



Program Abstracts
The 38th Forum for Behavioral Science in Family Medicine
September 13-16, 2017

THE GATHERING IN

Wednesday, September 13, 2017 | 5:15 – 6:30 pm

Gathering In: Bringing the Patient's Voice to the Conversation: Can you hear it?

Molly Clark, PhD; Tom Bishop, PsyD; Katie Fortenberry, PhD

Join with fellow Forum attendees as the co-chairs of the STFM Group on Family and Behavioral Health introduce the 2017 Forum theme, The Patient's Voice and lead the group in activities that welcome and build connections with new and seasoned attendees.

MARK YOUR CALENDARS

The 39th Forum for Behavioral Science in Family Medicine

October 10-13, 2017

Chicago, IL

PLENARY ADDRESSES

Opening Plenary

Thursday, September 14, 2017 | 8:00 – 9:15 am

Macaran Baird, MD, MS: One Physician's Story: Illness, Recovery and a New Syndrome

Dr. Baird has spent most of his career caring for patients, teaching and writing about integrating behavioral health into family medicine. In 2012 he developed a life-threatening illness and spent a combined 5 months in the hospital and additional year on chemotherapy. Surviving was his early goal and eventually the challenge was how to live post-illness in a meaningful way. With this presentation he will share his experiences as both health care professional and patient. Factors that he found favorable for survival, resilience and gratitude seem to have combined with expert care to benefit him as a patient and teacher. The goal of his presentation and audience participation is to explore themes that weave through his story and may assist others with patient care, teaching and, perhaps, personal adaptation to serious illness.

Keynote Plenary

Friday, September 15, 2017 | 12:15 – 1:45 pm

e-Patient Dave deBronkart: Let Patients Help: The Era of the Participating Patient

“e-Patient Dave” deBronkart has been quietly and not so quietly altering the balance of power in health care by creating a new dynamic in how information is delivered, accessed and used by the patient. He actively promotes opening health care information directly to patients which has the power to revolutionize the relationship between patient and health care providers. In his new world of participatory medicine, patients become potent agents in managing their own health partnership with their physicians. This new relationship is a collaborative partnership in which both parties are more fulfilled. Ultimately, e-Patient Dave’s passion is to establish a new paradigm of health care in which all patients are empowered, engaged, equipped and enabled. He will share his personal health experiences and wisdom on how to empower patients by giving them access to their records, encouraging them to Google their health concerns, and by involving them directly in complex clinical decisions.

Closing Plenary

Saturday, September 16, 2017 | 10:30 – 11:30 am

Kathryn Fraser, PhD: Do You Hear What I Hear? How Listening to Patients’ Stories Can Reduce Health Disparities and Enhance Care

Health care providers should be attuned to hearing the patient’s real voice during the medical interview. This requires patience, understanding, and humility. Providers often encounter misunderstood and mistreated patients due to their unique cultural characteristics. They should be open to hearing stories of outright discrimination, subtle bias, and everything in between. This session will provide examples from patients who have felt unheard, dismissed or ignored by their healthcare providers. Participants will hear evidence-based recommendations for fostering patient disclosure and forging connections instead of promoting isolation and silence. The session will review research about health disparities but will primarily focus on facilitating a deeper experience for the participant that encourages a shift in thinking about personal bias and prejudice. We will examine what narrative medicine describes as the benefits of hearing the patients’ voice and their story, as well as how Relational-Cultural Theory informs us on creating connection and mutual empowerment with patients of difference. Finally, participants will reflect on their conference experience regarding stories from the patient’s voice and find common connections with their co-attendees to produce their stories in small groups. The presenter will conclude the plenary with examples of the role of her voice as a patient.

Workshop 101

Resident Wellness

Emilee Delbridge, PhD, LMFT; Amy Polsinello, MD; Kristie Espinal, MEd

The Quadruple Aim identifies physician wellness as the fourth leg supporting successful healthcare delivery. As we train residents to improve population health, while reducing overall healthcare costs and increasing patients' satisfaction and experiences with the medical systems, we also focus on ways in which to increase physicians' satisfaction working in primary care through work-life integration. When our faculty and residents identified the challenges of working and training in Family Medicine, we decided to develop a monthly wellness program that is primarily experiential, with a didactic element that included key research and literature. Since a few residents identified wellness as an interest, they have taken the lead by specifying session topics and including appropriate community partners. During this workshop, we will present examples of the monthly sessions' topics since inception last academic year, resident feedback, application to patient care and/or personal wellness, and co-facilitators' lessons learned. We will discuss future goals for more fully integrating wellness into our curriculum and program, including faculty wellness and engagement.

If You Build It, They Will Come: Creating a Successful Resident Support Group Program

Jennifer Ayres, PhD

Resident support groups are a common way to promote resident wellbeing and wellness. This workshop will present a support group program that is based on three goals: (1) Promoting resilience & buffering burnout, (2) Building cohesion, and (3) Skill building (provider-patient communication, emotional processing/debriefing difficult encounters). This workshop will focus on how to tailor a support group to meet program parameters/needs and (1) incorporate resilience-related concepts (e.g., self-compassion, mindfulness, gratitude), (2) use structured and unstructured activities to foster self-reflection, group cohesion and community building, and (3) facilitate skill building in a safe manner that fosters resilience and group cohesion. This workshop will be experiential and participants will be invited to participate in multiple self-reflection activities and share their experiences in small and large group formats. Participants also will be invited to share successful support group activities, facilitation tips, and strategies to overcome unique challenges involved in facilitating resident support groups (inconsistent attendance due to block & call schedules, multitasking during group, role conflict for the facilitator, varying levels of resident psychological mindedness, confidentiality issues).

Lecture Discussion 102 (3:30 – 4:30 pm)

Milestone Evaluation of Physician-Patient Communication: Assessing Resident Skill

Angela Buffington, PhD, LP, ABPP-CP; Erin Westfall, DO

The ACGME Family Medicine Milestone Project created a new lexicon to be used in resident assessment. With this change came a need for new resident assessment tools that use this milestone lexicon specifically. Thus, we created the Minnesota Evaluation of Relationship Interaction Tool (MERIT) to evaluate resident Milestone progress in the competency domain of Communication. The MERIT lists detailed behavioral anchors that describe skills residents need to exhibit to show mastery of each related Milestone. The MERIT is in electronic format so that it is user friendly; tablets and other mobile devices can be used to track behavioral anchors observed, and progress reports to track resident growth over time are automatically generated. Psychometric properties of the MERIT will be reviewed. It has sound content validity in that it was created using standards of assessment set by the ACGME and using behavioral anchors from existing measures and tools that pertain to physician communication. The MERIT has sound face validity in that multi-disciplinary faculty experts were engaged to select, align and judge behavioral anchors. Pending data from a comparison study will be shared. Ratings from the MERIT are being compared to communication ratings using existing tools (e.g., Patient Centered Observation Form). Furthermore, user ratings of ease of use and resident ratings of relevance and helpfulness of the feedback MERIT provides will be discussed.

Workshop 103

Using Self-Disclosure to Improve Trainees' Understanding of the Patient Experience

Jessica Hauser, PhD

As behavioral scientists and mental health professionals, we are trained to maintain professional boundaries by avoiding dual relationships and deflecting personal questions posed to us by patients. The same cannot necessarily be said for medical training, as it is commonplace for physicians to treat one another, friends, coworkers and family members, or to have social relationships with patients outside of the office. One of these boundaries, self-disclosure, also varies by profession. In medicine, self-disclosure by physicians is fairly frequent (present in up to a third of patient visits (McDaniel et al., 2007)), and can serve to enhance patients' perceptions of the physician as more believable and more motivating (Frank et al., 2000). This professional cultural shift can be challenging mental health professionals working in primary

care, particularly for early career behavioral scientists in academic medicine or those moving into academic medicine from traditional mental health settings. This workshop will explore self-disclosure as a potential teaching tool. Qualitative research has shown physicians feel an increase in empathy for the patient experience when they have experienced a personal illness (Fox et al., 2009; Woolf et al., 2007). Through interactive activities and small group discussion, participants will be asked to consider their own personal and professional boundaries and explore ways in which self-disclosure could enhance their behavioral science teaching skills. Excerpts from a sample lecture in which a behavioral scientist's use of self-disclosure and narrative medicine to convey her patient experience to family medicine trainees will be provided to illustrate the techniques discussed.

Workshop 104

Delivering News: The Good, the Bad and the Ugly

Heidi Musgrave, PhD; Amberly Burger, MD

While Family Medicine Residents are required to obtain competencies in a number of procedures, exposure to managing family conferences during residency is not generally guaranteed. The number of trials to achieve competence in leading a family meeting is unknown. Residents are continually delivering a range of news. From simply adjusting medications; reviewing labs; denying narcotics to patients; to informing a patient of a terminal illness, communicating vital information is a daily activity. What could be joyful news to one patient, could be devastating to another. To better ensure that the news is delivered in a kind and comprehensive way, it is critical that the health care provider understand the circumstances that surround the patient. This seminar will provide a guide for teaching residents how to deliver news and competently manage complex family conferences.

THURSDAY, SEPTEMBER 14, 2017 SESSIONS
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Clinical Practice Update 105

Suicide in Older Patients

William Johnson, MD; Scott Fields, PhD

A suicidal patient in a primary care office presents numerous challenges. Evidence exists that over ¾ of patients who complete suicide have visited their primary care doctor within that year (1). Additionally, there is an increased risk of suicide in patients 65 years and older (seniors). The rates of completed suicide in seniors is generally at or near the top when compared to other age categories (2). Thus, the opportunities for prevention of suicide abound when working with senior patients. The causes of higher rates of suicide in this age group vary but include negative changes in employment, income, housing and medical status that often accompany older age (3). Furthermore, suicide is more frequently viewed as an option for older patients dealing with end of life or palliative care (4). A thorough depression and suicide assessment can provide a way for practitioners to help detect patient issues with mental health problems, suicidal thoughts and suicidal behaviors. The goal of this presentation is to provide updated literature that will help refine conference attendee's skillsets so that behavioral scientists and family physicians can utilize evidence-based treatments that are available in both the short and long term for optimal patient care (5). It is also important to demonstrate how everyone in the primary care clinic can optimally collaborate in the care of senior patients with suicidal thoughts or plans (6). The use of a developmental approach to more accurately view suicide in seniors will also be discussed (7).

Lecture Discussion 106

Doc, Can You Do Me a FAVER? The Inappropriate Patient Request - Getting to NO

Michelle Kane, PsyD; Lee Chambliss, MD

Patients often make requests that providers feel are inappropriate. These requests commonly involve controlled substances, work excuses and expensive tests. We will explore why these requests feel uncomfortable for physicians and identify what makes them inappropriate. We will introduce a simple, standardized approach physicians can use to respond to these requests. The "FAVER" approach minimizes patient and provider conflict and helps to maximize rapport. Participants will be taught to recognize "Feelings" to inappropriate requests, "Analyze" what feels uncomfortable about the request, "View" the patient in the best possible light using patient centered communication, "Explicitly" state their position, and work to restore the patient-provider "Relationship." We will use cases to illustrate this approach and report the results of our follow up survey of physicians who have used FAVER. We will have ample time for audience questions and suggestions.

