



Program Abstracts

The 39th Forum for Behavioral Science in Family Medicine

October 10-13, 2018

THE GATHERING IN

Join with fellow Forum attendees as the co-chairs of the STFM Group on Family and Behavioral Health introduce the 2018 Forum theme, *Embracing and Advancing the Value of Teams in Family Medicine* and lead the group in activities that welcome and build connections with new and seasoned attendees.

Wednesday, October 10, 2018 | 5:15 – 6:30 pm

Gathering in the “Team” - Together Everyone Achieves More

Thomas W. Bishop, PsyD; Katherine Fortenberry, PhD; Corey D. Smith, PsyD

The needs of patients seen within primary care today simply extend beyond the abilities and resources of a single provider and are more efficiently met through an interprofessional team. The Institute for Healthcare Improvement indicates that team care has a positive impact on a range of measures including access to care, prevention, and movement toward health goals. Team based care is the hallmark of the National Committee for Quality Assurance’s recommendation for patient centered medical homes, which inspires quality, cultivates patient engagement, and improves costs. While the Agency for Healthcare Research and Quality suggests that team training improves patient care and safety, it could be argued that resident training continues to be largely inadequate in preparing residents to function within team based care. Training that emphasizes strong communication skills, the ability to collaborate, and an understanding of team leadership. Residents would benefit from training that emphasizes competencies such as the knowledge of “team workings” including the development and functioning of teams, the capacity and skill in functioning as a team member, and the mindset of seeing one’s self as a team member when making decisions or approaching problems. The teaching of these competencies becomes possible when resident experience mutual trust among team members, a sense of team identity, and a belief that the team can perform well by working together rather than as individuals. So how is this training achieved? As indicated in the focus of this year’s forum theme – how can teams within Family Medicine be understood, promoted, and taught, and what role do behaviorists serve in this endeavor? It begins by recognizing our own membership of a team and what we learn and achieve together. This session is designed to create an interactive experience where we first experience ourselves as members of a team, where we have the opportunity to strengthen communication, play various roles within a team, strengthen a sense of team identity, and problem solve together. Secondly, the experience will provide some reflection on strategies that we may each utilize in training residents to do team based care.

MARK YOUR CALENDARS

The 40th Forum for Behavioral Science in Family Medicine

September 18-21, 2019

Chicago, IL

PLENARY ADDRESSES

Opening Plenary

Thursday, October 11, 2018 | 8:00 – 9:15 am

Nancy Ruddy, PhD: The Ripple Effect: Finding and Fueling Your Professional Sprit

Dr. Ruddy is nationally known for her clinical, scholarly, and advocacy efforts to integrate behavioral health into primary care settings. She has cared for patients, taught behavioral science and interdisciplinary team based care to physicians and behavioral health providers, served as an independent consultant, and served in leadership roles in the American Psychological Association. This wealth of experience in the context of systems not always open to change has led to insights about teamwork, leadership, and survival. This presentation will focus on the importance of uncovering and addressing stagnation in one's role, curriculum, or program to avoid burnout. The presenter will share her professional journey that started with small initiatives to support team-based care and ultimately resulted in transformative changes to clinical and teaching processes and larger system change.

Keynote Plenary

Friday, October 12, 2018 | 12:15 – 1:45 pm

Andrew Morris-Singer, MD: Relational Leadership™: Building Teams, Resilience and Advocating for Change

Dr. Morris-Singer, board certified in internal medicine is President and Founder of Primary Care Progress (PCP), a family medicine educator, and a practicing clinician. With nearly twenty years' experience of advocacy, he regularly writes and speaks on current trends in primary care, community organizing strategies to advance primary care reform, and the emerging model of Relational Leadership™. He has been a strong advocate for the integration of behavior scientists into the primary care setting and is an engaging presenter. In this plenary, Dr. Morris-Singer will share insights based on the cutting edge work by Primary Care Progress.

Closing Plenary

Saturday, October 13, 2018 | 10:30 – 11:30 am

Amy Odom, DO , Amy Romain, MSW: Looking Inward: Embracing Vulnerability, Creating Meaning and Finding Resilience

A 15-year partnership as behavioral science educators at the Sparrow/Michigan State University Family Medicine Residency Program has provided many opportunities for plumbing the resources of teamwork and supportive relationships to foster resilience and growth. In this session, they will explore why vulnerability is key to creating meaningful connections and review research that links the power of relationships to resiliency.

Dr. Odom is a family medicine physician and residency faculty at the Sparrow/Michigan State University Family Medicine Residency Program who has given numerous national presentations on resident education in patient centered communication and family-oriented care; Ms. Romain is the Director of Behavioral Medicine at the Sparrow/Michigan State University Family Medicine Residency and is an educator in the College of Human Medicine and the School of Social Work at MSU.

Workshop 101

Emotional IQ Sets Top Performing Teams Apart: The Medical Educator EQ Toolkit Workshop

Susan Franks, PhD; David Farmer, PhD, LMFT; Cynthia Carroll, MA, LPC

As teamwork increasingly becomes the driver of quality medical care and decision-making, physicians of the future need to be poised to effectively collaborate to achieve key patient and organizational outcomes. Highly emotionally intelligent teams are able to create a shared vision and achieve results through mutual trust that is fostered through empathy, flexibility, emotional awareness, and other key social and self-regulation skills. Emotional intelligence has been found to predict empathy, psychological well-being, life satisfaction, success in collaborations, and interpersonal relationship quality. Additionally, emotional intelligence aids higher level thinking through the development of advanced cognitive strategies used to understand and respond to others, and thus impacts other aspects of patient care such as diagnostic reasoning and clinical decision making. However, studies have found that emotional intelligence diminishes through medical school and into residency, threatening the patient-physician relationship and diminishing the effectiveness of team-based care. In our undergraduate medical education and Family Medicine residency programs, we are implementing educational activities to improve the skills of emotional intelligence that are crucial for team-based, patient-centered care. The purpose of this workshop is to share activities from our Emotional IQ (EQ) Toolkit with medical educators. By engaging an interactive experiential workshop, participants will walk away with the knowledge, skills, and practical tools necessary to begin developing targeted activities in their own programs to facilitate acquisition of team-based, patient-centered competencies related to emotional intelligence.

Workshop 102

Using Conversations about Teaching to Create and Support a Learning Community

Jeffrey Sternlieb, PHD

Too often, too many of us work in isolation. Unlike most medical procedures, teaching does not have only one right or best way to do it. Atul Gawande wondered if a ‘coach’ would help him in his operating room, and invited a retired, former instructor to observe him to learn if that would be helpful - it was! Parker Palmer has written about ways teaching occurs at the intersection of our personal and professional lives. And he notes that sometimes, teaching goes so well we think we were born to do this while at other times it goes so poorly we wish we were never born! How often have you talked about the process (not the content) of teaching with your colleagues? Probably very little! And yet this is the essence of what we do with groups and individuals over the course of a three year cycle. This program is designed to provide the leadership, sample topics and the ground rules to stimulate constructive, productive conversation about what it is we do when we teach. Participants will experience two of these conversations in small groups, followed by the larger group’s brain storm about applications of this process.

Seminar 103A

If Behavioral Science Faculty Ran Intern Orientation

Lauren Penwell-Waines, PhD; Susan King, LCSW; Randall Reitz, PHD, LMFT; Max Zubatsky, PhD, LMFT

Intern orientation provides an important opportunity to bring new residents into the program culture and establish rapport within the team. This objective may compete for time with multiple ACGME requirements and covering other necessary logistic information. Unfortunately, orientation often skews toward the latter, being crammed with information and involves limited reflection or engagement. We seek to describe best practices for increasing resident engagement while meeting the informational and support objectives of the orientation time. Such strategies may include behavioral assessment, self-reflection, ropes courses or other team-building activities, and Balint or support groups. We also will discuss the importance of carrying orientation activities throughout the intern year to further professional development.

Seminar 103B

Building the PGY 1 Family Medicine Resident team from day one of orientation

Laurie Sullivan, PhD; Sonia Velez, MD, JD

Social Psychology and organizational behavior have provided many suggestions for how best to build teams. J. Richard Hackman, who began researching teams in the 1970s, identified the necessary conditions for a successful team. These include; a compelling direction; a strong structure; a supportive context; and a shared mindset. Embracing these elements,

we have designed an orientation for our 10 incoming family medicine residents that strengthen the supportive context and shared mindset with exercises that raise awareness of attribution as it impacts our understanding of others. Our ranking of residents in the MATCH is weighted heavily in terms of team player qualities; however, the composition of the group is left to chance. Given this limitation it is up to the faculty, staff and other residents to jump start the team building effort as soon as the group is identified. This experiential workshop proposes to simulate, for a group of no more than 15 people, the part of our team building orientation that focuses on the supportive context and shared mindset.

Workshop 104

Interdisciplinary Video Review: Assessing Milestones & Providing Feedback

Emilee Delbridge, PhD, LMFT; Tanya Wilson, MD; Jared Ankerman, MD; James McGregor, MD

Family Medicine Residency faculty members are expected to observe interactions of resident-patient encounters and provide feedback on residents' skills. Behavioral science and physician faculty will provide examples of how we have developed and revised the review format and the evaluation form to meet the needs of the program, resident development and competence, and patient care. We will focus on how we review physician-patient interpersonal and communication skills and medical knowledge using interdisciplinary faculty to review video-recorded resident-patient encounters. Resident presenters will provide their perspectives on this evolving process and the pros and cons of different formats for review and feedback. We will also present faculty and resident survey results about the previous and current evaluation processes. We will present two different video examples of physician-patient interactions and have participants (1) provide informal feedback and (2) use a condensed version of our evaluation form that is linked to the Milestones. Small groups will discuss the videos and their feedback. The goal of the second small group discussion will be for participants to practice using our condensed form, and also to think about their own evaluation/feedback process. We will provide questions to prompt discussion focused on the process of evaluating. We will also discuss how the video observation is used in our CCC review of residents (mapped to Milestones). Time will be designated for a large group discussion about potential changes to observation and feedback processes, as well as opportunities to identify specific refinements to one's program's evaluation of residents.

THURSDAY, OCTOBER 11, 2018 SESSIONS

Lecture Discussion 105

Integrating the Languages of the Interdisciplinary Team for Optimal Patient Care

Ronald Hunt, MD; Anne Van Dyke, PhD, ABPP; Lori Lackman-Zeman, PhD; Elena Kline, PharmD, CBGP, BCACP

Increasingly, Behavioral Medicine and Pharmaceutical Sciences are becoming integral to the provision of primary care medical services. In order to work effectively as an interdisciplinary team, it is imperative that all providers speak the same language. This can be challenging when the training of team members occurs in divergent training cultures.

Behavioral Health providers may use "psychological jargon" and physicians and pharmacists may talk in "medicalese" when discussing illness, laboratory studies, procedures, and physical health in general. How then does one promote a common language? What is there to be learned and appreciated about both cultures and languages?

For several years, our teaching institution has included an on-site Health Psychology team, and more recently a clinical pharmacist, to assist Primary Care Residents and Attending Physicians with the care of their ambulatory and hospital patients. We have learned that just as the mind and body are intertwined, so must the cultures of medicine, pharmacy and psychology in order to provide the most effective treatments for our patients and best teaching environment for our learners. In this lecture, we will provide some practical training on the do's and don'ts of integrated primary care.

Clinical Practice Update 106

Addressing the Psychological and Medical Impacts of Infertility and Pregnancy Loss

Kimberly Foley, PhD; Holli Nelman-Hart, MD; Angie Godejohn, MD

Infertility and pregnancy loss are commonly encountered in primary care (by both behavioral health and primary care providers). Approximately 11% of women and 9% of men ages 15-44, have difficulty with infertility (Natl Health Stat Report, 2013). Furthermore, 15-20% of all clinically recognized pregnancies result in miscarriage and another 1% in stillbirth (CDC, 2017). Historically, medical providers receive little training regarding the psychological aspects of infertility and pregnancy loss and behavioral health providers receive little training about the medical aspects of infertility

and pregnancy loss. Studies have shown increased rates of depression and anxiety in those suffering from infertility and women who suffer from early pregnancy loss have higher rates of depression and anxiety in subsequent pregnancies compared to women with no history of miscarriage. The objectives of this presentation include providing evidence-based and practical information, statistics, psychological, and medical updates on this important clinical issue.

