Program Abstracts

The 40th Forum for Behavioral Science in Family Medicine

September 18-21, 2019

THE GATHERING IN

Join with fellow Forum attendees as the co-chairs of the STFM Group on Family and Behavioral Health introduce the 2019 Forum theme, *The Evidence, the Art, the Outcomes* and lead the group in activities that welcome and build connections with new and seasoned attendees.

Wednesday, September 18 | 5:15 – 6:30 pm

Gathering In: The Art of Healing

Katherine Fortenberry, PhD; Corey D. Smith, PsyD; Courtney Barry, PsyD

The relationship between family medicine and the behavioral sciences runs deep through the history of family medicine residency programs. Behavioral scientists as educators are an integral part of family medicine programs, often key among research personnel and in shaping the character of programs. However, given that in many locations the behavioral scientist may be the only individual from their profession in their role, a high potential for isolation occurs. As loneliness and isolation have been consistently related to increased rates of professional burnout and depression, the threat of isolation within a professional role should not be overlooked.

Fortunately, the Behavioral Science Forum has served for 40 years as a professional "home" for behavioral scientists/family system educators. This conference builds community within what could otherwise be an isolated profession. It also serves as a venue for disseminating best practice guidelines, building research collaborations, and enhancing teaching skills.

MARK YOUR CALENDARS

The 41st Forum for Behavioral Science in Family Medicine

September 9-12, 2020

Chicago, IL

PLENARY ADDRESSES

Opening Plenary

Thursday, September 19, 2019 | 8:00 – 9:15 am

Sandra Burge, PhD

Professor Emeritus in the Department of Family and Community Medicine, University of Texas Health Science Center in San Antonio

Act Scholarly! Embrace Your Inner Behavioral Scientist

Since Family Medicine's beginning as a medical discipline 50 years ago, behavioral science faculty have informed its vision, practices and traditions. We have worked alongside physician colleagues, shaped communication and mental health treatment skills in new doctors, and co-developed interdisciplinary health care practices. Models such as Collaborative Care and Behavioral Health Consultants were born in Family Medicine and have changed the experience of healthcare. But – are they effective? A recent systematic review of Primary Care Behavioral Health (PCBH) outcomes stated, "the implementation of PCBH services is ahead of the science…" This observation points to a need to study what we do and document its value to patients, families, and physicians. In this talk, Dr. Burge will encourage Behavioral Science Faculty to see themselves as Behavioral Scientists and Scholars, and to envision The Forum as a learning community in which to join forces, build scholarship skills, and generate new knowledge. She will define scholarship as a fundamental activity within a learning community, and emphasize small and large ways that we can contribute to the science of behavioral science. She will share lessons learned from 30 years of doing and teaching research, with the goal of helping research-naïve faculty "up their game" toward a more scholarly approach to their work.

Keynote Plenary

Friday, September 20, 2019 | 12:15 – 1:45 pm

Dennis J. Butler, PhD

Professor Emeritus of Family Medicine, Medical College of Wisconsin

Forty Years: The Changing Psychology of Being a Behavioral Science Educator

In his address Dr. Butler will describe how the Forum has chronicled and influenced the maturation and advancement of behavioral science in family medicine for forty years. His address will examine the critical shift in the role of behavioral science education from curricular uncertainty to alignment of core content and the personal development of behavioral science educators from role confusion and isolation to integration and a strengthened professional identity, noting bumps, setbacks and detours along the journey. He will challenge attendees to think beyond reliance on professional affiliation and documentation of the utility of behavioral science as the mainstays for integrating behavioral science in family medicine. The Forum has provided an archive of essential content but do behavioral science educators possess the authority and skills to demand trainee accountability? Is it time to answer the question, "Can a resident fail behavioral science?"

Closing Plenary

Saturday, September 21, 2019 | 10:30 – 11:30 am

Colleen Fogarty, MD, MSc

University of Rochester Medical Center

Connecting is Job Number One: Using Kindness, Compassion, and Connection to Help Healers Learn

On April 28, 2019, Dr. Beat Steiner, president of the Society of Teachers of Family Medicine, proposed that STFM focus on increasing kindness and compassion in our lives and the world around us. As teachers of Family Medicine, we are poised in the intersections among healing, teaching, training, and caregiving. Faculty are held accountable for ensuring that our learners achieve certain milestones and demonstrate certain competencies. We have a long list of topics, biomedical and psychosocial, to be sure our learners understand, and procedures of all types that our learners must do. This talk will explore principles of kindness and compassion that provide the underpinnings of our work as teachers, and will provide an opportunity for attendees to reflect on opportunities for kindness and compassion in their careers.

Workshop 101
Narrative Medicine: Re-engaging and Re-energizing Ourselves through Story
Andre Lijoi, MD; Ana Tovar, PhD
Physicians and other allied health professionals have many distractions from their work and what motivated them to become health caring professionals. Factors detracting from making meaningful connection with patients result in high levels of work dissatisfaction and burnout even at early stages of career or training.
Narrative Medicine provides an antidote to these influences. It is an experiential discipline that draws on the Humanities, connects health professionals to their original motivation to care, cultivates the ability to engage patients and stimulates professional growth. When practiced with interdisciplinary teams, commonalities and mutual purpose are highlighted, promoting group cohesion and appreciation. The practice of this discipline and development of narrative competence relates closely to the advancement along numerous milestones, particularly patient care, communication and professionalism competencies.
Narrative competence results in an energized, highly skilled professional who reads closely the story before them in the exam room, and in their own mind. Capturing these stories positions one to know their patient well and how best to care for them. It prompts critical thinking about what is going on with patients, their interaction with that patient and their own professional development.
This workshop will present an introductory didactic that explains the disciplines key concepts and guidelines on how to conduct a program. Program evaluation data will be presented. Attendees will participate in a complete experiential Narrative Medicine session. Curriculum plans will be provided to aid those who wish program in their own residency.

Workshop 102
Teaching Family Interviewing to Residents: Basic Concepts and Applications
Hernan Barenboim, PhD
The treatment of chronic conditions in primary care is complex and involves a longitudinal and biopsychosocial understanding of the life of patients. Family and friends frequently accompany the patient; however, they are often not included in the communication with the provider. Understanding the patients support systems can be useful in the management of chronic conditions and family and friends can be key allies for patients trying to implement treatment strategies offered by health care providers. Family interviewing skills develop over time with dedicated, guided practice, making residency training the perfect time to learn them. We have developed a model of skill development for primary care physicians in residency. We will explore the core elements of this model and recommendations for incorporating this model into residency training.

Seminar 103
Overcoming Barriers to Mental Health and Substance Use Care in Pregnancy
Betsy Manor, MD; Jeremy Waldhart, DO; John Hayes, DO; Kristin Magliocco, MD
Studies suggest that up to 20% of women suffer from mood or anxiety disorders during pregnancy. Tobacco, alcohol, marijuana, opioids, and other illicit drug use is also prevalent in pregnancy, ranging from 1% to 25% depending on the substance. While pregnant women in general are highly motivated to modify their behavior compared to the general population, there are several barriers to optimizing mental health and substance use care in pregnancy: patients personal feelings of guilt or shame, general stigma surrounding mental health and substance use, patients fear of legal consequences, patients and providers concern about pharmacologic safety in pregnancy, and patients and providers lack of understanding of the specific impacts of mental health and substance use on pregnancy.
Our seminar will focus on reducing these barriers by providing patient perspectives on mental health and substance use diagnosis and treatment, education about pharmacology in pregnancy, and education about the specific impacts of mental health and substance use on pregnancy and neonates. The audience will participate by being asked to consider their current knowledge of the topics presented, developing specific strategies to overcome barriers that impact the care of their patients, and asking questions of the presenting panel.

Workshop 104
Core Values & Resilience Promotion in Family Medicine Education
Jennifer Ayres, PhD; Valerie Ross, MS, LMFT
In her book, The Upside of Stress, McGonigal (2015) proposes that a meaningful life is a stressful life and that a persons perception of stress hinders or enhances performance. Her research indicates that awareness of ones core values has a significant impact on stress perception and resilience. This workshop will explore how family medicine educators remain true to their core values and enhance resilience by reframing their perception of stress and anxiety. Via self-reflection, experiential learning activities and participation in group discussions, participants will: (1) identify core values, (2) explore the relationship between core values and resilience, (3) share resilience strategies to facilitate well-being during incompatibility of core values and job demands and (4) learn tools to facilitate similar experiences in their residency programs.

THURSDAY, SEPTEMBER 19, 2019 SESSIONS

Lecture Discussion 105
You'll Shoot Your Eye Out
Lynn Simons, PsyD; Meaghan Beasley, MD; Bonny Rye, LLP; Christine Medaugh, MD
Video violence exposure, as contained in media, films, videogames, television and the internet increases the risk of viewer violence, similar to risks incurred in actual exposure to a violent environment. These risks included increases in the viewer's risk of engaging in violent behaviors as well as diminished pro-social behavior. Short term and long term harmful impacts are known, including increased aggressive thoughts, physiological arousal, hostile appraisals of others, aggressive behavior and desensitization to violence. The United States has a violence from gun death rate that is five times higher than expected, mirroring the trauma and violence nationwide that occurs. Despite physician education to parents, and patients, families still do not demonstrate awareness of the negative impact of media violence. Parents also do not monitor or enforce safe media behavior. Skills to help communicate effectively with parents and patients are reviewed, and common theories about parental resistance are explored.

Lecture Discussion 106
An Evidence Based Approach to Team-Training in Healthcare
Adam Guck, PhD; Meredith Williamson, PhD; Katherine Buck, PhD, LMFT
Behavioral science professionals are often recruited for team-training efforts in healthcare and academic settings. Among the myriad team-training activities in common use, one that remains highly popular is the use of team-based personality assessments. These assessments usually involve generation of personality profiles for each team member as an entry point for discussion of team-based learning or experiential team-training activities. They remain a popular aspect to team-training as they foster discussion of similarities and differences across team members and can provide team members with insights into their individual strengths. While behavioral science professionals are often requested to perform these assessments, they may feel that they lack a true evidence base for such assessments. Compounding this difficulty is the high proliferation of team-training methodologies in private business sectors which has extended personality assessment beyond a grounding in psychological theory and/or empirical evidence. We provide a review of existing literature and the common measures used to highlight those with grounding in psychological theory and sound psychometric-evidence. The measures reviewed will including the Myers-Briggs Type Indicator (MBTI), DISC profile assessment, the Enneagram, the DRiV, the NEO Five Factor Inventory and others. Review of evidence will inform suggestions for measure selection and discussion will center on practical suggestions to enhance team-training efforts.

Research on Integrated Care 107
Moderator: ***Heather Kirkpatrick, PhD***
Research 107A - Patient Satisfaction of an Integrated Care Model in a Family Medicine Residency and FQHC
Aubry Koehler, PhD, LMFT; Julienne Kirk, PharmD; Edward Ip, PhD; Stephen W. Davis, MA; Gail Marion, PA, PhD
In 2015, we implemented an integrated care model in a family medicine clinic and an affiliated Federally Qualified Health Center (FQHC). This model utilizes warm-handoffs from medical providers (residents, attending physicians, and advanced practice practitioners) to behavioral health providers (BHPs), brief BHP intervention at the point of primary care, and short-term BHP follow-ups. We have elicited patient feedback as a means of evaluating and improving our

integrated care program. Literature on patient satisfaction of integrated care is limited (1). Some researchers, centered primarily in the UK and Canada, have been working over the past several years to develop reliable measures of care integration that also include self-reported patient satisfaction (2-4), but there is still little consensus on how patient experience of integrated care should be quantified.
We used a validated measure, the Agency for Healthcare Research and Qualitys Consumer Assessment of Health Care Providers and System (CAHPS®), Home and Community Based Services version. In this presentation, we will discuss 2-year data from our clinical sites, implications of patient ratings for our programs, generalizability and applicability of results to other integrated care sites, and limitations of using this assessment to measure patient satisfaction of integrated care. Our hypotheses are as follows: (a) patients self-report of physical health will show a direct correlation with satisfaction level, and (b) patients self-report of emotional/mental health will show directly correlated with satisfaction level.