Lecture Discussion 107

The Patient's Voice in a Family Context: Educational Methods in Family-Centered Care

Daniel Felix, PhD; Max Zubatsky, PhD; Laura Sudano, PhD; Emilee Delbridge, PhD

Patient's family members often understand more about, and have greater influence on, our patients than we do. Partnering with our patients' family members can allow us to more fully hear our patients' voices, but acquiring family-centered care skills that allow us to offer treatment aligning with a patient's unique family context and culture can be difficult and time intensive. In this presentation, we will describe and demonstrate various methods for training resident physicians to improve their family-centered care skills. We will discuss four different educational approaches being used at four family medicine residencies across the U.S., each of which utilizes two open-access training tools, namely the Family-Centered Observation Form (FCOF) and its accompanying free electronic training module. We will demonstrate our training methods using videos and graphic data to highlight key strengths and challenges of each training approach. Our emphasis will be on helping attendees adopt some or all of these methods into their own settings, based on curricular and scheduling needs.

Lecture Discussion 108

Wellness Groups Not Going So Well? We Can Help!

Lauren Penwell-Waines, PhD; Valerie Ross, MS; Susan King, MSW. LCSW

Behavioral science faculty often are responsible for facilitating resident and faculty groups that range from support groups to Balint groups. These groups can have goals that vary from promoting professional development and wellness to reflecting on the patients' and providers' experiences. Each type of group and group membership presents its own set of challenges and opportunities. The panel will review common difficulties they have faced in leading resident and faculty groups; they also will offer points for consideration and possible strategies to overcome barriers for behavioral science faculty who are implementing such groups.

Lecture Discussion 109

Walking in the Shoes of the Person with Diabetes

Anne Daly, MS, RDN, BC-ADM, CDE; Wendi El-Amin, MD

Diabetes is a chronic disease that requires the person with diabetes to make many daily self-management decisions and perform complex care activities. Diabetes self-management education and support provide the foundation to help develop skills for informed decision making, daily self-care behaviors, problem solving and coping skills. Providing diabetes care is not as simple as telling patients what to do. Psycho-social issues and feelings of the person with diabetes play a key role when managing diabetes. SIU Center for Family Medicine is a federally qualified health center (FQHC). FQHCs are designed to provide comprehensive primary care to medically under-served populations and provide resources to those who cannot afford or have challenges to access to care. For the past 3 years, we have been developing a successful model to teach family medicine residents how to provide diabetes care that is evidence based, using a collaborative, integrated care approach. We will role play patient scenarios about patient feelings, and show a video of people with diabetes describing their journey toward successful diabetes management after having received diabetes self-management education and support.

Lecture Discussion 110

What Do I Do Now? The Ethics of Honoring the Patient's Voice

Aaron Grace, PsyD; Heather Kirkpatrick, PhD

As members of a helping profession, many of us have an instinct to honor the wishes of our patients. Often, doing so is easy, or at least straightforward. But what about when the voice of the patient conflicts with our deeply held beliefs, or our professional ethics, or the desires of the patient's family member, or the law? What then? This interactive session will tackle some of these uncomfortable questions and attempt to untangle the web of honoring our patients, ourselves, and our profession as healers. This challenging issue is viewed through a professionalism lens, and is one that our trainees can also benefit from as they find their own professional identities and learn to balance the competing voices of patient, personal beliefs, and professional ethics. Our session will discuss how to begin this conversation with trainees. Handouts to run this exercise in your own residency will be provided.

Lecture Discussion 111

Can You Hear the Patient's Voice? Creating Patient Advisory Councils to Impact Practice

S. Alicia Williams, MA, CSAC; Thomas Bishop, PsyD

Patient input has been shown to improve healthcare outcomes and decrease costs. Many providers use surveys for patient feedback which significantly limits the "voice" that patients have. Unfortunately, less than one third of practices use patients in an advisory capacity. Though limited guidance is available on establishing Patient Advisory Councils (PACs), behavioral health providers (as trained facilitators) can be effective agents in initiating PACs. This presentation will

review the steps taken in a primary care residency to establish and maintain a PAC within the first year. We will review suggested steps for forming a PAC including building support from stakeholders, selection of facilitating staff, recruitment of PAC members, initiation of the first meeting and accountability for execution of projects. Barriers and solutions will be identified in the review of the implementation process. Participants will receive sample of documents used with our PAC and facilitation of meetings.

Partnering with Patients: Creating a Patient Advisory Council

Jim Schmidt, LISW; Melissa Jefferis, MD

Earning patient trust through genuine connection, demonstrating an understanding of their concerns, and enlisting them in the development of a plan for their outlines the underlying principles of meeting a patient's medical and emotional needs. A Patient Advisory Council puts this into practice by partnering with patients to enhance the care provided by the staff, residents, and faculty.

During this presentation, participants will learn how a Patient Advisory Council can be utilized to assist with service and quality improvements within a practice, strategies on how to implement a Patient Advisory Council, and processes to evaluate the effectiveness of a Patient Advisory council.

Lecture Discussion 112

Focusing on Doctor Patient Interaction: Peer to Peer Feedback through Blog Reflections

Elise Morris, MD; Jeanine Turner, PhD

Feedback for residents on their doctor-patient communication ability is important but difficult to provide given the time constraints and demands of the residency schedule. Over the past 4 years, the Family Medicine Program at Georgetown University-Providence Hospital and the Georgetown University Communication, Culture & Technology Program has collaborated on a study exploring doctor and patient interaction within a blog environment. Specifically, our research team has created a password protected blog where residents are filmed interacting with their patients. Each resident is filmed once per year and that video is uploaded to the blog. Then residents are able to view those videos and discuss and reflect on their doctor and patient interaction with each other within the blog. In addition, they meet one-on-one with a residency faculty member to review their communication, with a focus on health literacy. This project provides an asynchronous opportunity (communication that does not happen in real time) for resident training and specific focus on communication and patient interactions. Over the past four years we have uploaded 58 doctor and patient interactions to the blog. Currently, we have been analyzing the 230 blog posts that residents have posted to each other as they comment on the videotaped interactions. We will discuss the set up of this program, some initial research findings, and lessons we have learned over our 4 year implementation.

Lecture Discussion 113

Teaching Harm Reduction: A Critical Skill in Treating Substance Use Disorders

Amber Hewitt, PsyD; Alexander Brown, PhD

Primary care providers are increasingly caring for patients with opioid use disorders (OUD). Providers nationwide are recognizing the critical role and unique capability primary care has in addressing our nations' heroin epidemic, and as such, medication-assisted treatment (MAT) is being offered within primary care. Several family medicine residency programs have made it a priority to adequately prepare residents to care for patients with opioid use disorder (OUD) by providing requisite education and supervised treatment of patients with OUD so they may obtain their DEA X number upon graduation. Learning to care for patients experiencing addiction can pose a steep learning curve, especially when a patient repeatedly engages in behaviors that threaten their safety and health. Teaching residents harm reduction approaches and interventions may enhance their confidence in caring for a patient who is not ready to completely abstain from substances.

Lecture Discussion 114

Providing LGBTQ-Affirmative Care in the Family Medicine Setting

Cynthia Kim, LCSW; Stephanie Richers, LCSW

Historically, LGBTQ, in particular transgender, individuals are at markedly greater risk for poor health and mental health outcomes than those in the hetero-normative population, largely due to lack of access to appropriate, sensitive, and quality care to address the unique needs and presentation of this population. In an effort to reduce such disparities, our organization has developed an initiative to bring LGBTQ-affirmative, including cross-gender hormone therapy, into the realm of mainstream primary care. In doing so, we have adapted a protocol for the provision of cross-gender hormone therapy currently in pilot use at one of our sites, in conjunction with organization-wide training efforts to integrate LGBTQ-sensitized healthcare. The ultimate goal of this initiative was to finalize and implement the protocol throughout other IFH sites so that quality care is accessible for all of our LGBTQ patients.

Lecture Discussion 115

The Veil of the White Coat: Uncovering Physicians' Empathy of Patients' Experiences

Mark Dixon, PhD; Sundonia Williams, PhD

Physicians' ability to appreciate patients' subjective experience and express empathy is critical to the development and sustainment of a therapeutic, or helping, relationship (Mercer and Reynolds, 2002). As such, empathy becomes a significant contributing factor related to positive patient outcomes in family medicine (Hojat, et al., 2011). Physician empathy as a concept proves to be theoretically complicated and influences patients' perception of clinician expertise, trust, and collaboration in the physician-patient dyad (Kim, Kaplowitz, and Johnston, 2004). Empathy proves to not be a static character trait, but rather, research has also found that empathy declines among medical students and residents over time, largely as a function of increased distress (Neumann, et al., 2011). Due to this complexity, a recent review suggests that the patient-physician relationship needs to be examined beyond simply communication and empathy and needs to address additional theories and constructs (Grossemann et al., 2014). Given the importance of empathy to the physician-patient relationship, further understanding of associated factors requires deeper exploration.

Research on Patient Care 116

Moderator; *Mary Talen, PhD*

Research 116A - Personal Characteristics that Moderate the Effect of Childhood Trauma on Health

John Muench, MD, MPH; Sheldon Levy, PhD; Kristin Gilbert, MD; Rebekah Schiefer, MSW, LCSW; Rebecca Rdesinski, MPH

There is an extensive medical literature that demonstrates associations between childhood adversity as measured by the Adverse Childhood Experiences (ACE) questionnaire and many forms of adult morbidity and mortality. (Felitti, Anda et al. 1998, Gilbert, Breiding et al. 2014) The most complex patients seen in primary care are those who suffered abuse and neglect as children, often presenting with depression and medically unexplained symptoms such as chronic pain. Yet, a subset of patients with high ACE scores do not suffer from poor health outcomes. (Werner 2004) Understanding the factors that enable some to overcome childhood adversity and live long, healthy lives might enable identification of more effective interventions for preventing, or addressing associated problems. We explore the hypothesis that attachment style and resilience are two mediators of the relationship between childhood adversity and future health. We mailed surveys to patients of four family medicine residency clinics in order to assess ACE score, attachment style and resilience and then searched the subjects' electronic health record (EHR) problem lists for diagnoses that make up the Elixhauser co-morbidity index. We report the results of this survey and the strength of associations between our four variables, childhood adversity, attachment style, resilience, and current health co-morbidity.

Research 116B - Identifying Psychosocial Risk Factors for Medical Rehospitalization

Terri Wall, PhD; Coral Gaffney, PsyD; Max Solano, MD, MSc

Preventable readmissions are common among older adults for reasons that are not easily understood. One in five Medicare beneficiaries who is discharged from a hospital is readmitted within 30 days. The Hospital Readmission Reduction Program requires the Centers for Medicare & Medicaid to reduce payments to hospitals that have "excess readmissions." Therefore, there is a need to identify factors associated with readmissions. The majorities of these studies identify clinical and pharmacological issues, as well as follow-up appointments after discharge from the hospital as potential interventions to reduce readmissions. Only a few studies investigate sociodemographic features, and studies including the patient experience from a qualitative point of view are lacking.

We describe an integrated biopsychosocial approach to providing a longitudinal and transitional narrative of the patient experience that allows identification of potentially preventable causes of readmission and helps the primary care physician to reflect on psychosocial issues that otherwise would be absent compared to traditional models of care. An existing program Safe Recovery after Hospitalization (SARAH) was expanded to integrate the behavioral health fellow with the medicine team to select patients that undergo semi-structured interviews documented in their medical records. Also, sample interviews of providers and patients are conducted. Thematic analysis of these notes and interviews will be used to identify the role of the patient experience during hospitalization, community transition and continued health care once in the community.