Lecture Discussion 107

Helping the Grieving Healer: Strategies for Assisting with Physician Grief

Amber Cadick, PhD; Christopher Haymaker, PhD; Megan Barclay, MS

Many physicians go into medicine to heal and care for their patients. However, a significant and impactful portion of practicing is experiencing patient death. Participants in this interactive lecture will construct a concept map to explore the impact of patients' deaths on the family medicine provider. Next, in a brief lecture, we will detail formal, active coping strategies for processing death. We will also identify warning signs of complicated grief in family medicine providers and systematic pitfalls for residency teams to avoid when coping with a death as a medical system. The session will end with practice using the Death Debriefing Tool.

Lecture Discussion 108

Beyond the Myers Briggs: Emotional Intelligence for Resident Leaders of Teams

Megan Brown, PsyD; David Simpson, PhD

Family medicine inpatient service rotations provide the most rigorous, challenging training for residents during their three years of training. Assigned a new team every month, residents are challenged to not only provide excellent medical care and work long hours, but work together with residents, faculty, and other hospital staff in order to do so. Learning to work well with others is an essential skill taught from the preschool and kindergarten, but becomes increasingly challenging as workload increases in volume and complexity. How do you work together well while under an enormous amount of pressure and stress? This session will introduce the use of The Birkman Method, with its strength in identifying an individual's needs from the environment, as a springboard to coach senior resident leaders about group dynamics and how to serve interns well.

Lecture Discussion 109A

Resident Research Curriculum

Courtney Barry, PsyD; Linda Meurer, MD, MPH; Jamila Kwarteng, PhD; Laura Brusky, MD; Jeff Morzinski, PhD

Family medicine residents are required to complete scholarly projects prior to graduation. Venues for sharing completed scholarly projects are broad and at our midwestern medical school, include an end-of-year Research Forum, where faculty, fellows and residents from our four affiliated residency programs are invited to submit scholarly abstracts for peer review and presentation. However, inconsistency of quality in resident abstracts suggested that additional scholarship training and support were needed. An interdisciplinary team of primary care research fellows and junior faculty representing medicine, nursing, pharmacy, psychology and social sciences, convened as participants in a faculty development program, with a group task of applying a systematic curriculum design model to the development of a resident research curriculum. A comprehensive needs assessment revealed inconsistency in the process and outcomes of resident scholarly project completion. The identified needs included basic training in articulating research questions, literature review, and study design, as well as, mentorship training, statistical, and IRB support. Our assessment also revealed that faculty highly value scholarship and research, and welcomed the opportunity to develop related skills and strengths, in this area. This needs assessment and literature review are helping to inform educational strategies to enhance scholarship department-wide. This lecture-discussion will 1) describe the interdisciplinary faculty development program in instructional design aimed at re-invigorating resident scholarship; 2) share the results of our needs assessment and curricular products, and 3) elicit attendees' discussion and best practices related to teamwork to meet and exceed the scholarly requirements of family medicine residents.

Lecture Discussion 109B

Hey Siri... A Team Based Approach to Engage Residents In Research Skill Development

Heidi Musgrave, PhD; Gordon Bokhart, PharmD

In today's day and age, reliance on smartphones to answer questions has become the norm. However, the quality and validity of the answers are often unknown. Enticing learners to find answers to their questions using the scientific method is challenging. Developing skills such as searching the scientific literature; critically reviewing scientific articles; creating

a hypothesis; presenting a proposal to an IRB; collecting and analyzing data; as well as presentation of results at a scientific conference can be daunting. Developing a team-based approach to conquer these steps will reduce the sense of being overwhelmed. Creating a team of researchers that have varied experience and skill sets will foster an environment in which research is encouraged and valued. This session will demonstrate how to create a community based research team to promote quality research and scholarly activity.

Lecture Discussion 110

Undergraduate Medical Student Value in Interprofessional Health Systems Teams

Leanne Chrisman-Khawam, MD, MEd

Health Systems Science incorporates quality improvement, evidence-based initiatives, ethics, professionalism, population health and social determinants into the everyday practice of primary care. Health Systems educators will be needed and additional training may be needed to prepare to train medical students and residents. Still, behavioral medicine specialists have been bringing many of these elements to clinical education. Measuring the value that medical educators and undergraduate medical students can bring to the clinical practice is needed to advocate for this educational topic within our graduate and undergraduate medical training venues. This lecture will introduce the need and importance of addressing Health Systems Science in undergraduate and graduate medical education. It will explore the experience of one primary care accelerated track that is incorporating medical students from their first week of medical school and exploring the ways in which to measure the value proposition to the clinical practice.

Lecture Discussion 111

Methods for Developing and Modifying Behavioral Medicine Curriculum to Prepare Residents for Interdisciplinary/Integrated Care

Molly Gabriel-Champine, PhD; Andrew Champine, PsyD

Healthcare is becoming increasingly focused on interdisciplinary teamwork and, as such, medical education should follow. With ACGME's milestones and core competencies providing significant direction in the graduate medical education world, there has been increased attention drawn to how to best incorporate behavioral health training into a resident's curriculum. Thus, combining these two elements we look at the utilization of interdisciplinary teams in the development of behavioral training and medical education for primary care. This talk will discuss how two clinical health psychologists, within two distinct residencies, provide solutions targeting behavioral gaps by using a team-based approach. This discussion offers not only literature based recommendations for developing a behavioral medicine curriculum, but also real-world suggestions to take back to your own residencies, as well as pitfalls to avoid.

Laura Daniels, PhD; Scott Nyman, PhD

The latest Human Behavior and Mental Health Curriculum requirements, as defined by the ACGME, state that Family Medicine (FM) residents should attain a breadth and depth of experiential and didactic training in Behavioral Science through a longitudinal training experience. Additionally, it is increasingly likely that FM residents will obtain clinical positions in integrated Primary Care Behavioral Health (PCBH) settings that are certified as Patient Centered Medical Homes (PCMH). Many FM Behavioral Science curricula were designed prior to the updated recommendations and rapid shift toward the integrated PCBH practice model. Thus, residency training often falls short of developing the necessary attitudes, knowledge, behaviors, and skills for PCBH-PCMH settings. This presentation will open with a facilitated discussion surveying how attendees prioritize their curricular goals and structure their Behavioral Science curriculum, accounting for the unique time and resource constraints of their practices. Next, the presentation will review the methodology for revising and developing a PCBH-based curriculum that aligns with ACGME requirements and FM Milestones. This framework aims to enhance resident competency across three overlapping domains: mental and behavioral health, chronic disease self-management, and professionalism and interpersonal effectiveness skills. The goal of this model is to provide an underlying framework of core principles from which attendees can design a customized curriculum suited to their own practice settings. Finally, attendees will be engaged in an interactive discussion to explore areas within their curriculum where experiential or didactic training opportunities could be incorporated to better prepare their residents for practicing within a PCBH-PCMH setting.

Lecture Discussion 112

A Tale of Two Approaches: Caring for Patients with Complex Care Needs

Nancy Newman, MD, LMFT; Kristin Cook, BSN, RN, PHN; Theresa Eckstein, LISW, MSW; Lourdes Martinez, CHW

Experiential training in population health can be challenging to develop and sustain. As a component of our longitudinal population health curriculum, our FM residency program decided to focus on our clinic's population of patients with complex needs, to improve the Triple Aim and offer residents experience working within a focused "enhanced care" team. Complex patients were defined as individuals with medical, behavioral or social needs that were not well addressed by traditional models of care delivery. We will describe the evolution of this interdisciplinary team based training site for third year residents. Initially we had a dedicated half-day clinic to serve patients identified by PCPs or nursing staff as having complex comorbidities and/or conditions made complex by social determinants. After a year using that structure we reorganized to be an interdisciplinary care consultation team that serves providers where they work and complex patients where they are cared for, in the residency's primary clinic. Presenters will discuss the advantages and disadvantages of these two different models. Feedback from resident learners will be highlighted. Attendees will take home a summary of lessons learned which can be applied to similar initiatives in their own institutions.

Lecture Discussion 113

Bridging Barriers to Care with a Robust Behavioral Health Group Program

Katherine Fortenberry, PhD; Sarah McCormick, PhD; Ruben Tinajero, MS; Kara Frame, MD

Increasingly, primary care models of care delivery are moving toward integrating behavioral health providers as members of integrated care teams through co-location and collaboration. However, despite well-documented benefits of improved access and reduced stigma, lengthy waitlists and inadequate behavioral health insurance coverage continue to create barriers to care for patients. In this presentation, we will describe how developing a robust behavioral health group program can address concerns with access and insurance coverage. Group treatment is an effective behavioral health model that meets patient needs while managing high-volume caseloads; it has also been shown to be as effective and acceptable to patients as individual treatment⁵. Within the context of a healthcare setting in which psychological complaints are associated a medical diagnosis, group encounters can be billed to insurance through Health and Behavior Assessment and Intervention (HBAI) codes, rather than traditional group psychotherapy codes. HBAI codes provide a financially innovative way to bill for group treatment, typically requiring the same out-of-pocket expenses for the patient as a primary medical care appointment. Furthermore, a behavioral health group program provides unique opportunities for interdisciplinary collaboration and training among medical and behavioral health practitioners. We will address specific challenges and solutions related to developing a robust behavioral health group program, describe the financial impact of this type of service, and explore the implications for patient care.

Clinical Practice Update 114

Not Just Too Much Sugar: Diagnosis and Treatment of Childhood ADHD in Family Medicine

Oliver Oyama, PhD; Elizabeth Lawrence, MD

Childhood Attention Deficit Hyperactivity Disorder (ADHD) is common, affecting up to 11% of children and adolescents. Many of these patients are identified during regularly scheduled annual physical examinations with their family physician. Consequently, it is imperative that family physicians and other clinicians in the family medicine setting be familiar with the assessment, diagnosis and treatment of childhood ADHD. In this proposed Clinical Practice Update we will review the epidemiology of childhood ADHD; present our current understanding of the etiology of ADHD, its differentials, comorbidities, and the potential consequences of unidentified or misdiagnosed ADHD; describe the assessment and diagnosis of childhood ADHD in family medicine including changes in the DSM-5; present guideline-driven treatment options by age group for childhood ADHD; and share national resources available to professionals and parents for the assessment and management of childhood ADHD.

Lecture Discussion 115

Facilitation: An Invisible Skill in Successful Organizations

Kim Marvel, PhD

Residency programs are complex organizations with competing demands. Aligning the diverse educational and clinical activities requires leadership and management skills. In addition, embedded within organizations are valuable employees who are talented at facilitation. That is, they make processes flow easier. Such people and their unique skills may go

unrecognized and blend into the workforce. This presentation describes a qualitative study which highlighted the characteristics of exemplary facilitators. Seven characteristics were identified, such as attendance to detail, anticipation of others' needs, compassion, humor, enthusiasm, and a problem-solving orientation. Employees with this unique skill set can bring value to the clinical and QI teams as well as the educational and administrative arenas. Participants will observe video clips of interviews of exemplary facilitators, explore how to identify such individuals, and use the skills of exemplary facilitators to maximize organizational effectiveness. The session will feature compelling stories, videotaped interviews, and research to demonstrate how exemplary facilitators bring skills that complement the skills of leaders and managers.

Lecture Discussion 116

Teaching Residents to Skillfully Respond to Patients Reluctant to Engage with a BHC

Amber (Hewitt) Cahill, PsyD; Karen Kersting, PhD

The “warm handoff” and initial introduction to the behavioral health provider (BHP) is a foundational skill for family medicine residents working in integrated care settings. Primary care providers (PCP) often encounter reluctance from patients when introducing the idea of meeting with a BHP. This reluctance can result in the patient missing out on behavioral health approaches that could improve their health. There are many circumstances that could lead patients to express ambivalence about seeing a BHP in primary care. This is a critical opportunity for residents to engage patients in conversations that explore uncertainty and provide targeted information that could change the patient's attitude toward seeing the BHP, all while using techniques that ensure patient autonomy and choice. Exploring this ambivalence can reveal important insights about the patient, their history, and guide specific responses from the resident to help resolve fear or misinformation. Facilitating warm handoffs can be challenging for providers, especially when patients respond with reluctance, so it is important for family medicine educators to teach these skills in a specific and focused fashion. These are high-level, interpersonal communication challenges and merit instruction as unique micro-skills to be broken-down and practiced. While the “warm handoff” is essential to facilitating the benefits of integrated care and a critical skill for resident physicians, an equally important ability is to skillfully respond to patients who are uncertain or hesitant in meeting with a BHP.

