U.S. AIR FORCE BEHAVIORAL SCIENCE USER MANUAL

EPISODE 1

THE PADAWAN LEARNER

By

Lt Col Ebon Alley, USAF, BSC, PhD

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Cover and title inspired by Travis Air Force Base's Family Medicine Residency manual *The Jedi,* now on its 21st edition. Created by Duursema & Anderson (2004).

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(Chankar, 2004)

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(Lucas Film Ltd, n.d.)

CHAPTER I: THE CULTURE OF FAMILY MEDICINE RESIDENCY

Welcome to the world of family medicine and behavioral science education. You may never be surrounded by a group of more compassionate, intelligent, and talented people in your life. Air Force family medicine residency faculty are the best of the best. They represent the finest of the medical profession, nested within the most powerful military in the world. The goal of this section is to shed light on the family medicine culture by sharing some of my initial impressions after working with the team over the past 2.5 year. I hope that this section helps new behavioral scientists to assimilate into the culture in a seamless and efficient manner.

Qualities of Family Medicine Faculty:

1) Freakishly talented: Being a physician provider requires tremendous dedication and intelligence however, you'll soon learn that "Kate" is also a concert-level violinist, "Brett" played division 1 football, and "Jack" performs as a magician when he's not doing TED talks. In addition to these talents, family medicine doctors are human, have emotions, family stressors, strengths and weakness just like everyone else. The behavioral scientist is there to assist the team to understand a broader spectrum of health care.
2) Non-traditional youth and young adulthood: To fully understand primary care, you must understand the backgrounds of the faculty and residents. Many are spurred by a strong intrinsic motivation to learn, practice, and achieve. This quality has forced many to delay customary pleasures of young adulthood including lazy days of personal reflection and starting a family. Many have exceeded expectations in virtually every aspect of their academic lives. Perfection or performance close thereof is the norm. This background may predispose some interns to be vulnerable to the emotional setbacks and failures inherent in residency training. Further, displaying emotions of pain, shame, or guilt may be construed as a sign weakness or unreliability in the world of high stakes medicine. The behavioral scientist plays an important role in educating primary care residents and faculty on aspects of the emotional mind and how it can impact education and the delivery of care.
3) Strong sense of pride: The grueling years of self-sacrifice and dedication to their craft has also cemented a strong sense of pride in family medicine doctors. Recently, my team's commitment to safety was called into question in a public forum. Being familiar with my team's work, I dismissed the statement as uninformed. Upon returning to my office I was mildly surprised to find my team so upset. Four faculty sat me down "intervention style" and explained to me how they had dedicated their lives to the safe delivery of medicine and would go to great lengths to

serve their patients, and protect their license. New behavioral scientists may find themselves in similar "hot spots" as they familiarize themselves with the culture. They are encouraged to seek greater empathy and understanding of their new colleagues whenever possible.

4) Professional: The Air Force has high standards for the quantity of information and training that each Airmen is expected to handle. Family medicine faculty have an uncanny ability to "triage" the important from the less important. This ability to see "the big picture" is exemplified in their military customs and courtesies. In spite of the longstanding poor reputation that medics have regarding professionalism, family medicine faculty will routinely shine when it comes to military standards. For example, they will reflexively address a senior ranking officer by their surname and then seamlessly transition to collegial conversation amongst themselves. Conversation amongst staff is frequently marked by humor, logic, and civility.
5) Independent thinkers: Building upon #4, family medicine faculty can be independent thinkers. Don't expect them to blindly "storm the hill" without first "buying in" to the plan. One physician faculty explained, "Supervising doctors is a b***h. For the most part, we are a bunch of prima donnas and don't care about rank. In fact we don't really trust doctors with high rank because they have been out of the clinic too long. When we arrive at a new clinic, we look for the smartest person in the room and listen to them." Given the demanding nature of their profession, physicians may not always be as accessible as one might hope. In spite of these intermittent challenges, my experience has taught me that they tend to be there for you when you really need them.
6) Tough love & genuine love for the job: I remember sitting in my first clinical competency committee feeling amazed at how seemingly critical the faculty were. The performance of each resident was dissected with surgical precision. The learner's "hands," knowledge-base, personality, and decision making were scrutinized at a level of detail previously unseen in my development as a social worker. Later I learned that that the scrutiny I observed was rooted in a genuine love for the profession and wish for the learners to succeed in their residency. It is likely that these customs have been passed from teacher to learner for hundreds, perhaps thousands of years with the goal of preparing the novice doctor to deal with the emotional and intellectual stressors of healthcare.
7) Speak a different language: There is litany of terminology, acronyms, and symbols associated with primary care. You may find yourself squinting as you attempt to recall the terms you learned in anatomy class. Use contextual cues and good judgment to decide appropriate times to interrupt for clarification. When used correctly, clarifying questions serve as a reminder for doctors to limit their use of medical jargon during patient care and team meetings. Further, you will learn that

knowing whether the fracture occurred on the proximal or distal end of the fifth metatarsal is often less important to the behavioral scientist than understanding the emotional and behavioral aspects of the case. Finally, a quick Google search can often resolve most questions relating to medical jargon.

In summary, serving as a behavioral scientist has been one of the most rewarding jobs I've had in the Air Force. I attribute these feelings to the privilege of working with these inspiring professionals in the amazing culture of family medicine. My hope is that sharing my stories will help you to assimilate quickly into the culture. Below are some readings which may further enlighten your perspective on the culture and stressors of the field.

Recommended Readings

Brower, K. J., & Riba, M. B. (2017). *Physician Mental Health and Well-Being: Research and Practice (Integrating Psychiatry and Primary Care)*: Springer.

Myers, M. F., & Gabbard, G. O. (2009). *The physician as patient: a clinical handbook for mental health professionals*: American Psychiatric Pub.

(Brooks, 2015)

CHAPTER II: THE CORE PRINCIPLES AND ROLES OF THE BEHAVIORAL SCIENTIST

Principles of behavioral science, as well as the roles in which behavioral scientists serve has continued to evolve since the earliest attempts to define the profession in 1979 (Task Force on Behavioral Science Education, 1979). The profession has broadened its scope of attention from the foundational focus on family dynamics and behavioral health care, to physician well-being, contextual care, and team-based communication (Baird, Hepworth, Myerholtz, Reitz, & Danner, 2017). Further, "The educational and clinical functions of behavioral science faculty have expanded, with significant contributions to research and scholarly work that have defined academic family medicine, and development of leadership roles within clinical teams, academic departments and centers, and larger health systems" (Baird et al., 2017, pg. 296). For the purposes of this a manual, the following definition of Behavioral Science Faculty has been adopted:

> **Behavioral Science Faculty:** Professionals who are faculty and teach psychosocial aspects (e.g., how complex relationships between the patient, the environment, and the patient's health status impact the patient's health) of medicine within residency education such as how family factors influence medical illness and/or how medical illness influences family. These professionals are from a variety of specialties including but not limited to medical family therapy, psychology, marriage and family therapy, social work, psychiatry, Doctor of Osteopathic Medicine, and Doctor of Allopathic Medicine (Sudano, 2015).

Core Principles of Behavioral Science/Medicine

According to the STFM Board of Board of Directors, "The role of behavioral science faculty is to consult and teach physicians and other health care providers; treat patients and families on emotional, family, and psychosocial issues; contribute to the knowledge base through research, publications and presentations; and continually upgrade one's knowledge and skills in behavioral science.

Behavioral science faculty and practitioners operate from a core set of principles, drawing upon behavioral and social science pedagogy and research. The principles include elements of other related evidence-based fields such as behavioral medicine, behavioral health, health psychology, integrative medicine, and integrated mental and behavioral health. These core principles apply, but are not limited to, physicians, nurses, behavioral medicine specialists, social workers, psychologists, psychiatrists, or counselors working in health care or community settings" (Society of Teachers of Family Medince, 2008)

Those who apply these principles:

1) Use bio-psycho-social and relationship-centered approaches to care
2) Promote patient self-efficacy and behavior change as primary factors in health promotion, disease prevention, and chronic disease management
3) Integrate mental health and substance abuse care into primary health care services

4) Integrate psychological and behavioral knowledge into the care of physical symptoms and diseases
5) Promote the integration of socio-cultural factors within the organization and delivery of health care services
6) Emphasize the impact of familial, *social, cultural, spiritual, and environmental contexts in patient care to improve health outcomes*
7) Practice a developmental and life-cycle perspective with learners and clients
8) Encourage and support provider self-awareness, empathy, and well-being (STFM, 2008).

The Many Roles of the Behavioral Scientist

Armstrong, Fischetti, Romano, Vogel, and Zoppi's *Position Paper on the Role of Behavioral Science Faculty in Family Medicine* (1992) serves as a foundational article for the profession. The paper concluded that the roles and responsibilities of behavioral science faculty include Education, Administration, Patient Care, Professional Development, Scholarship, Research, and Community Service. More recently, Reitz et al. identified additional roles including mentor/advisor, teacher, evaluator, and gatekeeper (Reitz et al., 2013). These roles suggest a wide variety of responsibilities that family medicine faculty may play while educating and supporting residents in healthcare education. See Dr. Sudano's "Cheat Sheet" below for brief definitions of these roles (Sudano, 2015).

1. Educator (teaches biopsychosocial curriculum to residents, helps residents increase awareness of psychosocial and behavioral factors in health, etc.)
2. Patient Care (consults with residents on patient care, provides referrals and clinical care to patients, etc.)
3. Scholar/Researcher (reads current literature, maintains collaborative relationships with colleagues and seeks consultation for problems encountered in training/clinical practice, prepares grants, conducts research, etc.)
4. Community Service (participates in community task forces, boards, organizations, etc.)
5. Administrator (develops/evaluates curriculum, documents resident participation, evaluates efficacy of the residency program, etc.)
6. Mentor/Advisor (helps guide a resident on clinical interest(s) or development of a skill, provides information on maintenance of work-life balance, etc.)
7. Evaluator (completes summative assessments of residents/learners)
8. Gatekeeper (controls access to entry into a system such as determining if a learner is qualified to matriculate through levels of a program)

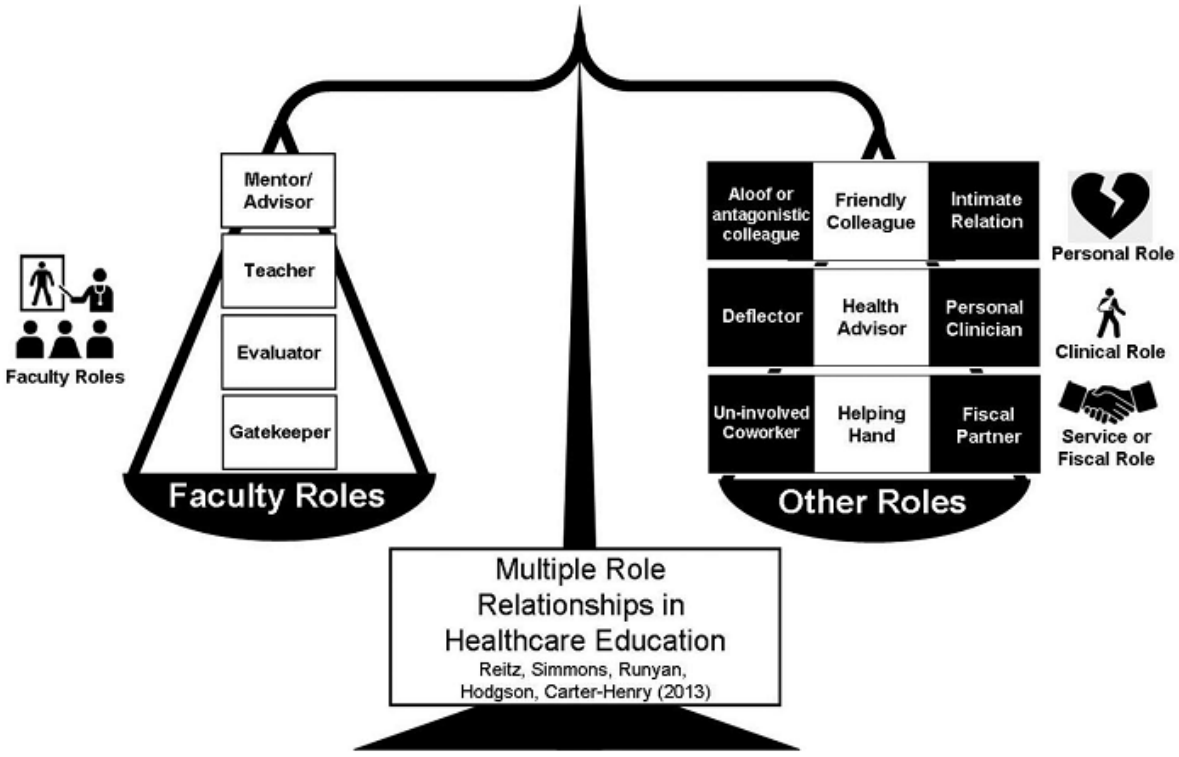
Dual Roles in Healthcare Education

The article *Multiple Role Relationships in Healthcare Education* captures the unique ethical dilemmas that faculty must manage when working with learners in the medical arena (Reitz, Simmons, Runyan, Hodgson, & Carter-Henry, 2013). The author notes "Healthcare faculty, unlike most of their professional peers, practice their discipline while simultaneously educating and sharing responsibility for

patient care with potentially younger and less-experienced clinicians. Faculty members are exposed, therefore, to both the rewards and risks of teaching and supervision. Training settings also juxtapose the learner and his or her faculty member(s) in a relationship prone to idealization, transference, countertransference, and a power differential that changes throughout the learner's course of training. The pressures, intimacies, and risks inherent in education create a unique set of vulnerabilities to professional boundary violations" (Reitz et al., 2013, pg. 97). These issues may be particularly salient for behavioral scientists who traditionally do not receive comprehensive training to prepare them for these roles (Sudano, 2015).

In response the highly nuanced environment of the medical training residency, Reitz and colleagues developed the following model to help faculty in healthcare education manage their multiple roles (see Figure 1).

Figure 1: Multiple Role Relationships in Healthcare Education (Sudano, 2015)



According to Reitz et al., "The intent of this model is to demonstrate the interaction between the primary roles of a faculty member (i.e., mentor/advisor, teacher, evaluator, and gatekeeper) and other roles that frequently exist between faculty and learners (i.e., personal role, clinical role, and service or fiscal role). In the model, faculty roles (left side) exist on a vertical continuum, moving from less invasive and more supportive on one end (mentor/ advisor) to more controlling and potentially more acrimonious on the other (gatekeeper). There is a horizontal continuum among all the other roles on the right side of

the model. The basic premise of the model is that a fundamental and dynamic tension in the faculty–learner relationship exists in that the 'other roles' can either enhance or detract from the 'faculty role.' We assert that both sides of the model are most likely to remain in balance if the 'other roles' remain in the middle (white section) of the continuum. This middle ground represents a 'golden mean' between apathy/antipathy, on one hand, and over involvement and enmeshment at the other extreme" (2013, p. 102).

Reitz's "other roles" may have unique qualities when viewed through the lens of the Air Force. For example, "friendliness" and "helping hand" may either be enhanced or inhibited by aspects of the military culture. It is not uncommon for Air Force members to be geographically separated from their family and loved ones. This can inherently foster a sense of camaraderie and community that may be less apparent in other work environments. Simultaneously, military members also wear their rank at all times resulting in unmistakable power differentials. In these circumstances, a behavioral scientist may need to mentor a new Air Force learner on how to balance these relationships.