Research 107B - Effect of Prior Authorization Paperwork Efficiency on Physician Burnout
Aaron, Grace, PsyD; Katie Gesch, DO, MS
On average, physicians spend two hours doing paperwork for each direct-contact hour (Sinsky et al., 2016). Navigation of insurance coverage and constantly changing formularies lead to an ever-increasing workload, as paperwork comprises approximately one third of a physicians time (Gilchrist et al., 2005). Furthermore, physicians cite excessive administrative burdens as a major driver of burnout (Shanafelt et al., 2017). At our residency clinic, each physician was responsible for completing their own medication prior authorization paperwork outside of patient contact hours. This responsibility was complicated by off-site rotation responsibilities, requiring them to make a special trip to clinic to complete this paperwork when not scheduled in clinic. This resulted in delays in patients receiving medications. A quality improvement (QI) project was initiated by one of the authors, a resident at our outpatient family practice residency clinic. The aim was to reduce burnout, reduce time to patient receipt of medication, and improve physician paperwork efficiency. After implementation of the improved process, physicians reported decreased levels of burnout. Furthermore, paperwork was completed more quickly, and residents nonclinical time was initially unaffected and at 1-year follow-up it decreased. Blocking providers time for paperwork completion may reduce provider burnout while improving timeliness and efficiency of care.

Research 107C - Integrated Chronic Care Management in Family Medicine
Elizabeth Lawrence, MD; Oliver Oyama, PhD, ABPP, PA-C
Successful chronic disease management is a cornerstone of family medicine and should be part of the education of our next generation of family physicians. The most effective family physicians master the use of interprofessional collaboration to accomplish this often challenging task. In this session, the presenters (a family physician and a clinical psychologist) will describe a collaborative chronic care management model successfully used at their residency program targeting patients with uncontrolled diabetes. Project results will be discussed, including a statistically significant mean reduction in A1C levels in a challenging population of patients with markedly uncontrolled diabetes and limited resources.

Clinical Practice Update 108
Genius Genes: A Helpful Guide to Understand & Interpret Psychopharmacogenomic Tests
Christopher White, MD, JD, MHA; Kevin Brazill, DO; Stephen J. Warnick, Jr, MD
The line between commercially available genetic tests and those ordered during physician visits has blurred over the past year. Several genomic testing companies have developed buccal-swab-based collection vehicles to help predict individual patient responses to the many available psychiatric medications. These companies are now marketing their tests directly to patients online and at local pharmacies, resulting in patients bringing their results to their doctors or therapists for assistance in interpretation. Increasingly, these companies have broadened their outreach to family medicine physicians because they recognize that 40-50% of psychiatric cases in the US are treated and managed in the primary care setting. While psychopharmacologic standards of care for many mental illnesses are well-established and implemented by primary care physicians, the medications available to treat such conditions can be confusing and confounded by patients responses to prescribed therapies. This session will review the various genetic elements evaluated by two leaders in the psychopharmacogenomic testing world (Assurex Health, Genomind), and take the learner through basic general interpretation of test results. Discussion leaders will provide a general overview of the various genetic markers and how to use results in a real-world clinical setting. Two separate cases will be presented with learner engagement regarding pharmacologic choices based on genetic test results in combination with other therapeutic interventions. Finally,

conference attendees will develop strategies to help patients and colleagues use test results to improve communication and, ultimately, patient outcomes.

Lecture Discussion 109
Meaning in Medicine: Putting Meaning Back in Medicine
Miranda Huffman, MD; Lindsay Fazio, PhD
Residency faculty members 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 ones 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. We will present strategies used by faculty at 2 different institutions to work towards satisfaction both at work and at home. 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 110
Ethical Implications of Religion and Culturally Responsive Care
Shena Johnson, PsyD
Culture and religion are ingredients that arent often integrated well into western medicine. The gray areas around ethics, culture, and religion are found in many patient care situations. It is important for providers, regardless of their own and their patients cultural or religious backgrounds, to engage with patients in a way that is both helpful and meaningful. Research suggests that cultural competence can improve physician-patient communication and collaboration, increase patient satisfaction and enhance adherence thereby improving clinical outcomes and reducing health disparities. Medical trainees and even experienced clinicians can be uncomfortable with the challenges that arise in this arena often from the laudable desire to avoid offending or violating patients rights. This session addresses common ethical challenges related to culture and religion presenters have faced while training clinicians and family medicine residents. We will share a number of resources and educational activities participants can bring back to their own programs. Participants will have the opportunity to discuss the challenges they face in teaching about these topics.

Lecture Discussion 111
Hi, I'm Your Doctor: How to Establish a 20-Minute Relationship
Mark A. Dixon, PhD; Steven Hyer, PhD, LCSW
Medicine has gone through several transformations, one of which is the shift towards patient-centered care as a means to improve health care utilization and reduce costs. However, the current managed care environment also presents some challenges to family medicine physicians in maintaining continuity and a quality doctor-patient relationship. The limited time physicians are allotted to spend with their patients proves a significant barrier to developing the doctor-patient relationship, despite the critical role this relationship plays in the quality of health care and positive health outcomes. Further, the doctor-patient relationship can improve the well-being and the job satisfaction of doctors. The literature demonstrates the doctor-patient relationship improves with effective communication, mutual respect, professionalism, and physician empathy. The challenge is learning to develop this relationship despite the constraints and through maximizing the strengths of modern-day medicine, including the integration of behavioral health faculty in family medicine residencies. This presentation aims to explore the key concepts supporting the doctor-patient relationship, to integrate these concepts through modeling, and to gain additional tools for resident education. This will be accomplished through small team activities, large group discussions, and a targeted review of the evidence-based literature.

Lecture Discussion 112
Lighting the Path: Helping New and Experienced Behaviorists to Thrive
Jeri O'Donnell, MA, LPCC; Jennifer Reynolds, LCSW
Graduate Medical Education (GME) is a fast-paced and dynamic field. Those with many years of experience in GME often forget all of the questions that we had when we were starting out on our career paths. When orienting someone new,

we may make assumptions about their knowledge base, taking for granted that they already know what has now become second nature to us.

Alternatively, some of us who have been in long-term positions may opt to change to a new position in a different health system. Similar to new faculty members, experienced faculty may also find themselves facing many questions about their new system (e.g. computer system, program traditions, curriculum, etc.)

In this session, we will discuss what both new and experienced faculty moving into a different system need to know as they transition into their new positions. We will explore the information that should be included in the orientation of both of these groups. The session will include active participation and small group discussion to enhance content mastery.

Lecture Discussion 113
An Integrated Care Model for Medication Assisted Substance Abuse Treatment
Amber Cadick, PhD, HSPP; Hannah Helman, PharmD; Sara Ritter, LCSW

Substance Use Disorder does not discriminate and Family Medicine Physicians are on the front line in this battle. Family Medicine Educators need to provide learners with the tools needed for this fight. Substance Use Disorder is a pervasive problem and the treatment needs to be multifaceted. This session will detail an integrated substance dependence treatment program housed in primary care which includes individual and group therapy as well as pharmacologic treatments.

Lecture Discussion 114
Resident Wellness: Understanding it and Applying the Evidence
Limor Gildenblatt, PhD, LCSW; Alexander Brown, PhD; Jose R. Nino, MA, LCPC; Aimee Valeras, PhD, LICSW; Loulya Chahine, MD; Mario Hagar

A.) Resident physicians are vulnerable to burnout due to significant stressors during their training years. Burnout in residents not only affects them and their families, but also their patients. Monitoring the wellness of residents throughout their residency training may create opportunities to help them address and reduce potential burnout. Residency programs would benefit from a system that would help to monitor residents well-being and their signs of distress along with a method to intervene while still protecting the residents autonomy and privacy. This presentation will focus on a project we developed for our respective residency programs in the same hospital system in Chicago that assesses for the wellness of our residents on a yearly basis. Additionally, we will discuss how we have handled issues of autonomy and privacy when signs of distress were reflected in the data. Residents in both programs complete a series of surveys each year until completion of their program. Results provide faculty with information about the state of well-being in their residents as well as means to offer them additional resources and referrals when they show signs of distress. We will also discuss the collaboration of two residencies, the preliminary survey results, and implication for future collaboration about resident well-being and resilience.

B.) Graduate medical education is increasingly focusing on the promotion of resilience through a range of curricular and extracurricular efforts aimed at resident well-being and burnout prevention. An 8-8-8 FMR developed and proposed structured Resident Wellness Initiative, using available evidence to guide the design, that included process groups run by non-faculty consultants to create a confidential opportunity to share stories and receive support with the explicit objective of reducing burnout and increasing personal growth among residents.

Lecture Discussion 115
Telemedicine: The Art of Innovative Technology in Family Medicine
Oliver Oyama, PhD, ABPP, PA-C; Elizabeth Lawrence, MD

Technology is one of the most rapidly advancing aspects in our culture. There is an ever-increasing demand for digital technology for every-day services like entertainment, banking and shopping. The interest in telehealth has mirrored this growth in other areas. Telemedicine specifically has been shown to be effective in enhancing interest in wellness, access to health care and the quality of health care, while also lowering the cost of care. Nearly half of all hospitals in the United States now have active telemedicine programs and various specialties such as neurology, psychiatry, dermatology, and wound care appreciate how providing remote care via telemedicine can extend their reach and enhance patient outcomes. Our family medicine learners must not only have knowledge in health technology but also become proficient in utilizing the latest advances in technology that benefit both patients and providers.

Clinical Practice Update 116
Cure or Curse? The Latest Evidence Behind Cannabis Use and Mental Health
Kevin Brazill, DO; Christopher White, MD, JD Stephen Warnick, Jr, MD
Cannabis is the most commonly used illicit substance in the United States and Canada (adolescents and adults). As of February 2019, 10 states and Washington, DC have legalized cannabis use and an additional 22 states have medical marijuana laws with wide variations of implementations that cover a variety of medical and mental health conditions. In Canada, cannabis is legal for medical and recreational use across the country. Because the US Drug Enforcement Administration (DEA) categorizes marijuana as a Schedule I Drug (drugs with no currently accepted medical use and a high potential for abuse), it is important for physicians, psychologists, and therapists to understand current evidence regarding use and abuse of cannabis in its many forms and its impact on people concomitantly using it to cope with various mental health issues. To some, cannabis represents a panacea for anxiety, pain, post-traumatic symptoms, and insomnia. To others, the drug poses a serious threat to physical and mental health with worsening psychosis, increasing anxiety, and psychological dependence as potential side effects. Unpacking the latest evidence on Americas biggest cash crop is essential for behavioral health professionals and physicians working in all corners of the US and Canada.

Lecture Discussion 117
"A Million Gray Areas": Addressing Diversity, Allyship and Cultural Connections
Kathryn Fraser, PhD; Karen Samuels, PhD
In medical education, finding your allies is vital for people of cultural/ethnic minority backgrounds. White-identified people of the majority culture can learn about dynamics of race, power and privilege by connecting deeply with minority colleagues. This can only take place through authentic conversations that are multifaceted, far reaching and frank. We believe that silence or avoidance perpetuates further harm, invites microaggressions and marginalization. As faculty, we must be able to offer our trainees the opportunities to have these conversations so they can find safe havens and opportunities for growth. Ethnic groups who are underrepresented in medicine often seek support from faculty with whom they can relate. Its important for faculty of all backgrounds to be able to offer this for URM trainees. As mental health faculty, behavioral scientists are uniquely positioned to help colleagues and learners address the thorny emotional and professional aspects of dealing with these issues. This presentation follows the journey of two psychologists, one Black and one White/Jewish, as they navigated the waters of residency education early in their careers, as well as their own racial /cultural/power differences. Presenters will demonstrate how unwavering attention to their inequities and differences deepened their empathy for each other across racial/cultural/ethnic lines and how all faculty can benefit from this experience. The presenters will teach participants communication techniques to broaden conversations about race, oppression and inequity, with the ultimate goal of promoting optimal health care for all.