Lecture Discussion 117

Reflecting on Burnout and Changing Culture through the Use of Photovoice

Amy Odom, DO; Amy Romain, MSW; Julie Phillips, MD, MPH

The statistics regarding physician burnout are staggering. In recent years, the academic community has offered volumes of research on the rates and reasons for burnout. There has also been a noticeable shift to focusing on the development of individual resiliency skills and cultures that promote wellbeing. Following this trend, we will describe how to use a qualitative research method called Photovoice as a means of reflection on the self-identified causes of resident burnout and individual wellbeing and resiliency skills. We will show how structured group conversations around the meaning of the photographs can lead to individual empowerment and the identification of common themes that can be used in advocacy to affect culture change to promote wellbeing within a system. Participants in this session will be provided with education and resources on how to replicate a similar project in their own settings.

Lecture Discussion 118

Empowering Your Team: How to Light the F.I.R.E to Thrive in Your Work Again!

Janelle Von Bargen, PhD, MSW; Kathryn Fraser, PhD; Terri Dalton, IMFT; Dael Waxman, MD

The time constraints and requirements of healthcare have a negative impact on our ability to take time to engage with colleagues and patients. It is not unusual to go through an entire day of interactions with others and still feel disengaged. We are in danger of omitting the thing that should distinguish us as health care providers "the ability to connect with others and provide healing. Engaging in purposeful interactions can offer comfort, and promote growth and development. There is no doubt we are stronger in teams when we can connect on a deeper level, go below the surface and really express our struggles, as well as our joys. For many healthcare providers, the feeling of "thriving at work" may seem like an unattainable notion. Behavioral health providers can be the leaders as we may have an advantage over our physician colleagues due to our ability and training to process things on a deeper level. Our goal should be to teach faculty to engage in honest self-reflection and attempt real behavior change to enhance their interactions with others. This purposeful self-reflection skill can enhance professional development and increase satisfaction in teaching and patient care. It also can promote humanism, one of the more challenging aspects of the Professionalism Milestones to teach. In this workshop

participants will learn how to spark the F.I.R.E for engaging in interactions with colleagues, learners, and patients. Presenters will share the literature on improving productivity in health care through deeper connections and reclaiming meaning in our work.

Clinical Practice Update 119

Tobacco Use Disorder: Helping Your Patients Extinguish the Fire

Scott Fields, PhD; William Johnson, MD

Although tobacco use has steadily declined in the United States since the 1960s, it remains the number one preventable cause of death in the country (CDC, 2017). About two thirds of those who use tobacco will eventually die from a tobacco-related illness (Fiore, et al. 2008). Medical and behavioral health providers can begin the process of helping patients quit tobacco by having a clinic wide method for assessing tobacco use. Various successful clinical assessment strategies exist within the context of current tobacco treatment guidelines. In addition to assessment, evidence-based treatment of tobacco use is paramount to helping patients reach their goals. Treatment options with consistent efficacy include the utilization of cognitive-behavioral strategies, motivational interviewing techniques, pharmacotherapy, and nicotine replacement (Mayo Clinic Nicotine Dependence Center, 2017). Common pitfalls in the treatment of tobacco use are how aggressively to treat patients and how to deal with the seemingly never-ending cadre of fad treatments. It is also important to demonstrate how all professionals in the primary care clinic can collaborate to optimally treat the use of tobacco in our patient population.

Educational Research 120

Moderator: *Max Zubatsky, PhD, LMFT*

Research 120A - Actual & Perceived Patient Health Literacy: How Accurate are Residents' Predictions?

Laci Zawilinski, PhD; Heather Kirkpatrick, PhD; Barbara Pawlaczyk, MD; Himabindu Yarlagadda, MD; Elizabeth Fleagle, PsyD

Health literacy has been the focus of research for decades. Compared to adequate health literacy, inadequate or low health literacy is associated with a multitude of negative outcomes, including but not limited to poorer medication adherence, poorer physical and psychological health, and poorer self-management of chronic diseases (e.g., hypertension, diabetes; Grosse, & Auffrey, 1989; Sheriden et al., 2011).

Previous research has shown that physicians of all experience levels have difficulty accurately identifying the health literacy levels of their patients and tend to overestimate patient health literacy (Bass et al., 2002). In addition, recent research has indicated that instruments used to measure health literacy may be limited and provide an inadequate measure of a patient health literacy (McCormack et al., 2010). However, newer instruments designed to measure health literacy have emerged in recent years and have been thought to better measure the health literacy construct (Bann et al., 2012; McCormack et al., 2010).

Therefore, the overall purpose of the present study is to replicate and extend the findings of previous research by examining residents ability to predict health literacy levels in patients using a newer validated measure of health literacy. Specific aims of the study include determining the level of health literacy of patients seen at local residency clinics and assessing residents abilities to accurately identify patients health literacy levels.

It is hypothesized that patient health literacy levels will be lower than the general population and that residents will overestimate the level of health literacy of their patients.

Research 120B – Using Parallel Process in Collaborative 360 Evaluation in Residency Training

Angela Antonikowski, PhD; Jennifer Lee, MD

Family Medicine residencies across the country report struggling with multiple issues in relation to resident evaluation. Most evaluations for residents are global assessments, the majority of which are performed in the inpatient rather than the outpatient setting. We have similar struggles with our resident evaluation system and see Direct Observation of outpatient clinical encounters as a way to improve upon how we evaluate residents. Direct observation of residents, while resource intensive, provides one of the best opportunities to provide the learner with specific and meaningful feedback from a multidisciplinary perspective to help them grow professionally. We have expanded our direct observation of residents from a single video-taped encounter in the first year to three directly-observed encounters annually using a video monitoring system and have created a novel evaluation form, with the aim of providing formative feedback at the end of each directly observed encounter. Residents complete a self-evaluation, preceptor evaluation, direct observer evaluation, and patient evaluation and an assessment of the parallel experience of being evaluated in the way that our patients often

feel evaluated. The data allows us to look for correlations in multiple domains such as medical knowledge, patient care, communication, and professionalism.

Research 120C – Medical Student Attitudes Before and After an Interprofessional SUD Clinic Experience

Laurel Witt, MD, MPhil; Wendi Born, PhD; Duncan Rotich, MS; Emma Mumm, LCSW;

James Kleoppel, PharmD; Anita Moudgal, BA, MEd

Substance use disorders (SUDs) are on the rise nationally [2]. Despite this, national reviews of medical education indicate learners receive insufficient exposure to SUDs and their management [3, 6]. To address this disparity at our institution, we have built an interprofessional SUD-focused sub-clinic into our family medicine teaching clinic, where advanced learners from several health professions work in interprofessional teams to see patients and present to attending providers from medicine, psychology, pharmacy, social work, and occupational therapy. With this SUD-focused teaching sub-clinic, which we call Recovery Clinic, we build on existing structures and relationships our teaching clinic has practiced from an interprofessional approach for many years. And we see Recovery Clinic as an opportunity to expand our abilities as a team, to improve the interprofessionalism we teach and practice. Our hypothesis is that learning SUD topics in the clinical moment, as delivered by high functioning teams, will change learner attitudes toward interprofessional care, generally, and toward patients with SUDs, specifically.

In our session, we will describe our teaching environment and the Recovery Clinic, itself. We will discuss the integral ways each profession is involved, spending time on contributions from medicine and psychology/behavioral science. We will discuss the methods by which we are studying our clinic as a curricular intervention and its impact on learner attitudes. And we will present on our first wave of outcomes.

Lecture Discussion 121

Playing Nice in the Sandbox - Engaging the Team in Primary Care

Christine Borst, PhD, LMFT; Irina Kolobova, PhD; Amelia Muse, PhD, LMFTA

Team-based care is touted in the literature as the new standard for providing patient care. Despite the overwhelming support for the use of multi-disciplinary or interprofessional teams, the implementation of the approach remains cumbersome. The complexities of "real-life" implementation inhibit many outpatient practices from providing team-based care for their patients, despite the best of intentions. This presentation will provide a review of best practices for building successful teams and will provide attendees with practical techniques for employing and engaging a multi-disciplinary team. The presentation will include hands-on activities to inspire participants to engage members of their own team in practical ways.

Lecture Discussion 122

Integrated Care Group Visits: A Team Approach to Treating Opioid Use Disorders

Stephanie Case, PsyD; Carrie Anderson, MD

The opioid epidemic is moving much faster than healthcare has been able to meet its demands. The somewhat fragmented traditional method of the primary care physician managing medication assisted treatment, a rehabilitation center handling detox, extended inpatient treatment, or sober living, and long-term community services (e.g., Narcotics Anonymous) have been inadequate when facing a less than linear path of opioid addiction and use. These methods, although important to achieve recovery, might be missing the key component of communication between providers. This communication is necessary to achieve the goals of the patient centered medical home. Our clinic has followed several pilots to treat the whole patient in one location, at one visit, to address various stages of opioid use disorder as a team. The integrated care group visits allow patients to check in with their physician, record vitals, refill prescriptions, and participate in a supportive and educational psychotherapy group. This method has allowed for improved communication and direct participation by mental health professionals, nursing, and physicians during a two in a half hour appointment twice per month. These types of visits remove the barrier of insufficient communication between providers, as each provider participates throughout the encounter. Moreover, the group provides a community in which the patient feels secure revealing relapse and additional need for resources that transcends beyond group visits to specifically target the non-linear path of opioid use and recovery.

Lecture Discussion 123A

Addressing Adults with ACEs in Primary Care Requires a Team Approach

Mark Prodger, MD; Aimee Valeras, PhD, MSW

This presentation aims to discuss the latest medical and psychosocial research on ACEs as a hazardous, quantifiable exposure which has a substantial and direct impact on health outcomes, which will include screening options and action plans to respond in a patient-centered trauma-focused way.

The audience will learn concrete ways to recognize red flags that indicate ACEs, to identify and treat risk factors, and to incorporate available resources into their care. This talk will also delve into the necessity to incorporate self-awareness and self-care into the frame of working with people with ACEs.

Lecture Discussion 123B

Assessing Resident Confidence in Screening and Intervening with Patients' ACE Scores

Thomas Cahill, PhD; David Mohr, DO; Nick Yunez, MD

This presentation aims to discuss the latest medical and psychosocial research on ACEs (Adverse Childhood Experiences) as a hazardous, quantifiable exposure which has a substantial and direct impact on health outcomes.

Also, we will present our educational initiative which began in July 2017 and required 22 residents to score the ACE questionnaire on all patients presenting for a complete physical or new patients establishing care. The patients were asked how it is affecting them today. Patients were listened to, accepted and given feedback which noted their courage and allowed for a better understanding of their problems. Patients were also given the Pennebaker writing assignment and a follow up appointment. The resident and faculty have participated in focus groups to discuss their experiences with the ACE intervention and we will summarize this information in our lecture presentation.

Clinical Practice Update 124

If I Cannot Sleep, Then Neither Can You: Pediatric Sleep Disorders

Lynn Simons, PsyD; Meaghan Beasley, MD; Christine Medaugh, MD

Pediatric sleep disorders arise from biological factors, maturation, parenting knowledge and behavioral learned factors. Understanding pediatric sleep cycles, good sleep hygiene for infants, toddlers and children, and generating reasonable expectations go a long way in helping parents get their children to sleep. Sleep disturbances in children contribute to behavior, learning, temperament, health and social development difficulties. Sleep disturbances and sleep associations that produce nocturnal problems for children will be reviewed. Normal and dysfunctional sleep patterns, and interventions for initial insomnia and frequent waking will be reviewed.

Workshop 125

Team Work: Developing Curriculum for Appropriate use of the Extended Care Team

Christopher Haymaker, PhD; Emily O'Brien, Pharm D; Rosalie Cassidy, MD

Team-based care in the outpatient clinic has become increasingly common. Integrated team-based care forms an important foundation for PCMH and patient-centered care. In order to prepare, Family Medicine residents must develop competency in team-based care. During this workshop, we will present our framework for teaching residents about engaging the extended care team. We will present a developmental framework that incorporates behavior change models to encourage a process towards more skillful use of the extended care team to improve patient care. During this workshop, we will discuss building relationships with team members, barriers to team-based care, targeted didactic strategies and individual precepting strategies to give feedback on team-based care. Brief snapshots of our curriculum and structured group activities will allow participants to develop plans to identify resources and implement curriculum ideas in their own outpatient settings.