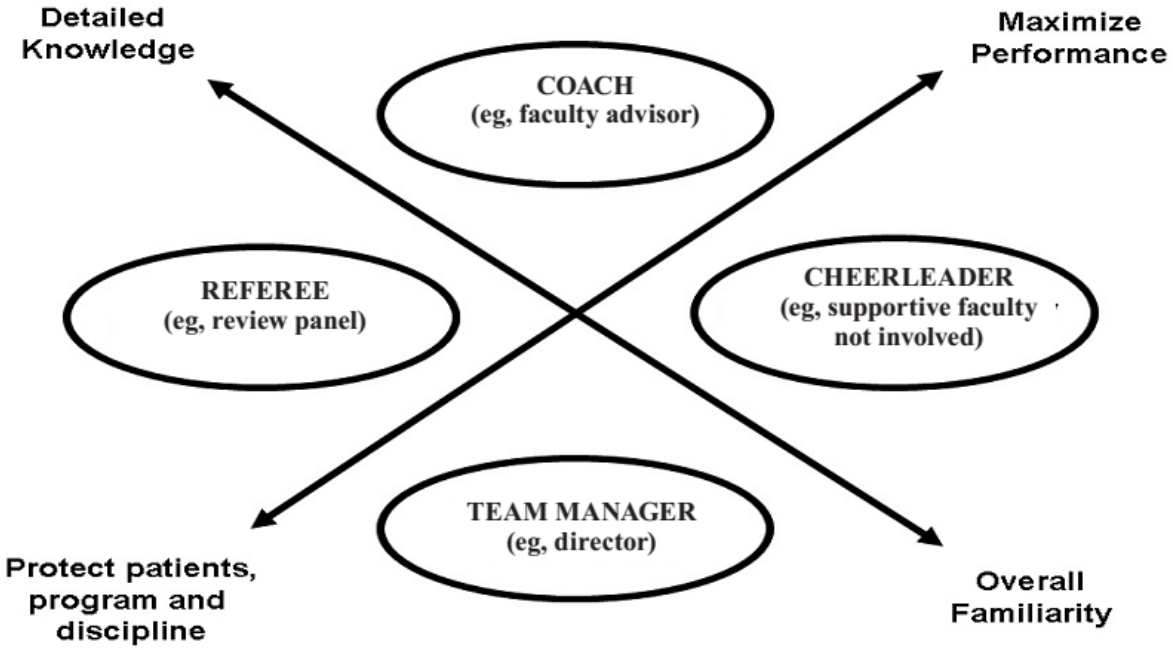
In recent years more experienced Air Force behavioral scientists have begun to assume the role of Flight Commander (aka director of operations) at family medicine residency programs. When "dual-hatted" as a Flight Commander, the behavioral scientist assumes leadership and responsibility for the entire program. There are mutual benefits to this arrangement; social workers require the leadership experience for promotion while physicians can be resourced to patient care. This is an unprecedented leadership dynamic given the developing role and at times uncertain future that behavioral science held in the family medicine arena (Medalie & Cole-Kelly, 1993). New Flight Commanders are encouraged to work closely with the Program Director, Medical Director and Flight Chief as they adjust to their new role. Flight Commanders have increased responsibility as gatekeepers, particularly in relation to maintaining Air Force standards. This may stand in conflict at times with the support role traditionally assumed by behavioral scientists. Behavioral scientists may wish to defer support to the internal behavioral health consultant when role conflict exists.

Behavioral Scientists Roles with Residents in Difficulty

Figure 2. demonstrates Smith, Stevens and Servis' (2007) conceptualization of the various roles that faculty may assume while working with residents in difficulty (discussed in detail in the next chapter). The model is built upon two axes. The first represents a spectrum of familiarity that the faculty has with the case, while the other indicates whether the goal of the relationship is to maximize performance or protect the patients, program and discipline (Smith, Stevens, & Servis, 2007). In my personal experience, I have frequently found myself in the role of "cheerleader," due to my service as a performance enhancer. Simultaneously, my detailed knowledge of the residents tends to be less than their

advisor. Occasionally, a behavioral scientist may find themselves in the role of "coach," particularly if you and the resident have developed a strong rapport through personal consultation. As noted above, a behavioral scientist who is also serving as the Flight Commander may also assume qualities of the "team manager." In these circumstances, the Program Director will typically handle management of GME concerns while the Flight Commander will address issues related to Air Force standards of conduct. Finally, it is rare for a behavioral scientists to partake in review panels, however, some programs have incorporated their services into formal remediation teams (Simons, 2012). See chapter two for additional details on residents in difficulty.

Figure 2: A Model for Conceptualizing Different Faculty Roles With Residents in Difficulty (Smith, et al., 2007)



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(Sebastian, 2018)

CHAPTER III: RESIDENTS IN DIFFICULTY

After extensive discussion by faculty regarding a resident who is struggling, a time will come when the gaze of the team will turn to the behavioral scientist for feedback and recommendations. According to Lucey and Boote, a "problem resident" is a resident who is unable to meet the standards of performance in one or more of the competency domains delineated by the Accreditation Council for Graduate Medical Education (ACGME) (Lucey & Boote, 2008). In order to avoid pejorative connotation, this manual utilizes the term "resident in difficulty". This term may be further specified by using it in collaboration with one of the ACGME requirements, for instance "resident in difficulty…with professionalism." Statistics on the frequency of residents in difficulty vary, however, such residents are generally considered common within medical residency programs (Yao & Wright, 2001). Responding effectively to residents in difficulty is important due to their high demand on resources (Guerrasio, Garrity, & Aagaard, 2014), elevated risk for being placed on academic probation (Guerrasio, et al., 2014), threat to program integrity (Yao & Wright, 2001), and potential threat to the safety of patients.

The spectrum of potential areas for resident difficulty is broad when viewed through the lens of the ACGME core competencies. See attachment 1, *Alarm Bells for Resident Training: A Tool to Identify Problematic Behavior Patterns in Resident Trainees* for a comprehensive depiction of areas of focus (Hempstead, 2015). It's normal for new behavioral scientists to initially feel overwhelmed by the breadth and unfamiliarity of these concerns. To help alleviate this initial shock, Brotherson's *Competency Based Remediation Resources* provides an efficient reference guide for resources on typical core competency deficits (attch 2) (Brotherson, 2009). Further, reviews of the literature routinely indicate that medical knowledge and professionalism are the most commonly cited concerns for learners (Zbieranowski, Takahashi, Verma, & Spadafora, 2013).

New behavioral scientists are encouraged to support the team within the scope of their comfort and competency. While each behaviorist comes to the table with a unique skill set, most have advanced training in human behavior, interpersonal dynamics, communication, coping skills and leadership. This background serves as a strong foundation to assist with difficulties in the core competencies of professionalism and communication. Professionalism includes aspects of self-care, interpersonal dynamics, leadership and cultural proficiency.

Professionalism: Self Care

Self care is critical for residents due to the well documented emotional rigors of residency training (Brazeau, et al., 2014). Emotional stress can cause avoidance of learning, memory problems, withdrawal and lower aspirations. Further, residents with affective difficulties may also be disorganized,

inefficient, and have poor time management skills (Smith, Stevens, & Servis, 2007). First year residents may be particularly vulnerable to subclinical episodes of depression (Kalet & Chou, 2014). These experiences may be caused or exacerbated by multiple social factors including transition to the military, relationship concerns, changes in support network, being "average" for the first time when compared to peers and maladaptive coping skills such as excessive alcohol use (Yao & Wright, 2001). Left unchecked, these circumstances may lead to emotional burnout and disciplinary concerns (Dyrbye, et al., 2015).

Despite a behavioral scientists natural desire to help by providing psychotherapy to these residents, it's important to maintain the integrity of the faculty/resident relationship. This issue was discussed in detail in the preceding chapter. Behavioral scientists can assist by providing education and mentorship on various topics including but not limited to: dealing with stress, test anxiety, maintaining physical health and personal interests. Further, facilitating community outreach, assisting residents to build meaningful relationship, mindfulness skills, communication skills and personal reflection may also be helpful (Dyrbye, et al., 2015; Kalet & Chou, 2014). Residents who exhibit mental health or substance use concerns that require services beyond your role as mentor should be recommended to specialty services. This may include the internal behavioral health consultant, Chaplain or the Mental Health Flight.

Prevention may be the best option for optimizing resident adjustment and performance. Lucey and Boot describe the "7 D's" or, *Common Secondary Issues Complicating Resident Problems* as warning signs to watch for with residents at risk (Lucey & Boote, 2008).

1) **D**istraction; family concerns (adjustment, work/life balance)
2) Sleep **D**eprivation
3) **D**epression and other affective disorders
4) **D**rugs and alcohol
5) **D**isease (acute or chronic medical concerns exacerbated by stress)
6) Learning **D**isabilities (learning disorders and ADHD)
7) Personality **D**isorders

Additional warning signs may include (Schnellbacher, 2015):

1) Avoidance/no interest
2) Poor performance/task completion
3) Poor/inappropriate interactions
4) Tardiness/poor time management
5) Mood changes
6) Critical incident

Fraser article, *Skill of Encouragement for Motivation: Make Sure all Learners Have Both the Ability and Willingness to Do Their Jobs* provides guidance for mitigating these warning signs (Fraser, 2013). These tips include:

1. Show complete acceptance
2. Express empathy

3. Show confidence
4. Focus on strengths and assets
5. Focus on effort and improvement
6. Facilitate decision "Doing"
7. Set learning goals
8. Coach by encouragement
9. Give encouraging feedback
10. Give encouraging performance evaluations
11. Encourage self-evaluation
12. Encourage self-encouragement

There is a stigma against help seeking amongst residents that likely serves as barrier to accessing helping resources (Dyrbye, et al., 2015). Similar to the military, Dyrbye (2015) believes that the stigma is the result of fear of negative professional consequences. Behavioral scientists should take steps to reduce stigma by normalizing human qualities such as imperfection and vulnerability, enhancing trust with clear communication about boundaries and confidentiality, assertively combat discriminatory behavior, and by dispelling myths. Behavioral scientists Major Robert Williams had great success building trust by going door to door on Friday afternoons with candy. It was affectionately termed the "candy run." This gateway, along with his personality, allowed for him to foster strong trusting relationships during his tenure that resulted in one third of the residents and multiple staff to seek his private consultation.

Other Aspects of Professionalism

Professional problems may manifest themselves in various other forms including relationship difficulties in the workplace, "attitudinal problems," reliability, attendance, truth telling, teamwork, boundary issues, privacy, and record keeping (Brazeau, et al., 2014; Guerrasio, et al., 2014). According to Smith and colleagues (2007), residents with interpersonal difficulties may present unique challenges, "They can be unmotivated, defensive, manipulative, condescending, or have racial, ethnic, or gender prejudices" (p. 333). Further, the likelihood of difficulties with professionalism tend to increase as learners progress through medical school to post-residency (see Figure1. below) (Guerrasio, et al., 2014).

Figure 1. Breakdown of learning deficits by learner type (Guerrasio, et al., 2014).

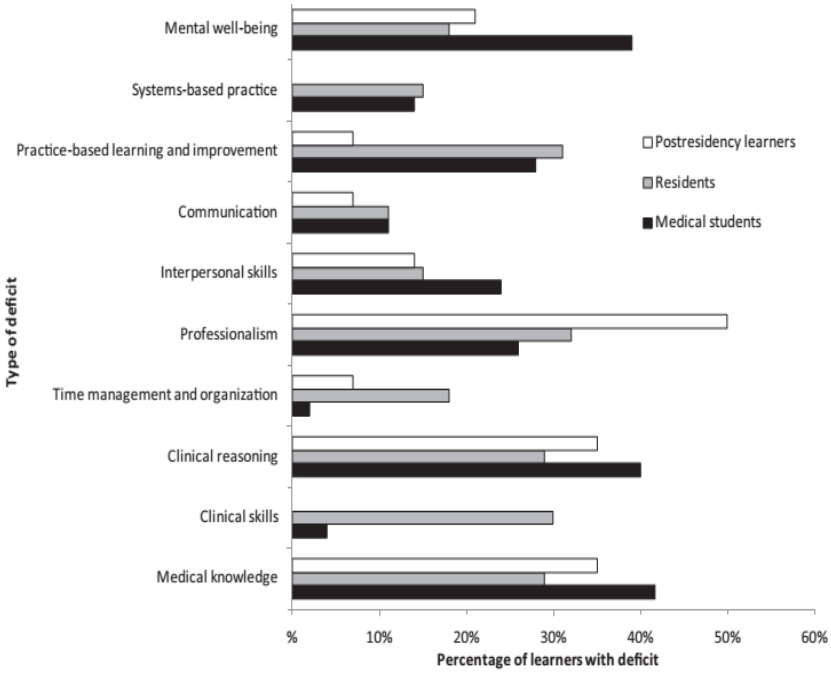

Figure 1 Percentage of 151 learners with each type of deficit by level of training, University of Colorado School of Medicine remediation program, 2006–2012. Although trends emerged among the learners, the only statistically significant finding was that mental well-being difficulties were more common in medical students ($P = .03$). Most learners had more than 1 of the 10 deficiencies studied.

Timely specific feedback and support resources are critical for learners struggling with professionalism. Tools to assist residents include role modeling, role-playing, assigned readings, and reflection pieces. Lucey (2008) notes that having residents shadow the strongest faculty during medical rounds can be helpful. Further, completing video reviews and multisource feedback from 360 evaluations may also be effective. Additionally, psychoeducational groups such as Anger Management and Sleep Hygiene offered through base helping agencies are also at your disposal. Finally, The Implicit Association Test by Harvard University (https://implicit.harvard.edu/implicit/) may assist in developing insight and modifying behavior relating to implicit bias.

Medical Knowledge

Behavioral scientists may be consulted when residents struggle with learning skills, and medical knowledge such as synthesizing information or poor test scores. There is very little literature on the frequency of residents with learning disabilities, however, rates among medical students are approximately 3-5% (Lucey & Boote, 2008; Rosebraugh, 2000). According to Rosenbraugh, “Telltale signs include when the learner’s verbal skills and knowledge base are strong, but they have a history of trouble with standardized tests and written communications” (Rosebraugh, 2000). Other learners may report recent onset of concentration concerns previously undetected. These residents may have taken

additional time to complete assignments in the past which is now not available in the high paced residency environment (Kalet & Chou, 2014). Lucy and Boote (2008) offer the following Table for common symptoms of learning disabilities and ADHD.

Table 13-2 Common Signs of Learning Disabilities in Physicians and Attention Deficit/Hyperactivity Disorder in Adults

Feature	Learning Disabilities*	Attention Deficit/Hyperactivity Disorder†
Working definition	Differences in the acquisition or use of information presented in oral or written format that lead to problems with reading, writing, listening, speaking, or reasoning	Symptoms of inattentiveness, restlessness, and impulsivity that affect performance and have existed since childhood
Common manifestations	Inefficient study skills Reliance on study groups rather than reading Poor performance on standardized tests Strong verbal and interpersonal skills	Impaired auditory vigilance Difficulty with executive functioning (sequencing and complex tasks) Psychiatric comorbidity (anxiety, depression, substance abuse) is common
Less common manifestations	Difficulty with organization and sequencing activities	

*Data from Guyer BP, Guyer KE: Doctors with learning disabilities: Prescription for success. Learning Disabilities 2000;10(2):65–72.
†Data from Spencer T, Biederman J, Wilens TE, Faraone SV: Adults with attention deficit/hyperactivity disorder: A controversial diagnosis. J Clin Psychiatry 1998;59(Supp 7):59–68.

Behavioral scientists should be prepared to discuss the impact that social and emotional challenges on a learner's performance. For instance, anxiety and/or depression may be the precursor or consequences of attention concerns. However, specialized knowledge of study skills deficits and learning disabilities may fall outside of a new behavioral scientist's comfort zone. In these circumstances, they should consult with local resources that specialize in learning skills enhancement such as the base Education Center. Formal psychological testing and pharmacological treatment should also be offered to residents with apparent cognitive difficulties. Finally, faculty should keep in mind that resident problems may also arise from cultural differences, language difficulties, discrimination, and bullying (Yao & Wright, 2001).

Attachment 1: Alarm Bells for Resident Training: A Tool to Identify Problematic Behavior Patterns (Hempstead, 2015)

Alarm Bells for Resident Training: A Tool to Identify Problematic Behavior Patterns in Resident Trainees.
What needs remediation or intervention or would prevent a resident from passing a rotation or progressing to the next level?

Patient Care

Data gathering

- Fails to perform complete history and/or physical examination.
- Fails to collect essential data from the patient.
- Information from patient is not accurate or reliable
- Fails to recognize severity of patient's condition. Sick / not sick
- Does not read or consult information sources.