Research 116C - The Role of Health Literacy and Illness Perception in Value-Based Care

Angela Antonikowski, PhD

The transformation from fee-for-service care towards value-based reimbursement has shifted the landscape of primary care and changing what is identified as value.¹ As part of this shift, renewed focus on behavioral health has ushered in an opportunity for behavioral health scientists to continue to positively impact patient care in primary care settings. The skills of behavioral health scientists in assessment and clinical care can be put to adequate use in this new landscape in which patient outcomes are continually assessed as an indicator of clinical success.² Not only are objective indicators of patient physical health such as glycemic control and emergency department utilization identified as indicators of value-based

care, but changes in patients' psychological functioning are highlighted as well. 3 The ability of behavioral scientists to partner with patients to guide the nature of behavioral health interventions in the context of value-based care requirements should be further explored particularly as it relates to fluid constructs such as attributions and beliefs about health. These constructs could have equal importance in gauging patients' ability to reach health milestones. 4 The current proposal utilized a population-health approach to understanding the relationships between physical health and behavioral health indicators. Factors such as patient engagement in care have been identified as important to health outcomes, however, additional factors such as patient's beliefs about illness may have predictive effects on patient's ability to engage.

Clinical Practice Update 117

Beyond Opioids: Helping your Patients Develop Active Pain Management Skills

Julie L. Rickert, PsyD; Megan Schmidt, BS, RD; Thomas Seaver, BS

Caring for patients with chronic non-cancer pain (CNCP) can be a frustrating and discouraging experience. Relying on opioid analgesics as the primary treatment rarely leads to the best outcomes. Incorporation of behavioral strategies is associated with better quality of life, safety, and reduced impairment. Not every patient will have access to the services of a multidisciplinary pain management program. Family physicians, even ones in rural areas, can utilize locally available services, simple office-based interventions, and electronic self-help resources. During this presentation, we will share behavioral management strategies with the best evidence. Participants will be given strategies to identify resources available to their own patients and participate in a brief communication activity to promote patient self-management. Participants will receive a CD with patient education materials and links to electronic pain management resources.

Lecture Discussion 118

Pay Attention: Developing Protocols for ADHD Across the Lifespan

Patricia McGuire, MD

According to the CDC, the number of school-aged children in the US diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) has risen from 7.8% in 2003 to 11% in 2011. The number of adults seeking treatment for ADHD in primary care clinics has also substantially increased over the past decade.

Family medicine providers are often on the front line in the assessment and treatment of ADHD in child, teen and adult patients. Limited patient access to psychiatry services and patient preference to get ADHD care in the primary care setting play a role. Yet, many primary care providers feel inadequately equipped to diagnose and treat ADHD across the lifespan. Providers often share concerns about over-diagnosis of ADHD and misuse of stimulants, particularly with older teen and adult patients.

This presentation highlights a QI project to address ADHD across the lifespan in our Family Health Center.

Implementation steps include: 1) devising structured protocols for ADHD evaluation and treatment; 2) building EHR templates and point of care access to ADHD protocols, tools and resources; 3) providing training to primary care providers, office staff and behavioral health clinicians about ADHD across the lifespan; 4) obtaining on-going provider feedback regarding training and resource materials; 5) determining next steps to refine the protocols.

Lecture Discussion 119

Forgotten, Silent, and Over-Ruled: Hearing the Voice of the Nursing Home Patient

Ande Williams, MS; Amber Cadick, PhD, HSPP

Approximately 1.5 million Americans live in nursing home/long-term care facilities (Unwin & Provaznik, 2010). Per Accreditation Council for Graduate Medical Education (ACGME) guidelines (ACGME, 2016), Family medicine residents are required to gain experience and competence working in nursing home/long-term care facilities; however, this unique environment poses several challenges for residents to hear the wishes of their patients over the demands of the patient's medical care team and family members. Also, many patients in long term care/nursing home facilities have sensory impairments (e.g., poor eyesight, deafness) and/or cognitive deficits (e.g., dementia). One solution for hearing the patient's voice over the demands of medical professionals and family members is to train physicians how to overcome communication barriers with their patients. In this heavily interactive session, we will discuss solution-focused approaches to reducing the barriers of sensory and cognitive impairments through the use of adaptive equipment and learning nonverbal signs of pain and other conditions. The session will also present strategies for residents to encourage current patients to establish their wants and needs prior to placement in a long term care facility, and how to balance the patient's wishes with overbearing family or staff. These recommendations are designed to assist with reducing physician frustration, increasing patient's input in medical decision making, and improve communication across the patient care team.

Grant Writing Workshop with a Focus on Behavioral Science and Primary Care (limited enrollment) 1:30–3:15 pm
David Nelson, PhD Leslie Ruffalo, PhD Melissa DeNomie, MS

This workshop will help participants to develop either an initial or deeper understanding of how grants can fit into their roles as a clinician, researcher or member of the clinical team. Each role can not only build individual careers around grant writing and research, but also the careers of others including colleagues and learners at all levels. This workshop will be grounded in principles of community-engaged research, focus on health disparities, and incorporate the patient/community voice into the discussion. Patients and community members are a critical stakeholder in research. We will honor this important role by offering strategies to integrate the patient voice in both the grant writing and research. We will discuss and navigate a number of grant resources to support an engaged learning environment during the workshop. We will present evaluation models to guide participants to think about ways to evaluate research from the perspectives of multiple stakeholders. At multiple time points during the workshop, we will use short vignettes (based on the presenters own grant experience) to contextualize concepts. These examples will be deconstructed by participants to point out strengths and weaknesses. Finally, this workshop will assist participants to either develop an idea that can be built upon or identify next steps wherever they may be in the grant writing process.

Clinical Practice Update 120

Supporting Families Managing Parental Mental Illness/PTSD: Challenges and Resources

Michelle Sherman, PhD

Internationally, one in five youth has a family member living with a serious mental illness (SMI), major depression, bipolar disorder, or schizophrenia. Adults with a SMI or post-traumatic stress disorder (PTSD) are just as likely as those without to be parents, and the role of parent may be one of their most prized life roles and motivations for participating in treatment. Offspring of parents with an SMI are at elevated risk for a range of emotional and behavioral health problems, and longitudinal research has documented that these outcomes often persist into adulthood (Beardslee, Gladstone, & O'Connor, 2011). Family physicians and behaviorists in primary care settings have a unique opportunity and responsibility to understand and support all members of the family, and they can be especially useful to families managing both serious mental illness and PTSD (National Research Council and Institute of Medicine, 2009). This session will review the impact of mental illness/PTSD on parenting and the experiences of children growing up in these families. Numerous challenges for these families will be explored, such as fear of loss of custody, stigma, and separate healthcare systems for parents and children. Ten specific ways in which behaviorists and family physicians can support these families will be explained, and resources for these parents, children, and family systems will be described.

Lecture Discussion 121

Essential Elements of Successful Leadership in Family Medicine Education

Oliver Oyama, PhD, PA-C; Elizabeth Lawrence, MD

Is leadership innate? Do effective behavioral science educators make successful leaders? How does one become a successful leader in the setting of family medicine education? The future of family medicine depends on developing successful leaders, particularly those knowledgeable in the behavioral sciences, its impact on health and more fundamentally on its use in family medicine physician education. This session is designed for aspiring family medicine leaders who wish to grow into leadership positions. Attendees of this interactive session will be presented with what we believe are the essential elements for successful leadership. Each element will be clearly presented with practical examples of how they are manifested. Attendees will be given the opportunity to reflect on these elements, to share their experiences and insights on family medicine leadership, to identify personal goals toward leadership and, if appropriate, to commit to focus on one of the essential elements of leadership for professional growth after they leave the conference. The seminar will be co-led by an Affiliate Professor/Associate Program Director/Behavior Science Director (psychologist) and an Affiliate Assistant Professor/Clinic Medical Director/Associate Program Director (formerly Interim Program Director – physician) who have worked in residency training cumulatively for 40 years. Both bring their unique perspectives and individual backgrounds to the discussion of family medicine leadership.

Lecture Discussion 122

A Curriculum for Teaching Professionalism and Ethics through Patient Stories

Jacqueline Maxwell, PsyD; Jason Rieser, MD

The importance of professionalism and ethics in medicine has been increasingly emphasized in recent years. Specifically, teaching professionalism is essential for residency accreditation as evidenced by inclusion in the ACGME competencies, milestones, and the CLER site visits. The presenters believe that storytelling and the potential lessons contained in the patient's narrative is an ideal way in which to longitudinally teach professionalism and ethics in residency training. Family Practice Stories, is a large collection of stories and essays told by, or about, 48 family doctors practicing in the mid-20th century. These physicians, of that Greatest Generation, were the founding fathers of family medicine. There are many lessons to be learned about professionalism and ethics, as well as our specialty's values, from these many patient/physician

stories. Each story reveals much about the physician's style of practice and how both patients and physicians touched each other's lives. Through these stories, physicians share how they listened to their patient's voice and how even years later their patient's voice continues to impact them. Family Practice Stories was a project of the Indiana Academy of Family Physicians Foundation and was supported by the AAFP Foundation. The presenters do not have any financial interests as all royalties from the book have been donated to the Indiana Academy of Family Physicians Foundation.

Lecture Discussion 123

Preparing Residents for Integrated Behavioral Health: A Competency-Based Curriculum

Matthew Martin, PhD; Thomas Bishop, PsyD; Elizabeth Banks, PhD; Linda Myerholtz, PhD

Jennifer Harsh, PhD; Amber Hewitt, PsyD; Max Zubatsky, PhD; Allison Bickett, MS

Family medicine educators need an evidence- and competency-based curriculum to prepare students and residents to work with behavioral health clinicians in primary care. This presentation is based on a project funded by the Society of Teachers of Family Medicine. The aim of the project is to identify core competencies for physicians practicing integrated behavioral health, design a curriculum based on those competencies, and evaluate the effectiveness of the curriculum at multiple sites across the country. The purpose of this presentation is to introduce medical educators to the initial project findings. We will describe the curriculum and review effectiveness outcomes from a pilot study, invite participants to experience part of the workshop training, and then discuss strategies for implementation.

Lecture Discussion 124

Focusing on Strengths: Does This Reduce Burnout and Improve Engagement?

Lindsay Fazio, PhD; Miranda Huffman, MD, MEd

An epidemic of physician burnout is happening in our country. According to current studies, from 35-65% of physicians are experiencing the undesirable effects of burnout. Unaddressed burnout leads to poor patient satisfaction, lower quality of care, increased risk of medical error, turnover, decreased provider satisfaction, depression, substance misuse and suicide. Burnout and engagement are described as two opposing variables.

We will present on a quality improvement project lead by a behaviorist and a family physician to promote engagement amongst faculty members.

After completing the Maslach Burnout Inventory (MBI), the Area of Work Life (AWL) inventory, and a StrengthsFinder assessment, faculty reviewed their scores followed by education on recognizing and managing burnout. An outside consultant discussed the StrengthsFinder tool and its application to academic family medicine. Finding Meaning in Medicine groups started meeting monthly to provide a venue for reflection. Faculty developed Individualized Learning Plans (ILP's) based on feedback from students and residents, their current level of burnout, and their individual strengths. Accountability groups were formed to meet regularly to support each other's growth.

While overall scores were positive, analysis of subgroups showed clinical areas that require attention. Efforts in improving the outpatient areas will have the greatest benefit for our department. AWL scores show faculty who do not have regular administrative responsibilities are the most disengaged. Focus groups were conducted for qualitative analysis of data.

Lecture Discussion 125 (3:45 – 4:45 pm)

HEARTSINK: “Difficult” Doctor/Patient Interactions (and How to Survive Them)

Gregory Sazima, MD

This presentation will focus on encounters with “difficult” patients, also known as “heartsink” patients. After identifying some specific characterological “archetypes” of such patients, we will approach the subject from a novel perspective - looking not just at patient character styles but also physicians' own archetypal character styles of perfectionism, narcissism, and counter-dependency - to examine the situation holistically as a “difficult interaction”. We will also advance practices in increasing one's own self-awareness in the midst of such interactions. Participants will be able to demonstrate a general knowledge of the interactive characteristics of difficult encounters and tools to develop improved self-awareness for such encounters. The presentation will also address how teachers and mentors can help trainees' skills and self-awareness in identifying their own strengths and vulnerabilities in these challenging encounters.