Workshop 126

Sustaining the Culture Change of Team-Based Care: A Pecha Kucha Experience

Randall Reitz, PhD, LMFT; Laura Sudano, PhD, LMFT; Amy Davis, MD; Glenda Mutinda, MA

Adopting a team-based model within a residency can be an overwhelming effort. It requires changing systems, staffing, finances, curriculum, rotations indeed an entire residency clinic culture. Sustaining the team-based effort and the culture that supports it are equally important, but often overlooked next steps. Without changing an entire culture to embrace teams, the system will either revert to standard practice or fail to fully achieve the desired clinical and academic benefits.

Fortunately, much has been written about how to change and sustain culture. Some of our favorite insights come from Daniel Pink's "Drive", Patrick Lencioni's "Five Dysfunctions of a Team", and Charles Darwin's "On the Origin of Species". We've also gained insights from our lived experiences and colleagues.

We will open the workshop with 4 Pecha Kucha presentations on sustaining the culture of team-based care. Pecha Kucha is an emerging format that interweaves narrative, images, and teaching points in evocative mini-presentations. Following the opening presentations, we will take a deeper dive into the material from the 3 books and assist the participants in applying the key points in sustaining culture in their own residencies and clinics.

Workshop 127

Creative (and Fun) Activities that Foster Team Building, Meaning-Making & Reflection

Jennifer Ayres, PhD

Per Google (2015), successful teams have five components: Psychological safety, dependability, structure & clarity of roles/goals, meaningful work tasks, and an awareness of the broader impact of their work. This experiential learning workshop will discuss how to incorporate these components into resident education via engaging residents in team building activities that foster group cohesion, reflection, and meaning-making. Participants will discuss strategies to overcome common challenges to team building exercises and how to create activities that balance introvert & extravert processing and different learning styles. We will discuss how to use post activity processing to promote self-reflection and team-reflection, group cohesion and resilience. We will discuss how to tailor team building activities to time constraints and didactic topics. Participants will be invited to participate in multiple brief activities and one extended activity.

Seminar 128

Should They Stay or Should They Go: Best Practices for Remediation of Medical Learners

Terri Wall, PhD; Janelle Von Barga, PhD, MSW; Sonya Dominguez, MD; Molly Clark, PhD;

Melissa Arthur, PhD, LMFT

All training programs struggle with the universal concern of how to best support and remediate the struggling medical learner and if necessary how to approach the dismissal process. The Competencies and Milestones give us a standard for evaluation, but each program must decide on the appropriate policies and procedures related to remediation and dismissal for their program. In addition, the culture of the program in regards to mistakes, competition, and asking for help must be considered in any approach to the struggling learner. As educators, we must also be aware of the need for a progressive plan of action that moves from coaching, to remediation, to probation, and then dismissal. This plan would ideally be transparent and standard for the program, but also able to be uniquely tailored to each learner and the specific area of concern. In this panel presentation, we will share the approach we take in our programs to the struggling learner and will discuss the unique role that the Behavioral Faculty can serve for both the resident and the program.

Workshop 129

Balint Groups: the Art of Relationship in Family Medicine

Phillip Phelps, LCSW; Jeffrey Sternlieb, PhD; Jose Nino, MA, LCPC; Allison Bickett, PhD, MS; Chris Rule, MSW

Much of the art of medicine has its roots within the relationship between the doctor and the patient. The potential healing, as well as the professional fulfillment, that may occur within the relationship is hard to overestimate and increasingly in danger of being overlooked.

With growing time constraints, competing priorities, and a "customer satisfaction" focus, the artful pursuit of empathic relationships in medicine is challenged. Professional stress and job dissatisfaction are on the rise. Thus, training methods that enhance our ability to understand and manage the frustration that can be a routine part of today's medical environment are hotly pursued.

Balint groups train physicians to understand and use the doctor-patient relationship as a therapeutic tool. They can be a powerful method to assist students' and residents' ability to see inside the relationship, consider the context and the motivations of both patients and themselves.

The Balint group uses an experiential method that enhances empathy and reflective practice. This two hour workshop will provide a direct experience for those interested in learning about Balint training methods. A full Balint group will be conducted. Time will be provided to discuss group process, leadership, and the practical aspects of starting and maintaining Balint Groups.

FRIDAY, OCTOBER 12, 2018
Round Table Discussions 7:00 – 8:00 am

Humanistic Habits of Care: Teaching about Suffering throughout Medical School

Katinka Hooyer, PhD

Recent research illustrates that medical students feel insufficiently prepared to identify, empathize and manage human suffering and that attention to suffering is rarely addressed after preclinical training. In the comprehensive care that is the hallmark of family medicine, this involves the ability to identify and manage social suffering in addition to physical pain. Developing humanistic habits of care require compassion and an understanding of the broader structural violences that contribute to patient distress. In this round table we will identify strategies to teach clinical skills to assist medical students, often coming from privileged backgrounds, to manage suffering in patients. This will require exploring approaches to teach about the structural violences that lead to this suffering.

With new initiatives to transform medical education that focus on compassion and character building, confronting issues and exploring solutions around teaching humanistic habits of care are timely. This round table will: 1) utilize a social science lens to define social suffering and structural violence; 2) engage group discussion to identify the clinical skills necessary to manage human suffering and curricular challenges, and; 3) explore strategies, and; next steps.

Early Lessons: Team Development for Medical Care Transitions Post-Incarceration

Sabrina Hofmeister, DO; Jeff Morzinski, PhD; Wendi El-Amin, MD

There is an urgent need to better address the health needs of chronically ill prisoners returning to the community. An estimated 80% of returning prisoners have one or more chronic diseases, and over half are dually diagnosed, with co-occurring mental illness or substance abuse. High death rates have been reported during the first weeks after returning from incarceration to the community, with mortality 12 times the expected rate of non-reentry populations, due to overdose, suicide, heart disease and violence. The majority of US states do not coordinate health care transitions for chronically ill inmates upon prison release. The care gap is especially wide for men, who make up the majority of the prison population. Once released, many of these men are left with unmanaged, chronic and complex medical and psychosocial conditions, resulting in greater disruption to the community as well as greater morbidity and mortality. Community care teams may be especially effective in facilitating the transitions and care of these complex patients. However, we have learned that several factors limit team development, including inadequate training, political, organizational and system gaps, lack of funding and poor access to cross-disciplinary expertise. Therefore, this round table discussion reveals the team formation experience of a Midwestern medical school and urban residency program impacted by mass incarceration, including challenges and ‘lessons learned’ to date. We will discuss national best practices, elicit the views and experiences of attendees, and explore the roles of family medicine as essential to team success.

Behaviorist Role in Chronic Pain Management

Stacy Melton, LCSW; Sarah Bockhold, LCSW

Chronic Pain Management and the use/abuse of pain medications have been increasing. The death rates related to opioid drug use/abuse are steadily increasing. Our clinic formed a committee that included Physicians, Physician Residents, Physician Assistants, Nursing, Behavioral Health, Student Learners, PharmD, and reception. This committee was formed to come up with a universal way to deal with chronic pain in our clinic starting from reception. We will discuss how everyone worked together to form a collaborative and integrated approach to helping people with chronic pain have a better quality of life. Behavioral Health has a role to help manage the difficult patients as well as the patients who could benefit from CBT, group, or individual therapy. Behavioral Health professionals are available to work with people in groups for chronic pain as well as individual and family therapy.

Exchanging ideas: How Do You Teach Behavioral Science at Your Residency?

Limor Gildenblatt, PhD

Behavioral Scientists differ in their backgrounds and teaching styles (Goldstein et al., 2017). If an average week of a Behavioral Scientist's job was compared across multiple residencies there would be variability in regards to how time is spent between teaching, clinical, supervision, research and administrative duties. Over time, behavioral scientists are able to fine tune their teaching skills and decide when and where it may be most effective to teach residents, whether in

didactics, during inpatient rounds, or when shadowing in outpatient clinics. It could be very valuable for experienced behavioral scientists to share what they have learned throughout their careers and share an “average week” of how they spend time in their residency. Additionally, newer behavioral scientists or ones from different educational backgrounds (i.e., who focused on family therapy or early childhood development during their studies) can provide ways they have been teaching in their residencies and offer seasoned behavioral scientists with fresh ideas. This round table discussion will provide an opportunity for behavioral scientists to exchange teaching ideas and share what has or has not worked well in their residencies. The possibilities for how and when to teach residents are endless and should be shared.

Community Medicine and Community Based Team Experiences: Learning Leads to Practice

Shari Holland, MA, LPC; Robert Sukolsky, MA

As Behavioral faculty we hope to help residents become good partners and advocates in the communities they serve. Residents are team members with their colleagues and other physicians and medical staff in many contexts, the inpatient FM House team, Night Float team as well as in a variety of other ways during residency. In this breakfast roundtable discussion, two behavioral faculty will discuss how they have been involved with a local provider council and how this provides residents exposure to teams of other professionals outside the medical setting and the importance of understanding the nuances of the community around them. We hope to share ideas and discuss ways that others have provided opportunities for residents to work in community contexts and teams that help encourage and enhance their skills as partners in health in the community.

Why a Psych Referral? From Stigma to Acceptance

Sheerli Ratner, PhD; Eric Berko, PhD

The Family Medicine doctor is often the first stop for a patient with Mental Health issues. The patient may come with specific mental health concerns, or with physical symptoms that may be masking psychological distress. It is not always clear what the right course of treatment may be, or whether symptoms have a psychological root cause. And even if it becomes clear that mental health concerns are at play, the physician may question the necessity of a psychology referral, and the willingness of the patient to consider such a referral.

Changing Paradigms Takes Time: Institutionalizing OB group visits

Pamela Webber, LMFT, MD; Audrey Hall, DO; Hannah Schreiber, DO

Making clinic wide changes in a residency clinic can be challenging, particularly when those changes impact the work flow of several groups. Ten years ago, as part of the Patient Centered Medical Home (PCMH) movement, our clinic established an OB PCMH group. One of the multidisciplinary team’s tasks was to create an OB group visit for women at 24-28 weeks. This provided an opportunity for residents to lead a group visit. An attempt was made to standardize the education that women received about the glucose tolerance test and gestational diabetes. Although the group visit occurred monthly with different residents and nursing staff, it required a large amount of scheduling time, relied on one faculty member, and was not part of the clinic culture. In the past year a group of residents has made this group visit a QI project. This, along with other changes implemented by the OB PCMH group, are beginning to institutionalize the group visit. In this session, participants will learn about our challenges and successes, review some of the key principles of change, and have a chance to apply these lessons to work team projects in their residency program.

A Behaviorist, a Medical Provider, a Nurse and a Patient Walk into a Rural Clinic

Lisa Goldstein, MD; Megan Neace, CSW

Current standards of care for treating most mental health concerns- including anxiety and depression, grief reactions and other primary care mental health issues involve both cognitive behavioral therapies as well as medication management if needed. We have a local counseling program, but the ability for them to prescribed medication is limited. As a teaching Family Medicine Clinic located in a rural community, we are approximately 45 minutes from the nearest hospital, and the majority of other specialty services, including psychiatric services. Trying to merge these two services in our local patient population has continued to be a challenge, until a Grant Awarded in 2012 allowed us to embed a behavioral health provider within our clinic. Our counseling social worker (pending LCSW) sees patients for private counseling, takes referrals from our providers as well as working as a team to provide synchronized patient care. She is also able to provide feedback on medications, their usage and effectiveness for individual patients. Because many chronic medical health conditions are affected by incompletely treated anxiety or depression, these mental health concerns not only have a direct but also large indirect consequence to the medical care of our population. The academically-focused goal of this

presentation is to look at our percentage of primary care patients who have 50 percent or greater improvement in their PHQ-9 scores for depression looking at treatment types. These are divided into sub groups of medication only, counseling based services provided by our counseling social worker and combined treatment groups.

FRIDAY, OCTOBER 12, 2018 SESSIONS

Seminar 130A

Inpatient Behavior Rounds: Bringing the Learning to the Learning Environment

Della Rees, PhD, LPC; Maria Shreve, MD

The 2017 ACGME Family Medicine training requirements clearly articulate behavioral health curricula is to be integrated into the residents' total educational experience, including the physical aspects of patient care. But how does a medical residency structure behavioral health training within a medical context?