Reasoning with the Data

- Has difficulty interpreting data.
- Makes incorrect inferences from data
- Fails to recognize critical labs

Making a Diagnosis

- Unable to Prepare adequate differential diagnosis
- Fails to order appropriate tests
- Problems lists are incomplete

Formulating a Treatment Plan

- Management plans are consistently incomplete or missing important aspects
- Makes decisions not based on current evidence

Outcomes of Care

- Patients have been harmed
- Not capable of managing 5 patients/day on the inpatient service.

Medical Knowledge

- *InTraining examination* scores on the composite is <10% (compared to PGY peers taking the exam).
- Has more than three areas on the in-training exam that is <20% (compared to peer group).
- Does not exhibit an *investigatory approach* to knowledge deficits:
  a. Generating questions
  b. Knowing where to look for information
  c. Looking for information
  d. Discerning how to apply this information to the clinical situation
  e. With feedback fails to develop an investigatory approach to patient care (initiative and curiosity).
- When questioned is unable to demonstrate knowledge
- Difficulty in analyzing patient problems and identifying what knowledge is needed.
- *Knowledge of specific common problems* associated with the rotation is still deficient at the end of the month.
- *Fails to demonstrate improved proficiency* when encountering repeat diagnoses or problems (assimilating and applying new knowledge).

Practice Based Learning and Improvement

Reflective Learning from Patient Encounters

- Does not do self-evaluation of clinical encounters; does not learn from clinical experiences; repeats the same mistakes and errors

Personal Improvement

- Does not work to improve on areas identified as needing improvement
- Does not develop and/or implement a personal plan for learning or improvement.

Critical Appraisal Skills

- Does not demonstrate critical appraisal skills

Facilitating Learning by Others

- As a team-leader or supervising resident: does not facilitate or encourage practice based learning of others

Improving Technique

- Fails to follow Universal Precautions or sterile technique.

Interpersonal and Communication Skills

Direct Communication with Others

- Fails to provide clear verbal explanations or presentations to patients or others on the health care team.
- Written or dictated communication is unorganized, difficult to follow, in-accurate and/or incomplete.
- Others do not understand the physician's use of English language.

Working as a Team Member

- Unable to work effectively with others on the health care team (all levels physician colleagues and ancillary staff); e.g., disruptive or disrespectful.
- Projects negative attitudes toward physician colleagues.

Outcomes of Communication Style

- Promotes lack of confidence in his or her clinical skills due to poor interpersonal or communication skills.
- Repetitive problems with patient complaints due to poor communication or interpersonal skills.

Professionalism

Character Traits

- Tardiness at required activities/services.
- Disrespectful. Shows disrespect to others: patients, members of health care team.
- Dishonesty-demonstrates lack of trustworthiness; lies/falsifies information.
- Demonstrates laziness.
- Irresponsible-fails to take responsibility commensurate with the level of training.
- Uncoachable. Ignores or defies suggestions for improvement or changed behavior.
- Demonstrates lack of compassion or sensitivity to patients.
- Self-interest supersedes needs of the patient.

Physician Role Behaviors

- Fails to respond to pages or attempts at contact.
- Inappropriate relationships with patients.
- Emotional lability when not appropriate.
- Demonstrates poor hygiene or normative levels of dress.
- Fails to appreciate limitations as a physician.
- Does not follow informed consent.
- Patient confidentiality; shares inappropriate info.

Systems-Based Practice

Medical Record Quality

- Deficiencies in documenting the medical record:
  a. Incomplete history and physical, progress notes, office SOAP notes
  b. Incomplete problem lists
  c. Incomplete drug lists
  d. Incomplete health maintenance record
  e. Does not keep discharge summaries current.

Advocacy for Patient and the Health System

- Fails to consider cost in medical decision making
- Fails to demonstrate patient advocacy

Practice Management

- Does not code or bill correctly.
- Shows little interest in learning about practice management.
- Does not participate in quality improvement activities on the clinical services.

Attachment 2: Competency Based Remediation Resources: Description of Resources Based on Core Competency Deficits (Brotherson, 2009)

Core competency	Deficit identified	Competency based remediation
Medical knowledge	Insufficient medical knowledge to understand pathophysiology of disease Insufficient knowledge to pass ITE/ Low scores on ITE Inability to complete mock ITE examination	Exam Master Study from Core Family Medicine texts Practice tests Structured Board Review Self study Assigned readings
	Incongruence between medical knowledge and clinical knowledge	Referral to Educational psychologist Test taking skills Desensitization therapy Neuropsychiatry testing
	Poor Critical thinking skills – resident lacks appropriate judgment in clinical situations	Chart audits Directed chart review Exercise in critical thinking skills
Patient care	Inadequate Data gathering	
	Lacks ability to synthesize information and develop treatment plan	
	Procedure deficits or poor technical skills	Procedure videos OB skills review
Interpersonal and communication skills	Inadequate communication with patient Unable to develop therapeutic relationships Spoken communication difficult to understand Inadequate scholarly communication to faculty peers Difficulty organizing patient information for oral or written presentation Inadequate documentation medical chart	Videotape review and feedback Skills training in patient centered interviewing One on one precepting with psychologist Direct observation by faculty Speech therapist Language therapist Use of presentation templates Review and feedback of documentation by faculty
Professionalism	Poor leadership	Executive coaching

	Lack of confidence Failure to demonstrate cultural competency	Acting coach Assigned readings Attendance at institutional conferences n cultural competency Self evaluation and reflection Cultural mentors / cultural wellness center
Practice Based Learning & Improvement	Lacks insight into deficits. Unable to design program for self improvement	Review of written self reflective narrative Guided reflection
Systems Based Practice	Does not demonstrate cost effective practice Unaware of resources for patient at discharge	Collaborative learning with clinical pharmacist Collaborative learning with Social Worker
Mental health		Referral to RAP Referral to psychotherapist Monthly Meeting with behavioral counselor

(Skelover, 2017)

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CHAPTER IV: INTRODUCTION TO GOVERNING STANDARDS OF BEHAHVIORAL SCIENCE AND MILESTONES

by Carrie L. Lucas, Maj, USAF, BSC

Understanding human behavior and mental health are a critical component of family medicine residency programs (AAFP, 2015). As such, there are governing standards that guide behavioral medicine, to include the Accreditation Council for Graduate Medical Education (ACGME) and American Academy of Family Physicians (AAFP). This document will (1) introduce the ACGME and AAFP, (2) discuss ACGME and AAFP requirements for behavioral medicine knowledge, and (3) review how the ACGME and AAFP influence evaluation of resident milestones in regard to behavioral medicine. Faculty are encouraged to have a broad understanding of ACGME requirements along with more specialized understanding for their area of expertise.

Accreditation Council for Graduate Medical Education (ACGME)

The ACGME provides the program requirements for graduate medical education in family medicine. ACGME recognizes that becoming an independently practicing physician requires experiential learning to develop clinical competency and personal responsibility in patient care, with an emphasis on the doctor-patient relationship in regard to the individual, family, and community (ACGME, 2016). The ACGME highlights program requirements, such as institutional responsibility, program personnel and resources, resident appointments, educational programs, evaluation, and resident duty hours (ACGME, 2016).

The sponsoring institution (section I) commits to fulfill requirements through the primary location and program letters of agreement with participating sites. The program personnel and resources (section II) includes (1) an identified program director who has authority and accountability for the operation of the program (II.A.), (2) physician and nonphysician faculty (II.B.), (3) other program personnel (i.e. professional, technical, and clerical personnel; II.C.), (4) resources for resident education and specialty program requirements (II.D.), and (5) medical information access (II.E.). The resident appointments (section III) clarifies what is required for eligibility as a residency program and fellowship programs (III.A.), the number of residents appointed to the program (III.B.), requirements for resident transfers (III.C.), and appointment of fellows and other learners (III.D.). The educational program (section IV) has required curriculum with competency based goals and objectives, didactics, ACGME competencies, demonstration of medical knowledge, practice-based learning and improvement, and professionalism, (IV.A.) and residents' scholarly activities (IV.B.). The evaluation component (section V) includes resident evaluation through a Clinical Competency Committee (V.A.), faculty evaluation (V.B.), and program evaluation and improvement through the Program Evaluation Committee (V.C.). Finally, the

resident duty hours (section VI) includes professionalism, personal responsibility, and patient safety (VI.A.), transitions of care (VI.B.), alertness management/fatigue mitigation (VI.C.), supervision of residents (IV.D.), clinical responsibilities (VI.E.), teamwork (VI.F.), and resident duty hours (VI.G.).

Behavioral Medicine – ACGME Program Requirements

In regard to the ACGME (2016) behavioral medicine aspect, behavioral scientists are considered nonphysician faculty and are required to have the appropriate qualifications and certifications in their field (e.g., social work or psychology; II.B.4.). The ACGME (2016) denotes there is to be faculty members who are designated to integrate behavioral health into the program (II.B.10.) and provide the structure necessary for residents to be able to (1) "diagnose, manage, and coordinate care for common mental illness and behavioral issues in patients of all ages," (IV.A.5.a).(1).(a).(iii)) and (2) demonstrate the knowledge and application of social-behavioral sciences (IV.A.5.b)). The structured curriculum within the family medicine residency program is expected to have behavioral health (1) integrated into the "total educational experience" including physical aspects present in patient care (IV.A.6.n)) and (2) as a component that allows residents to be "educated in the diagnosis and management of common mental illness," (IV.A.6.o)).

While not clearly denoted as behavioral medicine, there are other aspects of the ACGME (2016) program requirements where behavioral scientists can be of assistance. For example, faculty within family medicine residency programs are expected to "establish and maintain an environment of inquiry and scholarship with an active research component," (II.B.5.). As such, behavioral scientists can be present and involved during clinical discussions (II.B.5.a)) and offer a behavioralist perspective, when warranted. Another example is involvement in peer-reviewed funding, publications, presentations at local, regional, or national meetings, or participation on national committees or educational organizations, as appropriate and available (II.B.5.b)). As behavioral scientists are nonphysician faculty and offer behavioral health interventions with residents' patients, they also have a prime opportunity to verify residents communicate effectively (IV.A.5.d).(2)), coordinate patient care within behavioral clinical specialties (IV.A.5.f).(2)), and "work in interprofessional teams to enhance patient safety and improve patient care quality," (IV.A.5.f).(5)).

American Academy of Family Physicians (AAFP)

The AAFP was established in 1947 and has a vision to "transform health care to achieve optimal health for everyone" and mission to "improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity," (AAFP, 2017). The major purposes of the AAFP include (2017):

- Providing responsible advocacy for and education of patients and the public in all health-related matters
- Preserving and promoting quality cost-effective health care
- Promoting the science and art of family medicine and ensuring an optimal supply of well-trained family physicians
- Promoting and maintaining high standards among physicians who practice family medicine
- Preserving the right of family physicians to engage in medical and surgical procedures for which they are qualified by training and experience
- Providing advocacy, representation, and leadership for the specialty of family medicine
- Maintaining and providing an organization with high standards to fulfill the above purposes and to represent the needs of its members

Behavioral Medicine – AAFP Curriculum Requirements

The AAFP provides recommended curriculum guidelines in regard to human behavior and mental health. The recommendations are in line with ACGME goals and promote experiential learning, didactics, conferences, and workshops that are focused on outcomes and evidence-based studies for patients of all ages (AAFP, 2015). One primary element recognized by the AAFP is the relationship between the patient and the patient's family in order to better understand human behavior and mental health (AAFP, 2015). There is emphasis on the mind-body connection and how relationships with others, wellness, and illness can impact how a patient presents (AAFP, 2015). Residents are also expected to learn how to recognize their own wellness in regard to their medical practice (AAFP, 2015).

While the AAFP clearly outlines the human behavior and mental health curriculum in AAFP Reprint No. 270, a few key take-aways will be highlighted here (AAFP, 2015). In regard to competencies, residents should be able to (a) recognize the stages and impact of stress in the lifecycle, (b) master a variety of motivational interviewing techniques to enhance the physician-patient relationship, (c) effectively interview and evaluate for mental health disorders, and (d) recognize, initiate treatment for, and utilize appropriate referrals for mental health, by the end of residency training (AAFP, 2015). In regard to attitudes, residents should demonstrate (a) an awareness and willingness to address his or her biases in regard to mental illness, (b) acceptance of patient's right to self-determination, (c) an understanding the importance of a multi-disciplinary approach to enhance care, and (d) a willingness to explore motivators that impact a patient's medical decision making (AAFP, 2015). In regard to knowledge, (a) the ability to differentiate diagnoses of common mental health disorders and (b) demonstrate familiarity with the DSM-5 mental health disorders (e.g., neurodevelopmental disorders, feeding and eating disorders, elimination disorders, sleep-wake disorders, neurocognitive disorders, substance-related and addictive disorders, schizophrenia spectrum and other psychotic disorders, bipolar

and related disorders, depressive disorders, anxiety disorders, somatic symptom disorders, gender dysphoria, personality disorders, trauma- and stress-related disorders, dissociative disorders, and others; AAFP, 2015). In regard to skills, residents should be able to (a) perform a mental status examination, (b) use special procedures in psychiatric disorder diagnosing, (c) recognize common signs and symptoms mentioned above, (d) screen for depression and know the SIG-E-CAPS mnemonic, (e) understand the therapeutic role of the primary care doctor, (f) apply techniques to increase compliance, and (g) initiate the correct management of psychiatric emergencies (AAFP, 2015). In regard to implementation, residents should have a combination of experiences, such as (a) diagnostic assessment, (b) psychotherapeutic techniques (e.g., cognitive behavioral therapy, motivational interviewing, and self-reflection) and (c) psychopharmacologic management (AAFP, 2015).

Evaluating Resident Milestones (Competencies)

The following section provides an explanation of resident milestones (clinical competencies) and how behavioral medicine is incorporated into the milestones (The Family Medicine Milestone Project, 2013). Milestones are organized into a developmental framework (Level 1 to Level 5) that allows for residents to move through stages of growth while in a family medicine residency program. For example, Level 1 is a resident who has "some education in family medicine," while a Level 5 is a resident performing beyond residency targets and demonstrates "aspirational" goals – as such Level 4 is the target for graduation (The Family Medicine Milestone Project, 2013). Family medicine milestones include patient care (PC), medical knowledge (MK), systems-based practice (SBP), practice-based learning and improvement (PBLI), professionalism (PROF), and communication (C). The MAHEC-Family Medicine Residency Program in Asheville, North Carolina has provided an outline showing how components within the milestones align with behavioral medicine (Krall & Ray, 2014) with modifications and additions made by this author:

<u>Patient Care – 3 (PC-3):</u> Partners with the patient, family, and community to improve health through disease prevention and health promotion

PC-3-Level 1 – Collects family, social, and behavioral history

PC-3-Level 2 – Identifies the roles of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention

PC-3-Level 3 – Partners with the patient and family to overcome barriers to disease prevention and health promotion; mobilizes team members and links patients with community resources to achieve health promotion and disease prevention goals

<u>Patient Care – 4 (PC-4):</u> Partners with the patient to address issues of ongoing signs, symptoms or health concerns that remain over time without a clear diagnosis, despite evaluation and treatment, in patient centered cost effective manner

PC-4-Level 1 – Acknowledges that patients with undifferentiated signs symptoms or health concerns are appropriate for family physician to manage and commits to addressing these concerns

PC-4-Level 3 – Utilizes multidisciplinary resources to assist patients with undifferentiated signs, symptoms, or health concerns in order to deliver health care more efficiently (e.g., appropriately consults Behavioral Medicine to help)

PC-4-Level 4 – Establishes rapport with patients to the degree that patients confidently accept the assessment of an undiagnosed condition

Medical Knowledge – 2 (MK-2): Applies critical thinking skills in patient care

MK-2-Level 2 – Begins to integrate social and behavioral sciences with biomedical knowledge in patient care

MK-2-Level 3 – Recognizes the effect of an individual condition on families and populations

MK-2-Level 5 – Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans; collaborates with the participants necessary to address important health problems for both individuals and communities

Systems Based Practice – 3 (SBP-3): Advocates for individual and community health

SBP-3-Level 1 – Recognizes social context and environment, and how a community's public policy decisions affect individual and community health