Lecture Discussion 118
Physician Wellness, Moral Distress and Stress of Conscience
Corey D. Smith, PsyD
Physicians in the modern American healthcare system are faced with squaring the dissonance between the Hippocratic oath, a decade of training and the realities of making a profit from people at their sickest and most vulnerable. Often, medical providers must choose between the correct treatment plan and the plan the insurance company, the hospital or the clinic will support. This choice, and its consequences, has an effect on the deciders well being and symptoms of burnout via the constructs of moral distress and stress of conscience. Moral distress occurs when a person is prevented from the ethically correct decision based on external forces and/or obligations. Stress of conscience refers to the experience of stress as a result of a troubled conscience, or the subsequent emotional and cognitive results when a persons actions do not reflect her moral values. Research investigating the connection between burnout, moral distress and stress of conscience has previously focused upon nursing staff, members of the military, specialty physicians and others. Our study, utilizing self report measures of stress of conscience, moral distress and physician wellness, is the first to our knowledge to apply a critical eye to the connections between these constructs within the community of primary care physician faculty, residents and fellows.

Curricular Research 119
Moderator: ***Dennis J. Butler, PhD***
Research 119A - Cultivating Change – Engaging Residents in Research
Vikram Arora, MD, MPH, FAAFP; Paul Bell, PhD; Stephen Hagberg, MD
The ACGME guidelines for scholarly activity by Family Medicine (FM) residents include at least two activities per resident and encouragement for presentation at local, regional and/or national levels. This has traditionally been challenging due to a multitude of factors from lack of time and interest to limited administrative support. Studies have shown that residents' participation in a research activity was associated with higher levels of satisfaction in their residency training. We aimed to develop and evaluate effectiveness of incorporating a dedicated research curriculum in achieving ACGME goals for our FM residents.

Research 119B - First Year Behavioral Medicine Rotation: Evaluating Seven Years of Data
Amy Odom, DO; Amy Romain, LMSW, ACSW
Training family medicine residents to be proficient in behavioral medicine is a requirement for accreditation. Our residency program has a three year curriculum to teach this subject area, including a block rotation for first year residents which began in 2013. The content of this rotation is designed to develop basic competency in 1) patient-centered communication, 2) core psychiatric diagnoses and treatments, 3) contextual care, 4) reflective practices. This curriculum encompasses a series of prescribed didactic sessions, required readings, online activities, reflective exercises and review of video recorded patient encounters.
In this session, we will present seven years of data collected to evaluate the impact of the rotation. This includes resident self-assessment of knowledge, attitudes and skills in the four core curricular areas utilizing a post-pre assessment model and aggregate data from milestone evaluations. Comparison data across descriptive groups (e.g. sex, age, and medical school location - U.S. or international) will be presented. Participants will learn how this rotation model supports the development of resident competency in core behavioral medicine areas.

Research 119C - An Evaluation of a Simulation and Video Based Training Program to Address ACEs
Frances K. Wen, PhD; Julie Miller-Cribbs, MSW, PhD; Jedediah E. Bragg, MSW, PhD; Martina Jelley, MD, MSPH, FACP; Kim A. Coon, EdD; Ginger Sutton, BA; Kristin Rodriguez, MPH; Shannon Gwin, PhD, CHES
Family physicians (FPs) routinely care for patients affected by adverse childhood experiences or ACEs, which are ten types of child abuse, neglect, and household dysfunction. An extensive literature has demonstrated that ACEs are common in communities throughout the United States. Moreover, ACEs have a dose-response relationship with behavioral risk factors and physical and mental health conditions throughout the lifespan. In medical training, most educational efforts are directed toward prevention, early intervention, and treatment of ACEs in pediatric populations. However, model curricula are also needed to train FPs to effectively address the sequelae of ACEs with their adult patients. The ACEs team of the University of Oklahoma School of Community Medicine has developed a simulation and video-based training program to train primary care practitioners to address ACEs with adult patients, called the Professional ACEs-informed Training for Health (PATH). Family medicine (FM) and internal medicine (IM) residents participate in PATH training each year of residency. Since the initiation of PATH in 2015, two classes of FM and IM residents have now participated from internship through PGY3. This presentation will provide results from a work-in-progress evaluation of longitudinal quantitative and qualitative outcomes of resident performance in the simulation setting. Outcomes from this project will inform the refinement of PATH as well as the development and implementation of similar simulation training programs in other educational settings.

Lecture Discussion 120
Teaching Virtue, Fostering Idealism: Ethics Rounds on the Inpatient Service
Joseph P. Gibes, MD; Alfred Martin, MD
Medical ethics, when it is given time in the crowded residency curriculum at all, is typically taught using the Four Principles rubric (autonomy, beneficence, non-maleficence, justice). While this approach provides a valuable tool for "working up" an ethical dilemma, it focuses exclusively on the act without attention to the actor. We describe a curriculum element new to our family medicine residency that seeks to address ethical formation more holistically. The content and method are inspired by Alasdair MacIntyre's focus on the virtues as a normative account of professionalism. A faculty member with experience in medical ethics meets with the inpatient team at the end of each week. Residents choose and present a patient that they have cared for that week, usually one with whom they have experienced some

difficulty or distress. Using targeted questions, the faculty member leads a discussion addressing specific questions and concerns that the residents raise. Rather than focusing on specifically medical and technical elements, issues relating to the virtues of justice, truthfulness, and moral courage are elicited and discussed. The trust and continuity of the patient-physician relationship are emphasized. Discussion varies based on what is appropriate to the patient and the issues raised by residents, but often turns on questions of, What does it mean to be this patient's doctor? What do we owe this patient, the care team, ourselves? What is going well, what is going poorly, what could change? The inspiration and underlying theory of this approach and an outcomes evaluation will be discussed.

Lecture Discussion 121
Interprofessional Approaches to Teaching in Family Medicine
Sarah Dewane, PhD Kaitlin Leckie, PhD; Limor Gildenblatt, PhD; Sarah Kay Welch, DO
Over the years, Family Medicine residencies have emerged as natural settings for interprofessional collaboration and training opportunities.1,2 Learners from psychology, social work, pharmacy, family therapy, and other disciplines complete their practicum and internship placements in family medicine residency clinics, working alongside and learning from family medicine residents. As these learners have an opportunity to grow professionally together, family medicine residents also have the opportunity to participate in innovative learning activities and shared service provision that enhances their residency experience and helps them to meet the ACGME Milestone requirements related to Patient Care, System-Based Practice, and Professionalism. 3 In addition, interprofessional collaboration is a vital component of the Patient-Centered Medical Home model, as well as a response of efforts to address the Quadruple Aim.4,5 This session will provide a detailed overview of innovative interprofessional teaching approaches from four different family medicine residencies. Interprofessional approaches to teaching family medicine residents will include didactic teaching, experiential activities, simulation training, shared medical visits, medical group visits, and more.

Clinical Practice Update 122
Suicide: A Protocol for Screening, Risk Assessment and Evaluation for Family Medicine
Chris Rule, LCSW; Brooke Palmer, MA; Chasity Jiles, LCSW
Suicide is the second leading cause for ages 10-34 and the fourth leading cause for 34-54 and overall is the tenth leading cause of death in the U.S. With the increasing rates of suicide across many adult populations, every Family Medicine clinic must develop a standard protocol for screening, assessment and managing patients who present with this problem. We will review how to assess for risk factors and use appropriate screening questions for suicide risk, assessment of suicidality, management of the suicidal patient and safety planning. Current tools and approaches for suicide risk assessment all have limitations, so this update will also share our institutions recently developed protocol and how it has been refined and implemented by integrated behavioral health in our Family Medicine Clinic. Collaborative Care models work for managing suicidal ideation in primary care, and we posit that the same approach works for assessing suicidal ideation and risk.

Lecture Discussion 123
Leaning into Suffering: Personal Growth and Wellness through Empathy
Hugh Blumenfeld, MD, PhD
Caregivers' response to human suffering affects patient outcomes as well as our own well-being. Empathy is the most commonly accepted term to describe the physicians ability to connect with people in pain. It is generally agreed to have both cognitive and emotional dimensions, and some writers add a performative dimension the impulse to relieve suffering. Definitions of empathy vary, as do distinctions between empathy and similar responses like sympathy and compassion. The growing literature on vicarious trauma, physician burnout and compassion fatigue sends the ominous message that one can have too much empathy, that we must hold back in order to protect ourselves. However, I propose that a sufficient understanding of empathy will allow us to "lean in" to suffering, to find in it a source of personal growth and a balm to our patients.
I offer a taxonomy that defines four responses to suffering - pity, sympathy, empathy and compassion - and a teleology showing a natural progression from pity, our earliest response which can be seen in the childs caring for wounded animals, to compassion which is a mature response, often with spiritual connotations, and usually achieved only after much practice and reflection. Especially difficult is the distinction, and thus the transition, from sympathy to empathy. A progression suggests that the more mature responses can be learned, and making clear distinctions can help practitioners

avoid the unhelpful responses to suffering that cause burnout and foster the positive responses that lead to wellness and better patient outcomes.

Lecture Discussion 124
One Time Psychiatry Consult: Increasing Access to Care & FM Provide Knowledge & Skills
Catherine Schuman, PhD; Katya Alcaraz, MD; Mark McCabe, MD
A growing shortage of psychiatrists across the U.S. is making it harder for people who struggle with mental illness to get the care they need. The United States is suffering from a dramatic shortage of psychiatrists with the shortfall being particularly dire in rural regions, urban neighborhoods, and community mental health centers that often treat the most severe mental illnesses. Primary care has been the de facto for mental health services, but providers do not always have the training necessary to manage complex mental health issues. To address the two year wait list for psychiatric care at Gundersen Health System we developed a one time psychiatry consult that provides family medicine physicians (FMP) with evidence based medication recommendations and patients with real time care. The one time psychiatry consult includes a diagnostic assessment and a medication evaluation. The consult results in a diagnosis and medication recommendations being sent to the FMP. The medication recommendations are provided in a hierarchical list with start and maximum dosages. The recommendations provide FMPs with a learning opportunity over time and increased confidence for providers in prescribing medication for mental health issues.

Seminar 125
"What's the Problem?" Identification of Practice Gaps in the Clinical Setting
Mary Dobbins, MD; Jordyn Mathias, LCPC; Nicole Tenegra, MD
Primary care providers are increasingly expected to detect and manage mental health problems, yet this growing clinical demand has quickly outpaced the ability to proactively explore (and systemically address) the additional skills and knowledge most helpful to those providing these services. Using the premise of Problem-Based Learning, we will explore the decision-making process for referral to specialty services as a means to determine the learning needs of providers.

Workshop 126
Integrating the Arts into the Science: Teaching Strategies and Resources
Mary Talen, PhD; Aimee Valeras, PhD
Too often, there is a gulf between the science of medicine and the art of describing illness experiences. Medical providers are usually taught the science behind diagnoses and treatments with little attention to the patient experiences while humanities and medicine sessions focus on lived experience but ignoring the science. Yet, these two worlds can and should be dynamically inter-connected. Developing curriculum that integrates art into medical training rather than adding it on as a session, helps foster wholistic dynamic experiences of healing and medicine. The benefits and opportunities for connecting narrative and visual arts within the science of medicine will be highlighted in this session. Participants will also experience a variety of teaching strategies that weave together the arts and narratives with the hard sciences of medicine. Individuals will participate in experiences that demonstrate how to integrate the arts into didactic sessions, inpatient rounds, case presentations or other clinical teaching venues. Participants will be engaged in compiling a resource list of specific artistic and narrative pieces (essays, poems, book excerpts, videos, art, music) linked to scientific areas such as diabetes, asthma, miscarriage, or substance use disorder to build this integrated curriculum. The focus of this workshop is for participants to build a repertoire of resources that synchronize artistic patient perspectives within standard evidence-based teaching strategies for the purpose of enhance holistic care for patients, families, and communities.