Workshop 126

Resident Well-Being Workshop: A Therapeutic Afternoon

Bonnie Cole Gifford, JD, LMFT; Roberta Weintraut, MD; James Brunson, Jr., LAMFT

Stress, anxiety, depression, and burnout is reaching epidemic levels among medical residents. It has gained significant attention secondary to concerns regarding job performance and patient care. Approximately 70% of residents met criteria for burnout in a 2014 survey at the University of North Carolina at Chapel Hill. There were no differences by sex, age, marital status, number of children, race, ethnicity or in terms of postgraduate year. Statistics from the St. Louis School of Medicine show that depression rates for medical students are 20-30%, and anxiety and burnout rates are greater than 50%.

Sixty to ninety per cent of practicing physicians would not recommend the field to their children. Educators need to develop an active awareness of stress, anxiety, depression, and burnout among residents and students, and ought to consider incorporating relevant instruction and interventions during the process of training physicians.

Our program has developed an afternoon experience every year to attend to stress, anxiety, and burnout among the residents. Further, this conference places the resident/student in the position of “patient,” in that s/he is receiving “treatment” for patient complaints heard commonly – stress, anxiety, depression, and burnout. This treatment includes art work, guided imagery, chair yoga, biofeedback, breathing, the wellness wheel, and other interventions. This experiential afternoon is designed to teach residents how to recognize and cope with their own stress, anxiety, and burnout and to increase empathy with patients who are also experiencing these issues. The conference also teaches residents how to use these techniques with their patients.

Symposium on Formative Research 127

Moderator; *David Nelson, PhD*

Research 127A – Vaccinations: What Happens when You Disagree with the Patient's Voice

David Klehm, MD; Kristopher Dunbrack, MD; Archana Rajan, MD

The immunization rates for our clinic regarding Influenza Vaccine were significantly below the community average despite achieving exceptional rates for other childhood immunizations. We ask and we hear the patient's or the parent's of the patients voice declining our recommendations. Evidence based medicine preaches the virtues of receiving flu shots with relatively little risk of harm. Do we have unique barriers for improving immunization rates and, if so, how can we address them to improve the health of our patients through increased rate of immunization and patient education focused at the root causes.

Research 127B - Co-located Family Medicine and Trauma Services: The First Nine Months

Jim Mercuri, LCSW; Sandra Sauereisen, MD, MPH; Andrea Karsh, LCSW, BCD

According to CDC statistics, 18% of women reported experiencing rape, and 5% of men and women report sexual coercion in the last year. There is also a clear link between a history of sexual or physical violence and poorer health behaviors and outcomes. We collaborated with a not-for-profit community partner, Pittsburgh Action Against Rape (PAAR) a well established community agency in our area who provides services to victims of sexual and violent trauma as well as education regarding trauma and behavioral health sequelae. Based on a perceived need in our community and patient population, we devised a co-located model of counseling services within our Family Health Center. We will describe the initial nine months of utilization of trauma counseling services embedded in a Family Health Center. We suspect evaluating utilization will act as a surrogate for need and prevalence in our community and help to evaluate whether co-located services is an effective model of care.

Research 127C - Evaluate Applicant Situation Judgement and Personality Tests: Objective Interview Selection Elements

Leanne Chrisman-Khawam, MD, MEd; Rosellen Roche, PhD, MD

Selection of Medical Students and Residents for Training is a resource draining, arduous and complex process. Medical Schools and residency programs rely on cognitive elements because they are "objective." Systemic Review and met analysis reveal that only 9-23% variance in failing performance could be attributed to the objective cognitive performance measures traditionally used to select medical students and residents, namely performance on standardized examinations and Grade Point Average. While it is known that an individual's communication skills and personality traits around listening skills and "bedside manner" lead to improved patient satisfaction and decreased rates of malpractice claims, it is difficult to reliably and objectively select candidates based on these traits. Additional study of objective measures may aid in our understanding of successful traits of medical trainee selection. We will present our research design and results of first cohort of candidates for a special primary care 3+3 program at one osteopathic medical school.

Research 127D - Primary Care, 3-year UME/GME Continuum Education: Promoting a Patient-Centered Model

Leanne Chrisman-Khawam, MD, MEd; Rosellen Roche, PhD, MD

This osteopathic medical school has been approved for an accelerated primary care program that will integrate Quality Improvement, Population Health Science, Inter-professional Teamwork and Leadership training, as well as a Longitudinal Integrated Curriculum and early entry into their primary care residency position. The program hopes to show improved and continued commitment to primary care, geographical area and integration into a team-based model that will not only impact retention of the medical student to resident but also promote the team-based model to provide patient centered care.

Seminar 128

Race Matters: Addressing Racism as a Health Issue

Camille Garrison, MD; Bryan Johnston, PGY-2; Ashley Munroe, PGY-3; Veneshia McKinney, MD

The World Health Organization proclaimed in 1948 that “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹ In many underserved clinic communities, the individual and social well-being of patients of color is threatened. Our country is currently experiencing a great exacerbation of racial tensions and as health care providers, we are dealing with the effects of racism on a daily basis. In order to effectively address patients’ needs, it is imperative that physicians and behavioral health providers acknowledge the racial and socioeconomic challenges that patients face and recognize how these factors transcend to the physical and psychological medical conditions that patients experience. This presentation will outline the importance of addressing racism as a health issue and will highlight individual experiences and challenges in addressing it as such, within urban-underserved residency program settings. The presentation will offer various view-points on racism as a health issue and will be facilitated by two under-represented minority residency program faculty, a resident who is passionate about social justice who is ethnically different from the majority of his patients, and lastly an international resident of color who has experienced racism directly and indirectly during residency training.

Workshop 129

The Balint Group Experience: Promoting Relationship Awareness (Session 1)

Phillip Phelps, LCSW; John Freedy, MD, PhD; John Muench, MD, MPH; Allison Bickett, MS

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 patient’s 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 today’s medical environment for both doctors and patients. They can be a powerful method to assist the synthesis of cognitive and affective processing that can lead to a more precise, empathic, and practical understanding of doctor-patient interactions.

Balint groups train physicians to understand and use the doctor-patient relationship as a therapeutic tool. The Balint group uses an experiential method that greatly enhances relationship awareness and, by design, brings the patient’s voice into the room.

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.

FRIDAY, SEPTEMBER 15, 2017
Roundtable Discussions 7:00 – 8:00 am

Spirituality and Wellness Retreat: A Novel Approach to Preventing Resident Burnout

Richard Brandt-Kreutz, MA, MSW

Preventing burnout and promoting resident wellness is an ever-pressing need in Family Medicine residency programs. Individual and group-based wellness curriculum, as well as curriculum that enhances personal spirituality, have been shown to reduce risk factors for burnout and promote wellness among physicians and medical residents. Spirituality and wellness are overlapping and inter-related topics that when addressed together promote resident well-being in a holistic way. I will describe my residency’s experience sponsoring a day-long, yearly Spirituality and Wellness retreat including its development over the last 13 years and the partnership with our hospital’s Spiritual Care department. Lessons learned will be discussed as well as a summary of our outcomes based on participant feedback. A retreat planning tool and evaluation template will be shared with participants.

Where is the 'Patient's Voice' when Faculty Prepare for Promotion?

Jeff Morzinski, PhD; Sabrina Hofmeister, DO

Academic health centers claim strong commitments to community engagement, and many family medicine residency programs highlight initiatives in community medicine and patient-centered care (Moushey et al., 2014). Models of faculty development include advice on pursuing scholarship on community-engagement, with “patient voices” a main element (e.g., CCPH.org; compact.org). But what place do community and patient-engaged work – the voices of patients – have in residency educators’ academic advancement, and how do junior family medicine residency program faculty members collect and organize evidence of this type of scholarship for future steps toward academic promotion?

At this Round Table (RT) Discussion, presenters will introduce key resources and their department's long history of promoting the "educator's portfolio" for faculty development and academic advancement – including examples of community and patient voices. RT participants will describe their own personal experience with portfolios. The discussion will be guided to address three main questions. 1) What role (if any) should patient & community voices have when considering professional advancement? 2) What are responsible ways to identify and amplify patient voices as meaningful evidence of clinical, teaching and/or research quality? 3) What are steps to assess and build institutional support for genuine engagement of patient voices in promotion decisions?

“How Can We Best Prepare Residents for Rural Practice?” Teaching Priorities and Future Research

Jennifer Robohm, PhD

Behavioral science has been identified as a competency area especially relevant to rural practice, since behavioral health resources are often scarce in rural communities and specialty back-up is limited. However, little guidance exists in terms of how best to prepare family medicine residents to address behavioral health issues in rural practice, and behavioral science faculty from rural training programs do not always have other colleagues with whom to discuss their educational challenges and successes. The round table facilitator will review relevant research and challenges which make it more difficult to adequately prepare family medicine residents to address rural behavioral health concerns. Participants will explore these challenges and share strategies and tips that they have found to be effective in their own work. They will also discuss possible collaborative research projects that could provide greater guidance for behavioral science educators in family medicine residency programs with a rural training focus.

Southern California Behavioral Health Consortium: A faculty development model

Barbara Ackerman, PhD; Colleen Warnesky, PsyD; Brian Wexler, PhD

The Society of Behavioral Medicine informs that the field of Behavioral Medicine was first identified in the mid 1950's. They further define Behavioral Medicine as an interdisciplinary field combining medicine and psychology, and is concerned with the integration of knowledge in the biopsychosocial sciences to promote health and illness. Despite its inception to the field of medicine the reality today is that the majority of Family Medicine Programs generally have only one Behaviorist on faculty. This person is often alien to the culture of medicine because they are non-physicians whose expertise in behavioral medicine are not always appreciated or well understood. Many behaviorists integrate into medical systems with little formal training. They are challenged with finding and maximizing on opportunities that can creatively provide academic training in behavioral medicine topics and treatment approaches. Many behaviorists have anecdotally reported this to be a daunting task. To address the increasing need for support and education for behavioral health faculty, the Southern California Behavioral Science Consortium was created. The consortium model was designed to foster ongoing camaraderie and partnerships among family residency programs. The gatherings serve to break the isolation many of us face, help encourage confidence, provides guidance to help prevent burnout, and provide mentorship to new faculty to ensure their success and wellbeing. For those facing programmatic budget constraints, attending conferences or workshops may be unfeasible, however with programs approving/giving behaviorists time to attend the consortium has turned out to be a gift, which the consortium feels it is worth sharing.

The Program Evaluation Committee: What is it and Why You Should Chair it!

Michelle Kane, PsyD; Lee Chambliss, MD

The ACGME mandated Program Evaluation Committee (PEC) is on the front-line of ensuring the vitality and growth of residency programs. Despite the considerable breadth and depth of its mission – to promote continuous improvement in the residency – there are no specific requirements as to how the PEC should carry out its duties. Behavioral Science faculty possess unique strengths in administration and leadership and are prime candidates to successfully lead the PEC. We will provide a brief overview of the roles and responsibilities of the PEC before focusing on the successful structure and function of our residency's PEC, which is chaired by a Behavioral Science faculty member. Participants will have the opportunity to develop an action plan for involvement in their residency PEC.