SBP-3-Level 2 – Recognizes that family physicians can impact community health

SBP-3-Level 3 – Identifies specific community characteristics that impact specific patients' health

Systems Based Practice – 4 (SBP-4): Coordinates Team Based Care

SBP-4-Level 1 – Understands that quality patient care requires coordination and teamwork, and participates as a respectful and effective team member

SBP-4-Level 2 – Understands roles and responsibilities of oneself, patients, families, consultants, and inter-professional team members needed to optimize care, and accepts responsibility for coordination of care (e.g., considers use of Behavioral Medicine when appropriate)

SBP-4-Level 3 – Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs

Practice Based Learning & Improvement – 2 (PBLI-2): Demonstrates self-directed learning

PBLI-2-Level 1 – Uses feedback to improve learning and performance

PBLI-2-Level 2 – Incorporates feedback and evaluations to assess performance and develop a learning plan

PBLI-2-Level 3 – Has self-assessment and learning plan that demonstrates a balanced and accurate assessment of competence and areas for continued improvement

Professionalism – 1 (PROF-1): Completes process of professionalization

PROF-1-Level 1 – Recognizes that conflicting personal and professional values exist; demonstrates honesty, integrity, and respect for patients and team members

PROF-1-Level 2 – Recognizes own conflicting personal and professional values; knows institutional and governmental regulations for the practice of medicine (e.g., refers appropriately to adult protective services, knows commitment process)

PROF-1-Level 3 – Recognizes that physicians have an obligation to self-discipline and to self-regulate; engages in self-initiated pursuit of excellence

Professionalism – 2 (PROF-2): Demonstrates professional conduct and accountability

PROF-2-Level 1 – Presents him or herself in a respectful and professional manner; maintains patient confidentiality

PROF-1-Level 2 – Consistently recognizes limits of knowledge and asks for assistance; has insight into his or her own behavior and likely triggers for professionalism lapses, and is able to use this information to be professional

PROF-1-Level 3 – Recognizes own conflicting personal and professional values; knows institutional and governmental regulations for the practice of medicine

Professionalism – 3 (PROF-3): Demonstrates humanism and cultural proficiency

PROF-3-Level 1 – Demonstrate**s** compassion, respect, empathy; Recognizes impact of culture on health behaviors

PROF-3-Level 2 – Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity

PROF-3-Level 3 – Incorporates patients' beliefs, values, and cultural practices in patient care plans; identifies health inequities and social determinants of health and their impact on individual and family health

Professionalism – 4 (PROF-4): Maintains emotional physical and mental health and pursues continual personal and professional growth

PROF-4-Level 1 – Demonstrates awareness of the importance of maintenance of emotional, physical, and mental health; Recognizes fatigue,
sleep deprivation, and impairment

PROF-4-Level 2 – Applies basic principles of physician wellness and balance in life to adequately manage personal emotional, physical, and mental health

PROF-4-Level 3 – Actively seeks feedback and provides constructive feedback to others; recognizes signs of impairment in self and team members, and responds appropriately

PROF-4-Level 4 – Appropriately manages situations in which maintaining personal emotional, physical, and mental health are challenged

Communication – 1 (C-1): Develops meaningful, therapeutic relationships with patients and families

C-1-Level 2 – Creates a non-judgmental, safe environment to actively engage patients and families to share information and their perspectives

C-1-Level 3 – Effectively builds rapport with a growing panel of continuity patients and families

C-1-Level 4 – Connects with patients and families in a continuous manner that fosters trust, respect, and understanding, including the ability to manage conflict

Communication – 2 (C-2): Communicates effectively with patients, families and the public

C-2-Level 3 – Engages patients' perspectives in shared decision making

C-2-Level 4 – Effectively communicates difficult information, such as end-of-life discussions, delivery of bad news, acknowledgement of errors, and during episodes of crisis

Communication – 3 (C-3): Develops relationships/effectively communicates with physicians/other health professionals/health care team

C-3-Level 1 – Understands importance of health care team and shows respect for skills and contributions of others

C-3-Level 2 – Demonstrates consultative exchange that includes clear expectations and timely appropriate exchange of information; presents and documents patient data in clear, concise, organized manner
C-3-Level 3 – Uses Electronic Health Record effectively to exchange information; communicates collaboratively with the health care team by listening attentively, sharing information, and giving and receiving constructive feedback
C-3-Level 4 – Sustains collaborative working relationships during complex and challenging situations, including transitions of care

Growth and achievement of the milestones happen in various aspects of the three-year residency program. For example Buck and Reed (2015) highlight PC-3, PC-4, and MK-2 are met through didactics, PC-3, PC-4, SBP-4, and C-3 are met through care team, PROF-4 is met through physician wellness, and PC-3, PROF-3, C-1, and C-2 are met through video clinic review.

Conclusion

An awareness of human behavior and mental health are critical competencies for family medicine residents and future independent family medicine physicians. This document introduced and reviewed the governing standards that guide behavioral medicine within family medicine residencies (i.e., ACGME and AAFP). This document also articulated how milestones governed by the ACGME and American Board of Family Medicine provide guidance for how behavioral medicine is evaluated amongst residents (The Family Medicine Milestone Project, 2013).

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CHAPTER V: CURRICULUM BASICS

If you are a new to AF behavioral medicine, you will likely find that the curriculum for your program has already been established by your predecessors. A quick look on the shared drive or discussion with the program director should point you in the right direction. Family medicine residency training curriculums will typically fall in to either a "block" or "longitudinal" format. Block schedules tend to be more common and typically last for a four week period. The benefits of a block schedule include offering the learner a focused period to obtain competency in desired learning objectives. Longitudinal curriculums frequently span over the three years. While less concentrated, they offer the learner the opportunity to build upon skills gradually over time and potentially mimics real-world primary care scenarios with long-term relationships with patients and colleagues. While the American Academy of Family Physicians (AAFP) recommends the use of a longitudinal curriculum (American Academy of Family Physicians, 2015), there is little research in the field of behavioral medicine to support use of one framework over the other.

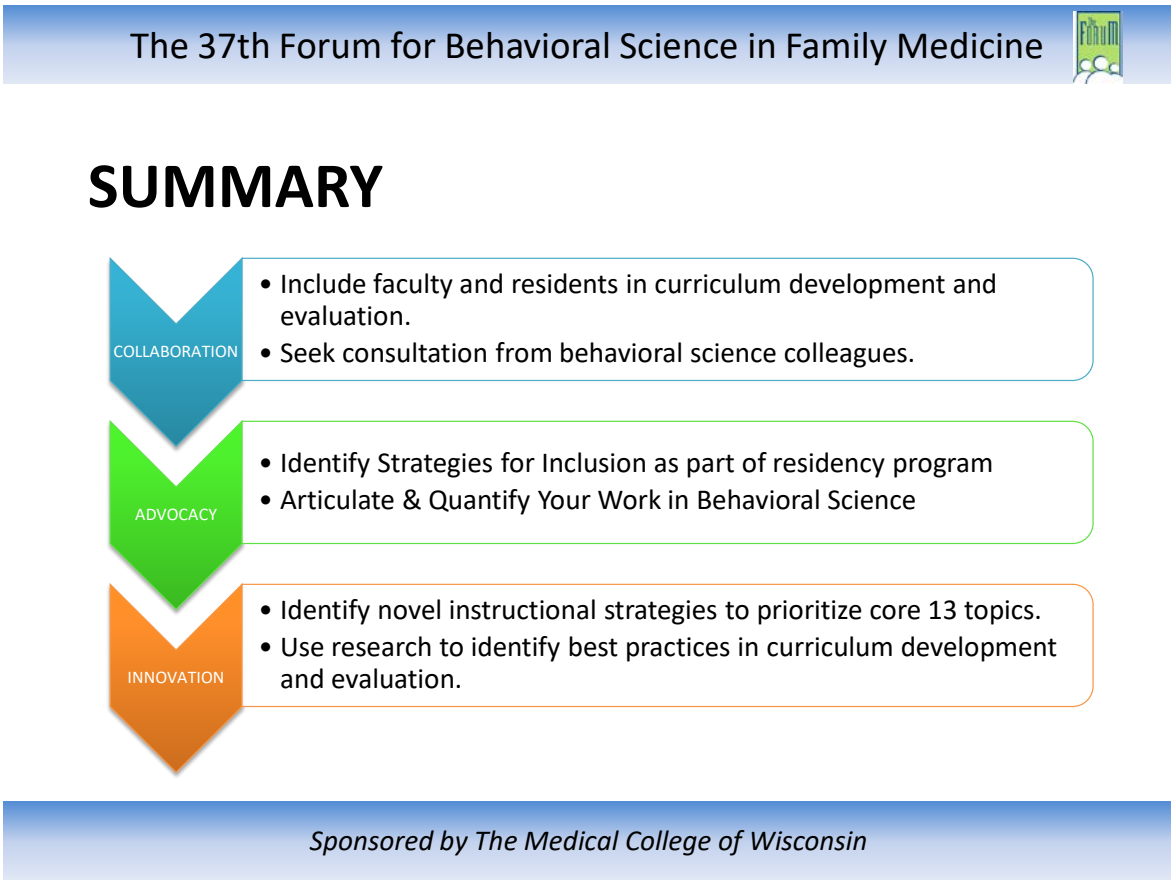
How to Develop or Modify a Curriculum

Whether working with a block or longitudinal format, the website wikiHow provides a multi-step method to guide for modifying or creating your curriculum (wikiHow, 2017). Some steps include…

1. **Define the purpose of your curriculum**: The AAFP's guidelines for Behavioral Health are a great place to start when building a curriculum. There you'll find excellent content such as, "Attitudes, behaviors, knowledge, and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME), www.acgme.org," (p.1 AAFP, 2015).
2. **Choose and appropriate title**: Example, *Behavioral Medicine (BMed) 2018-2019*. *Note: in my experience, residency staff routinely misuse the terms "BHOP" (Behavioral Health Optimization Program) and "BMed."
3. **Establish a timeline**: This will hinge on whether you are running a block or longitudinal program. Additionally, you'll need to work closely with your program director to agree upon the role of BMed in your program. BMed is one of many important components of a residency program and change is typically gradual.
4. **Determine how much you can cover in the allotted time**: Understand your audience and the time that has been allotted. Aim for quality over quantity. It's common for educators to try to teach too much in a designated time slot.
5. **Create a list of desired outcomes**: See list of core competencies on pages 2-3 of the AAFP article, *Curriculum Guidelines for: Human Behavior and Mental Health* (2015).

6. **Create draft of curriculum schedule:** A unique aspect of FMR scheduling is that staff and residents often perform different duties with each half day of clinic. For instance, a resident may in outpatient clinic in the morning and BMed in the afternoon followed by a different schedule the next day. This creates a dynamic atmosphere where effective communication is critical to meeting the various competing needs of the program.
7. **Consult existing curricula for inspiration and content details:** Continue reading for suggested content.
8. **Create learning goals and assessments for each section:** See the ACGME milestones for ideas (Accreditation Council for Graduate Medical Examination, 2015)
9. **Teach lesson and gain feedback:** Gain formal or informal feedback. Note how learners respond to different topics and teaching styles.
10. **Make revisions as needed:** Revisions can occur as needed or at pre-established timeframes.

Similar steps are offered by Clark and colleagues (2015):



Identifying Topics for Lecture

Identifying topics for lecture can be determined by multiple factors including the personal interests of the residents, established literature such as the AAFP Curriculum Recommendations (2015), the ACGME Milestones (Accreditation Council for Graduate Medical Examination, 2015), and the unique cultural qualities of your program. For instance, Air Force family medicine patients may experience higher levels of PTSD and lower levels of illicit substance abuse. I prefer to approach topic selection from a pragmatic approach, "What is essential for my residents to know as they enter their practice?"

In 2015, Clark replicated prior research by Marvel (1999) and Kendall (2003) identifying key topics for behavioral science education. Their findings are depicted below:

The 37th Forum for Behavioral Science in Family Medicine

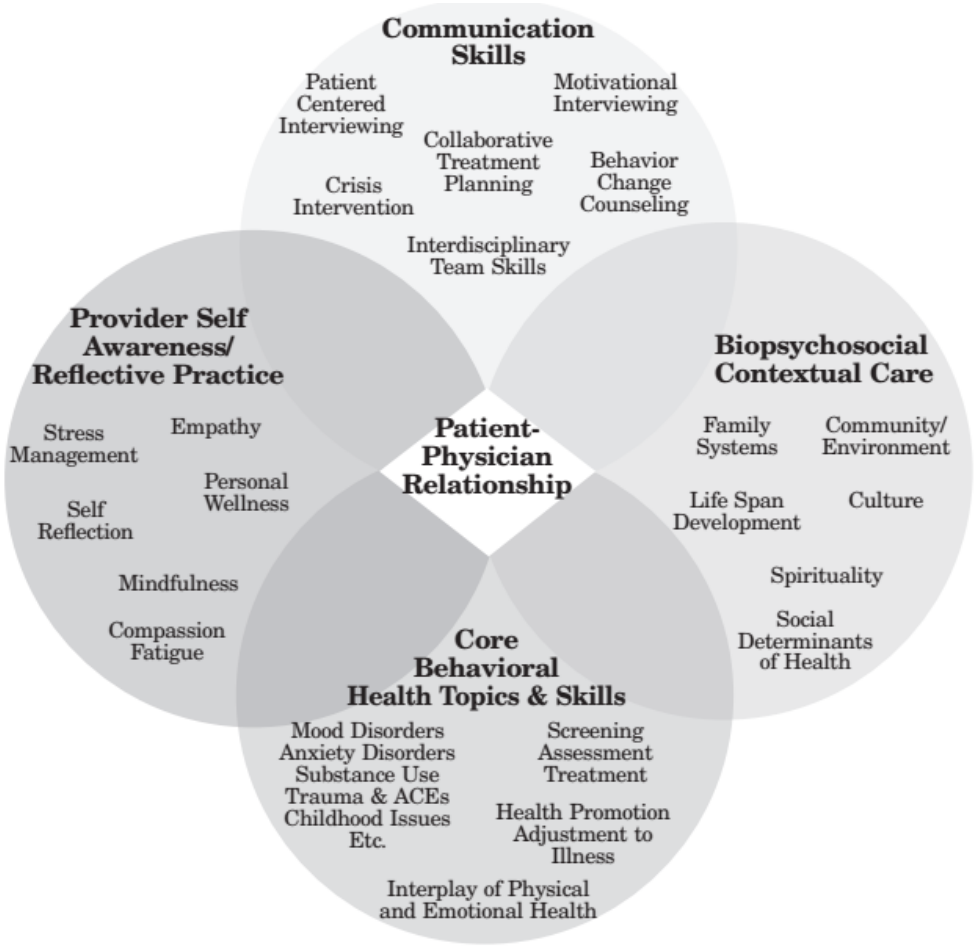
Topics	Colorado (1999)	Missisippi (2003)	Washington (2015)
Depression	1	1	1
Anxiety	2	2	3
Lifestyle Counseling	3	6	4
Headaches	4	4	11
Difficult Patients	5	7	10
Interviewing	6	5	2
Stress-related Disorders	7	9	11
Geriatrics	8	3	5
Physician Well-Being	9	12	13
Patient Education	10	13	7
Chronic Pain	11	7	6
Substance Abuse	12	10	9
Death & Dying	13	10	8

Sponsored by The Medical College of Wisconsin

Results from the study indicated that topics more akin to psychiatry (e.g. psychotic disorders) ranked at the bottom half while interpersonal skills such as interviewing ranked favorably. Their recommendations were to 1) prioritize the top mental health conditions (e.g. anxiety, depression); 2)

prioritize interpersonal processes (e.g. communication skills); 3) prioritize treatment of common illnesses; and 4) maintain variety (Clark, Diaz, & Brandt-Kreutz, 2016). See attachment 1 for additional details.

Another comprehensive depiction of curriculum topics can be found in Baird et al's *Domains of Behavioral Science Teaching* depicted below (Baird, Hepworth, Myerholtz, Reitz, & Danner, 2017):



Additional Resources

STFM Resource Library

http://resourcelibrary.stfm.org/home

Comprehensive library with modifiable search engine. All materials are screened by Resource Library staff before they appear live on the Resource Library site. Search for "curriculum" provides 4,059 hits.