Medicine is precise, positive/negative labs, and yes/no algorithms. Conversely, behavioral science has ranges, i.e. any five out of eight symptoms for a positive diagnosis. This lack of precision may lead a training physician to feel behavioral science elusive and murky. Medical learners need behavioral science techniques that fit a medical world, are quick, accessible and culturally sensitive. Open ended questions are not enough- they need to handle an angry patient, a parent being asked to give their teenager privacy with their doctor, helping with low health literacy issues, and the dreaded emotional patients. Behavioral training for residents is more of behavioral medicine rather than behavioral health. It needs to be medically applicable, integrated into medical care.

Behavior Rounds allow residents to openly discuss real time questions, fears, frustrations, and apprehensions related to, or stemming from, patient care, for example, experiencing sadness of a patient who died in their care. Behavior Rounds provides immediate discussion and debrief, reminds of tools or system-based resources, or reminds the residents of their humanity. It connects previous lessons, like an OSCE, to practical application. It brings the OSCE to real life.

Behavior Rounds provides application of behavioral science concepts into the medical management of a patient in a real-time experience.

Seminar 130B

Integrating Behavioral Health into Inpatient Medicine Rounds as a Model for IPE

Alexander Brown, PhD; Erin Cobb, MS; Haley Curt, MS, MA

Family medicine residents and behavioral health students are increasingly trained side by side, providing novel opportunities for interprofessional education and team-based care. This has been supported in part by the expansion of primary care-behavioral health (PCBH) integration, which is typically limited to outpatient care. Family Medicine residency training, however, does not occur in outpatient settings alone. At Concord Hospital, in NH, Dartmouth Family Medicine residents routinely round on our inpatient medicine service in order to provide continuity of care to Family Health Center patients during inpatient stays, but similar continuity has been inconsistently offered for behavioral health care. In an effort to replicate the interdisciplinary team that is found in primary care, we developed a model for including BH students in the inpatient medicine service. We will outline important characteristics of interprofessional education in a hospital setting, describe how we created the structure and workflows to include BH consults in inpatient rounds, and discuss how a block rotation design for residents impacts team and patient continuity. We will also discuss key aspects of the co-learning process, as behavioral health interns, residents, medical students, and pharmacy students learn and work together.

Workshop 131

A Method to Bridge the Gap between “Learning” and “Using” Motivational Interviewing

Claudia Allen, PhD, JD; Theodore Siedlecki, PhD

Patients' own behaviors account for 40% of the variance in premature death rates (Schroeder, 2007). With that in mind, much energy has gone into training physicians in Motivational Interviewing (“MI”), a method of evoking patients' own motivation to make behavior change. Physicians-in-training frequently report, however, that even after training in MI they are too daunted by the complexity and potential length of MI to use it in practice. In this workshop, presenters will share a compact method of bridging “the confidence gap” between MI training and actually using MI, with preliminary data that the method increases learners' confidence. While presenters will touch on MI principles, the bulk of the workshop will be spent in experiential learning. Presenters will first engage participants in an exercise designed to peak

learners' interest by evoking emotions associated with different types of influence. After a brief discussion of MI didactics, the presenters will walk participants through a flexible script designed to comfortably scaffold physicians-in-training through a motivational interview in an office visit. Having a personal wellness behavior in mind, participants will then practice the script in pairs. Because the script deviates depending on stage-of-change, it can be used with patients not yet interested in change as well as patients ready to take steps or wishing to maintain gains. Presenters will discuss their experiences using this script with medical learners, as well as preliminary data indicating positive effects on learners' confidence. Presenters will anonymously survey participants' confidence pre- and post-workshop and share outcomes with the group.

Workshop 132

Feedback: Thanks but No Thanks!

Stephanie Nader, MSW, LCSW; Kim Jones, MSW, LCSW

The ability to provide quality feedback is critical in resident development, addressing team challenges, and ensuring safe patient care. However, providing effective feedback is a skill in which there is often limited training for faculty. There is often a disconnect between how the residents and faculty perceive the frequency, quality and clarity of feedback. In this session we will explore the components of feedback, barriers to giving and receiving feedback and provide techniques to ensure that feedback is being received and understood. We will ask attendees to participate in completing self assessment worksheets as well as role plays to further develop their feedback skills. Attendees will have tools to take back to their home programs to further develop feedback skills with faculty and residents.

Wellness Showcase Seminar 133

Showcase 133A – Coaching a Healthy Team: Novel Ideas for Well-Being

Katherine Buck, PhD, LMFT; Adam Guck, PhD

Burnout and work-related stress are widespread and problematic among medical residents. Rates continue to increase and are shown to be associated with negative outcomes for patients, learners, and institutions. In an effort to reverse these trends, ACGME has increased program requirements aimed at enhancing resident well-being and resilience in clinical learning environments. We will discuss some of the creative components that we have used to make well-being work for a large full scope program with varied interests. These components include track specific activities, a targeted “intern rounds” program, collaborations with other departments, retreats, rotation based activities, hospital-wide activities, and a targeted system for outreach to residents with personal difficulty. We will discuss winning team strategies for well-being, including those at our program and novel strategies at programs represented by attendees. At the end of the workshop, attendees will receive a list of novel ideas that are working well in attendee programs.

Showcase 133B – Therapeutic Thursdays: “Health is a State of Body. Wellness is a State of Being”

Stacey Nickoloff, DO; Limor Gildenblatt, PhD, LCSW; Inyoung Na, DO

In early training years, physicians are taught how to best care for their patients. However, research has shown that often times this effort supersedes the personal needs of these same physicians. Physician wellness is often neglected due to time constraints, outside responsibilities and lack of training with regard to subtle wellness activities. In this session, the presenters will demonstrate how a structured wellness curriculum during residency can assist physicians in better treating themselves and thus their patients. Audience members will experience several mindfulness techniques that have been taught to the residents.

Showcase 133C - Identifying Intern Distress: Weekly Pre-Shift and Post-Shift Burnout Ratings

Tom Barbera, PhD

Behavioral Science educators are often expected to monitor resident distress and impairment in addition to their clinical and teaching responsibilities. Monthly support or wellness meetings provide opportunities to formally measure resident distress and informally check-in with residents. Ironically, it's more difficult for residents to attend support meetings during their most challenging rotations, typically night and inpatient rotations. Thus, when medical residents are suffering the most and have more to gain from attending a support meeting they are less likely to attend. This increases the likelihood that Behavioral Science educators will fail to identify peak moments of distress and miss opportunities to personally engage with residents or activate other resources within their programs, such as chief residents or faculty advisers, that may help residents recover or cope with challenging experiences.

There are several advantages of briefly measuring resident distress more frequently than on a monthly basis. Weekly measurement allows for early identification of resident suffering. Electronic reporting formats such as text message or email remove barriers for residents on rotations away from the residency clinic or hospital and for those working nights. Utilizing brief measures increases the likelihood that a resident will complete the check-in, even when on a busy rotation. Weekly measurement also gives residents opportunities to reflect on their distress level and consider potential coping methods. Lessons learned during a year-long and ongoing effort to improve early identification of resident distress through weekly pre-shift and post-shift subjective burnout ratings will be described.

Seminar 134

Integrating Principles of Military Team Development into Family Medicine Education

Mark Dixon, PhD, LCSW; Sundonia Wonnun-Williams, PhD, LCSW; Ebon Alley, PhD, LCSW; Steven Hyer, PhD, LCSW

Delivery of quality care consists of allied health professionals working together in teams designed to apply a broad spectrum of knowledge to impact patient care and health outcomes. However, team endeavors can often prove difficult, complicated, and rife with potential for errors and negative outcomes, unless deliberate actions are taken to optimize communication and cooperation (Weller, Boyd, & Cumin, 2014). The U.S. military excels at developing teams to accomplish a variety of tasks, almost always in coordination with other teams, amid fluid and high stress circumstances. A team's level of performance is made possible through effective leadership and development of high-functioning team dynamics (Yammarino, Mumford, Connelly, & Dionne, 2010). Effective military team development consists of eight principles: 1) training to standard, 2) train as you will fight (i.e. perform), 3) focus on fundamentals first, 4) develop adaptability, 5) conduct multi-echelon/concurrent training, 6) unit/team cohesion, 7) communicating commander's intent, and 8) use of internal and external resources (Bates et al., 2013; Britt & Oliver, 2013; Department of the Army, 2012). In an effort to augment the capacity and quality of patient care through improved team functioning, ground has already been broken to harness the tools, methods and strategies of military team development and leadership (Burke, Salas, Wilson-Donnelly, & Priest, 2004). Given the importance of team development and cohesion to quality health care, this presentation aims to adapt key military training principles to the education and cultivation of family physicians not simply as astute practitioners, but as exemplary organizational leaders.

Research on Patient Care 135

Moderator: *Randall Reitz, PhD, LMFT*

Research 135A - Psychiatric E-consult

Patricia McGuire, MD; Jiayun Lu, MD

Family medicine practitioners are a major provider of mental health care, especially in populations, such as urban and rural underserved, that have barriers in accessing mental health specialists. For complex behavioral health cases, family physicians often feel uncomfortable with management, leading to a need for psychiatric consultation. The Psychiatric E-consult model was developed to provide family physicians with timely access to psychiatric curbside consultation. The purpose of the Psychiatric E-consult initiative is to maximize the benefit of integrated behavioral health care in three family health centers connected with our family medicine residency. This model allows family medicine faculty and residents to place consults to psychiatry residents and faculty, with questions on diagnostic clarification, medication management, and appropriate level of care. The goal is to improve patient outcomes as well as provider knowledge and comfort with behavioral health. We anticipate that implementation of this integrative care model will increase provider knowledge and comfort with behavioral health issues, improve provider satisfaction, and increase patient access to timely mental health care.

Research 135B - Trauma-Informed Care within an Urban Primary Care Clinic

Courtney Barry, PsyD; Kevin Hamberger, PhD; Zeno Franco, PhD

Trauma is commonplace and can affect many individuals. If an individual experiences chronic traumatic events, physiological changes within the body can contribute to the development of somatic symptoms and chronic health conditions, which may lead to an early death. Trauma survivors may turn to their primary care providers to manage both their physical and psychiatric health conditions. These chronic health conditions may be the focus of treatment, but rarely is trauma assessed to determine if trauma contributes to the root cause of these health conditions. Several studies have assessed trauma within a primary care setting and have found rates ranging from 2-39%. The trauma prevalence in predominately African American primary care settings was 87.8%. The aim of this study is to conduct a prevalence study

of trauma experiences among an adult family medicine clinic population, using an adapted version of a previously validated survey instrument. The prevalence study will identify the number of traumatic experiences an individual has been exposed to both in developmental years (i.e. reflections on childhood experiences and adulthood) and identify associated medical conditions within the primary care clinic. It is expected the prevalence of trauma will be in alignment with other trauma studies and will demonstrate a correlation between trauma and health.

Research 135C - Motivating Patient Follow Up: A Prospective Interventional Study of Behavioral Referral Techniques in Primary Care *Elizabeth Fleagle, PsyD; Scott Nyman, PhD; Mark Vogel, PhD*

The Lifestyle Change Clinic (LCC) is a behavioral health clinic embedded in our primary care ambulatory family health center to address health behaviors including smoking cessation and weight management. Unfortunately, the clinic often experiences no-shows, which suggests the need for a modified referral system. Brief motivational interviewing (MI) interventions can be effective in encouraging patient engagement in screening and treatment^{1,2}. Warm handoffs have also been shown to improve follow through with referrals³. In the proposed study participants identified for LCC will be randomly assigned to one of three referral interventions including MI, warm handoff, and treatment as usual group. As a study primarily interested in referral effectiveness, the primary variable of interest will be attendance at LCC. Variables hypothesized to impact treatment engagement including readiness to change and psychiatric comorbidities will be collected. Data will be collected at referral and at initial LCC appointment. It is hypothesized that patients exposed to behavioral science staff via warm-hand off and MI will be more likely to follow-up in clinic and engage in ongoing clinical intervention. Furthermore, those who rate themselves as more motivated to change are more likely to follow up. It is hypothesized that MI group will rate themselves as more motivated than other groups at time of referral. It is hoped that the results of this study will provide guidance to improve effective referral techniques for this integrated behavioral science clinic in order to support patient engagement. We hope to use this information within future behavioral health curriculum for residents.