Quantity and Trends in Quality Time Allocated to Behavioral Science Training Goals

Timothy Spruill, EdD

There is a finite amount of time for faculty to train residents in acquiring the skills/milestones/competencies, during their 3 years of residency, Accrediting organizations tend to add requirements rather than subtract them in order to maintain accreditation. As medical science progresses, there is more biomedical information for residents to acquire. Recently in the researcher's program, a sports medicine rotation was made mandatory resulting in the end to the behavioral medicine 2 week block rotations in the 2nd and 3rd year of training. Other programs may have also been required to give up their block rotations and convert to a longitudinal rotation. While there is a logic behind this approach, unless time is allocated elsewhere in the curriculum for behavioral science faculty to interact directly with residents individually or in a group format, it is unrealistic to believe that the psycho-social skills and sensitivities which have been a traditional priority for

Family Physicians (2) will survive. Knowing that behavioral science faculty generally work in isolation from one another and must deal with program specific traditions and priorities, the question arises as to how much dedicated interaction time is built into each program. This research will sample as many Family Medicine residency programs as will agree to participate in order to determine the average amount of one-on-one time, group time and lecture time that behavioral science faculty are allocated to accomplish their training goals. Also of interest is the range of dedicated time among programs and the perceived trend.

Addressing the Needs of Your LGBTQ Patients and Beyond

Karen Nelson, MD

The LGBTQ community is just one of many sub-groups of patients we see in our offices everyday. Someone recently asked if I had been "trained" to take care of this community and I answered yes without thinking much about it. When I did start thinking more about it, I realized my recent training (both medical and social) was thanks to a resident in our program who has set up an informal curriculum in our training program. He has done a series lectures/discussions surrounding sexual orientation and the LGBTQ community. This discussion will focus on asking patients about their sexual orientation, speaking to patients about sexual health using appropriate language, and a fun way and interactive way to approach the subjective of sex and contraction with both patients and other providers ("The Banana Lecture")

FRIDAY, SEPTEMBER 15, 2017 SESSIONS

Workshop 130

Now What? Making the Most of Your Behavioral Science Career Now that You're Not a Beginner

Claudia Allen, PhD, JD; Theodore Siedlecki, Jr., PhD

Early career development is often an exciting roller coaster of uncertainty cushioned by a growing sense of mastery. What happens, though, after the 5-10 years that it takes to feel confident in your role? Where do you go from there? Behavioral Scientists in academic medical settings face unique challenges to mid-career development. The opportunities to move up into traditional leadership positions in our departments or medical schools are often not open to non-physicians. In addition, we are often the only person with our training in our department, perhaps in our institution, so we rarely have senior mentors to model an advanced behavioral science career. The risk is waking up mid-career with voluminous responsibilities that consume one's time and energy, but without a satisfying sense of moving forward professionally. Research on mid-career development indicates that academic health professionals rarely take time to reflect on their professional trajectory, and such reflection is key to long-term career satisfaction. In this workshop, we will offer the opportunity to pause and reflect on where we are now, what is working well, and what matters to us most, using carefully chosen questions. We will then draw on each other's experiences and knowledge to expand our visions of what advancement can look like and how we might continue to best use our skills and passions. Finally, we will work in small groups to coach each other toward a plan of action to help us resist the biggest risk to our thriving – passivity (Brown, 2015).

Workshop 131

Engaging Millennial Learners by Overcoming our Generational Differences

Beverlee Ciccone, PhD; Julianne Lucco, MD; Margaret Ciaverelli, DO; Ellen Duveneck, MD

Within the last decade millennial era learners have entered the stage of graduate medical training, and they are beginning to emerge as new physicians and young faculty. They are being taught and trained by faculty who are generally of the Gen-X and baby-boomer eras. Differences in generational culture, expectations, technology use and proficiency, teaching and learning styles contribute to frustrations and barriers on the part of faculty and learners alike. Medical educators often expect learners to value and conform to the style of medical training to which they were exposed, and outliers are considered "high-maintenance", difficult or even lacking in professionalism. As the culture will change with the shift in the learner population, it is important for faculty to recognize and adapt teaching and training to improve learner engagement and ownership along the numerous competency areas involved in family medicine education. We will compare the teaching and learning characteristics of the different generational groups, guide participants' identification and understanding of their own values and expectations for optimal learning, and facilitate the formation of strategies to adapt teaching and curricular activities that will improve the buy-in and satisfaction of both millennial learners and pre-millennial teachers of family medicine.

Integrated Care Showcase 132

Moderator: John Muench, MD, MPH

Showcase 132A - Challenges in Implementing Behavioral Health in Primary Care Out-patient Settings

Patricia McGuire, MD; James Mercuri, LCSW

Integrated Behavioral Health is becoming an integral part of family practice. Models of integrated behavioral health care are being adapted to serve the needs of different patient populations and out-patient settings. This presentation will discuss clinical challenges in implementing integrated behavioral health services in primary care out-patient practices.

Showcase 132B - Chasing Patient and Provider Satisfaction in Integrated Care

Laura Sudano, PhD, LMFT; Gail Marion, PA, PhD

Measuring the impact of integrating behavioral health care into primary care on patient and providers is important. The Quadruple Aim (Bodenheimer & Sinsky, 2014) seeks to maximize the healthcare system by focusing on four areas; two of the four areas that are essential to reach this goal include patient and provider satisfaction (Bodenheimer & Sinsky, 2014). To capture rich data, a primary care evaluation team uses mixed methods evaluation to capture these two outcomes. We will present our quantitative and qualitative findings and how this has informed our operational aspects of integrated care in a family medicine residency program.

Showcase 132C - Establishing an Integrated Behavioral Health Care Model in a Family Medicine Practice

Heather Martens, PsyD; Samuel Gontkovsky, PsyD

Integrated behavioral health care involves the systematic coordination of mental health, substance abuse, and primary care services. Research has suggested that such integration of general and behavioral health yields the best overall patient outcomes and functions as the most effective approach to caring for individuals with multiple medical needs (SAMHSA, 2017). In addition, data obtained from surveys of primary care physicians and staff members also has revealed that integrated models of practice have numerous beneficial implications, including greater access to care for patients, improved office work flow, and increased physician satisfaction (Clay, 2016).

The most effective strategies for incorporating integrated behavioral health care models into existing family medicine practices remains unclear. Prior to implementation of an integrated behavioral health care model, a needs assessment completed by family medicine staff members is beneficial in identifying existing deficits in service delivery. Assessment data will assist in clarifying service areas in need of improvement. Educating staff on potential benefits of integration of behavioral health care also may lead to increased use of the service as well as improved effectiveness of provided treatment.

This session will provide an overview of one approach for establishing an integrated behavioral health care model within an existing outpatient family medicine clinic providing care to an underserved urban population. The effectiveness of this approach will be demonstrated through the presentation of survey data obtained from family medicine physicians, residents, and staff prior to and six months following implementation of the new integrated model.

Showcase 132D - Training for Integrated Primary Care Teams: Implications from a New England Study

Robert Cushman, MD

This workshop presents what was learned from focus groups exploring issues related to the drivers and restrainers of integrated behavioral health in primary care, and the current and evolving status of the workforce to accomplish this model, across the six New England States. We sought out patients, providers, teachers, administrators and policy workers to deepen our knowledge of the drivers, restrainers, and recommendations to inform legislators, state and national administrators and trainers, Accountable Care Organizations and educators. There are many misperceptions by patients, clinicians, ACO and medical system planners, and legislators about the integrated behavioral health and primary care integration workforce. Participants will leave this workshop with a clear sense of how to address these misperceptions, how best to prepare our learners to provide care effectively in the existing and future workforce, and how to advocate for patients and for medical system that is built upon a strong integrated behavioral health and primary care base.

Seminar 133

A Holistic and Integrative Perspective on Resident Wellness

Nick Yagmour, MPP; Jeffrey Ring, PhD

In light of the recent suicides of medical residents and the alarming rates of burnout (55%) and depression (30%) reported in the literature, increased attention has been paid to the well-being of residents. Most of the discussion, however, involves the identification and “treatment” of impaired individual residents. Resident well-being is not an individual issue, and it cannot be addressed on a case-by-case basis. When the mental health of residents is thought of as separate from the simple absence or presence of mental illness, the day-to-day interactions and processes of residency training become opportunities for systematic, programmatic intervention. The World Health Organization’s broad definition of mental health and the elements of mental health outlined by Westerhof and Keyes demonstrate that concrete, realistic changes to

clinical learning environments and the interactions that occur within these environments can improve the well-being of residents, faculty, and staff who are working and learning in these environments. Medical educators must consider self-acceptance, a sense of purpose, autonomy, relationship quality, environmental mastery, and engagement in one's own personal and professional growth as integral parts of resident development. Program and institutional leadership must also create the context for coherence, acceptance, and integration in the clinical environments that they oversee while also ensuring that residents and staff both realize their contributions to patient care are valued as well as believe that their institutions and programs have the potential to improve in meaningful ways. Addressing the numerous elements of resident well-being requires a holistic and integrated approach.

Seminar 134

The Evolving Role of Patients' Voices in Residency Communication Curriculums

Daniel Hargraves, MSW; Keesha Goodnow, BAE; Christopher White, MD, JD

Encompassing four of the ACGME milestones, patient-provider communication is clearly at the center of care (Jansen, 2016). Residencies need to be well equipped for both teaching best practices and evaluating their learners in communication skills to effectively facilitate a patient-centric practice. With the use of established and modified tools at myriad touchpoints, the behavioral scientist is well positioned for both of these roles. This session will describe a family medicine residency's effective communication curriculum, detailing the evolution continuum of the program's training modalities ranging from the traditional, such as audio recordings, to emerging interfacing technologies such as Note Sharing. We will discuss the three core components of the residency program's curriculum embedded in this continuum (Recordings, Note Sharing/Secure Messaging, and Patient Family Advisory Council), share real time practice examples for how it is administered, and disseminate tools and resources that supplement both the teaching and evaluation of the curriculum. Throughout the session, tips and tricks and lessons learned will be shared in an effort to raise awareness of the successes and challenges of communication curriculums. Recognizing the collective wisdom of the group, ample time will be allotted for sharing local experiences with novel attempts to engage patients using communication curricular components for trainees.

Clinical Practice Update 135

Emotional Complications in the Perinatal Population

Julie Owen, MD; Christina Wichman, DO

Primary care providers (PCPs) continue to be first-line clinicians in maternity care teams, particularly in rural and academic settings. (1) Though there has been an observed decline over the past decade in the proportion of PCPs who deliver obstetric care in the United States (23.3 % in 2000 to 9.7 % in 2010), women who have received maternity care from obstetric specialists will return to their PCPs after their 6-week postpartum visits. Furthermore, as emotional complications in perinatal patients can arise at any time during pregnancy and up to 6-12 months postpartum, PCPs will frequently be called upon to evaluate and treat these psychiatric complications appropriately. This is especially true in areas with poor access to specialized psychiatric care. This presentation will outline the most common and/or the most emergent psychiatric complications of the perinatal period, discuss effective methods to screen for these disorders, and finally discuss up-to-date, evidence-based treatment recommendations to address these symptoms. Following a formal presentation on this topic, attendees will be asked to discuss a patient case in small groups, applying principles gleaned from the presentation.

(1) Tong, S.T., Makaroff, L.A., Xierali, I.M. et al. (2013). *Matern Child Health J*, 17, 1576. doi:10.1007/s10995-012-1159-8.