Family Medicine Residency Curriculum Resource

www.fammedrcr.com

A subscription-based resource sponsored by AFMRD and STFM with peer-reviewed, competency - based curriculum with presentations, facilitators' guides, and quizzes with new curriculum being added. As of 20 Feb 2018, 8 topics available under Behavioral Science.

From the Behavioral Science Basics (BSB) Library
(Society of Teachers of Family Medince, 2016)

Books

Kern, D, Thomas, P, Hughs, M (2009). Curriculum development for medical education: A six-step approach. Baltimore: Johns Hopkins University Press.

"Curriculum Development for Medical Education is designed for use by curriculum developers and others who are responsible for the educational experiences of medical students, residents, fellows, and clinical practitioners." Short, practical, and general in its approach, the book begins with a broad overview of the subject. Each succeeding chapter covers one of the six steps: problem identification and general needs assessment, targeted needs assessment, goals and objectives, educational strategies, implementation, and evaluation. Additional chapters address curriculum maintenance, enhancement, and dissemination." (Amazon.com)

Kurtz, S, Silverman, J., Draper, J. (2005). Teaching and learning communication skills in medicine. Oxford: Radcliff Publishing.

"This book and its companion, Skills for Communicating with Patients, Second Edition, provide a comprehensive approach to improving communication in medicine. It examines how to construct a skills curricular at all levels of medical education and across specialties, documents the individual's skills that form the core content of communication skills teaching programs, and explores in depth the specific teaching, learning and assessment methods that are currently used within medical education." (Amazon.com)

Core Competency Objectives in Behavioral Science Education

www.ebooksdownloads.xyz/search/core-competency-objectives-in-behavioral-science-education

Circa 1986. Describes the state of the art of Behavioral Science Education in the mid-1980's. Features exemplary curriculum and teaching strategies at the time.

Websites

Resource Guide for Behavioral Science Educators in Family Medicine

https://resourcelibrary.stfm.org/viewdocument/resource-guide-for-behavioral-scien

Published in 1999, this text examines the teaching of specific behavioral science content areas and the educational methods used to transmit this information to resident learners. Major portions of the document are devoted to multiple synopses of behavioral science content taught and methods used in teaching. Other chapters provide the history of the behavioral sciences in medicine and a discussion of the psychological theories behind this teaching.

Society of Behavioral Medicine:
www.sbm.org

This website includes a searchable archive of behavioral health course syllabi

American Academy of Communication in Healthcare (AACH)
www.aachonline.org

The AACH is the behavioral health organization associated with our Internal Medicine faculty development organization. It features multiple conferences of interest to behavioral health faculty, including an annual conference related to team development. It is also the site for Doc.com, with 41 complete instructional modules, each with numerous interactive functions and simulation videos. The cost is based on subscription fees.

(sXeven, 2018)

Family Medicine Residency Behavioral Science Curriculum Didactic Planning Tool

CORE Topics													
	Frequency			Learners				Venue				Presenter(s)	NOTES
Conditions/Populations:	Q1 yrs	Q2 yrs	Q3 yrs	R1	R2	R3	Otr	Wkshp 1 – 4hr	Noon talk	AM rpt	Otr	↓	↓
Depression/Bipolar/ Meds													
Anxiety/PTSD/ Meds													
Substance Use/Meds													
Chronic Pain													
Headaches													
Pediatrics/well-child (psychosocial)													
Geriatrics/Cognitive assessment (psychosocial)													
Suicide/Homicide/Safety													
Interpersonal Processes:													
Clinical Communication Skills & Patient Ed & MI													
Challenging Patients													
Lifestyle Counseling & MI													
Death and Dying													
Physician Wellness													

OTHER Topics													
	Frequency			Learners				Venue				Presenter(s)	NOTES
Conditions/Populations:	Q1 yrs	Q2 yrs	Q3 yrs	R1	R2	R3	Otr	Wkshp 1 – 4hr	Noon talk	AM rpt	Otr	↓	↓
Behavioral Pediatrics													
ADHD													
Autism Spectrum Disorders													
Enuresis/Encopresis													
Psychopharmacology													
Chronic Mental Illness													
Cognitive disorders													
Mental Status													
Sleep Problems													
Chronic Medical Illness													
Somatoform Disorders													
Psychotic Disorders													
Eating Disorders													
Sexual Problems													
Adolescent Care													
Policy/Advocacy/Justice													
Other:													
Interpersonal Processes:													
Culture/Diversity													
Community Resources													
Family violence													
Family Skills													
Spirituality and Medicine													
Other:													

References

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American Academy of Family Physicians. (2015). Recommended Curriculum Guidelines for Family Medicine Residents: Human Behavior and Mental Health http://www.aafp.org/medical-school-residency/program-directors/curriculum.html

Baird, M. A., Hepworth, J., Myerholtz, L., Reitz, R., & Danner, C. (2017). Fifty years of contributions of behavioral science in family medicine. *Family Medicine*, *49*(4), 296-303.

Clark, M. S., Diaz, K. M., & Brandt-Kreutz, R. L. (2016). What We Are Doing and Where We Want to Go: Utilization and Priorities in Behavioral Science Curriculum Development. from Society of Teachers of Family Medicine https://resourcelibrary.stfm.org/viewdocument/what-we-are-doing-an-1

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(Stanko, 2018)

CHAPTER VI: VIDEO REVIEW

Video review is a common method used by behavioral scientists to teach communication skills, time management, negotiation, and interviewing styles to residents (Eaton, 2014). Video review may be conducted in various formats including but not limited to independent viewing, 1:1 with faculty, and in small groups with peers. The insight gained from viewing a real patient encounter creates an ideal opportunity for learning (Pinsky & Wipf, 2000). Residents frequently punctuate these experiences with the statement "I never realized that I did that." Video with feedback has been shown to significantly enhance recall and retention and also serves as a tool to assess ACGME performance milestones in the areas of communication, patient care, and professionalism (Accreditation Council for Graduate Medical Examination, 2015). Further, it's common for doctors to experience less anxiety when equipped with effective communication skills. Despite these benefits there is substantial variation in how programs implement related policies and procedures, frequency of review sessions, and format of evaluation (Pinsky & Wipf, 2000).

Patient-Centered Observation Form (PCOF)

While there are numerous tools to assess and teach communication skills, the PCOF stands as the emerging "gold standard" in the field (Mauksch, 2014). Dr. Mauksch has devoted over 16 years to creating and analyzing the tool that helps to structure and operationalize conversations during patient care. Further, the form helps to facilitate feedback, develop self-assessment skills, and promote teamwork (UW School of Medicine, 2017)(see attch 1). The form is divided into 12 skills sets including: Establishing Rapport, Maintaining Relationships, Collaborative Agenda Setting, Efficiency, Gathering Information, Assessing Patient/Family Perspective, Use of Electronic Medical Record, Physical Exam, Sharing Information, Behavior Change/Self Management, Co-creating a Plan, and Closure. Each of these skill sets is further subdivided into elements. While observing the resident, the advisor counts the number of elements present for each skill set. The sum of elements determines the degree to which the resident is patient-centered in their communication style. Observers are cautioned to not give the "benefit of the doubt" and to check items only when observed. For further details, see attachment 2 containing my personal notes from Dr. Mauksch's presentation, *Strategies and Tools to Teach Patient Centered Interactions: Blending Efficiency and Quality* (Mauksch, 2017).

Direct access to training on the PCOF can be accessed at www.pcof.us. This URL may be difficult to access through some military servers. Two examples of training videos presented on the website include a "common" patient/provider interaction, and a "better" patient/provider interaction (UW School of Medicine, 2017):

Common: https://www.youtube.com/watch?v=Ob3gv4xsbJ4&feature=youtu.be (MD)

Better: https://www.youtube.com/watch?v=SbMW3ZieHfU&feature=youtu.be (MD)

Finally, the University of Washington offers the *PCOF: Category Explanation, Sample Phrases, and Preparing for Observation* (UW School of Medicine, 2017) (attch 3). This handout serves as a functional supplement to the PCOF by providing a brief explanation and examples for each of the 12 core skill sets.

General Tips

The following section provides best practices tips from the literature. Steinert (1993) offers the following recommendations which are still relevant 25 years after their initial publication:

Prior to the video review:

1. Work to overcome commonly encountered problems: Normalize discomfort in the face of passive resistance. You may wish to role model as needed. Also, ensure that video recording and review are built in to the normal schedule.

2. Ensure 'informed consent': Make sure that your form utilizes patient-centered language and has been approved by proper authorities.

3. Choose the best format for teaching and prepare the learner for the video review: Consider individual or group. Encourage the residents to self-assess their own strengths and areas for improvement.

During the video review:

4. Help the residents to develop a game plan: Reassess resident's goals and objectives. What would they like to focus on? What feedback have they received from faculty? The facilitator should lay out the agenda for the session.

5. Create a supportive environment and discuss the resident's reactions to being recorded

6. Determine how the session will proceed: For example, determine who should start and stop the video.

7. Request a brief description of what will be seen during the video

8. Review selected parts of the recording

9. Follow principles of effective feedback: Start with the resident's impression of their contact. What went well, what went not so well, and opportunities for improvement. Keep feedback to a reasonable amount so as not to overload the learner. Consider use of a standardized checklist (e.g. PCOF).

10. Focus the discussion: Limit discussion to 2-3 topics. For example, consider focusing on rapport building, agenda setting, and use of the electronic health record during the initial feedback.

11. Summarize and evaluate the review: Allow the resident to provide feedback on the experience.

Training and Utilizing Staff

Shepperd, Diaz, and Grace (2013) offer the following guidance on providing training, "Staff will likely play an important role in the video review process; therefore, it will be beneficial to ensure they have been adequately trained. An in-training with staff may be the best way to provide background on the purpose and procedures of video review within a residency program. Several examples of the roles staff may play include communication with the resident regarding patient selection, completing the informed consent form with the patient, starting and stopping the recording, and responding to resident issues, such as reluctance to make a recording. Providing a sample script, anticipating challenges, and educating staff from the beginning will help ensure a seamless video recording experience (pg. 15)"

Additional Information for Staff/Medical Technicians (Sheppard, Diaz, & Grace, 2013)

Hesitation: If the patient is hesitant to video, address any questions or concerns they have. If they are still not comfortable/unsure, discontinue the process. Reassure them that this is a voluntary process, their encounter does not need to be recorded today, and that refusal to participate will not impact the quality of care provided in any way. It is completely unacceptable for a patient to feel forced into participating.
Video Security: Videos are saved on the video server, secured by password that is only accessible to simulation/technology staff and supervising faculty. Videos will be deleted in a timely fashion after use. Cameras may be turned on or off at any point throughout the visit. The patient maintains control of this, and may choose to discontinue the recording at any time.
Nudity: If the patient has rashes, is here for genital/breast exam, or needs to expose private areas, do not request to record the encounter. Choose a different patient you are scheduled to see that day.
Privacy: If a patient refuses video and seems very concerned about privacy, you can stop recording and offer to move to a room with no cameras.

Informed Consent

Shepperd and colleagues (2013) offer the following guidance on informed consent:
"Informed consent" refers to the ***conversation*** that takes place with the patient about the video review process. The signed form is merely a way of documenting that the conversation took place. In the case of a person with impaired capacity or a minor, it is ethically and legally acceptable to obtain the consent from the guardian. However, assent must also be obtained from the patient. In general, informed consent forms tend to be too long, written at too high a reading level, and contain overly complex concepts. For the most part, simpler is better. The essential elements of an informed consent form are:

- That participation is voluntary
- Pt has the choice to stop the recording at any time
- Declining participation will not impact quality of care in any way
- The sole purpose for the recording is for education
- Explanation of who will see/have access to the recording (resident/faculty, the AF)
- Risks involved such as security of the recording and when it will be erased
- Specific timeframe when recording is permitted
- Signatures of involved parties

Air Force behavioral scientists are encouraged to work closely with their medical legal consultant to ensure adherence to policy. They are also encouraged to have the form approved by the Executive Committee of Medical Staff (ECOMS). Attachment 3 contains an example of an ECOMS approved video consent form.

(Nielsen, n.d.)

Attachment 1: Patient Centered Observation Form with Milestones (UW School of Medicine, 2017)

Patient Centered Observation Form- Clinician version

Trainee name_____ Observer_____Obsrvn#____Date_____

Directions; Track behaviors in left column. Then, mark one box per row: a, b or c. Competent skill use is in one of the right two right side columns. Record important provider / patient comments and verbal / non-verbal cues in the notes. Use form to enhance your learning, vocabulary, and self-awareness. Ratings can be for individual interviews or to summarize several interactions. If requested, use this form to guide verbal feedback to someone you observe.

Skill Set and elements ***Check only what you see or hear. Avoid giving the benefit of the doubt.***	*Provider Centered Biomedical Focus* ⟷ *Patient Centered Biopsychosocial Focus*		
Establishes Rapport ☐ *Introduces self (before gazing at computer)* ☐ *Warm greeting (before gazing at computer)* ☐ *Acknowledges all in the room by name* ☐ *Uses eye contact* ☐ *Humor or non medical interaction*	☐ 1a. Uses 0-2 elements	☐ 1b.Uses 3 elements.	☐ 1c.Uses ≥ 4 elements
Notes: ***FM GME Milestones- C 1.1 - 1.3;C 2.1; PC-4.4; PROF 3.1***			
Maintains Relationship Throughout the Visit ☐ *Uses verbal or non-verbal empathy during discussions or during the exam* ☐ *Uses continuer phrases ("um hmm")* ☐ *Repeats (reflects) important verbal content* ☐ *Demonstrates presence, curiosity, intent focus, not seeming "rushed" and acknowledges distractions*	☐ 2a. Uses 0-1 elements	☐ 2b. Uses 2 elements	☐ 2c. Uses 3 or more elements
Notes: ***C 2.3; PC 2.2,4.4; PROF 3.1***			
Collaborative upfront agenda setting ☐ *Acknowledges agenda items from other team member (eg MA) or from EMR.* ☐ *Additional elicitation- "something else?" * X_____* ** each elicitation counts as a new element* ☐ *Asks or confirms what is most important to patient.*	☐ 3a. Uses 0-1 elements	☐ 3b. Uses 2 elements	☐ 3c. Uses ≥ 3 elements
Note patient concerns here: **C 2.3; SBP 2.2**			
Maintains Efficiency using transparent (out loud) thinking and respectful interruption: ☐ *Talks about visit time use / visit organization* ☐ *Negotiates priorities (includes provider agenda items)* ☐ *Talks about problem solving strategies* ☐ *Respectful interruption/redirection using EEE: **E**xcuse your self, **E**mpathize/validate issue being interrupted, **E**xplain the reason for interruption (eg, for Topic tracking)*	☐ 4a. Uses 0 elements	☐ 4b. Uses 1 element	☐ 4c. Uses 2 or more elements
Notes: ***SBP 1.3-5***			
Gathering Information ☐ *Uses open-ended question* X____ ☐ *Uses reflecting statement* X____ ☐ *Uses summary/clarifying statement* X____ *Count each time the skill is used as one element*	☐ 5a. Uses 0-1 elements	☐ 5b. Uses 2 elements	☐ 5c. Uses 3 or more elements
Notes: ***PC-1.1;3.1 PROF 3.3-3.4***			
Assessing Patient or Family Perspective on Health ☐ *Acknowledges patient verbal or non-verbal cues.* ☐ *Explores patient beliefs (explanatory model) or feelings* ☐ *Explores contextual influences: family, cultural, spiritual.* *Number of patient verbal / non-verbal cues___*	☐ 6a. Uses 0 elements	☐ 6b. Uses 1 element	☐ 6c. Uses 2 or more elements
Notes: ***C 2.3 PROF 3.1-3.4***			