Workshop 127
Mission: It’s Possible! Dynamite Didactics for Wellness and Beyond
Kaitlin Leckie, PhD; Laura Sudano, PhD; Jennifer Ayres, PhD
Your mission, should you choose to accept it, is to translate your unique knowledge and skills as behavioral science faculty so that your medical learners remain actively engaged in their learning. Expect to fight competing demands for learners time, energy, and attention. Be prepared to entice multiple learning styles and to adapt to varying levels of skill and appreciation for behavioral science as you promote clinician well-being. Maintain constant vigilance of wellness, your learners and your own, in an ever more demanding system meant to promote health. All in 90 minutes or less.
For behavioral science educators in a medical residency, didactics represent both a challenge and an opportunity. To prepare you for this noble mission, this interactive session will illustrate unique approaches to discuss wellness and

improve resident engagement and medical knowledge. Engaging strategies will be used to show how creative techniques can be applied to teach wellness, and participants will explore how to apply these techniques to other topics.
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Workshop 128
The Art and Science of Developing Research and Grant Writing
David Nelson, PhD, MS Leslie Ruffalo, PhD; Melissa DeNomie, MS
Developing research is important for professional development and for the generation of meaningful scientific discovery. Research and grant writing can focus on clinical care, community topics, or primary care; some research questions may unite all three of these focal areas. Both grant writing and research are often done through collaborative teams that bring together multiple perspectives. Why important: There are three interconnected reasons why this topic is important.
1. Grant writing is often a strategy to gain resources to conduct research.
2. Research and grant writing can connect the clinic to the community context which can create meaningful and long-term partnerships between the two. 3. Research and grant writing provide a means to build a career on multiple levels to include peers and learners at all levels and disciplines.

Workshop 129
The Balint Group Experience: Promoting Relationship and Team Awareness
Phillip Phelps, LCSW; Chris Rule, LCSW; Jose Nino, MA; Shari Holland, LPC
Balint groups can be a powerful method to assist the synthesis of cognitive and affective processing leading to a more precise, empathic, and practical understanding of doctor-patient interactions. Bringing the patients voice into the room is part of the structured process. With decreasing resources and time constraints, it is an increasing challenge for physicians to generate and maintain an empathic doctor/patient relationship that promotes continuity and health. The patients voice can be lost to patient satisfaction surveys and the clicks of the electronic health record. Balint groups can help to understand and manage the frustration that can be a routine part of todays medical environment for both doctors and patients. Balint groups with multi-disciplinary participations function to enhance empathy and understanding across providers.
Balint groups train providers to understand and use the doctor-patient relationship as a therapeutic tool. The Balint group uses an experiential method that greatly enhances relationships. Two 1 1/2 hour workshops are offered that are designed to provide an ongoing experience for those interested in learning about Balint training methods. Participants may include all levels of experience with Balint. The first group serves as an introduction to the Balint method. The second group is offered for those participants who would like to learn about the Balint method in more depth. Participants are strongly encouraged to attend both sessions. All participants should be in clinical contact with patients and willing to present a case. Relationship awareness and, by design, brings the patients voice into the room.

40TH ANNIVERARY CELEBRATION AND POSTER SESSION

Comprehensive Obesity Bias and Education Intervention for Family Medicine Residents
Jessica Koran-Scholl, PhD
Working with patients with obesity can be a challenge for many family medicine providers. Understanding the complexities of this patient group including how our own implicit and explicit bias can impact the care we give our patients with obesity is important. We developed a half day educational experience for our family medicine residents in order to education them about the etiology and management of obesity, implicit and explicit bias in working with patients with obesity, understanding obesity pharmacology, nutrition in obesity, surgical interventions and the integration of partnerships for obesity management in primary care. Residents were screened on their comfort in working with patients with obesity and their understanding of their own biases both before and after the educational intervention. This educational session was well received by the family medicine residents and can be used as a model for other programs to develop educational tools for working with this patient population.

Expansion of Behavioral Health Services in Two Residency Outpatient Clinics
Josh Rainey, PhD, HSPP; Bethany Garcia, PsyD; Eric Lester, PhD, HSPP; Carolyn Shue, PhD
Improving access to behavioral health care in the outpatient setting is consistent with our professional goal of meeting at-risk patients needs. Often patients disclose behavioral health needs when visiting the clinic for other medical reasons. To be able to attend to those needs, in the moment they are voiced, promotes patient health. This is particularly true for patient populations that face challenges associated with acknowledging behavioral health needs, finding a trustworthy provider, or socioeconomic barriers. This poster outlines how our model of behavioral health integration in family medicine grew from one clinical psychologist to two clinical psychologists as well as serving as a training site for doctoral student interns and post-doctoral behavioral health fellows. Expanding and becoming a training site has allowed us to support warm-handoffs and short-term counseling for our most at-risk patients. Other medical specialties can benefit from behavioral health integration as well. For example, our internal medicine residency has adopted and adapted our model for behavioral health integration in their clinic. This poster details 1) our programs evolution and implementation steps, 2) maintaining cost and value effective expansion, 3) learning outcomes for residents in the area of behavioral health needs during outpatient visits, 4) obstacles and solutions to implementation barriers such as resources, time, and clinical staff buy-in, and 5) our integration outcomes to date in family medicine and internal medicine.

Veteran Classification of Alcohol Use Disorders: Risk and Protective Factors
Mark Dixon, PhD, LCSW; Karen G. Chartier, PhD
Increased use of alcohol among veterans has been noted in numerous studies and rates of alcohol use disorders (AUD) hovers around 40%. A culture of alcohol use exists within all branches of the U.S. military which only serves to exacerbate this situation. Understanding the risk and protective factors of veterans with AUD will assist in identifying at risk sub-populations among and potential prevention or treatment options. Latent class analysis (LCA) was utilized to classify veterans into groups based on factors consistent with holistic fitnesssocial, emotional, physical, and spiritual. A representative sample of veterans (n=3,119) was drawn from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC).

Fostering Cultural Humility in Medical Education through Service Learning
Mahir Mameledzija, BA, MBA, M4; Nicole Runkle, BS, M4; David Nelson, PhD, MS
Background/Significance: It is well known that many disparities exist in health care field, and that it is important for health care workers to deliver culturally sensitive care. As part of medical school accreditation through the Liaison Committee of Medical Education, it is imperative as an institution to ensure that medical students are well-versed in issues of cultural competency. Although students have some opportunities through service learning, volunteering opportunities, and lunch talks, our medical school curriculum could provide a more structured manner for all students to improve and reflect on their cultural competency skills. The goal of this project is to improve students cultural humility through community engagement so that they can provide culturally sensitive care.

Improving Mental Health Outcomes in Residency with Integrated Behavioral Health Model
Heena Panchal, MD; Patrick Corpuz, MD, PGY1; Brooke Harris, PhD; Kathryn Erickson-Ridout, MD, PhD; Francis Chu, MD
Primary care physicians are often the initial contact for patients who have mental health concerns. The collaborative care model has been shown to be an effective way of improving mental health outcomes in primary care through close collaboration and integration of mental health consultants within the primary care setting. We believe training the primary care residents using a novel application of the collaborative care model in residency training will: 1. Increase family medicine resident knowledge and comfort in managing mental health within the primary care setting, 2. Improve patient mental health outcomes within the primary care setting, 3. Ensure timely follow up and referrals to higher levels of services, and 4. Improve management of chronic medical conditions that are impacted by mental health. Within the first few months of implementation of the model, among patients active in treatment, a 66% improvement in PH-Q 9 scores have been noted (N=6) and 46% improvement noted in GAD scores (N=6). 4 patients were referred out for management of schizophrenia, substance induced psychosis, moderate cannabis use disorder, moderate severe alcohol use disorder, and suicidal ideation with plans for furtherance. Five patients declined treatment and follow up for mental health. Preliminary survey data shows improvement in primary care resident knowledge and comfort in mental health diagnoses, and improved patient care outcomes. This model may be helpful to other training programs.

Impact of Interdisciplinary Care of Chronic Disease Management in Primary Care
Jami Young, PharmD, AAHIVP, BCPS; Lizette Roque, PsyD, MS; Terri Wall, PhD
Caring for patients with multiple comorbidities is a complex process for providers in primary care; inadequate management of chronic disease can lead to suboptimal patient outcomes. Effective approaches to managing such complex care are needed, particularly when psychological and physical disorders coexist. It is well studied and proven, that having diabetes places one at increased risks for cardiovascular disease, which is amongst the top causes of morbidity, mortality, and expenditure of healthcare funding in the US. Major depression is significantly prevalent among patients with chronic conditions and is a risk factor for poor self-care, complications, and death. Studies have also demonstrated that prolonged elevations in blood glucose may lend to development of microvascular and macrovascular complications that can potentially induce biological effects that could increase the risk of depression.
A barrier to cardiovascular disease risk reduction, is lack of patient adherence and underutilization of medications. Poor medication adherence has been associated with disease progression, hospitalizations, disability, and death. Due to the identified barriers, utilization of an interdisciplinary-team, collaborative care model has the potential to improve overall chronic disease management. We will strive to demonstrate how collaboration of physicians, clinical psychologists, and clinical pharmacists, enhances care and encourages holistic treatment of disease state management, individualized medication optimization, and addressing any underlying behavioral components. This approach is proposed to demonstrate better disease control with quantified HbA1c and blood pressure reductions.

Well Being - Residents, Faculty and Staff
Stacy Melton, LCSW; Paula Mackrides, DO; Sarah Bockhold, LCSW
Primary Care Providers are having increased burnout, depression and suicide rates. As many as 400 physician (including resident physicians) commit suicide yearly. This is higher than most professions. A survey completed in 2013 showed 40% of physicians reported overall burnout. Family Medicine and Internal Medicine statistics were at 50%. SIU Medicine in Quincy is in the process of working on a Formal curriculum and a handbook to promote well-being to residents, faculty and staff. The beginning stages are focusing on Residents and will be expanded to faculty and staff.
A committee was developed to implement a formal process for this. Well-being activities and interventions have been started in Quincy in January of 2018. There will be a formal process in place in 2019.Overall important factors include; to increase happiness, overall well-being and decrease burn out by adding monthly well-being activities. A variety of activities are in place including a quarterly support group, monthly Balint meetings, exercise, mindfulness, meditation, dieticians, retreats, fun activities and more.

The Other Learners: Developing Curriculum for BHC Interns in Family Med Residencies
Grace A. Wilson, LMFT
This presentation highlights the development of a 50 week long training curriculum for BHC interns practicing in a Family Medicine Residency Program. The curriculum is anchored in competencies issued by SAMHSA-HRSA, the Eugene Farley Health Policy Center, and AAMFT. Organized into monthly themes, each week of the curriculum has a focus area, recommendations for a handout or learning material, and a mindful intention for learners to pursue that week. Development of the curriculum will be discussed, as well as opportunities for cross-discipline training of Family Medicine Residents and BHC interns.