Lecture Discussion 136

Medication Assisted Treatment: Integrating Learners in Rural Primary Care

David J Casey, MSW, CSWA, CADC II; Chloe Ackerman, PsyD

The impact of opioid use disorders on this country is a well-documented and much-discussed public health crisis. In 2014, 259 million prescriptions were written for opiates, 2 million people had a prescription opioid abuse disorder, and four out of five new heroin users were introduced to opiates through misusing prescription painkillers (American Society of Addiction Medicine, 2016). Prescription pain reliever overdose deaths increased 400% for women and 237% for men between 1999 and 2010, with an estimated social and health cost of \$55 billion each year (American Society of Addiction Medicine, 2016; Department of Health and Human Services, 2016). The Oregon Health Authority (2015) has determined to address the opioid epidemic through Medication Assisted Treatment (MAT) programs, a harm-reduction and trauma-informed approach to treating individuals and families with opiate addictions via medication to reduce cravings and behavioral health interventions to increase coping, resilience, and social support. MAT in the primary care setting fosters patient-centered care for a population that is often marginalized from healthcare. This presentation will outline the unique aspects of implementing MAT in a rural primary care clinic, with a particular focus on integrating family medicine residents and behavioral health students into the program. Attendees will learn best practices in establishing a MAT

program, unique challenges and recommended solutions for rural populations, and recommendations for integrating medical and behavioral health learners into the delivery of services.

Lecture Discussion 137

Developing a Behavioral Science Curriculum for Rotating Medical Students

Limor Gildenblatt, PhD Annmarie Walsh, DO; Shelly Capps, MD; Angelica Alonso, BS; Kim Reinhart, M4

Medical students first interact with patients during their third year clinical rotations, however, they receive minimal training in counseling skills prior to these physician-patient encounters. Further, psychiatric rotations may not fully prepare medical students in all necessary skill sets to help them increase confidence in establishing rapport with patients and families. We will demonstrate how a Behavioral Science curriculum during the Family Medicine rotation can assist medical students in becoming competent clinicians as they learn to develop meaningful relationships with patients and families. Additionally, we will discuss which Behavioral Science topics would be most relevant as well as what medical students believe would be most useful as they develop their clinical skills.

Lecture Discussion 138

Mastering the Warm Handoff: Patient-Focused Integrated Behavioral Health Referrals

Karen Kersting, PhD; Jim Sanders, MD, MPH; Nathan Ferda, MD

Same-day referrals from primary care providers (PCPs) to Integrated Behavioral Health Consultants (IBHCs) are key to achieving the Integrated Behavioral Health goals of increased access, decreased stigma, and efficient service delivery. These warm handoffs offer an opportunity for PCPs to transfer their established rapport with a patient to the IBHC while demonstrating understanding of the patient's psychosocial challenges and clarifying behavioral health goals. When done well, introduction of an IBHC to a patient for psychosocial and behavioral support is a shining example of a patient-centered approach and serves to amplify the patient's voice in his or her own health care. Best practices for facilitating same-day referrals include 1) clear communication with patients about the role of an IBHC, 2) concise provision of patient information to the IBHC, 3) collaborative goal setting, and 4) efficient follow-up. Managing these processes while providing a meaningful introduction for the patient to the IBHC requires advanced interpersonal communication competencies and deserves dedicated attention as a unique clinical skill. This workshop will review what constitutes an appropriate IBHC referral, outline best practices for facilitating warm handoffs, demonstrate ideal referral processes, role play a number of typical scenarios with the workshop's participants, and provide materials for the home-site training of providers. We will also discuss strategies for providing support to resident physicians as they develop skills for managing same-day referrals and examine barriers to best practice implementation.

Workshop 139 (9:45 – 11:45 am)

The Balint Group Experience: Promoting Relationship Awareness (Session 2)

Phillip Phelps, LCSW; John Freedy, MD, PhD; John Muench, MD, MPH; Allison Bickett, MS

See abstract from Workshop 129

Clinical Practice Update 140

Dementia - Update on Diagnosis and Pharmacotherapy

Christine Jacobs, MD

Family physicians who care for patients throughout the entire life spectrum encounter many patients with memory loss or altered cognition. Patients and caretakers rely on their primary care providers for assessment and treatment recommendations. We discuss assessment of dementia including validated tools. We will discuss diagnosis and differential diagnosis, using cases and board review type questions. We review the evidence for behavioral and medical therapy targeted at specific dementia types and symptoms. We will also discuss practical considerations of care for patients with dementia.

Research on Curriculum 141

Moderator: Timothy Spruill, EdD

Research 141A - Mindfulness and Burnout: Preliminary Data and Future Directions

Christopher Haymaker, PhD

Stress, burnout and resiliency have continued to be important topics to explore in graduate medical education as physicians in residency continue to be vulnerable to burnout, depression, substance use and stress (e.g., Eckleberry-Hunt, et.al., 2009). As educators have increasingly turned to building resiliency in residency to help residents bounce back from stress, many have turned toward wellness generally, and mindfulness specifically to help provide residents with the tools to respond to and recover from stress. Results of previous research suggest that interventions that incorporate mindfulness practices are successful in reducing symptoms of stress and burnout and increasing well-being (McCray et al., 2008). However, specific components of mindfulness including observation, description, acting with awareness, non-

judgmentalness and non-reactivity have not been studied to identify whether particular facets of mindfulness may be predictive of reduced burnout. Preliminary data collected at a single family medicine residency program showed significant negative correlations between two facets of trait mindfulness (the ability to have experiences without judging them and acting with awareness) and burnout. Better understanding of the links between burnout and mindfulness will help determine the utility of mindfulness based instruction and direct curriculum.

Research 141B - Video Reviews: Enhancing Impact and Resident/Faculty Satisfaction

Michelle Sherman, PhD

Effective communication with patients is a vital skill for physicians, and many residency programs commit substantial resources to this competency in training (Eaton, 2014). Numerous milestones pertain to communication skills, and residency programs evaluate these skills in a variety of settings and modes. Video review (VR) is a commonly employed teaching approach, and research suggests review of videos and feedback by experts can improve resident performance (Hammoud, Morgan, Edwards, Lyon & White, 2012; Wouda & deWiel, 2014).

Video reviews are designed to invite residents to observe and reflect upon their strengths and areas for development in communicating with patients. The process also affords medical and behavioral health faculty the opportunity to partner in focusing specifically on resident communication skills and to offer individualized feedback. Given the busy schedules of faculty and residents and the vital role of enhancing communication skills during residency, maximizing the impact and satisfaction of the VR process is important.

We sought to evaluate some specific improvements to our VR process, including a new feedback form, personalized tip sheets shared with residents on communication domains identified in the VR, and follow-up shadowing and coaching by behavioral health team members.

Research 141C - Creation of a Family Medicine Residency Blog: Implementation and Reaction

Kyle Bradford Jones, MD; Sonja Van Hala, MD, MPH; Osman Sanyer, MD; Katie Fortenberry, PhD

Purpose: To describe the educational goals that led to the creation and implementation of the Family Medicine Vital Signs blog through the University of Utah Family Medicine Residency Program, and to illicit and summarize feedback from blog participants.

Significance: Social media has played an increasing role in medical education in recent years. Many medical schools and graduate medical education (GME) programs now utilize Twitter, Facebook, blogs, podcasts, and other forums to enhance the education of their trainees. There is little reported in the medical literature regarding the use of a blog as an educational tool. This is the first Family Medicine residency blog that requires participation of all residents and faculty members. We view this blog as a mechanism to teach professionalism in writing and social media portrayal, as well as an avenue for professional development for defining areas of Family Medicine that are key to residents' identity.

Expected Outcomes: By implementing a residency-supported blog with weekly posts from residents and faculty we hope to find that participants find the blog worthwhile in achieving the following goals:

- a. Increase interest in pursuing Family Medicine among medical students
- b. Improve understanding of the field of Family Medicine within the medical community
- c. Establish the University of Utah as a national leader in Family Medicine education and innovation
- d. Engage in community and legislative advocacy efforts on issues related to patient health and the specialty of Family Medicine

Lecture Discussion 142

Turning the Tables: When Physicians Become Patients

Mary Talen, PhD; Jeffrey Rosenblatt, MD; Geraldine Malana, MD; Christina Durcholtz, MD

Training physicians to become person-centered is a primary goal of behavioral health curriculum. We have curriculum on doctor-patient communication skills and patient narratives to help physicians relate to the patient experience. However, there is nothing more effective than actually being the patient that gives providers an "AHA" experience of the patient's perspective. In this panel discussion, physicians will share their experience within acute urgent care, chronic disease management, and routine well healthcare. The physicians will describe how their experiences have had an impact in three areas: 1) their professional identity, 2) their connection with patients, and 3) their experience of the healthcare system and team. This panel will identify ways that providers can draw from this experience to enhance person-centered care and build on our collective experiences to get a glimpse into the insider perspective on patient experience.

Lecture Discussion 143

Clinical Teaching Methods for Helping Residents Develop Brief Counseling Skills

Dan Felix, PhD; Michael Bloom, PhD

Family doctors often provide brief counseling for patients to facilitate health behavior change. For example, motivational interviewing, solution-focused brief therapy, CBT, and other methodologies have been employed by physicians for many

years to help patients lose weight, quit smoking, manage emotional difficulties, and other similar behavior changes. Acquiring brief counseling skills during residency can be challenging, requiring clinical application and practice to be successful. In this presentation we will discuss curriculum and clinical teaching methods which we have successfully used to help residents develop competent skills. We will provide data from graduates of our program from 20+ years of teaching these methods. We will offer case examples and show video of actual clinical teaching encounters to demonstrate these methods. Our emphasis will be on helping attendees adopt some or all of these methods into their own setting.

Clinical Practice Update 144

Lions, Tigers, and Bears, Oh My! Childhood Anxiety Disorders

Lynn Simons, PsyD; Chelsea Gray, DO; Nadeen Jamil, MD

Childhood anxiety disorders are common and present frequently to the family physician (Beesdo, Pine & Lieb, 2010). Anxiety in children is associated with significant medical and psychological morbidity, and can lead to secondary mood disorders in children (Kendall, Brady & Verduin, 2001). Intervention and treatment are warranted to address the distress children experience and to reduce co-morbidities associated with anxiety disorders (Chorpita, Taylor, Francis, Moffitt & Austin, 2004). Anxiety disorders in children are supported by cognitions, behaviors and emotional reactivity. Cognitive distortions are common and fuel behavior which centers often around avoidance behavior. Avoidance behavior often works to effectively perpetuate the cognitive distortions, and persistence of the emotional reactivity in children. This session will explore common and uncommon anxiety presentations in children, and identify the role of anxiety, cognitive distortions and avoidance behaviors in clinical presentations. Successful intervention works to change maladaptive thought patterns, initiate problem solving patterns that confront the avoidance, and help reduce the child's fears, worries and withdrawal. Helping children become willing participants in treatment is a key factor in emotional and behavioral change. Intervention highlights will be reviewed and a model of engaging children and parents in treatment will be presented.

Lecture Discussion 145

A Change is Gonna Come: Starting a Dialogue about Social and Racial Justice in Residency

Rebekah Schiefer, MSW, LCSW; Amanda Aninwene, MD; Brian Park, MD, MPH

For many physicians, the practice of medicine extends far beyond learning and mastering clinical principles, algorithms, and evidence-based practice. New physicians may enter family medicine residencies with a commitment to health equity and to working toward social and economic justice in their communities. These same physicians may find the rigorous training required in residency leaves little time to engage or reflect upon activities that affect social or policy change. Furthermore, some residents may discover that the culture and values in their own residency program do not reflect what they hope for in their communities. There may be little time to attend to the emotions and personal reactions so common in times of social unrest, as clinical training may in itself be physically and emotionally exhausting. Is it possible to balance the demands of clinical medicine with the urgent need to address the issues of injustice, racial bias, and discrimination that we encounter in our communities and in the culture of medicine? How do we prepare ourselves and our residency to effectively address the injustices we see in our communities and in the lives of our patients? We will discuss methods for beginning dialogue and formalized training about social injustice and health equity in residency. This presentation will detail various teaching and social engagement strategies used to incorporate participation from residents, faculty and staff.