Patient Centered Observation Form- Clinician version

Trainee name_____ Observer_____Obsrvn#____Date_____

Skill Set and elements ***Check only what you see or hear. Avoid giving the benefit of the doubt.***	*Provider Centered Biomedical Focus* ⟷ *Patient Centered Biopsychosocial Focus*		
Electronic Medical Record Use ☐ *By 10 seconds, describes reason for each screen gaze* ☐ Shares/points at screen during at least 2 visit phases (agenda setting, history, Rx / Lab review, typing AVS) ☐ Maintains eye contact and/or shares screen at least 2/3rds of the visit ☐ Ask patient to confirm or contribute to documentation	☐ 7a. Uses 0 or 1 elements.	☐ 7b. Uses 2 elements	☐ 7c. Uses 3 or 4 elements
Notes: ***C3.3;C4.1-3***			
Physical Exam ☐ *Prepares patient before physical exam actions* ***and*** *describes exam findings during the exam* *("I am going to ___ " then "your lungs sound healthy")*	☐ 8a. 0-1 exam elements (eg., lungs)	☐ 8b. 2 exam elements (eg, heart, lung)	☐ 8c. > 2 exam elements (eg, heart, lung, ears)
Notes: ***C 2.1-2,4; PC 2.2***			
Sharing Information ☐ *Avoids or explains medical jargon* ☐ Summaries cover biomedical concerns ☐ *Summaries cover psychosocial concerns.* ☐ *Invites Q/A*	☐ 9a. Uses 0-1 elements	☐ 9b. Uses 2 elements	☐ 9c. Uses 3 or more elements
Notes: ***C 2.1; PC 4.3***			
Behavior Change/Self Management ☐ Asks if patient wants help with health behavior change. ☐ Explores pros and cons of behaviors (respects ambivalence) ☐ *Reflects comments about: desire, ability, reason, need.* ☐ *Asks permission to give advice* **If patient wants help, asks patient:** ☐ To brainstorm activities and choose one to reach goal ☐ To name activity frequency and time of day ☐ *Scales confidence in change (1- 10)* ☐ Assesses patient barriers ☐ Adjusts plan to address barriers ☐ Uses action plan worksheet (in AVS or separate) ☐ Affirms prior / current behavior change effort	☐ 10c. Uses 0-1 elements or lectures patient	☐ 10b. Uses 2-3 elements	☐ 10c. Uses 4 or more elements
Notes: ***C 2.4; PC 1.2; 2.3-5***			
Co-creating a plan ☐ *Describes options* ☐ *Discusses pros and cons* ☐ *Discusses uncertainties with the decision* ☐ *Assesses patient understanding* ☐ *Asks for patient preferences* ☐ *Identifies and resolves decisional differences* ☐ *Plan respects patients goals and values*	☐ 11a. Use 0-2 element	☐ 11b. Uses 3-4 elements	☐ 11c. Uses ≥ 5 elements
Notes: ***C 1.3;C 2.3-4; PC3.3; PROF 3.3-4***			
Closure ☐ *Asks for questions about today's topics.* ☐ *Co-creates and prints a readable After Visit Summary* ☐ *Uses Teachback. = Asking the patient to explain his/her understanding of the plan* ☐ *Combines Teachback and AVS creation while sharing the screen or notepad. (Counts for 3 elements)*	☐ 12a. Uses 0-1 element	☐ 12b. Uses 2 elements	☐ 12c. Uses 3 elements
Notes: ***C 4.1-4; PC 2.2***			

Attachment 2: Personal Notes from Dr. Mauksch's Presentation "Strategies and Tools to Teach Patient Centered Interactions: Blending Efficiency and Quality"

We have to make sure that MD's internalize skills and the only way to do that is through direct observation.

Key learning skills are to practice, reflect, and give feedback.

The purpose of the PCOF is to help structure and operationalize conversations regarding care. The goal is to help MD's become as effective as possible in the assessment process. We must maximize time efficiency and quality.

If you deconstruct what is said during a session, you help others while simultaneously gaining your own self-understanding.

Primary care is team sport; we all need to have the vocabulary and skill to provide care. The same language helps to promote use of the skills.

Use of the PCOF:

To right of the line is competence. Not all encounters require all skill sets to be used.

Don't give the benefit of the doubt, if you don't see it don't check it.

Follow general principles of feedback.

We cannot allow the patient to lead the session.

Group Exercise:

- Show group "Common" MD video and have them rate performance on the Establishing Rapport, Agenda Setting and Use of the EMR sections of the PCOF.
- Have group compare notes on grading.
- Ask group what the MD could do to do a better job?
- Encourage group to practice giving feedback in first person (as though they were talking to the MD in the video).

Giving effective feedback is not easy. Address examples of anxiety, laughing/joking etc…, and normalize it.

Residents are high strength learners. Coach them, be specific, be kind, help them grow. If you give them direct feedback they will likely use it.

It's important for provider acknowledges info passed on from medical technician in skill set 3 (Collaborative Upfront Agenda Setting) or the patient's trust will likely be compromised.

The more you train the technicians, the more responsibility to can turn over to them. Patient empanelment capacity can be doubled when done correctly.

Rapport Building

A lit review indicated rapport and relationship have ongoing influence throughout a session. It takes 20 seconds to build a relationship (e.g. eye contact, warm greeting, "How are the kids?").

Some MD's don't understand that there is a difference between rapport building and agenda setting. For example, when you meet someone on the street and ask "How are you doing?" That's OK because they don't know you are a doctor. When you ask the same question as a doctor, it can be confusing because the patient doesn't know if you are trying to build rapport or find out info on their medical status. This can cause trouble because you are not orienting them to create a problem list such as in collaborative upfront agenda setting.

Agenda Setting- Identifies patient's priorities and organizes the visit.

"In two studies observing 1000 interactions," (unknown source) patients and providers where much less likely to raise issues in the closing moments of the session when agenda setting was done correctly. In addition, patients and providers are less apt to ask "Anything else?" at the close of an appointment.

If patients have four or more problems, they are significantly more likely to have an underlying mental disorder such as anxiety or depression. It's a linear relationship. If the patient has eight problems, there is an 80% likelihood of an underlying mental health concern (unknown source).

Agenda setting does not increase the length of contact. Appointments were 90 seconds shorter in the larger study.

In a randomized controlled study between "something else?" vs. "anything else?" Patients asked "something else?" felt they had fewer unmet concerns (unknown source).

Efficiency

Interrupting patients and ourselves are critical skills for efficiency.

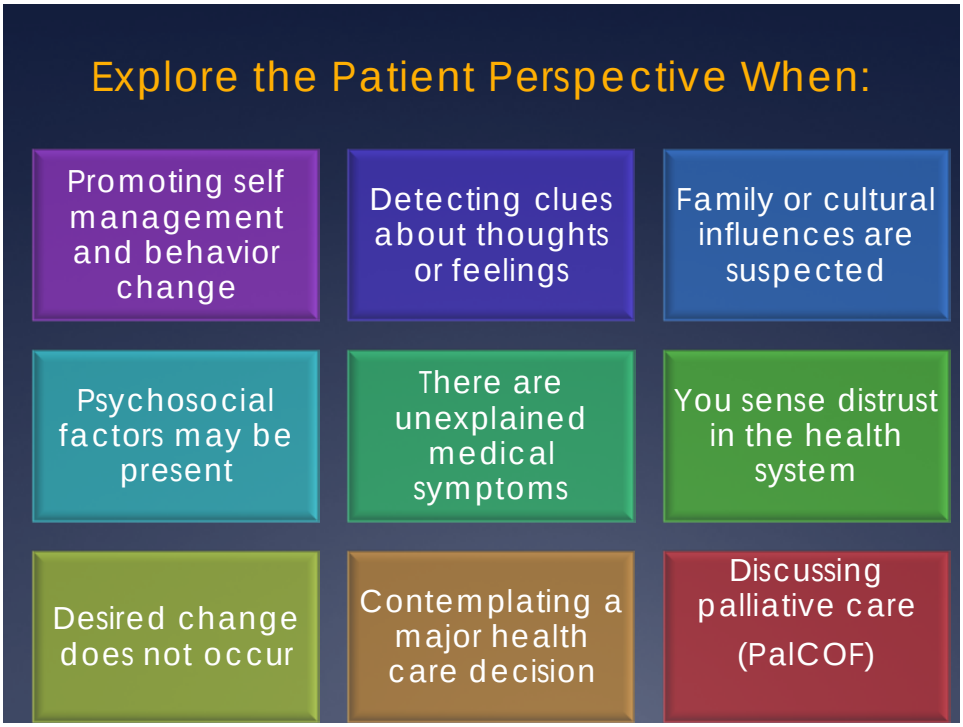
Sometimes providers need to interrupt themselves, "I'm sorry Mr. X, I'm getting ahead of myself. Before we go on to your blood pressure I just want to step back and ask if there was something else important you wanted to discuss?"

In a Beckman and Frankle study, MD's interrupted and did a premature diagnostic dive. MD's are exquisitely prepared to ask diagnostic questions, however, sometimes they are preoccupied with that.

Suggested stopping point between education sessions for residents

Exploring the patient's perspective- There are time when you want to explore the patient's perspective and world view (Articles from Archive of Internal Medicine and The Spirit Catches You When You Fall Down).

Curiosity and empathy are key, however, there is a time and place for open ended questions "Cleveland Clinic Empathy Video-displays what we don't know unless we ask".



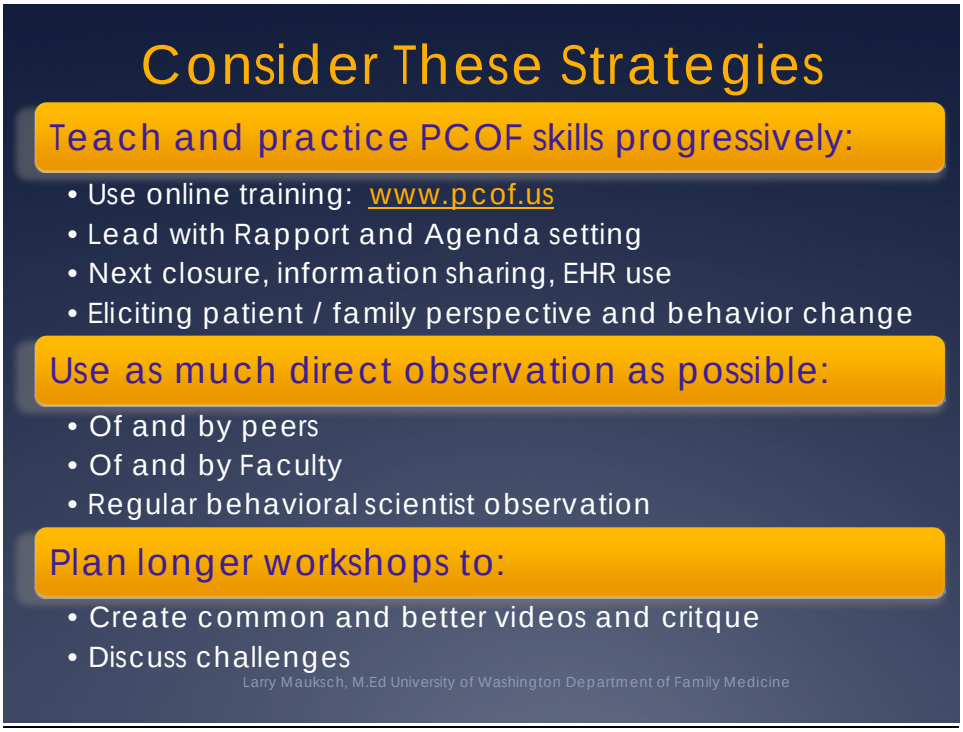
Co-creating a plan- It's very important to protect time at the end of the session in order to close well. Non-compliance is not a great phrase. There is always a reason that a patient does not follow their treatment plan however, we don't take the time to explore the patients beliefs, understanding, and confidence in the plan. Family opinion on problem solving is better predictor of behavior change than MD recommendations. Dr. Google is probably also a better predictor.

Dr. Mauksch strongly recommends learners create "common" and "better" videos. This exercise is empirically supported and can bring intangible teaching opportunities to fruition. Note: Don't make common videos ridiculous.

Shared Decision Making- It's an ethical obligation to teach/utilize shared and informed decision making.

Closure- In order to manage time and quality of care, combine co-creation of After Visit Summary and teachback (see pg. 2 of PCOF for details).

When learning or training on the PCOF…



The "spirit" of motivational interviewing has its merit however, Problem Solving may be more in line with PCM's training and occupational demands.

Team training is critical. Techs, nurses, and MD's should all train and observe one another. Imagine if basketball teams trained in groups by position and only came together on game day.

An independent didactic is not sufficient. The ideal use of the PCOF includes systemic training with all players.

Be aware of barriers such as your own anxiety regarding use of video and move forward.

Attachment 3: Video Consent Form

DEPARTMENT OF THE AIR FORCE
60TH MEDICAL OPERATIONS SQUADRON (AMC)

Dear Sir/Ma'am,

Our mission at the David Grant Medical Center Family Medicine Residency Clinic is to provide outstanding medical care to our patients and the highest quality education to our physicians in training. We have found that one way to help improve quality of our service is to supervise the care we provide to our patients through photographic, video and audio recording. This allows our teaching staff to observe medical providers during patient visits. Accordingly, we are seeking your assistance to help train our resident physicians and medical students. Please be assured that we place the highest value on your privacy and intend to use your information for the sole purpose of teaching within the Family Medicine Residency Clinic. The attached form outlines how your medical information will be protected should you voluntarily choose to participate. Your physician is available to answer any further questions.

Thank you for your assistance in helping to train the Department of Defense's finest family medicine doctors.

Sincerely,

Family Medicine Residency Flight Commander

Attachment:
Patient Release to be Photographed and/or Videorecorded

PATIENT RELEASE OR PARENT/GUARDIAN RELEASE FOR MINOR CHILD TO BE PHOTOGRAPHED/RECORDED AND/OR VIDEORECORDED

PRIVACY STATEMENT

AUTHORITY: AFI 41-103
PRINCIPAL PURPOSES: To photograph and/or videotape for official purposes.
ROUTINE USES: Information may be used or published for official purposes including but not limited to medical education.
DISCLOSURE IS VOLUNTARY: Failure to provide the information would result in the patient not being photographed and/or videotaped.

(a) I, _____ on my behalf or on behalf of my own child, or as
Print your name
guardian of a minor child named _____ hereby authorize the
Print name of child or "not applicable"
Department of Defense and the United States Air Force, to include the 60th Medical Group, and all individuals acting pursuant to its authority, to photograph or video record all or portions of my appointment today, or the appointment of my said child or ward. I hereby expressly consent to all lawful uses of these images. The term "lawful uses" shall include, but is not limited to, the right to reproduce, distribute, transmit, publish, exhibit, or otherwise use such video or photographs or any portion thereof. This permission is granted with the complete understanding that such photographs and/or video may be used for any official purpose, including but not limited to, medical education, which the United States Air Force, or those acting pursuant to its authority, deem appropriate and necessary.

(b) This authorization will expire on_____ (date). Initial:_____

(c) I have the right to revoke this authorization at any time. Initial:_____

(d) I have the right to request that the photographing or video recording be stopped at any time. Initial: _____

(e) I understand that the quality of my eligibility for care and/or benefits is not conditioned upon my signing this authorization or revoking authorization in the future. Initial:_____

(f) Signed this the_____day of_____, 20_____

Printed Name of Releaser:_____ **Relationship to Patient:**_____ **Date:**_____

Printed Name/Rank of Witness:_____ **Staff Position:**_____ **Date:**_____

PATIENT'S NAME *(Last, First, Middle Initial):*	DATE OF BIRTH:	FMP & SPONSOR'S SSN/IDENTIFICATION NUMBER:		GENDER:
SPONSOR'S NAME:	RELATIONSHIP TO SPONSOR:	DEPT/SERVICE:	UNIT:	RANK/GRADE:
			RECORDS MAINTAINED AT: *David Grant Medical Center*	

Approved by 60 MDG ECOMS 12 Sept 17

Attachment 4: Patient Centered Observation Form: Category Explanation, Sample Phrases, Preparing for Observation (UW School of Medicine, 2017)

- **Establishing Rapport:** Make a connection with everyone in the room using the interpersonal skills noted on the PCOF. Relationship development establishes trust and reduces some anxiety that children and parents often feel coming to the doctor's office. Using the first minute for relationship development makes the rest of the visit more effective and efficient.
    - Helpful phrases:
        - "Hi, nice to see you"
        - "Tell me something fun you have done recently"
- **Maintain the relationship throughout the visit.** This can be done by making sure patients feel heard, using humor in appropriate ways, and expressing empathy.
    - Helpful phrases
        - "….so the sore throat has lasted 5 days (reflection)"
        - "That sounds painful (empathy)
- Plan the use of time before using the time (**Collaborative Upfront Agenda Setting**). Medical assistants or nurses who see patients first should elicit family member reasons (asking "is there something else?") for the visit and when necessary ask patients to name which concerns are most important. Make sure that patients know that their concerns are passed on to the physician. Physicians should acknowledge what they have learned from the nurse/MA and confirm that the list of concerns is correct. This is called upfront agenda setting and helps you organize time and decrease the chance that new problems will surface at the end the visit.
    - Helpful phrases
        - "Before we talk about anything in detail, lets make a list of your concerns so we can figure out how to make the best use of time."
        - "I understand that you are here to talk about headaches. Before we talk about them is there something else important to talk about today? Do you need any refills? Any paperwork filled out?"
- Think out loud (transparent thinking) to **Maintain Efficiency** and maximize the patient's experience.