Healers and Helpers as Educators: Our Own Impact in Promoting Wellness in Trainees
Stephanie M. Case, PsyD
The negative consequences of healthcare provider burnout have been well established (Panagioti et al., 2018). Additionally, meta-analyses and literature reviews have revealed abundant variables associated with burnout including, but not limited to, personality, provider type, level of training, practice specialty, demographics, practice setting, social support, and patient population (Ballenger-Browning et al., 2011; Bartholomew et al., 2018; D'Souza, Egan, & Rees, 2011; OConnor, Neff, & Pitman, 2018; Olson et al., 2018; Panagioti et al., 2018). The combined results of these studies ultimately lead to increased initiatives to promote wellness for providers and patients across healthcare professions. However, after decades of identification and intervention, high rates of burnout persist despite efforts to target and address its prevention and management (Schwenk & Gold, 2018). The disconnect between learning, practicing, and applying the necessary skills to avoid burnout may originate while training. Within residency programs, faculty members often consist of multidisciplinary professionals, with overlapping roles and diverse expertise which offer unique combinations of protective and risk factors associated with burnout. Additionally, Social Learning Theory suggests faculty is important for

the establishment and reinforcement of skills in developing practitioners. However, few studies have focused on variables that faculty represent to foster the development of wellness and reduction of burnout in resident providers. Therefore, the current study seeks to collect and utilize data from faculty and learners in physician residencies across the United States to better inform the establishment of education, application, and modeling of wellness practices to reduce the incidence of burnout in physician learners.

A Review of Trauma-Informed Care Curricula for Primary Care Providers
Courtney Barry, PsyD, MS; Emily Laurent M3; Constance Gundacker, MD, MPH
Background: Traumatic experiences such as abuse, neglect, and household dysfunction affect nearly 50-75% of the population and can have negative impacts on health outcomes. However, many primary care providers (PCPs) do not feel adequately prepared to treat patients with prior traumatic experiences.
Method: Systematic identification and evaluation of the effectiveness of trauma-informed care (TIC) curricula for PCPs, utilizing key words such as trauma-informed care, primary care, and education.
Results: After a review of the literature, 6 articles (and 5 curricula) were identified as TIC curricula for PCPs. The majority of the curricula focused on primary care residents and were only pilot studies, with only 2 examining longitudinal follow-up. The majority of the curricula were assessed using pre/post surveys and illustrated an increase in provider knowledge, attitudes, and confidence in utilizing a TIC approach. Two of the articles were randomized controlled trials and demonstrated an improvement in patient centeredness scores and provider communication proficiency post- TIC training.
Conclusions: TIC curricula for PCPs demonstrate improved knowledge, attitudes, and confidence in utilizing a TIC approach. Further research is needed to examine the longitudinal effects of TIC training on quality of care, patient and provider behavior, and health outcomes. Based on the information provided, participants will have the opportunity to discuss what they would want to include in a TIC curriculum.

Connecting Solutions to Social Determinants to Primary Care
Nicole Runkle, BS, M4; Mahir Mameledzija, BA, MBA, M4; David Nelson, PhD, MS
Significance: Social determinants greatly impact the health of the communities. The conditions by which people live, work and play though recognized by family and community medicine as important are often overlooked within the clinic setting. Primary care is often focused on the immediacy of health issues which often equate to medical management of the patient. There is some evidence that continuity of care with patients may enable physicians and behavioral health practitioners with the opportunity to discuss such issues as food security, housing status, transportation and job status. This provides an opportunity for the medical home to both understand the issue and apply appropriate resources. Though primary care does not need to take on all issues related to social determinants, there are questions if more can be done to connect primary care, including behavioral health to community-based organizations that better understand the social conditions.

FRIDAY, September 20, 2019
Round Table Discussions 7:00 – 8:00 am

Strategies to Build Resiliency in Family Medicine Residents
Julie Brennan, PhD, RD, LD; Angele McGrady, PhD
Recent research identifies prevalence of burnout in medical residents and the effects on clinical performance and quality of life. The ACGME now requires programs to assess burnout and provide interventions to improve well-being. Despite these trends, little information is available on design and implementation of resiliency programs in family medicine residents. There is increasing evidence that reconnecting with finding meaning in medicine and an attitude of gratitude, cultivating mindfulness skills, and building healthy habits are strategies that build one's resiliency and are key to supporting one's well-being.
This round table discussion will consider specific evidence based strategies to build resiliency. Three examples of sessions successfully implemented with family medicine residents will be provided. Participants will be actively involved in experiencing these activities from a residents perspective. The first example is positive psychology, specifically the application of a gratitude exercises. The second example is using nature experiences to restore calm in residents hectic life. The third example is skill building to help residents change habits that are interfering with performance of their jobs.

This session is designed to provide practice examples and resources to facilitators of programs to meet the ACGME requirements. Another objective of this session is for others to share other interactive, fun and engaging ways others are teaching similar or other evidence based strategies to nurture a resident's well-being.

NCQA Distinction in Behavioral Health Integration: What You Want to Know
Oliver Oyama, PhD, ABPP, PA-C; Elizabeth Lawrence, MD
Behavioral health conditions commonly present to the primary care setting. These conditions include formal mental illnesses, substance use disorders and other conditions that may be a source of psychosocial concern and could affect other biomedical conditions. Patients who receive care for both their physical and behavioral health concerns within a patient centered medical home primary care practice are believed to have the best opportunity for ideal care, ultimately leading to optimal health outcomes and lower costs of care.
The National Center for Health Care Quality has just launched a new Distinction in Behavioral Health Integration for practices in the process of earning Patient Centered Medical Home (PCMH) distinction or who have previously earned PCMH distinction. This distinction is for practices to demonstrate to patients, payers and health care partners that the practice uses state of the art integrated care to address both medical and behavioral health conditions seamlessly. By using the appropriate resources, evidence-based protocols, standardized tools and quality measures, the practice delivers whole person care at the highest level. At this Round Table Discussion, the presenters will share the reason they challenged their practice to achieve this high designation and the criteria and competencies required for the designation.

Behavioral Health Education in Residencies: Trends, Challenges, and Opportunities
Annie Derthick, PhD; Terri Wall, PhD; Sarah Dewane, PhD, ABPP; Molly Clark, PhD
Family Medicine residency clinics are excellent settings for graduate behavioral health education training in integrated primary care, which is quickly becoming a priority in health care, evident by the abundant funding opportunities to create and enhance this kind of service delivery. For example, HRSA frequently funds graduate education programming in integrated primary care, such as psychology internships, substance use disorder fellowships, and social work training.1 The Agency for Healthcare Research and Quality explicitly advocates for using trainees to expand the workforce and capacity of integrated primary care teams.2 Furthermore, residency clinics create opportunities for interdisciplinary education and support the professional identity development of all learners, leading to behavioral health and medical graduates to collaborate in the future.3,4,5,6 Many residencies have been quite successful in developing internships and fellowships, often capitalizing on some of the funding mentioned above.7 However, some programs have recently experienced a decline in qualified applicants, which coincides with large-scale changes to licensing requirements, such as the EPPP Step 2 and the Model Licensure Act. This session will provide a brief overview of current trends that could impact the form and function of behavioral health training in family medicine residencies, and we will facilitate a discussion of shared challenges and strategies for adapting and overcoming them. We will also provide resources for programs that want to develop, expand, or modify behavioral health education in their setting.

Making Use of Spirituality and Religion with Family Medicine
Lori A. Garfinkel, MS; Carli Gurholt, MS; Heather Martens, PsyD
Spiritual and religious beliefs and practices (SRBPs) can be a significant part of a patients life and can color their worldview. SRBPs have the potential to affect their medical beliefs and treatment compliance. Despite the potential of SRBPs for augmenting the treatment plan, providers shy away from making use of SRBPs or discount their utility in advancing wellbeing. Studies show that patients expect to make use of SRBPs in counseling and therapy; we would expect their expectations to be similar in Family Medicine. Many physicians and other behavioral scientists are not trained on how to address these issues with patients, nor do they possess a comfort level in the area of discussing SRBPs with their patients. Providers desiring to address SBRPs may not have the same level of supervisory guidance that they have for other medical and psychological issues. The onus is on the provider to create a safe environment and opportunity to open all doors of a clients worldview, making inaccessible components of a patients life experience, including spiritual and/or religious beliefs, a part of the therapeutic process. The clinician's understanding of their own spiritual world is present in patient encounters and their internalized experience can either augment the endeavor or limit fully integrated care. The purpose of this exploration will be to explore, illuminate, and synthesize the clinicians experience when inquiring about and making use of patients SRBPs in Family Medicine.

How Can Dogs (or Alligators) Help Us Teach Residents Ethical Practice Management Skills
Linda Myerholtz, PhD
The ACGME requires residency programs to include 100 hours dedicated to health system management and this curriculum should prepare residents to be active participants and leaders in their practices. Part of this training should help residents learn to navigate ethical challenges that often face physicians and to develop skills in practice risk assessment

and policy development. In this session we will discuss how we have used issues around Emotional Support Animals (ESAs) to teach residents to explore their own values and biases, examine current literature to inform risk assessment, and to develop and implement a practice policy. We will discuss the value of integrating discussion of personal values and biases in curriculum domains where this may not initially seem as relevant and the vital role that behavioral scientists can play in facilitating this self-reflection.

Scholarly Activity: How to Create Opportunities in your Residency
Meredith Lewis, LICSW
Scholarly Activity is an essential part of training in graduate medical education and Family Medicine Residencies across the country. It is important to understand how behavioral scientists can collaborate with physician champions for scholarly activity in several ways, including their role in everyday practice in the office setting. This roundtable will outline how to develop, fund, and disseminate scholarly activity supported by physician faculty in residency programs. It will create a dialog about best practices when applying to Institutional Review Boards. It will further discuss how to increase scholarly activity through valuable mentor opportunities. Participants will walk away with tangible ideas to help carry out scholarly activities outcomes.

Cultivating Professionalism and Communications Skills through Balint Groups
Brian Wexler, PhD; Barbara Ackerman, PhD; Vidush Athyal, MD, MPH, FAAFP
This presentation will strive to discuss the methods and procedures for starting a Balint group for resident-physicians. We will present preliminary research findings to explore how participation in Balint Groups can foster growth in ACGME competencies, especially Professionalism and Interpersonal and Communication Skills. We will engage the audience to write an action plan for establishing a Balint Group in their Family Medicine Residency Program.

Training Family Medicine Residents to Lead Collaborative Care Teams Effectively
Jennifer S. Robohm, PhD; Ellen Bluett, PhD
During residency training, family medicine residents are expected to develop leadership skills and competencies in coordinating team-based care and communicating effectively with other health professionals (ACGME, 2015; AAFP, 2017). High-functioning primary care residency clinics optimize team-based care (Bodenheimer et al., 2016), but residency teaching clinics often face challenges in attempting to create stable care teams and a collaborative team culture (Gupta et al., 2013). Not surprisingly, family medicine residents request more training in a number of related domains, including effective teamwork and conflict resolution (Gallagher et al., 2017), and express a desire for clearer definitions of roles and expectations when providing collaborative care (Lounsbery et al., 2016). We queried our family medicine residents, program faculty, and the medical assistants and nurses with whom they work in clinic, to get a better sense of their experiences working with each other on collaborative care teams. We used some of their feedback to identify "trouble spots" and to shape a training curriculum for the residents around leadership and teamwork skills. (We also plan to develop related in-service training for the MAs/nurses on their collaborative care teams, to improve team functioning and workflow within the residency clinic at the systems level.) At the Forum, we will discuss the steps we took to develop our curriculum in this area, and solicit input from round table participants about their own experiences when trying to assess and promote collaborative care skills in their residents and to improve team functioning in continuity clinic.

