter, or would prefer to go home. That case really haunts me. So much of my work today is to make sure that doesn’t happen again.”

Pantilat is the founding director of the UCSF Palliative Care Program, which brings together a team of doctors, nurses, social workers and chaplains to help seriously ill patients achieve the best possible quality of life for as long as possible. “The ability to manage symptoms such as pain and shortness of breath is always job one, because they are very insistent – they grab your attention and don’t let go,” says Pantilat. “We have the expertise and tools to figure that out – it’s the rare case when we can’t make someone’s pain better.

“We also want to understand people’s hopes and fears,” says Pantilat. “People say, ‘I worry I’m going to be alone,’ or ‘I hope I get to see my daughter get married.’ We can use this information to help them make decisions that reflect their goals and values.”

The Palliative Care Program was established in 1999, one of the first in the nation to offer support to hospitalized patients and their families dealing with illness-related pain and stress. Hospice is the most familiar type of palliative care, but the field can help many other patients. “At UCSF, we are pioneering all the ways to get palliative care,” says Pantilat. Through a generous gift from the Hellman Foundation (please see article on the next page), the Palliative Care Program will expand to serve patients living at home with serious illness through home- and office-based palliative care services, and will enhance education and research.

For example, while the program has helped cancer patients through the Symptom Management Service, it is now partnering with other specialties to combine palliative care with treatment for conditions like dementia and heart failure. Such care has been shown to reduce pain, improve quality of life, help people live longer and relieve stress on patients’ loved ones. “It’s not, ‘Do you want to treat your heart failure, or do you want palliative care?’” he says. “Palliative care is an extra layer of support on top of the best care you can get for your illness.”

The program addresses concerns beyond physical symptoms because these things matter to patients. “Not only do they have pain that’s not being addressed, they also have social, psychological and spiritual needs,” says Pantilat. “We design programs that meet those needs.”

Communication and Self-Care

The Hellman Foundation’s gift is also helping educate palliative care fellows, and teaching communication skills to medical students, residents and nurses. “Nearly all doctors and nurses have to share bad news at some point,” says Pantilat. “Being able to talk compassionately, empathically and effectively with people is fundamental to all medical practice.”

One key is asking patients open-ended questions. “As doctors, we hate the silence,” says Pantilat. “I say, ‘Just be quiet for two minutes and let people talk. They’re trying to tell us things that are really important, but difficult to talk about.’

“Another powerful technique is to say, ‘I wish,’” continues Pantilat. “So often you’ll hear the doctor say, ‘There’s nothing more we can do,’ which is terrible, because there’s always something we can do. By saying, ‘I wish’ there was something I could do to make your cancer go away,” it reinforces to the patient that I am on their side and want to do all I can. It transforms the conversation. I can then follow up with, ‘Let’s think about what we can do to help you

Steven Pantilat, MD, the founding director of the UCSF Palliative Care Program, which is expanding its efforts to help patients achieve the best quality of life for as long as possible.
Improving Quality of Life is about living better and longer. People understand that palliative care if they don’t need to be, and help the end of life not be medical events to demand that serious illness and changes. Similarly, we need the public ‘We don’t like it this way. Birth is a sterile medical event, with the end of life. ’Fifty years ago, childbirth has evolved around the beginning and death but it’s important the art be informed care embraces the art of medicine, shortness of breath better? Palliative programs but then test them. “At UCSF, we not only create innova- research yet to do,” says Pantilat. “Palliative care is a relatively new field – we’ve only been certifying physicians in it since 2008, and there is much work to do,” says Pantilat. “At UCSF, we not only create innovative programs but then test them. For example, what makes patients’ shortness of breath better? Palliative care embraces the art of medicine, but it’s important the art be informed by science.”

He sees parallels in how our culture has evolved around the beginning and end of life. “Fifty years ago, childbirth was a sterile medical event, with the mother under general anesthesia,” he says. “Over time, people said, ‘We don’t like it this way. Birth is a natural process,’ and they demanded changes. Similarly, we need the public to demand that serious illness and the end of life not be medical events if they don’t need to be, and help people understand that palliative care is about living better and longer.”

To teach these skills, UCSF uses standardized patients – trained actors who portray patients and provide feedback. Learners also receive intensive coaching after meetings with real patients. “These conversations are not quick – they often take an hour,” says Pantilat. “To give someone feedback takes a lot of time if we are going to do it right.”

Trainees also learn about self-care. “If you’re depleted, you have nothing to offer,” says Pantilat. “If you’re not present with yourself, you can’t be present with patients.” Trainees identify which situations are most difficult for them, what helps them feel balanced, and where they can find support. “It’s also learning to integrate these practices inside the clinical setting, like taking a deep breath before going in to see a patient, or using the washing of your hands as a meditation of feeling your own body,” says Pantilat.