Health care providers make a lot of decisions very fast and sometimes forget to bring their patients along. This confuses patients, limiting the effectiveness and efficiency of the visit. When clinicians share their thinking about visit organization, priorities, and problem solving, patients are more likely to absorb information and less likely to be distracted or bring up new problems in the closing moments.

- Helpful phrases:
    - Visit organization: "Lets talk about each of these concerns first and then I will do an exam and then we can come up with a plan that makes the most sense"
    - Problem priorities: "We have a lot to cover today and I am concerned that we do a good job on the most important issues. In addition to talking about your headaches, I would like to spend some time discussing you diabetes"

        - Problem solving: "I am not sure what is causing your knee pain. We need to do a few tests and that will help me determine what the best next step is. Let me think out loud about the different options for next steps"

- **Gathering Information**. Once an agenda is created, the next step is to collect information about the separate issues based on priority. The temptation is to ask "closed ended questions". These are questions that request a "yes or 'no" or a single number like age. Patients need to be heard and so it is best to begin the discussion of each topic with an open-ended question. These questions begin with "how" or "what" or "tell me about. . . ".
    - Helpful phrases
        - "What are your headaches like?"
        - "How has it been for you to deal with having diabetes?"
        - "Tell me about your chest cold"

- **Watch for Cues.** Patients will often make comments or exhibit non-verbal behaviors (e.g. facial expressions) that reveal underlying feelings or beliefs about their health and well-being. It is important to acknowledge and explore cues as they may be related to the main reason for the visit or an important health concern.
    - Helpful phrases
        - "Sounds like you are concerned this might be serious. Tell me more."
        - "Is there anything else about this concern that you want me to know?"

- **Explore Patient or Family Perspectives.** on health and illness, when indicated. Everyone has his or her own beliefs about what causes illness and healing. Explore family beliefs when symptoms don't change, when a new chronic diagnosis is made, when psychosocial issues are in play, when you feel confused about why the patient is seeking help, and when patients express distrust in the health care system
    - Helpful phrases
        - "Does your family have any experience with diabetes?"
        - "What would your physicians in Russia do for chest colds?"
        - "What does your husband think is going on with your son?"
        - "How is it for you and your wife to coordinate care for your child?"

- **Using the Electronic Medical Record)**. The EMR can enhance or cripple the interaction. Tell the patient what you are doing, when possible, share the screen and maintain regular eye contact.
    - Helpful phrases
        - "Just a moment while I log into the medical record"
        - "I am going to type what you are telling me"
        - "I am going back in the record to the last time we saw you to review those lab results"

- **Physical Findings.** Medical assistants, nurses, and physicians should tell patients and parents what they plan to do and then share results of vitals or exam components
    - Helpful phrases
        - "I would like to take your temperature"
        - "The temperature is slightly high, at 100 degrees"
        - "I am going to listen to your heart (and maybe you want to listen to your mom's heart, too)"
        - "Your heart sounds healthy"

- **Sharing Information.** Share your impressions using language that the patient can understand. If you want to use a medical term, then define it immediately. Address all the issues you agreed to address during agenda setting- psychosocial and biomedical issues.
    - Helpful phrases
        - "Asthma means that your wind pipes sometimes get smaller and make it harder to breath. We have some medicine that can help make it easier to breathe"

- **Co-creating Plans.** It is always important to assess patient investment in the plan. Does the patient/parent believe it is feasible? Has the patient had an opportunity to express treatment preferences? In treatment plans with multiple options, it is ethical to describe evidence, pros and cons of viable options and of doing nothing.
    - Helpful phrases
        - "We have a couple options for treating…".
        - "Did you have a preference about how to proceed?"

- **Closure.** This phase of the visit is often given short shrift. Does the patient have questions about issues discussed today? Can the patient recite his/her understanding of the plan? Often, patients do not hear everything or may not understand the plan. For complicated plans, print an after visit summary (AVS) and check for parent/child understanding.
    - Helpful phrases
        - "Let me summarize the plan"
        - "To make sure that I did not miss anything, can you tell me your understanding of the plan"
        - Here is a copy of the plan. Does this make sense?

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(Li, 2015)

CHAPTER VII: TIPS FOR HOME VISITS

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Home visits are an integral component to family medicine residencies, allowing an opportunity for residents to gain a better understanding of not only the patient in her/his home environment, but to better understand psychosocial and spiritual aspects and how they may be influencing patients. Additionally, home visits have demonstrated the following benefits for doctors (Silk, Gleich, & Connell, 2012):

- Feels good (1 study = 70% of the time)
- Comprehensive care
- Learn a lot that can't be learned in the office (e.g. patient's environment, support systems)
- Decrease excessive use of medical services
- Relationship building
- Assess adherence issues
- Cost containment/Less overhead
- Good public relations for you
- Increase patient diversity

And the benefits for patients (Silk et al., 2012):

- Patients living longer and live at home longer
    - 13 % of the U.S. is over 65 years of age, and by 2025 it will grow to 20%
    - by 2030 there will be over 70 million US citizens older than 65 years of age (Unwin & Tatum III, 2011)
- Discharged from hospitals sooner
- Ease for patient (immobile, infirm)
    - 36% of 75-85 year olds can't walk 1 block (Unwin & Tatum III, 2011)
- Patients desire home care
- Technologies and therapies are available for home use

Home visits continue to routinely be practiced in family medicine residency programs despite being removed as a requirement by the Accreditation Council for Graduate Medical Education (ACGME) in 2014. This infers that program directors still value the skills obtained through home visit training (Sairenji, Wilson, D'Amico, & Peterson, 2017). Additionally, recent increases in home visits to Medicare beneficiaries as well as increased understanding of the importance of social determinants of healthcare further validate the importance of this traditional skill set (Bansal, 2013; Sairenji, Jetty, & Peterson, 2016). Home visits can be conducted for various reasons including, but not limited to: illness visits, palliative care visits, home

assessment, and post hospitalization. Furthermore, home visits can occur at various locations such as the patient's home, a nursing home, assisted living facility, and a family member's home.

Home Visits and Milestones

As all family medicine residencies have milestones dictated by the ACGME and American Board of Family Medicine, it is important to understand how home visits can help residents achieve these milestones and for the behavioralist to help facilitate learning in the home environment. Home visits can help in meeting the following milestones (The Family Medicine Milestone Project, 2013):

> Patient Care-1 (PC-1): Cares for acutely ill or injured patients in urgent and emergent situations and in *all settings*
>
> Patient Care-2 (PC-2): Cares for patients with chronic conditions
>
> Patient Care-3 (PC-3): Partners with patient, family, and community to improve health through disease prevention and health promotion
>
> Systems-Based Practice-2 (SBP-2): Emphasizes patient safety
>
> Systems-Based Practice-4 (SBP-4): Coordinates team-base care
>
> Professionalism-3 (PROF-3): Demonstrates humanism and cultural proficiency
>
> Communication-1 (C-1): Develops meaningful, therapeutic relationships with patients and families
>
> Communication-2 (C-2): Communicates effectively with patients, families, and the public

Setting Residents Up for Success

As behavioral scientists within family medicine residencies, it is our responsibility to help shape how home visits occur and to help set residents up for success. At Travis Air Force Base, we have chosen to focus our home visits on developing a holistic view that includes psychosocial and spiritual components rather than an emphasis on medical care. Resident goals are to:

- Develop skills to assess the psychological, social, and spiritual aspects of health care
- Develop data gathering, communication, and interviewing skills
- Become familiar with a framework of assessment, such as INHOMESS (discussed below; Unwin & Tatum III, 2011)
- Understand there is other information that is important to health care that may not be obtained in the office setting

- Enhance understanding of cultural competence and social determinants of health

Bansal (2013) utilizes the image below to teach residents to view patients as people enmeshed within a web of meaning. Biology and body represent only one strand in the web. Other strands may include religion, gender, socio-economic status, policy, access to health care, etc. All these together formulate the patient's health system.

Before the Home Visit

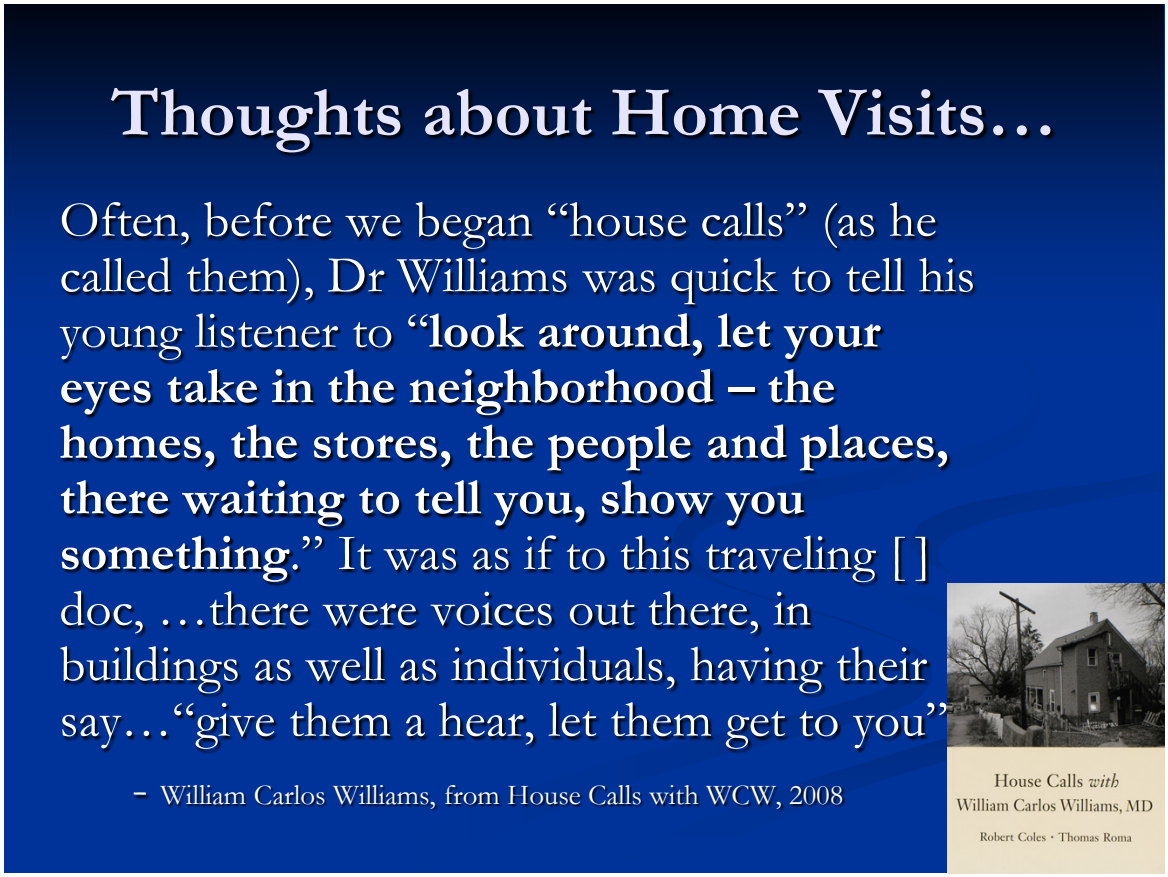
It is helpful to hold a brief meeting (approximately 15 minutes in length) before the home visit to discuss expectations for the pending appointment. The more residents know about (a) the patients and (b) what will be expected from them during the home visit, the better the experience will be for all involved. This is most helpful 1-2 day(s) prior to the home visit.

- Be clear on expectations for what type of information you will want the resident to review, such as a screener like INHOMESSS
- If facilitated by only a non-physician behavioralist, remind the resident to stay focused on the psychosocial aspects of the home visit
- Let the resident know that if the patient is identifying medical concerns that are *not* emergent it may be best to help coordinate a future appointment through the nurse once the resident returns to clinic
    - Let the patient know the plan and that the resident wants to provide the correct feedback with the medical record present
    - If an *emergent* medical need is identified, then this becomes the focus for the visit

    - Or, if it is evident there is a *grave safety concern*, this this becomes the focus and includes coordinating care to address the safety concern
- This is a good time to ask the resident if there is pertinent medical information you should have in mind prior to meeting the patient
    - This allows you to have some frame of reference when entering the house, as it is highly likely you will have never met the patient before the home visit
    - Ask if there will be any difficult topics, such as home hospice care
    - Consider if there are any educational materials that may be helpful
- Confirm visit time, address, and transportation plans
- Clarify how the visit will be documented, such as scanning the screener tool into the electronic medical record (EMR) and having it co-signed by the behavioralist
- Lastly, discuss with the resident any concerns that they may have such as personal safety, negative patient/family attitudes, or environmental hazards (Stausmire, 2009)
- See Attachment 1: *Home Visit Preplan,* as a model for your discussion (Myerholtz, 2016a):
    1) What is the reason that this patient needs a home visit?
    2) What information do you want to learn about this patient?
    3) What screening or assessment tools would you like to use during this home visit?

During the Visit

Silk et al. (2012) offer the following passage from William Carlos Williams book, *House Calls* (2008) to capture the spirit of the home visit:



Residents are encouraged to start the home visit by establishing rapport, introducing all parties involved, explaining the purpose and goals of the home visit (agenda setting), and answering related questions. The start of a home visit is often a good time for residents to ask for a tour of the house to help identify any safety concerns, especially in regard to bathing for older patients. The INHOMESS checklist is a recognized tool to help residents understand key areas of observation and discussion. See Attachment 2: *Sample House Call Checklist (Based on INHOMESS Mnemonic)* for additional details. INHOMESS includes:

- **I**mpairment/Immobility
  - Activities of daily living (ADLs), instrumental ADLs, sensory impairments, balance and gait problems, and fall risk
- **N**utrition
  - Meals, variety/quality of food, nutritional status, substance use
- **H**ome Environment
  - Neighborhood, interior of the home (crowding, hominess, privacy, pets, books, TV, memorabilia, etc.), exterior of the home
- **O**ther People
  - Social supports, patient attitudes, financial resources, surrogacy
- **M**edications

    - Prescription drugs (expiration dates/how stored/managed), non-prescription drugs, and diet supplements
- **E**xamination
    - General physical condition, general mental status exam
- **S**afety
    - Kitchen, carpets, bathroom, lighting, stairs, fire extinguishers, etc.
- **S**piritual Health
    - Presence/Satisfaction with spiritual health?
- **S**ervices
    - Any home health service needs?

If safety concerns are identified, an additional tool to consider is the Elements of Home Safety Assessment (see Figure 1) and if spiritual concerns are identified, an additional tool to consider is the Spiritual Assessment – FICA (Pulchaski & Romer, 2000) depicted below:

- **F**aith: Do you consider yourself to be a spiritual or religious person? What is your faith or belief? What gives your life meaning?
- **I**mportance: What importance does faith/believes have in your life? Have your beliefs influenced the way you take care of yourself or your illness?
- **C**ommunity: Are you part of a spiritual or religious community? How does this provide you support?
- **A**ddress: How would you like to address these issues in your care?