Lecture Discussion 136

Health Systems Genograms: Closing the Loop in Integrated Behavioral Health Settings

Jay Brieler, MD; Max Zubatsky, PhD, LMFT; Lauren Wilson, MSW, LCSW; Ashley Meyr, MD

Effective Behavioral Health Integration (BHI) requires specific and intentional modes of communication in order to maximize the differing but complementary skill sets of Medical and Behavioral Health providers. Behavioral Health Consultants, both in the hospital and outpatient setting, are often called to explore family systems, social determinants of health, and behavioral barriers to adherence with medical treatment plans. Communicating these often complex dynamics back to the referring medical provider is often difficult to achieve within the flow of Primary Care practice. Genograms have a long history in both Family Medicine and Family Therapy as tools to represent the complexity of family systems, and can function both as a record and a focal point of discussion. By incorporating specific health behavior / health literacy items into the genogram assessment, our group has created a standardized tool within our system that has streamlined the process of closing the loop during the BHI process. In this session, the authors will teach the use of the Health Systems Genogram, describe its development, and explore its application in transitions of care from the inpatient to outpatient setting.

Lecture Discussion 137

Somatization and Illness Anxiety: Strategic Engagement in Challenging Encounters

Tom Linde, MSW; Grant Scull, MD

Patients with features of illness anxiety and somatic symptom disorder can complicate care by requesting unnecessary workups and treatment, sometimes with an intensity that may challenge our compassion. We encounter an under-recognized double-bind: on one hand, benign findings and reassurance may provoke increased demands by the unmollified patient. On the other hand, a positive response to reassurance can shape a dependence on clinic visits as a comfort source. We may be inadvertently complicit in a pattern which supports their anxiety and repetitious visits. We will discuss the negative cycles perpetuated by the interactions between sensations, fear arousal and avoidant care-seeking. We will talk to the many providers who experience low efficacy with such patients, and we'll propose creative methods for managing challenging encounters - the theme being that exposure in the form of full contact with patients' emotions and values improves patient and provider experience alike. This session will help us in aiding residents with patients who otherwise leave them feeling ineffective. It is proposed that these techniques may help start young clinicians on a developmental pathway toward becoming calmly creative healers.

Lecture Discussion 138

Addressing Stress and Burnout Among Residents: A Standardized Patient Intervention

Adam Wilikofsky, PhD; Donna Cohen, MD

The ubiquity of the terms “wellness” and “burnout” is deeply rooted in the increasingly complex demands of modern life in general and medicine in particular. Studies demonstrate residency training is a peak time of stress with staggeringly high numbers of trainees experiencing significant difficulties. Training programs inherently place intense demands on residents with typically limited formal wellness curricula to address sleep, nutrition, exercise, personal relationships, and general well-being. Programs frequently focus on general wellness suggestions, but rely upon self-identification of problems before taking more targeted action. How residents identify and handle such issues with their colleagues has been less commonly addressed. We employed a standardized patient approach to help residents identify and facilitate assistance for colleagues who are experiencing work stress, burnout, and other emotional well-being related issues. The standardized patient methodology is a well-established training tool commonly used to assess and refine clinical skills. We utilized it to generate discussion, enhance awareness, and allow for in vivo practice around addressing burnout, providing emotional support for colleagues, and creating a sustainable culture of wellness.

Workshop 139

Balint Groups: the Art of Relationship in Family Medicine

Phillip Phelps, LCSW; Jeffrey Sternlieb, PhD; Jose Nino, MA, LCPC; Allison Bickett, PhD, MS; Chris Rule, MSW
(Please see Workshop 129)

Clinical Practice Update 140

Updates in Insomnia Psychopharmacology

Scott Bragg, PharmD; JJ Benich, MD; John Freedy, MD, PhD

Insomnia is a common patient complaint in primary care with estimates of approximately 1/3 to 1/2 of patients reporting some degree of insomnia. As a result, primary care providers are consistently asked by patients for strategies or medications to help treat insomnia or prevent insomnia. Time constraints and care coordination challenges seen in most primary care settings make differentiation of insomnia from other sleep disorders difficult. Moreover, medications for insomnia are commonly prescribed to help patients function more effectively, but many patients do not pursue first line non-pharmacologic changes such as sleep hygiene or undergo re-evaluation for how effective and safe medication therapy is for insomnia. To address a few of these issues with optimal patient care, we will highlight changes to the DSM-5 criteria for the diagnosis of insomnia, review non-pharmacologic approaches to treat insomnia (e.g., sleep hygiene options, CBT techniques), and identify how drug therapy can supplement first line treatment options in insomnia. Case vignettes will be used to help to providers differentiate chronic insomnia from other forms of sleep disorders and give audience participants a holistic view of insomnia treatment options. We hope participants can walk away better able to assess for factors contributing to poor sleep, implement non-drug treatment options, and identify best practices for using medicines safely.

Lecture Discussion 141

Creating a Human Trafficking Victim Medical Home in a Family Medicine Residency Clinic

Ronald Chambers, MD; India Fleming, PhD

Reactor Panel: Danielle Bela, LCMFT, LCAC; Anna Rempel, MD, PGY-2

Human sex trafficking is a public health crisis that the medical field has only begun to address. This presentation will provide an overview of the development of a highly successful medical home providing longitudinal care for victims of human sex trafficking. Information about human trafficking with physician guidance on identification of victims, protocols for intervention, and techniques for victim-centered, trauma-informed care will be presented. Expert opinion on the longitudinal approach of caring for victims will be reviewed. Best practices evolving from the collaboration between a family medicine residency clinic, a hospital system and several community organizations serving human trafficking victims will be described. The collaborative experience of partnering with many community agencies to create a network of informed providers facilitating care and sharing resources has enhanced both the medical and psychosocial care provided. This partnership includes the innovative step of embedding an advocate from a community service organization within the clinic itself to facilitate access to and coordination of care. In addition to working together to serve this vulnerable population we will report on a joint project to support caregivers, including physicians and counselors, in

addressing the vicarious trauma many report is a sequela of this work. Finally, the value of incorporating this work in a residency program for patient care, resident education and dissemination of knowledge will be shared.

Lecture Discussion 142

Patients Stay Better When We All Play Together: Complex Care with Psychiatric Residents

Anatol Tolchinsky, PhD; Lauren Ostarello, MS

There is a profound shortage in the availability of psychiatric resources. Primary care physicians are often the first contact for those who suffer from mental illness and are thus faced with difficult decisions regarding psychiatric medication management. Although traditional psychiatric outpatient services can help address some of these unmet needs, there are still many in need that are unable to receive these services due to limited access and stigma, among many other known barriers. From the perspective of psychiatry, many mild and moderate forms of psychopathology can be safely managed in primary care offices, thereby allowing the limited psychiatry workforce to address the moderate-to-severe psychiatrically relevant cases. Using the basic structure of the psychiatric collaborative care models proposed by the Centers of Medicare and Medicaid Services (CMS), a collaboration between a Family Medicine Residency and a neighboring Psychiatric Residency was created. Fortunately, through this collaboration, we were able to add psychiatry to our care team. This service has been monumental in helping not only meet the needs of our patient population, but additionally both types of providers have been reporting increased comfort and confidence in managing patients in primary care. Based on the aforementioned models of collaborative care, psychiatry learners conducted weekly chart reviews to help manage a myriad of purely psychopharmacological interventions, in addition to a variety of non-medication-based challenges which pertain to long term patient care. Additionally, psychiatry residents contributed to care team conferences and educated family medicine providers through curbside consultation as well as scheduled didactics.

Lecture Discussion 143

Shedding Light on Fatigue-Related Impairment

Lynn Simons, PsyD; Sarah Hewitt, MD

Physician impairment from fatigue is a profound and often ignored concern for physician wellness, resident learning capacity and safety of the patient. Fatigue is caused by too little sleep, fragmented sleep, disruption of circadian rhythms, primary sleeping disorders and impaired coping and wellness. Long work hours, plus altered circadian sleep cycles caused by rotation obligations, contribute to a work environment that is accepted and tolerated. Often residents, and attendings, are accustomed to "pushing through" rather than acknowledging the impairment and fatigue. Such a culture discourages identification and sought after interventions for addressing fatigue. Presenters will review common causes of sleep impairment in physicians and the impact of physician fatigue on their own wellness, on patient safety and on physician health. Addressing impairment, establishing a culture of change in acknowledging impairment, and facilitating awareness of fatigue are goals of the presentation.

Lecture Discussion 144

Once Upon a Time: Literature in the Personal and Professional Development of Residents

Roger Stilgenbauer, PhD, LMFT

Traditional physician-patient interactions have focused on objective, dispassionate exchanges (Aull, 2012; Cheron, 2001). An emerging holistic model calling for both emotional and intellectual engagement with the patient provides a more complex context for diagnosis and treatment (Aull, 2012). This new paradigm encourages physicians to be aware of their personal biases, preconceptions, fears, and anxieties, and the influence of these in decision-making and treatment planning for their patients (Aull, 2012; Cheron, 2001). Research suggests that the use of literature may provide novel pathways in which physicians can increase awareness of their own human and emotional needs as well as those of their patients, thus enabling the development of stronger alliances (Batt-Rawden, Chisolm, Anton, & Flicking, 2013; Chen, 2008; Shapiro, Morrison, & Boker, 2004). Many family medicine residents reported a deepened sense of resiliency, empathy, and cultural understanding and competence after the introduction of literature into the behavioral health curriculum two years ago by the presenter. The use of thoughtfully selected literature and the facilitation of focused, small group discussions will be explored. Such groups provide a safe environment for self-reflection, self-care, and the potential for philosophical development in one's personal and professional life. The session will include a review of anecdotal information from residents, as well as reading materials used. Discussion and questions are encouraged.

Lecture Discussion 145

Call It What It Is: Confronting Bias

Charlotte Navarre, RN-BC; Jennifer Hill, PhD; Rachel Jackson, PGY-2

Explicitly expressed racism, sexism, religious intolerance and bias are unfortunately still commonplace in hospital and clinic environments. As our physician and health care worker population becomes more diverse, a patient's refusal of care based on prejudice or targeted comments about the provider's race, religion or sex may increase. For the healthcare worker who is the target, the psychological and moral distress can lead to burnout. As hospitals, clinics, training programs, and individual clinicians respond to expressed bias, it also often raises ethical, clinical and legal issues. Physicians and other health care workers have employment rights that need to be balanced with patients' rights and preferences. Most organizations have provided no training, or have no formal policies, on handling patient bias. We will share the results of a survey conducted in early 2018 with faculty, residents and clinic staff that explored incidents of bias and discrimination. In collaboration with our hospital ethicist, our clinics and teaching program developed guidelines on how to respond to patients and families that both honors patient preference and respects the rights of our staff to work in an environment where they feel supported and protected.

Lecture Discussion 146

Enhancing Training of Family Medicine Residents in CBT for Chronic Pain Management

Stephanie Czech, PhD; Debra Moorhead, LICSW, PhD

The American Academy of Family Physicians (AAFP) clinical guidelines for chronic pain management advocate for trials of nonpharmacologic and nonopioid therapies as the preferred strategies. Further, if opioids are prescribed, it is recommended that they be combined with these alternative treatments as appropriate. Cognitive behavioral therapy (CBT) for chronic pain management has garnered strong research support as a nonpharmacologic alternative treatment. Medical residents may have more success engaging patients in CBT-oriented interventions if they are educated in the intervention strategies and have witnessed the benefits. In our family medicine teaching clinic, we provide a collaborative and inter-professional learning experience within a group medical visit setting for medical residents to gain hands-on practice providing CBT interventions for patients with chronic pain. Residents are coached by faculty, including a family physician, a clinical psychologist, and/or a licensed social worker, to deliver the intervention portion of the group medical visit. This model has been received well by residents, faculty, and patients alike. During this lecture discussion, we will describe the adaptation of CBT principles as an intervention alternative for chronic pain management. We will provide an overview of our teaching strategy, any challenges we have faced, and potential strategies to overcome barriers and optimize learning.