Discovering What Works
“Palliative care is a relatively new field – we’ve only been certifying physicians in it since 2008, and there is much research yet to do,” says Pantilat. “At UCSF, we not only create innovative programs but then test them. For example, what makes patients’ shortness of breath better? Palliative care embraces the art of medicine, but it’s important the art be informed by science.”

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Warren Hellman – private equity pioneer, philanthropist, founder of San Francisco’s Hardly Strictly Bluegrass festival and banjo player – finished writing one last song while hospitalized for leukemia in 2011. Hellman was about to play “The Big Twang Theory” for the first time when members of the palliative care team arrived – including Steven Pantilat, MD, the Alan M. Kates and John M. Burnard Endowed Chair in Palliative Care, and social worker Jane Hawgood, LCSW. “They came in, and it could have been like, ‘I’m sorry, that’s not important. We’ve got to talk about your medical care,’” recalls Tricia Hellman Gibbs, MD, one of Hellman’s four children. “Dad said, ‘I’m singing this song,’ and Steve said, ‘I’d love to hear it!’ That validated my father’s unconventional personality, and allowed him to express something really important to him. It established a bond, where Dad felt comfortable talking about end-of-life issues. “My father was a fighter all his life – he was an ultramarathoner, very devoted to athletics, extremely successful,” says Gibbs. “As he moved into staring death in the face, he couldn’t himself bring up the kinds of topics that he wanted to talk about. He needed to be given the opportunity to do that, which he received when he encountered the palliative medicine team. It was a tremendous relief to him.”

This experience inspired his family, through the Hellman Foundation, to make a gift to expand palliative care services and enhance the program’s educational and research efforts. (Please see article on the previous page.) “Philanthropic support is the venture capital for social good,” says Pantilat. “The gift from the Hellman Foundation has created a tremendous opportunity for us to innovate in a creative way, and to make sure that people who need palliative care can get it. Also, our goal is not just making care better at UCSF, but sharing these discoveries so that care gets better across the health care system.”

“Warren Hellman practicing the banjo in the hospital, a few weeks before his death in 2011.”

Excerpt from “The Big Twang Theory”
By Warren Hellman (pictured above) and Colleen Browne
We were drifting in eternal darkness
Free from joy or pain,
When someone plucked a banjo
And the universe began…
Well, one thing that’s for certain,
It’s been a cosmic trip.
Riding through the ether
On our old-time music ship.

“We are incredibly grateful to all the care providers at UCSF,” says Gibbs. “You need people who are experts in curative types of therapies. But as you move into an area where there isn’t a cure, the palliative medicine team is expert in issues that are so important to daily living, like how do you want your medical care delivered? Do you have pain control? How is your family doing? “We’d like to enhance access to palliative medicine for more people, so they can experience the great care that we did in the final days of my Dad’s life,” says Gibbs. “Hopefully we can inspire others to support the Palliative Care Program, because an investment at this stage would have long-lasting impact.”

To find out how to support the UCSF Palliative Care Program, please contact Senior Director of Development Olivia Herbert at (415) 476-9878 or oherbert@support.ucsf.edu.
Broadening the Circle of Care

The most important thing about building a program is putting things in place that will continue long after you’ve left,” says Stephen Tomlanovich, MD, medical director of the UCSF Kidney Transplant Program.

For almost three decades, Tomlanovich has helped improve patient outcomes and access to one of the world’s leading transplant programs. UCSF currently performs about 350 kidney transplants annually, and has developed many innovations that have increased patient survival and quality of life.

In 1983, he began his nephrology fellowship at Stanford University, which had recently closed its transplant program. “It was an incredible stroke of good luck that Stanford was sending nephrology fellows to UCSF for part of their training,” says Tomlanovich, who did clinical rotations with UCSF transplant nephrologists William Amend, MD, and Flavio Vincenti, MD. “The program here was the biggest in the United States, and was a model of surgery and medicine working closely together to take care of patients.”

Cyclosporin A, a game-changing immunosuppressant, had just been approved. It helped prevent rejection of transplanted organs, but could also cause kidney damage. Since UCSF did not yet have the tools to monitor cyclosporine levels, Tomlanovich would drop off a cooler full of patients’ blood samples at a Stanford lab on his drive home each night.