FRIDAY, SETPEMBER 20, 2019SESSIONS

Seminar 130
Inter-professional Practice Development: Practical Approaches Across Settings
Nataliya Pilipenko, PhD; Sharon Chacko, MD; Meredith Williamson, PhD
The growing complexity and severity of patients presentations as well as the primary cares status as the de facto mental health system challenge physicians to build strong inter-professional practice skills and enhanced clinical repertoire. This program will overview 3 unique and practical ways to enhance residents abilities to work with other disciplines while augmenting patient-centered care competencies in both urban and rural training programs.
Presentation 1 will focus on enhancement of residents engagement with the Collaborative Care Model. Practical steps for patient care coordination, case consultation, inter-professional education, case identification, follow up, and documentation will be discussed. Current training within one Family Medicine (FM) residencys Behavioral Medicine curriculum will be used to illustrate these practical steps.
Presentation 2 will discuss utilization of an inter-professional Integrative Medicine (IM) consultation clinic to promote training within both behavioral and integrative medicine. In this model, physician, psychologist, and FM resident co-

perform patient visits. Training goals for FM include promotion of patient-centered care, implementation of evidence-based IM therapies (nonpharmacological therapies including complementary/alternative therapies), and collaborative work towards shared patient care goals.
Presentation 3 will focus on the development of an evidence-based, inter-professional behavioral health consult service to train residents with a psychologist and FM faculty within a FM residency clinic in a setting where psychiatric services are unavailable due to the clinic location being in a mental health shortage area. Additional focus will be the implementation of evidence-based curriculum focused on preparing residents to provide behavioral health services in rural and underserved areas.

Lecture Discussion 131
Lifestyle Medicine Exposure Experience: Health Coaching for Residents' Wellness
Christopher Haymaker, PhD; Rosalie Cassidy, MD; Griffin Hickey, MPH
Despite the ongoing exploration of the well know tensions between patient care and physician wellness, residents in training continue to be vulnerable to stress, burnout, low satisfaction and limited empathy for behavior change.
Lifestyle Medicine holds some promise because of the emphasis on evidence-based lifestyle modifications to prevent and treat chronic disease. Lifestyle Medicine encourages physician self-awareness and lifestyle modification/behavior change, so physicians may be less vulnerable to burnout and more satisfied with their practice.
Our residency program aims to emphasize wellness and behavior change in the first month of residency using empirically validated tools, health coaching, and single subject research design. In this discussion session, we will outline our use of the Lifestyle Assessment Tool, developed by the American College of Lifestyle Medicine and Loma Linda University. Our first year residents completed this tool and met with a clinical health coach to identify behavior change priorities. During the first month, residents had three additional meetings with our health coach to define behavior change targets and reflect on their own experience in changing health behaviors
Activities during this session will demonstrate concepts that participants might use in development of Lifestyle Medicine curriculum unique to their site. We will also present de-identified quantitative data in single subject format as an illustration of core concepts of the curriculum. Qualitative data will be used to assess the viability of the program for shifting residency culture for behavioral change and improving physician empathy for behavior change.

Workshop 132
Research is a Team Sport!
Sandra Burge, PhD; Alex Reed, PsyD, MPH
Research is a team sport. Few researchers work alone. The image of a lone (mad) scientist hiding away in a spooky castle is the stuff of fiction. Research is give-and-take. We improve our own work by reading about other researchers methodologies, findings, and experiences. When we finish a project, we publish or present our findings and others learn from us. In recent years, the pressure to do research has increased. Updated ACGME requirements have raised the expectations that family medicine faculty will be involved in research and scholarly activity. How do we make this happen? Begin with the assumption that research is a team sport, and find collaborators to share the workload. Reach across residency programs; this has many advantages, with larger sample sizes, potential control practices for intervention studies, increased creativity, and the joy of working with your friends. This workshop is designed to connect you to like-minded peers to consider future research collaborations. Participants will: determine areas of research interest among behavioral science educators; identify peers with similar interests; and to initiate research collaborations for future studies. Workshop leaders will involve all participants in a brainstorming activity that generates multiple areas for research. Participants will then divide into discussion groups based on research topics. Participants will get acquainted, then start the process of planning a research project based on their mutual area of interest. By the end of the workshop, participants will have potential new research collaborators and a strategy for pursuing a new research question.

Workshop 133
Creative (Fun) Activities that Promote Resilience & Minimize Resistance
Jennifer Ayres, PhD
Neff and Germer (2018) discuss the need for balance between yin-focused self-compassion (gentle self-reflection, comforting, soothing, validating) and yang-focused self-compassion (action orientation, protecting, providing for ourselves). Similarly, resilience and personal growth require a complementarity of self-reflection and goal-directed action. This workshop will address strategic use of experiential learning and engaging exercises to foster resilience promotion and growth orientation in graduate medical education. Participants will learn strategies to balance self-reflective practices with activity-based interventions that foster incidental (and safe) learning for resistant residents. We will discuss how to facilitate successful process discussions.

Clinical Practice Update 134
An Integrated Approach to Addressing Opiate Misuse in Primary Care for Female Patients
Joanna Petrides, PsyD; Alexander Kowalski, DO; Jennifer Ehala, MPH, CHES
The opioid epidemic continues to escalate with a particularly concerning expansion among females. Until recently, minimal focus has been given to the rising use of opioids among women and the causes for such use. Primary care physicians report decreased awareness about patients who have a higher potential to be at-risk for opioid misuse resulting in oversight in asking patients about opioid use and other potential risk factors. Furthermore, primary care physicians have received minimal guidance on how to intervene with at-risk patients and will often feel unprepared to address such issues with patients during office visits. During our presentation, we will discuss the rising risk factors of opioid use and misuse among females and how primary care providers can screen patients for opioid misuse using Screening, Brief Intervention, and Referral to Treatment approach (SBIRT). Additionally, we will address how primary care physicians can intervene with patients who are at-risk for opioid misuse during an office visit and present appropriate interprofessional referrals to enhance the effectiveness of opioid treatment, including behavioral medicine interventions and osteopathic manipulative treatment used to treat chronic pain often associated with opioid use. Our Narcan administration training program for physicians and community members will also be presented.

Research on Clinical Care 135
Moderator: *Terri Wall, PhD*
Research 135A - Health Behavior Change (HBC) Clinic as a Vehicle for Behavioral Science Education
Jennifer S. Robohm, PhD; Ivie English, MD
We know that health-related behavior is a major determinant of morbidity and mortality (McGinnis, Williams-Russo, & Knichman, 2002). Researchers and clinicians have identified strategies that help to promote health behavior change (Greene et al., 2016; Hooker et al., 2018), but many physicians still struggle to address health behavior meaningfully during primary care visits. Since family physicians identify lifestyle counseling as a top priority for resident education (Robohm, 2017), we designed a Health Behavior Change (HBC) program in our residency clinic to promote training in motivational interviewing, evidence-based health behavior change interventions, and interprofessional practice. HBC clinic providers are interns taking part in a Behavioral Medicine rotation and doctoral students participating in an integrated behavioral health (IBH) field placement, under the direct supervision of a behavioral science faculty member. HBC clinic offers individualized consultations for patients wanting to learn strategies to better manage sleep, tobacco use, diet and weight, chronic pain, substance use, and stress. Trainees develop essential skills, referring providers and patients appreciate the service, and the success of the HBC clinic has paved the way for a more fully integrated IBH service in our residency clinic which will offer robust longitudinal behavioral health training for our residents and richer training opportunities for graduate students. Our presentation will describe the HBC service, talk about our training and patient outcomes, and leave time for interactive discussion with workshop participants about the benefits and limitations of using a similar model to support training in health behavior change for their family medicine residents.

Research 135B - Connecting Food Security to a Patient Centered Medical Home and Back Again
Nicole Runkle, BS; David Nelson, PhD, MS
Purpose/Significance: Food insecurity is a growing issue in the United States, and it is well established that food insecurity is linked to health and chronic illnesses. Food security is often thought to be handled by community-based organizations (CBOs), whereas chronic illnesses are traditionally addressed in primary care settings. Studies have shown the impact of CBOs on food access to clients and food security screenings performed in primary care offices, but the connections between CBOs and primary care medical homes in addressing food insecurity has not been thoroughly investigated. Each setting holds their unique relationship with users and can benefit from partnerships with each other to strengthen their role in improving health in their community. This research aims to describe the phenomenon of food security and primary care, to illustrate how CBOs and primary care can be connected and to develop initial policy recommendations for primary care clinics and CBOs moving forward.

Research 135C - Behavioral Medicine Rotation: Effects on Behavioral Skills and Documenting of Suicidality
Kaitlin Leckie, PhD, LMFT-S
Most, if not all, presenting problems in primary care have a behavioral component, which primary care providers must be able to help patients address. The physicians ability to do so is even more important when depression or suicidal ideation is present. People who die by suicide were more than twice as likely to have seen their PCP as a mental health clinician in the year and month prior to their death. Up to 90% had contact with their PCP in the year prior, and up to 76% in the month prior, to death (Luoma, et al). Assessing and documenting suicidality are vital for patient safety and care. The 4-week Behavioral Medicine Rotation (BMR) uniquely uses small group workshops, role/real plays, standardized patients,

and direct observations to teach evidence-based skills and physician wellness to enhance the healing relationship. To assess its effectiveness, the BMR was evaluated using two components: (1) pre/post self-evaluations and (2) chart review. Residents rated their competence with core behavioral medicine skills using pre/post evaluations. Moreover, to explore application of their skills, a random sample of their patients charts were reviewed from 3 months prior to and 3 months after BMR. Of specific focus was the residents use of the Patient Health Questionnaire (PHQ)-2 and PHQ-9 depression screening tools and their documentation of suicidality. Results add to the literature a better understanding of the method and effectiveness of behavioral medicine teaching. They can be used to enrich training, such as improved suicidality training to help physicians save lives.

Lecture Discussion 136
Talk About Wellness: Evaluating What Matters in a Wellness Curriculum
Julie Schirmer, LCSW; Mary Talen, PhD; Aaron Grace, PsyD; Lindsay Fazio, PhD
Wellness has become a hot topic in medicine and medical education. The health of providers and primary care teams is key to personal health, job functioning, satisfaction and retention, and has a direct influence on providers' degree of lifestyle counseling with patients and patients' overall health. Provider wellbeing has a direct impact on patients' experience and the overall costs of health care. Yet, how do we know if our teaching process and content are on the right track? Does our Wellness curriculum have the outcomes that we intend? Moving beyond measuring learner satisfaction, participants will leave this seminar with increased energy and focus to strengthen the evaluation of their Wellness curriculum and to collaborate with others to advance our collective knowledge about what we should be teaching and how it matters regarding provider wellness.

Lecture Discussion 137
Enhancing the Process of Professionalization with Peer Mediation
Barbara Ackerman, PhD
Residents in our program expressed an unwillingness to bring unresolved interpersonal conflicts with other residents to the attention of faculty for fear of disciplinary action. A discussion with residents led to the idea of creating a peer mediation service for the residents. We believe this peer mediation service can address a gap in curriculum for the core competency Professionalism. The peer mediation service offers a formal framework and avenue for self awareness and self regulation as well as conflict resolution skills acquisition.

Clinical Practice Update 138
Childhood Depression
Brianna Smith, PsyD; Megan Brown, PsyD
Depression in childhood and adolescence is prevalent and often goes untreated or undertreated. Primary care providers provide initial screening, assessment, and treatment for mental health disorders. This clinical practice update will provide an overview of what family medicine physicians need to know to screen, assess, and manage childhood depression in their clinics. It will also provide tips for integrated behaviorists and guidance for outpatient mental health clinicians about evidence-based treatments. This session will review clinical practice guidelines and developmental differences in presentation of symptoms of depression.