Lecture Discuss 147

Taking Care of Ourselves, Taking Care of Each Other: Resilience Promotion for Behavioral Scientists

Valerie Ross, MS, MFT; Jennifer Ayres, PhD

Maslach et al (2001) identified three dimensions of job burnout: Exhaustion, cynicism, ineffectiveness. As behavioral scientists, many of us are involved in burnout prevention and wellness support for our residents and our physician colleagues. But in recent years, little attention has been paid to burnout prevention for behavioral scientists who practice and teach in medical settings. While the behavioral scientist's jobs and roles are quite different from our physician colleague's, we are not immune to the stresses inherent in the current rapidly changing medical system. This seminar will invite attendees to participate in a structured, candid, and reflective conversation that will enable them to: (1) identify aspects of the job and role of behavioral scientist that create vulnerability to burnout and job dissatisfaction (2) reflect on and share experiences of burnout and resilience (3) identify and share burnout prevention and resilience promotion strategies, and, (4) encourage thinking about how to use larger systems to support burnout prevention. This seminar will involve significant personal reflection and discussion in small and large group formats. Given time limitations, discussion will focus on what could be done individually to promote resilience and what support could be provided to behavioral scientists as members of a larger collaborative. All conference participants are welcome.

Clinical Practice Update 148

Treating ADHD in Adults: Facts and Fiction

Stephen Warnick, MD; Kevin Brazill, DO; Christopher White, MD, JD, MHA

Attention deficit hyperactivity disorder (ADHD) affects up to 11% of children in the United States, and for adults the point prevalence of ADHD is 4.4%, with lifetime prevalence up to 8.8%. Despite the high frequency of this disorder in primary care, many doctors express discomfort with treating ADHD in adults. This session will review the changes in

diagnostic criteria for Adult ADHD from DSM-5 as well as other symptoms common in ADHD, identify the differential diagnosis for adults with ADHD symptoms, discuss screening tools for Adult ADHD, review the evidence for ADHD as a biologically-based disorder, and update participants on the pharmacological and psychological treatments for Adult ADHD. Delving into adult ADHD in these areas will provide participants a broad overview of adult ADHD so that they will become more comfortable treating patients. Given the breadth of this topic, participants should bring a mobile device or computer to take a pre-session assessment, which will aid in aiming this talk to the questions and level of the audience.

Workshop 149

I never wanted to say, “Me, Too”. Residency Response to Medical Errors.

Leah Johansen, MD; Terri Dalton, IMFT

Physicians who experience adverse patient events are vulnerable to the effects of shame unless provided support, nurture and mentoring about how to process the experience of being a “second victim”. Unprocessed shame is highly correlated with addiction, depression, violence, aggression, bullying, suicide, and eating disorders. Residency programs are charged by the ACGME to create and support a healthy learning and working environment which includes many aspects of clinical, personal and professional development including education about how to best heal from a medical mistake. In the life of a physician all doctors will, at one time or another, experience an adverse patient event where they are the treating physician. In this workshop participants will learn steps to creating a best practice Residency Response Plan (RRP) for their residency that will provide support, mentoring and healing for residents who have experienced an adverse patient event. Participants will learn how to be confident mentors, how to educate faculty to promote best practices for dealing with fear, shame and vulnerability which are core emotions embodied during and after an adverse event. Developing a RRP will focus upon the ability to help a physician evaluate their actions against their expectation of perfectionism. People can be incredibly adaptive when supported and taught how to “emerge from the ashes” where they are able to thrive and grow from an adverse event. This supports creating a culture within residency programs foundational to the development of healthy physicians who will experience lifelong satisfaction in medicine.

Workshop 150

Finding Adventure in Teaching Teamness: A Workshop in Team Skill Development for IPE

Thomas Bishop, PhD

As stated in this year’s theme for the Behavioral Forum, residents are finding more and more of their training occurring within the context of teams as a means of advancing the value of team base care within Family Medicine. The challenge then is how to create opportunities for “teamness” or “collaborative competence” where skills such as team work, leadership, roles and responsibilities, group communication, and team problem solving can be taught and experienced. Adventure Based Learning (ABL), which is closely related to Problem-based learning, can serve as a vehicle for providing innovative tools for teaching team skill development. ABL is an experiential approach to instruction where there is a deliberate use of sequential activities, such as games, initiative activities, and problem solving tasks that allow for individuals to experience themselves within a functioning team, and to develop team skills. Many instructional approaches fall short of providing enough challenge, experience, and adequate team context for developing adequate team skills. The aim of this workshop is to provide active participation in ABL, where the audience is in fact part of a team and walking through a curriculum that has been utilized for interprofessional education and team skill development. Participants will not only be exposed to a theoretical overview of ABL, but will leave with innovative teaching tools and strategies that they can apply in developing or strengthening their own curriculum for interprofessional education.

Workshop 151

Navigating the Land of Oz: The Opioid Epidemic & Team Based Treatment in Family Medicine

Lorne Campbell, MD; Andrea Barbis, LCSW-R; Saba Zaman, MD

“Opioid Epidemic” has become a commonly used term in a variety of news sources as well as on the political landscape. According to the US Department of Health and Human Services (2017), 42,249 deaths occurred due to opioid overdoses in 2016 and over 2,000,000 had an opiate use disorder. Although most physicians did not choose family medicine with a desire to work with addiction, it is unrealistic to think this is a “tornado” that can be avoided. Accepting this can bring a practice to the colorful Land of Oz. This workshop will draw from the experience of a seasoned family medicine doctor with an addiction medicine fellowship and behavioral science faculty member who recently integrated into the Established Opioid Use Disorder Clinic, to further augment counseling skills and compliment the medication management as well as holistic aspects of treatment. In order to safely maneuver the poppy field, Dorothy relied on the support of a team she

gathered along the way. A team is also needed for successful treatment of addictions, and sometimes other professionals and staff are resistant to these endeavors. This workshop will explore biases, focus on teaching patient interactions through self-development of vignettes for use in role play, and elucidate the use of psychotherapeutic techniques without “looking further than your [sic] backyard.”

Workshop 152

Reflective Expression through Mask Making—Discovering Your Professional Identity

Peter Rainey, MS; Mark Stephens, MD; Sal Aiello, MS

We all wear masks from time to time during our professional day. Our masks are shaped and molded by our specific professional discipline and the professional roles we play. The formation of the masks we wear is known as professional identity formation (PIF). PIF is the transformative process of identifying and internalizing the ways of being and relating within a professional role or context. PIF is an essential element of each clinician's, MD or behavioral science, education. Since professionalization is often part of the hidden curriculum PIF is often an unconscious, internal and emotionally charged experience. Clinicians, both in and out of functioning collaborative care settings, endure many challenges related to PIF especially as they move from the learner role to that of a faculty or staff. We tend to put on a mask when our roles are unclear or we do not think we are competent. The visual arts, mask-making in particular, provokes personal reflection of our professional identity and how we present it in the professional roles we fulfill. We invite you to explore your professional identity through the reflective expression of mask-making. We believe the creation of visual art to be a journey of expression that provides both a product of expression (the mask) and a process of self-discovery (reflection before, during and after the creation of the mask). It is our hope that through the creation of visual art we can better understand our professional roles and improve our ability to competently fulfill them.

Workshop 153

Grant Writing with a Focus on Teamwork in Family Medicine

David Nelson, PhD; Leslie Ruffalo, PhD; Melissa DeNemie, MS

This topic is important for professional development and generation of meaningful research. The topic can have a clinical focus, community focus or focus for primary care. Grants are best approached as a team activity. This workshop will help the participants develop either an initial or deeper understanding of how grants can fit into their roles as a clinician, researcher or member of the clinical team. Each role can not only build individual careers but also the careers of others including colleagues and learners at all levels. In addition to building a greater understanding of health disparities this workshop will strive to bring the patient voice into the discussion. A number of resources will be discussed and made available to support the learning environment. At multiple steps, short vignettes will be used by the team from their own grant experience to build relevant concepts with the participants. These examples will be deconstructed by the group to point out strengths and weaknesses. Finally, this workshop will enable participants to either develop an idea that can be built upon or identify next steps wherever they may be in the grant process.

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| SATURDAY, OCTOBER 13, 2018 SESSIONS |
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Lecture Discussion 154

Adapting Our Clinical and Behavioral Health Skills to the World of Family Medicine

Debra Moorhead, PhD; Carolyn Minor, LCSW

Adapting Our Clinical and Behavioral Health Skills to the World of Family Medicine

“How do I fit in? What is my role here? Where can I find support?” These questions may sound familiar to behavioral scientists when they come to Family Medicine education from established careers in other fields or disciplines. They may have been successful psychotherapists, clinical program directors or perhaps academic scholars and teachers. They find that adjusting professionally and personally to the family medicine environment can be challenging, especially as they learn to adapt the knowledge and skills acquired in their behavioral health careers into the primary care setting. Often there are few others in their programs with their specific training and background, and it is difficult to find mentors to guide them through the transition. In this workshop participants will have the opportunity to explore how they got to family medicine (decision making process), what their expectations were of what the experience would be (reality check), and how they can make the experience the best it can be (acceptance). The presenters will do this through the use of reflective writing and small group discussion which will allow participants to draw on each other's experiences and

knowledge in realizing their individual strengths and what they each bring to their programs. They will learn how they can use those strengths to educate other faculty and residents about the significance of behavioral science in family medicine and to become mentors to others who come after them.

Lecture Discussion 155

Wonder Teams Activate: Our Story of Developing a Dual Training Model in Integrated Care

Terri Wall, PhD; Sonya Dominguez, MD; Lizzette Rogue, PsyD

As a whole, our health care system is moving toward more integrated care models to meet the quadruple aim of better patient care; better outcomes, lower cost, and better provider satisfaction. Family Medicine residency programs are uniquely situated to be trail-blazers in training both physicians and behavioral health providers to work collaboratively on these complex and dynamic teams. In this presentation, we will share our journey in developing a behavioral health training program within our residency. We will share tips, tricks, and pitfalls that we have learned along the way. This is an opportunity to provide resources for programs who may be considering starting a training program for behavioral health providers, as well as allow those already on the journey to share their experiences and to learn from others. We will talk about the unique roles of the Behavioral Faculty and Physician Faculty in the training of family medicine residents, psychology fellows, and mental health counseling interns. We are excited about the benefits and opportunities that training family medicine physicians and behavioral health providers side by side bring to both professions and to the field of integrated care.

Lecture Discussion 156

Meaning in Medicine: Putting meaning back in Medicine

Lindsay Fazio, PhD; Miranda Huffman, MD

Academic family physicians are pulled in multiple different directions on a daily basis patient care responsibilities conflict with teaching demands, professional meetings conflict with personal appointments. It is easy to see how those engaged in such rigorous work would be quickly overwhelmed and burned out. Much of the discussion of maintaining work-life balance to prevent burnout focuses on setting boundaries and managing time efficiently. While these are critical skills to learn, structuring one's personal and professional life so that it is focused on meaningful activities is also necessary to maintain well-being. The training of future family physicians and the provision of primary care services to diverse populations is certainly meaningful, yet many in academics still report feelings of burnout (Agana, Porter, Hatch, Rubin, & Carek, 2017; Dyrbye, 2011). We will present on strategies used by faculty at 2 different institutions to work towards satisfaction both at work and at home (Cole & Cole, 2014; "Finding Meaning Discussion Groups," n.d.; Fitch, 2014). Participants will assess their own levels of burnout, resilience, grit, and sense of meaning, then use this data to develop plans for putting meaning into their work and home lives.

Lecture Discussion 157A

Using a Multidisciplinary Team Approach to Teach the Annual Wellness Visit

Heidi Musgrave, PhD; Robert Wilkins, MD

The Medicare Annual Wellness Visit (AWV) is a benefit that focuses on creating a Personalized Prevention Plan for recipients. There are many components to this exam that are fertile ground for educating residents in multiple areas of competence. Although these evaluations can be conducted by Allied Health Professionals, the physician is ultimately responsible for ensuring that personnel are trained in implementation and documentation. A curriculum for a multidisciplinary, station-based AWV that is conducted in the community was created. Stations include a pharmacist conducting a medication reconciliation; a social worker discussing End-of-Life Issues; a psychologist conducting a mental status exam and depression screen; a nurse obtaining vitals and health risk assessment; financial personnel ensuring that correct benefit information and documentation for billing are collected; and attending physician specializing in geriatric medicine to review the prevention plan. Residents rotate with patients through the stations to learn each component of the visit. Residents then meet with the patient and attending to create an appropriate and individualized prevention plan. The goal of this curriculum is to not only have residents become proficient in executing AWV, but be able to teach their future staff and Allied Health Professionals to perform these exams in their own offices.