Tomlanovich joined the UCSF faculty in 1985, and helped lead clinical trials of many new medications. “In the ’90s, there was an explosion of new immunosuppressive drugs, and the field needed studies to understand how they would work best and what were the right combinations,” says Tomlanovich. “Because of the large volume of transplants we performed, we became a large center for clinical research, and were involved in all the sentinel studies.” This research helped improve patient outcomes significantly – in the early 1980s, only half of kidney transplant patients still had a functioning kidney one year after transplant, a figure that has now risen to about 95 percent.

On the Road

Tomlanovich also made kidney transplant accessible to more patients. He established outreach clinics in Walnut Creek, Stockton, Fresno, Monterey and Hawaii where patients can meet with a physician, nurse and social worker to discuss transplant as an option. Although patients still come to UCSF for the transplant and follow-up, these clinics make it easier to start the process, and half of new patients are referred through them.

In 2007, Tomlanovich also launched a partnership with Kaiser in which UCSF performs kidney transplants for Kaiser patients, and then provides follow-up care onsite at Kaiser San Francisco through a combined team of Kaiser staff and UCSF transplant nephrologists. Kaiser recently expanded this model to its South Sacramento facility. “The patient gets the best of both worlds: they have a highly integrated health plan, as well as expert transplant nephrologists who are managing them,” says Tomlanovich, who serves as medical director for both Kaiser clinics.

He credits his “incredibly dedicated” colleagues at both UCSF and Kaiser for the success of all the program’s efforts. “The team approach has been the hallmark of this program from the start,” he says.

Inspired by Patients

Among Tomlanovich’s career highlights is receiving the 2012 UCSF Exceptional Physician Award. “I consider Steve to be one of the finest physicians at UCSF,” says John P. Roberts, MD, chief of the Division of Transplant Surgery and the UCSF Medical Center Transplant Service. “His clinical acumen, administrative judgment and dedication to both his patients and the field have allowed UCSF to become the premier transplant program in the United States, if not the world.”

“Steve is a superb clinician, and a passionate advocate for improving the care of patients with end stage renal disease,” says Vincenti, holder of the Endowed Chair in Kidney Transplantation. “He is recognized nationally and internationally for his expertise in the field of transplantation.”

Tomlanovich plans to retire next year to spend more time with his wife, retired immunologist Susan Hudak, and increase his community involvement. “One of my goals is to be arrested for some social justice cause,” he says with a laugh.

Above all, he appreciates caring for patients. “My sanctuary is to go to clinic and see the fruits of our hard work,” Tomlanovich says. “The patients are amazing – they are the heroes. To get that hug or see a picture of a grandkid that they would never have seen is the ultimate gift.”
quality & safety corner

Philanthropy Powers Innovation

Philanthropy is often focused around discovery of new treatments,” says Niraj Sehgal, MD, MPH, the Department of Medicine’s associate chair for quality and safety. “In addition to supporting the development of vitally important therapies, there is also a need to support the science that allows us to improve the delivery of care we provide. Even when we know the right thing to do for patients, plenty of evidence suggests that a focus on the delivery system is the primary driver to improved quality, access to services, and patient-centered care.” To help meet this need, the Rotasa Foundation recently made a generous gift to improve quality and safety at UCSF. Their gift will support two initiatives:

- **Patient Advisory Council:** “We spend significant time and energy trying to create a patient-centered health care delivery system, but have not been very systematic about incorporating patient input in this process,” says Sehgal. To help address this, the Department of Medicine will be recruiting patients to serve on an Ambulatory Patient Advisory Council at UCSF Medical Center. Patients will meet regularly to provide feedback about ways to improve the patient experience across the department’s outpatient clinics. The group will also include medical students and residents who will help develop specific interventions focusing on some of these ideas, and these projects will be presented at the annual Department of Medicine Quality and Safety Symposium.

  “Having the patients’ voices makes the stories much more real and personal,” says Sehgal. “When a patient says, ‘This was my experience,’ it’s often more compelling than me telling a group, ‘We need to communicate and work better as a team.’ This new initiative will really help drive improvements in the quality of care we provide.”

- **Action Research Program:** UCSF recently piloted the Action Research Program on the Parnassus campus, in which faculty and medical students identified “hotspots” or specific bottlenecks to delivering more efficient and high-quality care. For example, demand greatly exceeds supply for UCSF Endocrinology clinic appointments. The Action Research Program team worked with clinic staff, nurses and leaders to develop ways to increase new patient visits, such as reducing no shows and late cancellations with pre-visit phone calls, and providing patients with follow-up phone visit options. It also became clear that medical students could perform many of these activities.