Workshop 139
9:45-11:45
The Balint Group Experience: Promoting Relationship and Team Awareness
Phillip Phelps, LCSW; Chris Rule, LCSW; Jose Nino, MA; Shari Holland, LPC
Reference Workshop 129

Lecture Discussion 140
Integrating Homeless Outreach: A Longitudinal Component of Family Medicine Residency
Brian Wexler, PhD; Rosa Lucas, RN, FNP-C; Valentine Nuzhny, MD; Christopher Robinson, MD
Homelessness impacts over 550,000 individuals in the US, of which includes almost 10% military veterans. More than 20% of the homeless suffer from severe mental illness and nearly 40% are alcohol or drug dependent. The financial impact on hospital services is staggering. The intent of the workshop is to describe our multi-disciplinary multi-agency approach towards developing a successful residency-based Street Medicine outreach team focused on serving those experiencing homelessness, which often involves issues related to mental health disorders and addiction. We believe that outreach teams can be cultivated to meet the specific needs of each community, and we will demonstrate that our model can be reproduced in other sites. Our program is centered in a community-based free clinic which integrates Family

Medicine residents with medical and behavioral health providers, local police, non-GMO food service providers, graduate and undergraduate medical education programs, as well as many lay volunteers.

Lecture Discussion 141
No More Talk About Wellness! In Search of Direction in Assisting Residents to Flourish
Jill Schneiderhan, MD; Tom Bishop, PsyD
The last several years have been marked by many signs and examples of how residents are struggling with well-being and experiencing burnout. This has prompted national as well as internal conversations about how residencies are supporting the wellness of trainees in Family Medicine. This in turn has given attention to the development of curriculum that spans from encouraging skill development to the fostering of joy in practice. There have been efforts to make systemic changes that would foster well-being. To date, the literature is sparse in terms of well researched interventions given the small size of individual resident programs and the lack of national coordinated research efforts. As a result, resident programs are trying new things and working to be innovative in how they support and encourage residents, with some successes and some failures. With all of this effort, there is little conversation in how to approach resident push back against wellness programs and what themes emerge as new curriculums are implemented. Our program has been working on an innovative, iterative wellness curriculum for the past three years and in the process has wrestled with differences in expectations between residents and faculty leading to challenges. In this session, we will articulate some of the common reasons residents might express disinterest and desire for wellness programming and offer some suggestions and discussion around how to address these challenges. A growth mindset and a spirit of collaboration will undergird potential solutions and how challenges may be used to a programs advantage.

Lecture Discussion 142
Responding to Inappropriate Patients: What to Say When You Don't Know What to Say
Michelle Kane, PsyD; Lee Chambliss, MD
Communication around challenging topics is an essential skill for physicians. A recent survey has highlighted the frequency with which residents are exposed to, or are on the receiving end of, comments or behaviors from patients that are perceived as offensive, hurtful, or upsetting due to their sexual, racial, religious, or ethnic content. When confronted with these inappropriate patient comments and behaviors (IPCBs), physicians may have difficulty, in the moment, responding in an appropriate and satisfying way. This can lead to an increase in work related stress. Family medicine educators are in a position to teach skills in this area and to appropriately respond to comments made to or about their trainees.

Lecture Discussion 143
Breaking the Eggshells: The Ethics of Providing Feedback to Medical Learners
Scott Fields, PhD; Allison Seavey, LCSW
Numerous articles address how to discuss difficult topics with medical patients, and useful frameworks exist for resolving a number of clinical conundrums. However, less is written about how to bring up and discuss serious ethical topics with medical learners. While written reviews and 360 degree evaluations proliferate in clinical training, heart to heart talks with residents sometimes get lost in the shuffle. This presentation will explore the evidence and the art of resolving ethical dilemmas with medical learners. This includes highlighting situations that educators may face with learners such as performance related issues and personal problems (i.e., burnout, mental health concerns). A framework will be proposed for addressing and discussing difficult topics with medical learners, and particular attention will be given to tight spots that faculty may find themselves in at times. Available online resources will be provided and participants will discuss ways to incorporate those into their curricula. The overall goal of the session is to create and encourage a culture that supports the discussion of ethical dialogue with medical learners.

Lecture Discussion 144
E-Cigarettes: What We Know, What We're Teaching
Beverlee Ciccone, PhD; Cindy Barter, MD, MPH; Debra Moorhead, PhD
The use of electronic nicotine delivery systems (ENDS), or e-cigarettes, has grown rapidly over the past decade, especially among American youth under age 18. One of the reasons for this sharp increase is the misbelief that e-cigarette use is a harmless alternative to using combustive tobacco products. While primary care providers (PCPs) routinely ask about tobacco use, it is unclear whether they specifically screen for the use of ENDS products, especially with their younger patients. In fact, it is not clear whether health care professionals are under some of the same misconceptions regarding use of these products. After giving the participants a brief questionnaire regarding their own understanding and clinical behaviors regarding ENDS, we will present current information about the topic. We will then report the responses

of PCPs from two geographic sites to the questionnaire. Finally we will discuss ways to increase both residents and practitioners knowledge of the importance of providing this information to their patients.

Lecture Discussion 145
Beyond Genograms: The Art of Engaging Medical Learners in Systems Thinking
Amy Romain, LMSW; Julie Woodwarner, PhD; Emilee Delbridge, PhD, LMFT; Julie Rickert, PsyD
In this day and age of electronic health records and double booked clinics it is becoming increasingly difficult to help young, busy physicians appreciate the relevance of systems and contextual factors to the medical care of their patients. While the data is clear that context can be as important as genetics and behavior in determining outcomes, physicians need to have the skills and confidence to evaluate and intervene using a systems lens. Presenters from four different settings will explore the challenges in teaching systems perspectives and share a variety educational strategies which can be adapted for use in participants' programs.

Clinical Practice Update 146
Medication Assisted Treatments for Opioid Use Disorder
Patricia McGuire, MD; Alyssa Bruehlman, MD; Marianne Koenig, PharmD, BCPS
Opioid overdoses and Opioid Use Disorders (OUD) are a major public health crisis. The Centers for Disease Control (CDC) statistics indicate that drug overdose deaths continue to increase in the United States, with over 700,000 deaths from 1999-2017. In 2017, about 68% of the >70,000 drug overdose fatalities involved opioids including prescription and illicit opioids (heroin, fentanyl). The CDC reports that about 130 Americans die every day from an opioid overdose. The National Survey on Drug Use and Health 2016 estimates that 1.9 million people have OUD with prescription pain meds and nearly 600,000 people have an OUD with heroin.
This presentation will focus on the nuts and bolts of Medication Assisted Treatment (MAT) in the primary care setting. We will begin by describing the scope of the opioid epidemic and reviewing the diagnostic criteria for OUD.. We will then introduce the principles of harm reduction and cite evidence behind various harm reduction strategies for opioid OUD including MAT. We will review the various MAT options for acute overdose (naloxone); acute withdrawal in the outpatient setting (comfort meds including clonidine, loperamide, ondansetron) and opioid dependence (methadone, buprenorphine, naltrexone XR). Particular emphasis will be spent on understanding the pharmacologic actions (agonist, partial agonist, antagonist) and pharmacodynamic principles (formulations, dosing, side effects, drug interactions) of medications used to treat OUD. We will also examine monitoring strategies (patient agreements, clinic visit/counseling attendance, urine toxicology screening) to support recovery.

Lecture Discussion 147
Principles of Adult Learning: Application to Family Medicine Residencies
Mark A. Dixon, PhD; David Snowden, PhD; Charu Stokes-Williams, PhD
Learning is an ongoing, developmental process with different needs arising and methods utilized throughout the life course. Principles of learning specific to adults can be taught and enhanced through effort and practice. Some of these principles include self-direction, active integration, and relevancy orientation. Life experience and a personal frame of reference can also be used to assist the adult learner to increase motivation, efficiency, and engagement with the learning process. Research has indicated that learning is best achieved within a relationship-based environment which allows for a respectful sharing and transmission of ideas and knowledge. This presentation will help the behavioral scientist integrate principles of adult-learning into family medicine education. Participants will learn to apply these concepts and skills through collaboration in small teams, large group discussions, and a review of evidence-based principles of adult learning.

Lecture Discussion 148
Storytelling and Research: The Oral History Project and Crossing the Divide
Thomas Bishop, PsyD; Julie Schirmer, LCSW
There is perhaps nothing more powerful as a tool for teaching then the Story. Stories allow us to enter into an experience, walk around, and develop insight and gain wisdom. It provides a means of moving from simple instruction to the transformation of a learner, who is encouraged to see their craft with a deeper vision. The stories of many senior faculty, who are wisdom carriers, have not yet been shared with many of us coming behind. In fact, several influential faculty have already retired with others planning to retire in the coming years. The stories of these Pioneers give us an opportunity to hear where we have been and reflect upon the struggles, growth, and potential for the future. The aim of the Behavioral Oral History project is to identify and interview pioneer faculty who have shaped behavioral training in Family Medicine. This would allow us to capture our history, glean insight and wisdom, and impact those coming behind. The intent of this session is to first describe what led to the project and the power of story in research and how others may pursue this work. The process of determining who is a pioneer including how focus groups and a Delphi study were

conducted will then be discussed, as well as struggles over definitions and representations. Stories and themes will then be shared, with attention given to how our field has evolved and where we seem to be going. The session will encourage active participation, engagement, and discussion.

Workshop 149
Cognitive Behavioral Therapy? But I'm Not a Therapist! I Don't Have Time for This!
Cynthia Jauregui, PsyD; Lynn Rogers, LCSW
Full training in Cognitive Behavioral Therapy (CBT) is lengthy and time is a common barrier. This fun and interactive workshop will introduce brief CBT techniques that promote interaction between the physician in training and the patient, enhancing rapport and promoting continuity. We will discuss how a patients thoughts about a specific situation affect how they feel emotionally and physically as well as how this affects the patients overall behavior and compliance. This experiential learning workshop will demonstrate how residents can implement practical CBT exercises while working within the constraints of a typical medical visit. We will also discuss how Behavioral Scientists can use these interactive activities in didactics to promote resident wellness.

Workshop 150
Deep Dive into the "Well": How Behavioral Science Faculty Create a Culture of Wellness
Kathryn Fraser, PhD; Harry Blanke, MD PGY3; Danielle Blea, LCMFT, LCAC; Chantel Long, MD
Despite the increased focus on wellness in medicine, physicians continue to experience alarmingly high rates of burnout. It has now become extremely important to create and implement physician wellness strategies in medical education. According to reports on the rise of burnout, a large part of the problem is a lack of physicians reaching out for help. It is clear that there are circumstances that we as faculty cannot control such as the effects of the cumbersome use of the Electronic Health Record. However there are ways to make improvements in physicians work environments. CLER guidelines now mandate that educational institutions have a plan to monitor physician wellness and, more importantly, to promote healthy lifestyle. This presentation will provide a framework for behavioral faculty to use their influence to permeate wellness culture throughout their programs and host institutions. Participants will learn about the various way that stress and burnout affects how residents function, and also specific activities and strategies designed to promote wellness. The presenters will identify ways to infuse wellness into didactic presentations, retreat activities, support groups, faculty/resident/staff events, ACGME Milestones and CLER review processes, and overall resident support frameworks.

Workshop 151
Conducting Ethical Scholarly Activity and Research, Common Conundrums
Heidi Musgrave, PhD; Cherise Dixie, LCSW
According to the ACGME guidelines Research and Scholarly activities are a requirement for both residents and faculty. Far too often there is limited knowledge regarding not only research methodology, but ethical challenges that are encountered on these endeavors. Most professional organizations in the health care field have ethical codes that include conducting research on human subjects as well as Federal Laws governing these activities. Ethical challenges facing the healthcare field tend to focus on moral dilemmas that the patient and provider face with regards to treatment. There is not a significant amount of content at conferences with regards to ethical challenges that face the researcher in family medicine residencies. This workshop will entail discussing ethical challenges that family medicine residencies face. Specifically, guidance on how behavioral science faculty can lead the way with educating their programs on how to address these challenges and providing guidance to develop and conduct ethical research projects.