Lecture Discussion 146

Revisiting the Canons of Psychiatry: Teaching CATIE, STAR*D & STEP-BD to Family Medicine Residents

Kevin Brazill, DO; Stephen Warnick, Jr., MD; Christopher White, MD, JD

Family medicine physicians are often the first providers to encounter and identify mental illness in their patients. Having a solid understanding of three landmark studies – Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), Sequenced Treatment Alternatives to Relieve Depression (STAR*D), and Systemic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) – can significantly improve a family medicine physician's approach to mental illness and treatment choices, and ultimately improve patient outcomes. Each of these studies has generated dozens of publications, and consolidating the fundamentals of each one is essential for a resident to retain and implement findings in a real-world setting when treating patients with depression, bipolar disorder, and schizophrenia. Learners will take pre- and post-presentation questions about the treatment and current guidelines pertaining to the three studies. Discussion leaders – physicians double-boarded in family medicine and psychiatry – will present key findings, clinical guidelines generated from each study, and updates since their respective publications. Learners will interact with the presenters and generate ideas for future discussion topics. At the conclusion of the talk, each participant will receive a power-point slide deck and one page summary for use in teaching at their home programs.

Lecture Discussion 147

Beyond the Identified Patient: From Family Medicine Resident into Systems Thinker

Jay Brieler, MD; Max Zubatsky, PhD; Randy Gallamore, MA; Alicia Brooks, MD

Many challenging cases in Family Medicine involve not only diagnosing and treating complex medical issues, but negotiating difficult family dynamics. In order to manage these situations, physicians must be able to step outside the medical model, with its traditional focus on the one-on-one doctor-patient relationship. Through a partnership between the Family Medicine Residency and Medical Family Therapy (MedFT) Program, we have developed and are currently investigating specific curricular activities to improve the skillsets of residents in systems thinking. During this session, we will describe the use of reflecting teams, complex family simulations, and genograms on the inpatient service as methods to provide residents with this broader perspective on patient care. A resident and MedFT graduate student will give their perspectives on the experiences, and a coordinated discussion on family systems in residency training will conclude the session.

Research on Integrated Care 148

Moderator: *Thomas Barbera, PhD*

Research 148A - Efficacy of Brief Behavioral Health Interventions at Free Rural Medical Fairs

Claudia Allen, PhD, JD; Theodore Siedlecki, Jr, PhD

Given the significant and well-documented unmet mental health needs of rural residents (Snyder 2013), we investigated whether single session behavioral health services could be effective if supplied at rural medical fairs. As mental health care has been documented as lacking in many rural areas of the United States (Roll, 2013), it would seem natural to include mental health services at free rural medical fairs. In reality, however, the fairs typically offer vision, dental and medical care, and often lab and pharmacy services, but rarely mental health. We found no published studies of the efficacy of mental health interventions at free rural medical fairs. There is also a scarcity of research on the efficacy of single-session mental health interventions offered at international humanitarian medical fairs after natural disasters and in war zones, and there has been a recent call for this research (Tol, 2015). Increasingly, mental health providers are offering point-of-care behavioral treatment in primary care and other medical contexts. These "integrated behavioral health interventions" are designed to be useful as single contacts with patients, as many patients do not need, want, or have resources for further treatment (Bloom, 2001). We hypothesized that the one-time behavioral health interventions used in our primary care clinic might be a useful model for interventions at these fairs.

Research 148B - Examining the Strengths and Limitations of a Primary Care-Embedded Psychiatry Consult Service: A Nine-Year Review

Dennis Butler, PhD; Dominique Fons, MD; Sara Bodenhamer, DO; Julie Owen, MD; Marc Gunderson, MD; Travis Fisher, MD

Multiple approaches are being taken to integrate mental health services in primary care due to the high prevalence of patients with psychiatric disorders seen by primary care physicians. In an embedded model, a psychiatrist is co-located in a primary care clinic to provide one visit evaluation and provide consultation on clinical management to the primary care physician. Although the embedded approach has been shown to be an effective intervention for patients with some disorders, no reports have examined the key design components which contribute to the implementation of an embedded consultation or factors which limit the utility of an embedded approach. In this investigation a framework which delineates the critical stages of mental health referral was applied to examine an embedded consultation service in a family medicine residency program over a nine-year period. The strength and success of the service was verified for specific areas of practice but offset by physician, consultant, patient and system factors at different stages of the referral process.

Research 148C - What is an A1c? Patient Experiences being part of a Diabetic Medical Group Visit

Melissa Arthur, PhD; Christopher Adiletta, MD

The project is two-fold it is an opportunity to assist, educate and support patients with diabetes in a medical group visit format while also providing an unique educational experience to family medicine residents. The medical group visit meets monthly and is co-lead by the behavioral science director and the family medicine residents, Visits are structured to include education, group support and a focused individual medical check in by the physician. Collaborative learners are also included by presenting educational material to the group. These professional learners include, dental residents, ophthalmology residents, nutrition pharmacy, and social work graduate students. The group members and the residents also participate in a "walk with a doctor" a national program to encourage exercise. Qualitative data will be presented from semi-structured interviews conducted with each of the participants. The data will be analyzed to determine themes regarding the patients experiences as a participant in the medical group visit and walk with a doctor program. The significance of this study is to include the patients experience as part of the research being conducted on the group. At this point, anticipated outcomes include positive responses examples of how the group has assisted their DM management)

from attending regular medical group visits and insight into barriers for those individuals who do not attend the group on a regular basis.

Workshop 149 (3:15 – 5:15 pm)

Behavioral Science Faculty as Change Leaders: Assess Your Skills & Add to Your Toolbox

Deborah Taylor, PhD

Family Medicine department and program leadership have long recognized and benefited from the comprehensive skill set of Behavioral Science faculty. We have been asked to be “at the table” around many highly valued functions including strengthening team function, teaching and shaping feedback skills, conflict identification/management and remediation of learners in difficulty. It is critical that Behavioral Science faculty understand the skills that they bring and can offer as leaders in the current climate of high change in medical education as well as healthcare in general. STFM created a set of online learning modules emphasizing the importance of Leading Change skill development. The dissemination of this important curricular area within an interactive workshop format is a primary goal of this workshop. Attendees will review vital components of/skills for leading change, examine how styles and levels of leadership influence one’s efficacy, and explore a specialized set of supplemental skills for consideration by Behavioral Science faculty leaders. A didactic component outlining the knowledge/skills/attitudes needed for effective and sustainable change will be combined with other more reflective and interactive (small and large group) methods. These will include but not be limited to a gap analysis, the value of peer coaching and mentoring, and the development of a professional improvement plan designed to successfully execute in the coming year.

Workshop 150

Put on Your Own Mask First: Practicing What We Teach & Other Self-Care Strategies

Jennifer Ayres, PhD

Being overwhelmed in our work settings is a double-edged sword. On one hand, it means that we are well integrated into our settings, others value our contributions, our opinions are respected, etc. However, being overwhelmed also increases risk of burnout and decreases our ability to engage in the self-care, self-compassion and resilience promotion interventions we teach and encourage residents to incorporate into their daily lives. This workshop will focus on identifying our actual and self-imposed job descriptions, evaluating our performance and satisfaction in each domain, and identifying how to incorporate boundary setting to facilitate self-care. We will also discuss overt and subtle signs of burnout and compassion fatigue and how to mitigate their effects. Participants will participate in self-reflection activities and group discussions about barriers to boundary setting, burnout and compassion fatigue, and incorporating self-compassion and resilience promotion into our daily work. In short, this workshop will address (1) why we do not put on our own masks first, (2) giving ourselves permission to practice what we teach, and (3) building a work life that rids us of the need to seek work-life balance.

Workshop 151

Workshop on Writing and Listening: Exercises that Reach Caregivers and Reduce Stress

Mark Marnocha, PhD; Deborah Schultz, MD; Suzanne Marnocha, PhD

Physicians and nurses show increased risk of burnout and task overload. These increase as the patient story is obscured, and the caregiver's distress is more entrenched. This session will examine self-awareness skills for health care students and residents via the coherent application of spontaneous writing, mindful attention, targeted relaxation techniques, guided imagery, specific writing exercises (eg, 55 word story; caregiver-patient dialogs; response to prompts and others' writings, etc), and family system explorations. Such techniques all align with evidence-based approaches to writing assignments as a component of health care; burnout reduction interventions; relaxation techniques for patient care; incorporating family as a context of health-care; and enhanced empathy and self-management skills.

Workshop 152

Put Down the Power Point: Dynamic Strategies to Improve Engagement and Learning

Amber Cadick, PhD; Nicole McGuire, DHSc, MS, RRT, CNP

Glassy eyed stares, checking cell phones, writing notes, sleeping. These are all common occurrences during didactics – a presenter’s worst nightmare. This workshop will encourage presenters to back away from the podium, put down the mouse, and detox from PowerPoint. We will describe and demonstrate several interactive teaching strategies geared to the adult learner. These techniques will have your audience engaged and asking for more. Employing these techniques will make you feel more confident in your teaching ability and will improve learner retention of knowledge.

Bringing Sexy Back: Active Learning Strategies to Entice and Engage Medical Learners

Kaitlin Leckie, PhD; Laura Sudano, PhD

Behavioral science educators, like other medical educators, are challenged to find new and innovative ways to deliver mandated ACGME curriculum. Cognitive science, learning theory, and a growing body of literature in medical education support the benefits of active learning (Graffam, 2007). Yet, work demands, time constraints, and other barriers often leave medical educators turning back to the traditional ways (e.g., lecture), at the risk of losing learners. Active teaching strategies for adult learners could help improve resident engagement and medical knowledge (Sawatsky, Berlacher, & Granier, 2014). This workshop will provide an overview of active learning options to implement in a residency curriculum, as well as experiential activities to illustrate such strategies. As presenters discuss active learning strategies, the participants will also be participating in the active learning strategies. At the completion of the workshop, participants will be able to identify active learning techniques, evaluate their curriculum for opportunities to use active learning strategies, and apply such strategies in their educational setting. Whether you call it isomorphism, or meta-teaching, or allowing the content to become the process, no longer will you promote “death by PowerPoint.” Activate your learners today!

Workshop 153 (3:15 – 5:15 pm)

The Infinite Connection between Safety, Health, and Emotional Regulation

Terri Wall, PhD; Bethany Crawley, JD, RYT; Maria Mahmoodi, MD, FAAFP

Trauma, in its many different forms, is a nearly universal experience with very individual expressions. Trauma can be experienced as a one-time event or as a repeated exposure to events that the individual finds overwhelming their ability to cope, leading to fear of death, bodily harm, and/or psychological harm. Our professional lives are colored by the trauma of our own personal narratives and by the witness we bear to the emotional and physical suffering of those we work with in our clinical practices. While it is difficult to estimate the prevalence rate for trauma survivors in primary care, the National Center for Post-Traumatic Stress Disorder in a review of several different studies reported life-time prevalence rates for PTSD ranging from 6% to 70%. It is well known that the most common concerns we address in primary care visit is anxiety, depression, and complicated biopsychosocial problems. Trauma is a cognitive, emotional, and physical phenomenon. Many of our approaches to trauma address the cognitive and emotional aspects, while overlooking the real physical manifestations in our visceral body. Visceral safety is linked to imbalances of the ANS and left untreated perpetuates the stress and anxiety we see in providers and in patients. We would like to present an approach that shows mindfulness as a tool for establishing visceral safety.