  With support from the Rotasa Foundation, the Action Research Program will expand to San Francisco General Hospital. “We are excited to use this team approach to help improve care for vulnerable populations, while providing medical students with a front-line clinical experience that will help them appreciate the patient perspective early in their clinical training and teach them strategies for improving the health delivery systems in which they will be working,” says Ralph Gonzales, MD, MSPH, associate chair for ambulatory care and clinical innovation for the Department of Medicine. “Some of the very problems that hinder care delivery can become opportunities for learning, and trainees, clinicians and patients can all benefit from successful interventions that emerge.”

  “We are tremendously grateful to the Rotasa Foundation for investing in the Department of Medicine’s quality, clinical and training innovations,” says Sehgal. “These pilot programs have the potential to not only improve care for our patients, but to serve as models that can be disseminated more widely.”

Promotions and Awards

- **Marguerita Lightfoot, PhD,** has been appointed chief of the Division of Prevention Science and director of the Center for AIDS Prevention Studies, after serving as interim chief since October 2012. The Division’s mission is to conduct research on the prevention of disease and promotion of health, with a particular focus on HIV/AIDS, and includes faculty from a variety of social, behavioral and policy science disciplines. Lightfoot received her undergraduate degree and doctorate in counseling psychology from UCLA, and joined the UCSF faculty in 2008. She has developed HIV interventions targeting adolescent, low-income and mentally ill populations. She seeks to develop cutting-edge programs to increase the well-being of the most vulnerable populations.

- **Michael A. Matthay, MD,** received the UCSF 2013 Lifetime Achievement in Mentoring Award. He is professor of medicine and anesthesia, senior associate of the Cardiovascular Research Institute and associate director of the Moffitt-Long Intensive Care Unit. Matthay earned his undergraduate degree from Harvard University, his medical degree from the University of Pennsylvania, then completed clinical and research training at the University of Colorado and UCSF. His research includes studies of lung injury and trials of new therapies for acute respiratory distress syndrome. He has mentored more than 40 trainees in research, including 10 current UCSF faculty members in three departments, academic investigators at other universities, industry leaders and clinicians.

- **Bradley Monash, MD,** has been appointed associate chief of the medical service at UCSF Medical Center. He will help manage the teaching service, which includes 80-100 patients. He attended the University of Michigan prior to earning his medical degree from the University of Pennsylvania. He subsequently completed his residency through the Harvard Combined Internal Medicine and Pediatrics Residency Program, and served as chief resident in pediatrics at Massachusetts General Hospital. Monash joined the UCSF faculty in 2010, and is an assistant clinical professor of medicine and pediatrics. He has championed efforts to improve hand hygiene, and founded the Cases & Conundrums clinical conference series.

- **Alan P. Venook, MD,** has been appointed the Madden Family Distinguished Professor of Medical Oncology and Translational Research. He earned his medical degree from UCSF, then completed his residency at UC Davis and his hematology/oncology fellowship at UCSF. He joined the UCSF faculty in 1988 and is a professor of clinical medicine. Venook has pioneered new approaches to treat liver tumors, and co-founded the Gastrointestinal Oncology Program at UCSF. He chaired the UCSF Committee on Human Research for seven years and presently chairs the GI Committee of the Alliance for Clinical Trials in Oncology (formerly CALGB). He is also an associate editor for the *Journal of Clinical Oncology.*
The Program for the Aging Century was established at UCSF in 2011 through a gift from the S.D. Bechtel, Jr. Foundation. “Our vision is to serve as a catalyst for change,” says Christine Ritchie, MD, MSPH, the program’s director and the Harris Fishbon Distinguished Professor in Clinical Translational Research and Aging. “We serve as an incubator for testing new strategies and approaches.”

The Program for the Aging Century brings together visionary leaders, and creates transformative models in clinical care, research and education. It also amplifies efforts within the Division of Geriatrics, providing additional resources to evaluate, refine, and scale up successful pilot projects beyond UCSF. It has already leveraged several other major grants, and is helping UCSF become a premier center of innovation in geriatrics.

“We are pleased to support the Program for the Aging Century in its efforts to spur significant change in how we care for older adults,” says Lauren B. Dachs, president and executive director of the S.D. Bechtel, Jr. Foundation.

“By educating health care providers and community leaders, building and testing innovative care models, and conducting state-of-the-art research, UCSF is a national leader in addressing the critical and timely challenge of improving care for frail elders.”

“Philanthropy provides essential resources for testing new models of care, preparing for the clinical needs of the future, and supporting the next generation of clinicians, educators, and researchers,” says Ritchie. “We have been able to capitalize on the S.D. Bechtel, Jr. Foundation’s generous gift and expand on it substantially, and are tremendously grateful for their partnership.”

“We serve as an incubator for testing new strategies and approaches.”

– Dr. Christine Ritchie