Lecture Discussion 157B

Teaching the Value of Interdisciplinary Collaborative Team-Based Care

Lynn Wilson, DO; Nyann Biery, MS

With the rise of multi-morbidities in an aging population, healthcare professionals are faced with the challenges of caring for elderly patients with complex care needs. Shifting from working in silos to team-based care can facilitate better and cost-effective care for patients, but healthcare professionals may have little or no training in interdisciplinary collaboration for providing such care. However, establishing interdisciplinary teams in primary care residency practices can offer opportunities for physicians-in-training to learn how to collaborate with other disciplines in healthcare. With an aging population in an Eastern Pennsylvania region, a health system deployed interdisciplinary home visit teams consisting of a Guided Care nurse, community health worker, and pharmacist in primary care residency practices located in urban and rural communities. Both medical and non-medical needs of elderly patients are addressed by the interdisciplinary team, which may involve partnering with community organizations to link those with social needs to appropriate resources available in the community. In addressing the non-medical needs of the elderly, the interdisciplinary team demonstrates the need and value of collaborating with community-based organizations to health occupational students and primary care residents. Deploying interdisciplinary care teams in residency practices has allowed the demonstration of interdisciplinary collaboration to residents, health occupation students, and even practicing health professionals. Modeling interdisciplinary collaboration through care teams enabled learners to acquire knowledge and skills to practice healthcare in collaborative efforts. Strategies to form effective team-based care for the elderly and practices for successful collaboration will be discussed for replication at other primary care offices.

Research on Wellbeing 158

Moderator: *Claudia Allen, PhD, JD*

Research 158A- A Quality Improvement Process for Individuals, Teams, and Organizational Wellness

Mary Talen, PhD

In response to the burnout epidemic, residency programs are developing wellness programs that address this individual's burnout through crisis intervention, mindfulness, and stress management. However, wellness needs to expand beyond the individual and become the responsibility and goals of leadership and organizational systems within residency programs. Our goal has been to bolster the next generation of healthcare providers and shift the culture of medicine to curricular, organizational, and leadership-led initiatives that enhance the wellness of residency training. Our focus has been to address the wellness of physicians during their residency training through four core areas: culture of meaning and mission, capacity in team-based care, control and flexibility in decision-making, and creativity in work-life balance. In order to assess the impact of these wellness initiatives, we have conducted a quality improvement process around our curriculum, culture of wellness, and organizational-leadership strategies. Our research has focused on a quality improvement process using the DMAIC model: 1) define the problem and concepts; 2) measure the quality of our wellness on the individual, team, and organizational levels, 2) analyze and share the results with our team and leadership, 3) implement curricular and leadership interventions to improve the wellness climate and 4) re-assess and control the wellness climate at the individual, team, and organizational levels.

Research 158B- Building Resiliency in Family Medicine Residents

Angele McGrady, PhD; Julie Brennan, PhD

The stress of medical residency often is associated with distress, poor quality of life and burnout (1). The ACGME duty hour restrictions have not resulted in improvement in prevalence of burnout, so another approach is needed. In contrast, focusing on building resiliency skills in physician trainees may lessen distress, prevent burnout and improve residents quality of life (2). This study aimed to develop and implement a resiliency program for family medicine residents incorporating coping skills, mindfulness and time management to improve resiliency. Our hypothesis was that with training, PGY 1 residents would decrease one or more indicators of burnout and PGY 2 residents would maintain the improvements they had made in the first year. Twenty-eight residents have completed the program to date and the results support the hypothesis. Two indicators of burnout decreased at the end of year one. Preliminary analysis of evaluation data suggest that the program was well received by residents. Further data analysis, particularly of year 2 is ongoing. Reducing duty hours and providing support groups for residents are positive steps, but based on this study, it appears that more specific skill based interventions are needed to reduce burnout in medical residents.

Research 158C- Community and Caregiver Perceptions of Giving Care to Seniors

Annie Waniger, M2; David Nelson, PhD

Background: Family caregivers of seniors and disabled adults frequently bear the responsibility of aiding in instrumental acts of daily living, locating resources, and often raising their own families. As the demand for caregivers rises, these individuals may experience declining physical health and increased social and emotional stress compared to their non-caregiving counterparts. This project aims to better understand the journey of unpaid family caregivers to identify and define opportunities for improvement across organizations, policies, systems and teams. Methods: A purposive sample of 28 current and former unpaid caregivers of seniors or people with disabilities (26 female, 2 male) participated in 4 separate focus groups (duration of 60-80 minutes). Recording were transcribed verbatim and analyzed using open coding. Results: Six major themes surrounding the experience of caregiving emerged from the coding process: Ambivalence, Family Dynamics, Boiling Point, Acknowledgment and Acceptance, Coping, and Interaction with the System. Interviews indicated an urgent need to identify and support unpaid caregivers earlier in their trajectory of caring for a senior and provide consistent, right-time resources over the trajectory of the seniors lifespan. Discussion: Within family medicine, many different providers including behavioral scientists are needed to provide support to both care-receiver and caregiver. Despite the inherent need, caregivers are often unrecognized by healthcare as part of the team. To provide family-oriented care, family medicine clinics and in-patient systems need to identify caregivers as equal members of a care-receivers team earlier in the process and develop an information network between providers, family members, and community resources

Lecture Discussion 159

Risk Assessments in Primary Care: Creating a Structured Pattern

Alexander Macdonald, PhD, LCSW; Mark Dixon, PhD, LCSW

Primary care providers are key in the assessment of individuals who may be at risk for suicide (McDowell, Lineberry, & Bostwick, 2011). Statistics reflect the critical role of primary care providers. Approximately 45% of individuals who died by suicide had seen their primary care provider the month before and up to 82% had contact with their primary care physician within 90 days of their death (Schulberg, Bruce, Lee, Williams, & Dietrich, 2004). Additionally primary care providers identified one third of their patients as mental health patients (Abed Faghri, Boisvert, & Faghri, 2010). According to another study, a diagnosable psychiatric condition was identified in 90% of suicide cases but in half the case the condition was not treated (Bertolote & Fleischmann, 2002). Additionally, it has been demonstrated that only 36% of primary care physicians assessed for suicide in depressed patients (Hooper et al., 2012). Physicians respond in several predictable patterns to patients with suicidal ideations, only one of these methods proved effective in reducing the risk of suicide among elderly patients (Vannoy, Tai-Seale, Duberstein, Eaton, & Cook, 2011). Despite the significance of suicide risk assessment in primary care, the American Foundation for Suicide Prevention (2016) asserts that while a majority of mental health care occurs in the primary care setting, suicide risk assessment training is inadequate. In short, "The need for training exists" the mandate does not." Given the significance of suicide risk assessment in primary care, a discussion of a structured pattern for risk assessment is warranted.

Lecture Discussion 160

Behavioral and Medical Collaboration at End of Life: Better Outcomes for All

Jo Weis, PhD; Krista Wiger, MD

Providing care to patients and families at end of life is a privilege and responsibility that typically has a disproportionate amount of training and attention relative to the resources dedicated to the prevention and management of disease. Patients and families often times have suffered from the traumatic nature of prolonged illness and impending death which will continue to impact them throughout their clinical course. Additionally, as medical providers, we are vulnerable to our own assumptions, biases, and experiences around death and dying. The unique intersection between medical and psychological factors involved often amplify and complicate communication and care at the end of life. In this presentation, a palliative psychologist and physician team together to explore multiple factors involved at end of life. The first component is developing an appreciation of the traumatic nature of prolonged illness and impending death in terms of psychological and medical sequelae. Secondly, the myriad of psychological, medical, and personal roadblocks for patients and families that hinder collaborative communication specifically at end of life is addressed. Lastly, the key components and ultimate goals of collaborative problem solving, specifically for patients and families at end of life are reviewed.

Focused Lecture Discussion 161

Promoting Inter-professional Team Communication/Training via Case Conferences

*Patricia McGuire, MD; Sandra Sauereisen, MD; Jayne Lu, MD; Marianne Koenig, PharmD
James, Mercuri, LCSW*

Comprehensive care models succeed through development of teams representing multiple disciplines. Maintenance of effective inter-professional teams requires time and on-going attention to development of communication and therapeutic skills within the team.

This session reviews development of an Integrated Behavioral Health case conference in our family medicine residency. The monthly case conference is attended by residents as well as members of our inter-professional team - family medicine faculty; pharmacy residents/faculty; combined family medicine/psychiatry residents; psychiatric faculty; behavioral health clinicians; medical students; social work students. We initially aimed to educate family medicine residents on behavioral health issues using a case based learning model. However, feedback from attendees indicated that the case conference was not only highly valued by our residents, but also by other members of our inter-professional team. We realized that the monthly case conference fostered communication and provided training for the entire inter-professional team.

The goals of our Integrated Behavioral Health case conference: 1) to provide behavioral health teaching for an inter-disciplinary group of learners residents, faculty, students from family medicine, pharmacy, social work; 2) to serve as vehicle to encourage and support communication within our inter-professional team; 3) to reinforce to the benefits and address the challenges of working within inter-professional teams.

This session will review development of our Integrated Behavioral Health case conference. We will describe our guiding principles and organizational process. We will invite attendees to participate in an abridged version of the case conference, followed by a group discussion of the interactive experience.

A Comparison of Two Methods of Interprofessional Education in Primary Care

Corey Smith, PsyD; Amber (Hewitt) Cahill, PsyD

As the healthcare system experiences challenges, including legislative battles over the ACA and physician burnout, family medicine remains vital to improving population health. Evidenced-based practice suggests integration and team work in the primary care setting are key to positive outcomes. The integration of pharmacists, behavioral health providers, physicians, nurses and other team members, where each professional's value, expertise and skills are focused upon to improve patient care, promotes positive provider and patient outcomes. Current graduate medical, pharmacological and psychological training is effective in producing skilled practitioners but fails to prepare future professionals with the knowledge and skills needed to deliver team-based care. The presenters developed interprofessional educational experiences to include medical, pharmacology and psychology students and focused upon smoking cessation and patient centered care provision. The proposed session will review the literature regarding teamwork in primary care, outline the development, implementation and evaluation of two educational interventions, and discuss sustainability and generalizability to diverse settings. Participants will be encouraged to set goals for interprofessional education and/or intervention at their respective institutions.

Lecture Discussion 162

Ghosts in the Exam Room: Identifying Empathy Myths & Finding Our Compassion

Jennifer Ayres, PhD

This workshop will explore multiple factors that affect empathic provider-patient communication. We will discuss insights gained from Jill Bolte Taylor's *My Stroke of Insight* (2008) and Rana Awdish's *In Shock: My Journey from Death to Recovery and the Redemptive Power of Hope* (2017). Prior reading of these books is not a requirement and all participants will be able to fully participate in the workshop. Participants will identify and discuss empathy myths that are passed down from generations of mentors and how these myths guide our views on professionalism, communication with patients, and compassion for self and others. Participants will use provided excerpts from both books to discuss barriers to provider engagement, how provider disengagement contributes to negative patient experiences and provider dissatisfaction, and how to use Dr. Taylor's and Dr. Awdish's insightful experiences to encourage resident reflection. Participants will discuss how to teach residents that clinical efficiency, self-care and empathic connection with patients are not incompatible goals. We also will discuss what we hope residents learn from their interactions with us and what they carry into challenging patient encounters. This workshop will involve self-reflection and optional small and large group participation.

Lecture Discussion 163

Caring for Patients: Track Behavioral Health Needs in Clinic Using Patient Registries

Lindsay Fazio, PhD; Mark Drexler, MD; Sara Lampert, BA

More individuals are receiving mental health care from their primary care physicians than from a mental health professional (Eckstrom, Williams, Avery & Unutzer, 2015). However, few individuals are receiving adequate mental health care. To address this concern, behavioral health has started moving into the front lines with physicians and developing integrated behavioral health programs. In this model, patients are identified by their physician through direct patient contact or screening tools and connected with behavioral health providers working in the primary care office. As the volume of patients with behavioral health needs increase and reimbursement becomes tied to quality outcomes, a process is needed to identify and track at risk patients to ensure better outcomes. Patient registries are a valuable tool to assist teams effectively manage this population of patients. A population-based approach allows clinical teams to support changes in treatment for patients who are not responding to treatment. We will present the relevant literature about patient tracking systems and describe the process of identification and development of a patient registry utilized at an academic medical center on the Northshore of Chicago.