Workshop 152
Yes, and for All: Teaching Improvisation Across the Medical Education Continuum
Alex Reed, PsyD, MPH; Valerie Ross, MS, LMFT; Winslow Gerrish, PhD
To be successful as a student, resident, staff member, or faculty member in a dynamic medical setting, such as medical school or a residency program, requires excellent communication skills and quick on you feet thinking. However, these skill sets vary widely and can be very hard to target with traditional teaching techniques. Poor communication can lead to unintended consequences ranging from issues in patient care to low morale and even turnover or professionalism and ethical complaints. Improvisation theater and its principles of equality, collaboration, flexibility, responsiveness and accepting multiple perspectives offers a unique and dynamic opportunity to enhance communication for all trainees, staff and faculty. Medical improv and its exercises are not role play, but an adjunct to existing methods of training that can fulfill a curricular and professionalism gap for trainees, staff and faculty.

Clinical Practice Update 153
Beyond Benzos – A Review of Pharmacologic Treatment of Anxiety
Kwanza Devlin, MD; Anshu Aggarwal, MD
While 18% of adults in the US suffer with anxiety, most are not managed by psychiatry. Family Medicine clinics are uniquely poised to give these patients timely and efficient care. However, many family physicians feel uncomfortable treating anxiety. This presentation is designed to give physicians an overview of anxiety medications and their evidence while providing a practical resource to use for ongoing care of this common condition.

SATURDAY, SEPTEMBER 21, 2019 SESSIONS

Lecture Discussion 154
How to Build a Research Proposal in Family Medicine
Courtney Barry, PsyD; Heather Martens, PsyD; Joanna Petrides, PsyD
Research capacity within Family Medicine may be limited, with 43% of Family Medicine departments having no or little research capacity, according to a survey by the Association of Departments of Family Medicine. Multiple barriers to research exist, including limited research training among residents and faculty, and limited resources for research to be conducted. In this workshop, we will outline the steps for how to begin with a research idea, develop it into a testable hypothesis, and identify how to implement the research proposal. We will also address identifying the appropriate partners for statistic design and intervention implementation within family medicine residency programs. We will also discuss the ways in which Behavioral Scientists play a pivotal role in the design and roll out of a research proposal, as well as, the process and benefits of conducting integrative research between family medicine and behavioral science.

Lecture Discussion 155
Expanding Behavioral Health Screening in Primary Care: A Stepped Approach to Diagnosis
Mark Drexler, MD; Lindsay Fazio, PhD; Sara Lampert, BA
An estimated 60% of mental health care is being provided in the primary care setting (Reiger, Narrow, Rae, et al, 1993). Proper diagnosis is critical to ensure proper management, avoidance of inappropriate stigma, and prevention of complications including death. Universal screening for depression has been widely implemented in the United States (USPSTF Grade B). Primary care clinics do not screen for additional mental health conditions; however, it is not unusual for patients to have comorbid mental health conditions. Some estimates show that 60% of patients with anxiety will also have symptoms of depression, and the numbers are similar for those with depression also experiencing anxiety. Mental health conditions can also be misdiagnosed because of complexity and overlap with other conditions. 69% of patients with bipolar disorder are misdiagnosed initially and more than one-third remained misdiagnosed for 10 years or more (Singh & Rajput, 2006). Expanded screening for conditions other than depression could help physicians correctly diagnose and manage behavioral health conditions. To address this issue, we have developed a stepped model for expanded screening that begins with a depression screener and followed by additional screeners when necessary. The expanded screener is continued with a distress screener if the depression score is positive. The comprehensive behavioral health screener is administered if the distress screener is positive. Testing and scoring is completed by medical assistants. Physicians are provided results along with customized treatment recommendations and patient educational materials.

Lecture Discussion 156
PRomoting Engagement for the Safe Tapering of Opioids (PRESTO)
Paul Hershberger, PhD; Dean Bricker, MD; Lori Martensen, MS
An important role for behavioral science educators in Family Medicine is to train physicians to interact with patients in an effective manner that can lead to healthy behavior change. These interactions can be quite challenging, such as the situation in which a prescriber desires to decrease a medication that the patient wants to continue or increase. One of the approaches to the opioid epidemic is to decrease the number and dosage of opioid prescriptions. The CDC (Centers for Disease Control and Prevention) has guidelines for safe opioid prescribing and the tapering, and there are state-level laws that prescribers must follow. While the use of motivational interviewing to gain patient buy-in for change in a medication regimen is encouraged, specifics for how this can be done are lacking. PRESTO (PRomoting Engagement for Safe Tapering of Opioids) is designed to give prescribers a protocol to address tapering of opioid medications with patients who have been on chronic opioid therapy. Similar to SBIRT (Screening, Brief Intervention, Referral to Treatment), PRESTO makes use of available assessment data and how this can be employed to develop discrepancy between the

patients current behavior and their goals, identify goals associated with the most emotion for the patient, and guide the patient toward motivation to reduce opioid use. PRESTO is also relevant for engaging patients in medication assisted treatment for opioid use disorder or for the patient needing to reduce benzodiazepine use. Session emphasis will be on how behavioral science educators can teach this approach to prescribers.

Lecture Discussion 157
Collaborative Care: Expansion and Education
Stephen Warnick, Jr, MD; Kevin Brazill, DO; Chris White, MD, JD
Collaborative care has a large evidence base supporting its utility in primary care, including meta-analysis showing its improvement in depression outcomes in primary care. As collaborative care is paid for by Medicare and more private payers, we will discuss strategies to improve PCP acceptance of this model of care, in settings where there is both low and high level of comfort in treating mental illness. In order to address Family Physician concerns regarding care for special populations, we will also discuss the expanding role of collaborative care in more populations, such as the medically underserved, prenatal, geriatric, and more severely mentally ill, where PCPs may also need assistance.

Clinical Practice Update 158
Treatment Options in Unipolar Depression in Adults
Dominique Fons, MD; Kimberly Krohn, MD
Unipolar depression is highly prevalent and disabling in adults and affects the entire family. It is also recurrent and remission can be difficult to achieve. Among the plethora of pharmacotherapy agents to choose, while clinicians learn pharmacology, less than 50% of clinicians feel adequately trained in psychopharmacology. This session will provide a summary for all classes of psychotherapeutic agents as well as factors to assist clinicians in determining adjustments to therapy.

Lecture Discussion 159
Transgender Care: The Role of Behavioral Science Faculty in Training
Alison Gurley, PsyD
Recent years have seen an increase in the number of people identifying as transgender or gender non-conforming (TGNC) and family physicians play an essential role in the care of TGNC patients. TGNC patients have higher rates of chronic illness, and many require gender affirmation treatments and procedures, some of which can be provided by family physicians. Further, TGNC individuals have higher rates of mental health diagnoses, substance use disorders and higher social needs, making a biopsychosocial perspective essential to their care. Despite these vulnerabilities and needs, TGNC patients report many negative experiences with physicians, often due to culturally insensitive communication and transphobia. Given the centrality of culturally sensitive communication skills and the biopsychosocial perspective for this population, behavioral science faculty play a central role in preparing residents for the clinical care of TGNC patients. This session will provide a starting point for behavioral science faculty who want to increase their knowledge of culturally sensitive TGNC care so that they can train family medicine residents. The lecture will cover common terminology and basic communication skills that form the foundation of culturally sensitive TGNC care, and faculty will be able to assess their own knowledge and skills through a pre and post lecture learning assessment.

Clinical Practice Update 160
Get the Lead Out! Lead Poisoning is a Concern from Womb to Tomb
Heidi Musgrave, PhD; Deborah McMahon, MD
Lead poisoning has been long identified as a hazard to the human nervous system. This heavy metal can be transmitted through the umbilical cord before birth as well as by environmental exposures after birth. The deleterious effects of lead neurotoxicity can last a lifetime. This session will cover the essential information with regards to sources of lead exposure; how to obtain a history from patients; the signs, symptoms and sequelae of lead exposure; prevention; testing and treatment; and how to discuss results with families. Specific guidelines for testing and mandatory reporting requirements will be presented using both an individual case and a puzzling population exposure in our local community.

Lecture Discussion 161

The Art and Science of BATHE: A Foundational Brief Therapy Tool that Learners Use and Love

Claudia Allen, PhD, JD; Joseph Tan, PhD

Primary care providers (PCPs) have often chosen primary care precisely out of a wish for meaningful personal relationships with patients. Yet PCPs report that they often ignore or fail to ask about patients' emotional concerns for fear of "opening Pandora's box" and having neither the time nor skills to deal constructively with the contents. Even when provided with a behavioral medicine curriculum, residents frequently lament that the counseling methods covered are too complex or time consuming to use routinely. Physicians-in-training require a simple yet effective tool to help them efficiently elicit patients' psychosocial concerns and render accurate understanding and empathy. Presenters will outline the specific steps of a such a tool (BATHE, Stuart & Lieberman, 2015) and demonstrate its effectiveness in real time. We will discuss its unique value in building a powerful bond between provider and patient, and highlight how each step of BATHE draws from evidence-supported therapies . Presenters will review the research on BATHE, including outcomes of an RCT (Pace et al., 2017). We will outline our method of teaching learners to use BATHE and share handouts and a script. We will discuss how BATHE can be valuable in a variety of medical contexts, including outpatient visits, inpatient rounds, integrated care, emergency department, phone triage, and with patients in crisis. Presenters will also share some unconventional uses of BATHE, including for self-care, to strengthen peer relationships, to enhance provider satisfaction, and to engage clinic staff. We will discuss limitations and lessons learned, and invite for participant comments.

Clinical Practice Update 162

Bipolar Disorder: Managing the Peaks and Valleys

William Johnson, MD; Scott Fields, PhD; Ellen Bluett, PhD

Bipolar disorder is a psychiatric illness with a 2.8% one-year prevalence rate in the United States adult population. It is a mood disorder that has numerous potential treatment pitfalls and a reputation, whether right or wrong, of being overly diagnosed. While an array of treatments exists, adherence issues often make it difficult for patients diagnosed with bipolar disorder to achieve and maintain therapeutic gains. Key concerns in addition to assessing bipolar disorder include finding the right therapeutic intervention, managing impulsivity, and on-going monitoring for potential harmful and / or suicidal behavior. Effective long-term treatment typically involves pharmacotherapy, close contact with the patient, and keeping an open mind clinically on the option of inpatient treatment. Cognitive behavioral therapy has been shown to be of benefit as part of the treatment milieu for individuals diagnosed with bipolar disorder. An inter-professional, collaborative approach to the diagnosis and treatment of this disorder in primary care clinics will be further discussed.

Lecture Discussion 163

How Can the Neuroscience of Compassion Help Me with My Patients Today?

Dominic Vachon, PhD

While clinical training focuses on teaching communication skills, what is often not well trained is how our internal attitudes about patients and our ability to make solid emotional connections can make or break anything we do with patients. Training excellent communication skills does not necessarily improve the inner clinician attitude. This workshop will demonstrate how to teach and apply the new Science of Compassion in engaging and impactful ways in residency training and clinical practice. It will focus first on the practical application of the Polyvagal Theory in making therapeutically safe emotional connections with patients. Second, it will provide ways to help residents identify and manage the source of their inner clinical attitude with patients. Finally, participants will be introduced to how to locate the inner clinical attitude in the Clinician Compassion Mindset which is based on the neuroscience of empathy and compassion. The new Science of Compassion has provided clinicians with incredible information based on biology, neuroscience, and psychology that is relevant to clinical practice, clinician self-care, and how to train compassion. Yet medicine has not yet learned how to teach and apply many of these new findings. Few medical schools and residency programs are aware of the findings of compassion science nor do they have engaging practical ways of teaching their application in clinical practice. This workshop will provide an overview of this cutting-edge work and how to use them in training to improve patient care and clinician well-being.