SATURDAY, SEPTEMBER 16, 2017 SESSIONS

Clinical Practice Update 154

Narcolepsy: Theory and Treatment Update

Heather Kirkpatrick, PhD; Megan Meade-Higgins, PsyD; Laci Zawilinski, PhD

Although unassociated with mortality, narcolepsy can be devastating to the patient and cause moderate levels of disability. Recent scientific advances have indicated that the etiology of narcolepsy can be at least partially attributed to immune-related processes. We will present a brief overview of these new understandings and their implications for treatment. Key diagnostic features of the disorder will be presented for review. A case will be presented along with recommended treatments which include both pharmacologic (stimulants) and psychotherapy (CBT-Narcolepsy) treatment. The importance of behavioral treatments will be discussed, as stimulants are only partially effective and patient satisfaction with stimulant treatment is low. Excerpts of patient's experiences with both the disease and the treatment will be provided to give voice to the difficulty of managing this neurological disease.

Lecture Discussion 155

Out of the Ruins: Visualizations and Narratives of those Formerly Homeless

David Nelson, PhD; Jeff Morzinski, PhD

Societal views of homelessness often emphasize personal responsibility and individual failings. The systemic and societal failure to care for the needs of vulnerable populations – the traumatic events and life circumstances that put individuals and families at risk – are often under-recognized and poorly understood. Within the US, there are over 500,000 individuals presently homeless, impacting families, youth, veterans and others – confronting issues such as mental health, substance use, victimization, accidental death and suicide. Though there are many pictures of homelessness by way of visual images of faces, these tend to create characterizations and stereotypes. Fewer images exist of the spaces and traces where homelessness exists.

In settings such as family medicine residency sites –inaccurate and incomplete awareness of root causes or personal inexperience of homelessness can limit our effectiveness as educators This session will provide a more personal view of

homelessness. Two sets of data from the same urban community will be the sources of analysis and discussion, beginning with a visual record of where and how homeless persons live and survive, followed by reflection and analysis of narrative passages taken from interviews with those formerly homeless. Through thematic analysis, presenters will lead a discussion of strategies that clinics can adopt to support individuals presently and formerly homeless who seek support and care.

Lecture Discussion 156

Beyond Didactics: Teaching Equitable Team-Based Care for Chronic Pain via Panel Review

Christine Danner, PhD; Cherilyn Wicks, MD

In 2015, The University of Minnesota Department of Family Medicine and Community Health developed an interdisciplinary work group to make recommendations regarding the management of patients with chronic pain in recognition of provider and community concerns related to overuse and abuse of opioid therapies for chronic pain. This guideline needed to strike a balance between offering compassionate, comprehensive care for patients with chronic pain while also implementing safeguards to protect against opioid abuse and addiction as well as implicit bias in the delivery of care to patients with chronic pain. The resulting guideline had many moving parts and high expectations for collaborative, team based care. It was also challenging from an educational perspective. What was the best way to teach residents the complexities involved in the care of the patient with chronic pain? Past efforts which had focused on didactic education were limited in their results. In this workshop, presenters will share an overview of the guidelines developed for the management of patients with chronic pain as well as essential tools for the implementation of this model and preliminary data related to both clinical and educational outcomes. The use of chronic pain panels for both clinical and educational purposes will be highlighted. Presenters will share lessons learned and future challenges.

Lecture Discussion 157

Interactive Clinical Case Review: Incorporating the Patient's Voice

Nancy Newman, MD; Marchion Hinton, PhD

The patient's experience of illness and healing can be challenging to convey to learners, especially within encounters rich with biomedical and psychosocial complexities. We will present an interactive case review format called "Patient-Centered Grand Rounds." A unique element to Patient Centered Grand Rounds is the opportunity for the patient to join a portion of the seminar to share about his or her own experience of illness and healing over time. Additionally, this interactive format emphasizes the integration of behavioral health with biomedical topics and includes experiential didactics to encourage critical thinking. Different sub-groups of our family medicine department take responsibility for facilitating PCGR seminars on a rotating basis with consultation from behavioral science faculty. Medical topics that have been addressed include obstetrics, integrative medicine, geriatrics, pediatrics, sports medicine, diabetes education, pain management, and "Chief's Choice."

Attendees will hear about the strengths and challenges of this format, as it has played out in our residency program over the last 4 years, and leave with information about how to implement such a seminar in their own residency programs.

Hearing the Patient's Voice through Case Conferences Facilitated by Learners

Anatol Tolchinsky, PhD; Lauren Ostarello, MS

Interdisciplinary case conferences are an excellent training tool for medical and non-medical learners to better understand the patient's voice while learning how to apply the biopsychosocial perspective. To capitalize on this training modality, case conferences were created utilizing graduate psychology students during their practicum training and third year medical students who were in their psychiatry clerkship. Due to comparable levels of graduate training, we were able to create a collaborative learning environment; we found that it was not stifled by large discrepancies in knowledge regarding the services other health providers offer, nor were the students affected by the hierarchical barriers commonly found in communications between similar interdisciplinary teams.

Cases were prepared by psychology practicum students and medically focused questions were created prior to each conference to help stimulate discussion and enrich training quality. Case presentations included traditional psychotherapy cases and patient encounters during integrated primary care visits. Medical students were encouraged to ask questions regarding the patients' experiences and how medical problems contributed to psychosocial issues and vice versa.

To measure impact on biopsychosocial competency, we created a survey consisting of questions about patient-provider relationships as well as questions based on the relationship of psychosocial stressors and their influence in the effectiveness of medical treatment. This survey was also given to medical students from another institution who had not participated in similar case conferences. Pre- and post- scores of biopsychosocial competency were compared. Preliminary data suggests potentially promising results in regards to improving biopsychosocial competency.

Lecture Discussion 158

There's an App for That: Behavioral Health Apps to Improve Patient Care and Education

Stephen Warnick, Jr., MD; Christopher White, MD, JD; Kevin Brazill, DO

One of the most important parts of working with patients with mental health concerns remains relationship building and engaging patients. Considering that most people in the United States have smart phones, and that those with smart phones engaged with their phones up to 150 times per day, having applications (apps) for patients to turn to for psychoeducation and even therapy remains an intriguing method to improve behavioral health care in a patient-centered way.

This workshop will provide an introduction to behavioral health applications, starting with providing a list of commonly used mental health applications. The presenters will then provide a framework recommended by the American Psychiatric Association for evaluating behavioral health applications. Participants in this workshop will then use this framework to evaluate a mental health application in small group settings, and then share their findings with the larger group. At the end of this workshop, participants will have an enhanced framework for evaluating applications and will also have a list of smart phone applications that they can use in their patient care, as well as in the education of residents and medical students in behavioral health care. Participants are encouraged to bring their smartphone for use during this presentation, in order to download and evaluate the apps discussed.

Lecture Discussion 159

Topical Influences on the Patient Experience: Why “Flint-stones” Still Won’t Drink the Water

Erin O'Connor, PhD; Syed Zaidi, MD

2016 was a particularly eventful year from a political, cultural, and societal perspective. Major topical events included the presidential election, a surge in the #BlackLivesMatter movement, and threats to social justice such as the Flint Water Crisis. The impact these events have on our patient population is undoubtedly great and pertinent to understand in order to provide optimal care. Therefore, a component of medical education should include an orientation to a learner’s community, including education on recent and relevant local issues. Additionally, training on cultural sensitivity is crucial to acknowledge the impact these topical influences have on the patient experience, and seek to maximize their care and satisfaction.

Lecture Discussion 160

A Novel Multimedia Approach to Understanding Young Adults Experiences with Depression

Nancy Pandhi, MD, MPH, PhD; Colin Kluender

Context: There is growing awareness of the importance of rigorously collected patient experiences and the limitations of anecdotal narratives. Those who come forward first to share their illness experiences may not represent the experiences of illnesses for many, particularly for conditions with concern of stigma such as depression. Objective: In this session we will describe the first application in the U.S. of an internationally-vetted method termed DIPEX of collecting diverse patient experiences. This method combines the power of rigorous qualitative research study conducted with broad participant and stakeholder engagement with a public facing multi-media website. We will describe how this work is being piloted with 3rd year medical students using an experimental design. Methods: For this first project, 38 young adults with depression were interviewed in states across the U.S. Interviews were conducted in the participant’s home or another familiar location, and were video or audio-taped. Participants varied in age, location, race/ethnicity, gender, education, sexual identity, relationship status, parental status, and living situation. 35 topic summaries illustrated by ~250 video, audio, and text clips are available both at www.healthtalk.org and healthexperiencesusa.org. Outcomes: The website and this method has garnered interest from diverse groups such national mental health foundations, medical school CTSA’s and primary care and psychology clinician educators. Outcomes of the randomized trial of this curriculum will be available by the time of the conference.

Lecture Discussion 161

Teaching & Providing Behavioral Sleep Medicine Services in a Family Medicine Residency

Gordon Bush, PhD

Sleep plays an essential albeit often under recognized role in health and healthcare. Disrupted, disordered, or non-restorative sleep can compromise health maintenance, serve as a contributing factor in the etiology of chronic health conditions, exacerbate their course or compromise treatment efforts [1-4]. Despite the importance of sleep in healthcare, many providers receive little formal training, and few patients have an understanding of sleep or the ways in which it can impact their health and treatment [5]. As a result, the conversations between healthcare providers and patients risk being of limited scope or underdeveloped as a component of routine health care. This presentation, based on experiences at the Memorial Family Medicine residency, has two primary intentions: first is to highlight the importance of sleep as a health concern in the treatment of chronic illnesses in primary care, and secondly, the vital role behaviorists can play in teaching and providing Behavioral Sleep Medicine (BSM) services within FM residency programs. This will be a review of BSM in a residency setting, and not focused upon specific treatment modalities. The presentation will begin with a brief

overview of basic yet important concepts about sleep [6] followed by examples of the key interactive role it plays in the management of chronic health conditions such as Diabetes [1-2,7] and Obesity [2, 8]. Finally, the presentation discusses methods of facilitating provider awareness of the issues and assisting patients in describing their sleep related difficulties.

Lecture Discussion 162

Managing Up and Around: Behavioral Scientists and Residency Leadership Coaching

Jeffrey Ring, PhD

Excellent health care is a team effort. This is also true for medical education. Teams can either be effective or dysfunctional, as can leaders. This session will review the characteristics of optimal team functioning and enlightened leadership. and will emphasize the precious role that behavioral sciences faculty can play in teaching leadership to residents and fostering improved leadership and team function in their department.

Lecture Discussion 163

Patient Voices Matter...until There is a Conscience Clause

Lynn Simons, PsyD; Chelsea Gray, DO; Nadeen Jamil, MD

Conscience clauses were initially identified in the military, with conscientious objectors, but have expanded over time to also exist in education and in health care. (1) However, modern conscience clauses in health care have expanded rapidly since the Supreme Court's ruling in Roe v. Wade, and legal protections developed to enable health care providers to practice their religious and moral beliefs within their occupations. Over time, such religious beliefs have included refusal to participate in medically related care such as an unwillingness to learn abortion procedures, refusal to prescribe birth control, non-compliance with assisted suicide, refuse to follow end of life directives, and refusal to dispense vaccinations. Parents and family have expanded conscience clauses and refused vaccinations, medical care, and at times, lifesaving medical intervention for minors and vulnerable adults. Providers have begun expanding the conscience concept to moral beliefs, including refusing to provide care to a baby of lesbian parents, refusing to inform rape victims of available care, or refusing adoptions to certain parents based on provider moral beliefs. (2)

With providers claiming abuse of their moral selves and patients claiming prejudice and discrimination, what about the patient's voice? Ellen Goodman refers to "conscience without consequences" to talk of the impact on the patient. (3) Does the patient experience differ if care is refused because they are a multiracial couple or if they are gay? Do such provider stances create an oppressive atmosphere for minority groups? This session will explore these issues, with attention to the patient experience.