Figure 1. Elements of Home Safety Assessment (Unwin & Tatum III, 2011)

Bathroom
Are handholds sturdy and in appropriate places?
Can the toilet seat be raised?
Does the bathtub/shower have a nonslip surface?
Is the bathroom floor slick?

Electrical cords/appliances
Are cords frayed or damaged?
Do cords cross walking paths?

Emergency actions/evacuation route
Are emergency numbers available?
Are there means of egress from home?

Firearms
Are firearms present?
If yes, are they secured? (e.g., gun lock, locked case/cabinet, weapon and ammunition separated)

Fire extinguishers
Are fire extinguishers present?
If yes, are they accessible and in working order?
Is the patient or caregiver able to use them?

Heating and air-conditioning
Are controls accessible and easy to read?
Is the home an appropriate temperature year-round?

Hot water heater
Temperature set below 120°F (49°C)?

Kitchen safety (especially gas stoves)
Is it easy to tell if burner or oven gas is on?
Does the patient wear loose garments while cooking?

Lighting and night-lights
Is lighting present and sufficient?

Loose carpets and throw rugs
Are carpets and throw rugs present?
If yes, do they need to be secured or removed?

Pets
Are pets present?
If yes, are they easy to care for?

Smoke and carbon monoxide monitors
Are they present?
If yes, are they functioning and monitored?

Stairs
Does the home have stairs?
If yes, are they carpeted and is the carpeting secure?
Are stairs well lit?
Are there railings?

Tables, chairs, furniture
Is furniture sturdy, balanced, and in good repair?

Utilities (gas or electric)
Are the systems monitored and maintained?

Water source
Is water from a public source or a well?
Is the source functioning and safe?

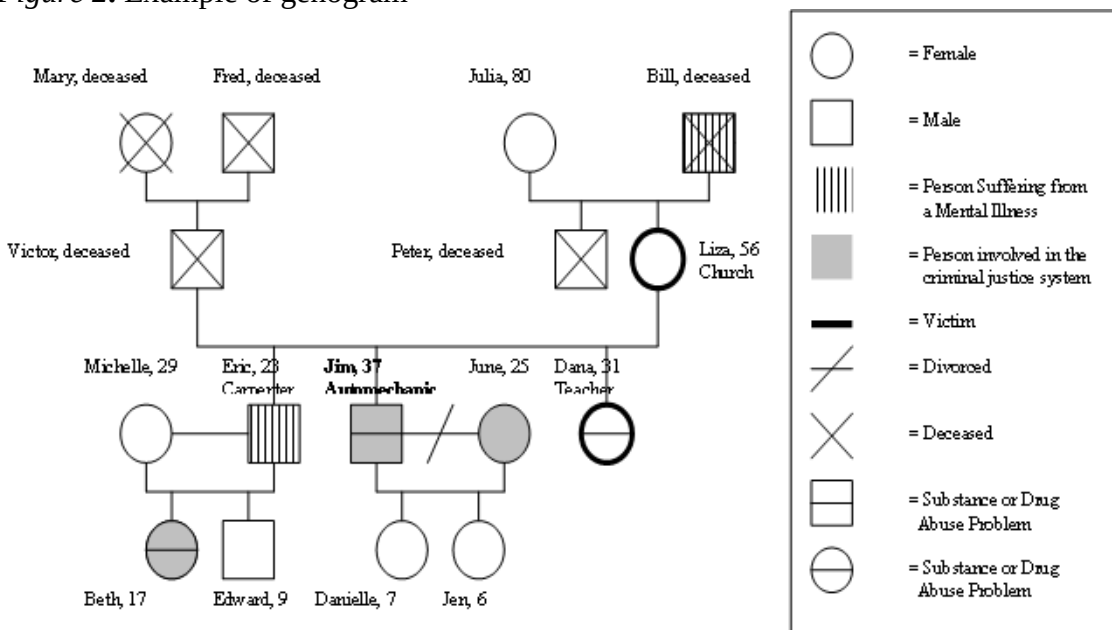
Adapted from Unwin BK, Jerant AF. The home visit. Am Fam Physician. *1999;60(5):1486.*

Lastly, home care is a team sport. The resident is encouraged to have a list of local resources and phone numbers to provide to the patients, such as Meals on Wheels, social services, and these others:

- Family Members
- Office Nurse
- Case Manager
- Social Worker/ Psychologist/Behavioral Health
- Occupational Therapy/Physical Therapy
- Pharmacy
- Geriatrician or Family Physician interested in Geriatrics
- Chaplain
- Hospice Team Member
- Elder Services

Another potential tool includes the use of a genogram to help residents understand the psychosocial components of their patients. This can be partially completed by the resident before the visit with known patient information and help guide future questions for the home visit (see Figure 2). In addition to Figure 2, known medical information and primary roles within the support system can be added (i.e. hypertension, diabetes, cancer, primary caregiver, cooks all the meals, etc.; see Figures 3 and 4).

*Figure 2***.** Example of genogram



http://aplg-planetariums.org/wp-content/uploads/2016/06/family-genogram-template-word-ddvc9nqc.png

Figure 3. Example of genogram with relationship information (Schellenberger et al., 2007)

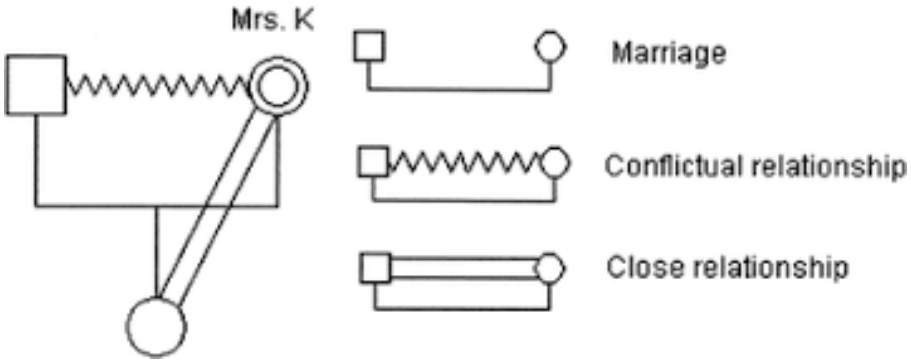
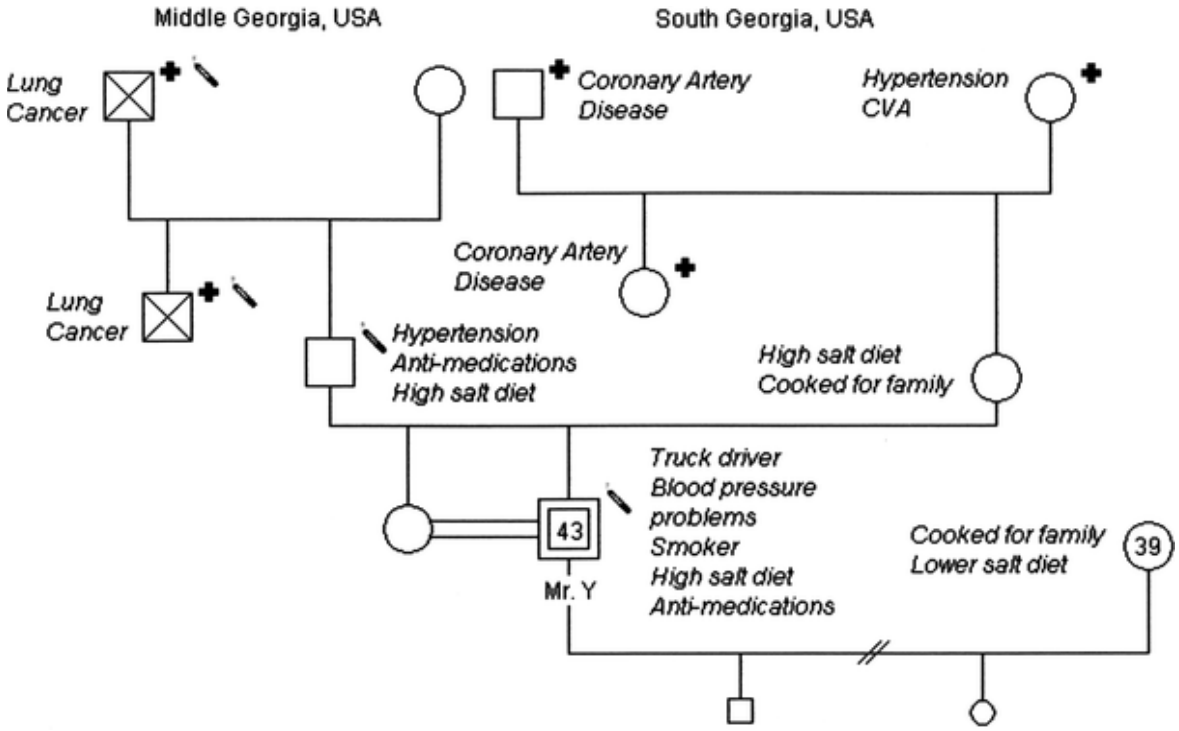


Figure 4. Example of genogram with medical information and roles (Schellenberger et al., 2007)



After the Visit

Home visits can be an emotionally powerful experience, particularly when involving end of life decisions and/or complicated family dynamics. Behavioral scientists are encouraged to take a moment after the visit to "check-in" with the resident. This can be as simple as asking the resident how they are doing during the walk back to the car. From a didactic perspective, behavioral scientists may wish to schedule an appointment with the resident to discuss their initial learning objective and experience. Myerholtz (2016b) encourages behavioral scientists to discuss the questions below with the resident (see Attachment 3: *Home Visit Follow Up & Learning Reflection,* for additional details):

1. Review the personal learning goals you identified for each patient in your pre-visit plan. Reflect on how well you met those learning goals.
2. How did the home visit experience impact your understanding of the patient? What did you learn that you could not have learned in the office?
3. How will you care differently for these patients in the future?
4. How did the home visit experience impact your view of yourself as a physician?

Suggested Resources:
Unwin, B. & Tatum, P. (2011). House calls. *American Family Physician, 83*, 925-931. http://www.aafp.org/afp/2011/0415/p925.html
American Academy of Home Care Medicine (www.aahcm.org/)

Attachment 1: Home Visit Preplan (Myerholtz, 2016a)

Home Visit Preplan

Your Name: Click here to enter text.

There are many reasons for doing a home visit with your continuity patients. For example, it may be a patient who was recently discharged from the hospital and needs a home visit to fill in the gap between discharge and when they can next be seen in the office. It may be someone you need to do a more extensive evaluation on such as an environmental home safety and fall risk assessment. Or, it may be that you need information about the patient's available resources & caregivers to better assist with the management of their medical conditions. In order to make this experience as valuable as possible for you and your patient, please answer the following questions.

Patient #1

What is the reason that this patient needs a home visit?	
What is your personal learning goal(s) for this home visit?	
What information do you want to learn about this patient?	
What screening or assessment tools would you like to use during this home visit?	

Preparation Checklist:

☐ Confirm visit with patient

☐ Verify address, phone number and transportation plans

☐ Prepare your "Black Bag":

- Anticipated screening tools
- Hand sanitizer
- Education material

Suggested Resource:

Unwin B & Tatum P (2011). House calls. *American Family Physician*, *83*, 925-931. http://www.aafp.org/afp/2011/0415/p925.html

Attachment 2: Sample House Call Checklist (Unwin & Tatum III, 2011)

Sample House Call Checklist (Based on the INHOMESSS Mnemonic)

Impairments/immobility

Evidence of cognitive impairment?
❑ Yes ❑ No

Demonstrated advanced activities of daily living (check all that apply):
- ❑ Employment/volunteering
- ❑ Reading
- ❑ Music
- ❑ Hobbies
- ❑ Socialization
- ❑ Other

Demonstrated activities of daily living (check problem areas):
- ❑ Ambulating
- ❑ Toileting
- ❑ Transferring
- ❑ Bathing
- ❑ Feeding
- ❑ Continence (bowel/bladder/both)
- ❑ Dressing

Demonstrated instrumental activities of daily living (check problem areas):
- ❑ Taking medications
- ❑ Finances
- ❑ Telephone
- ❑ Transportation
- ❑ Meal preparation
- ❑ Shopping
- ❑ Housework
- ❑ Driving

Demonstrated balance and gait (check problem areas):
- ❑ Balance
  - Static (Romberg test, standing reach test)
  - Dynamic (walking, tandem walk)
- ❑ Gait
  - Left: arm swing, stance, leg swing, step
  - Right: arm swing, stance, leg swing, step

Sensory impairments (check problem areas):
- ❑ Hearing
- ❑ Vision
- ❑ Smell
- ❑ Taste
- ❑ Tactile

Falls? ❑ Yes ❑ No

Nutritional status and eating habits

Eating habits: _____

Variety and quality of foods
- Pantry: _____
- Refrigerator: _____
- Freezer: _____

Nutritional status
- Obesity: _____
- Malnutrition: _____
- Other: _____

Fluid intake: _____

Alcohol presence/use: _____

Swallowing difficulty: _____

Oral health: _____

Home environment

Neighborhood: _____

Exterior of home: _____

Interior of home (check all that apply)
- ❑ Crowding
- ❑ Good housekeeping
- ❑ Hominess
- ❑ Privacy
- ❑ Pets
- ❑ Books
- ❑ Television
- ❑ Memorabilia
- ❑ Internet
- ❑ Information and communication technology

Other people

Caregiver? ❑ Yes ❑ No

If yes, who? _____

Tasks:
- Hours of caregiving per day: _____
- Stress? _____
- Coping? _____
- Abuse? _____
- Need for respite? _____
- Physically or emotionally capable? _____

Social supports? ❑ Yes ❑ No

Advanced directives? ❑ Yes ❑ No

Power of attorney? ❑ Yes ❑ No

If so, who? _____

Financial resources: _____

Patient attitude: _____

Medications

Prescription drugs: _____

Nonprescription drugs: _____

Dietary supplements: _____

Medications organized: _____

Medication compliance: _____

Medication discrepancy: _____

Multiple prescribers: _____

Allergies to medications: _____

Written instructions: _____

Examination

Weight: _____ Weight loss? _____

Height: _____ Blood pressure: _____

Glucose: _____ Urinalysis: _____

Other: _____

Mini-Mental State Examination: _____

Depression screening: _____

General physical condition: _____

Focused examination: _____

Safety (check all that apply)
- ❑ Access to emergency services
- ❑ Alternative power source if needed
- ❑ Adaptations to home needed
- ❑ Telephone availability
- ❑ Bathroom
- ❑ Kitchen
- ❑ Carpets
- ❑ Lighting
- ❑ Electrical cords
- ❑ Stairs
- ❑ Tables, chairs, and other furniture
- ❑ Hot water heater
- ❑ Fire and smoke detectors
- ❑ Fire extinguishers
- ❑ Emergency plans
- ❑ Evacuation route
- ❑ Gas or electric range
- ❑ Heating/air-conditioning
- ❑ Water source

Spiritual health (or cultural and ethnic influences): _____

Services (e.g., fire, police, emergency medical services, home health, social services, Meals on Wheels, hospice, transportation, legal, equipment, health benefit advisor):

_____

_____

Attachment 3: Home Visit Follow Up & Learning Reflection (Myerholtz, 2016b)

Home Visit Follow Up & Learning Reflection

Your Name: Click here to enter text.

Date of Home Visits: Click here to enter a date.

1. Review the personal learning goals you identified for each patient in your pre-visit plan. Reflect on how well you met those learning goals:
   Click here to enter text.

2. How did the home visit experience impact your understanding of the patient? What did you learn that you could not have learned in the office?
   Click here to enter text.

3. How will you care differently for these patients in the future?
   Click here to enter text.

4. How did the home visit experience impact your view of yourself as a physician?
   Click here to enter text.

Post Visit Checklist:

- ☐ Complete progress note for each visit in EMR
- ☐ Complete any agreed upon referrals/orders, etc.
- ☐ Send this Home Visit Follow-up to your home visit preceptor

References

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(McQuarrie, n.d.)

CHAPTER VIII: BALINT GROUP

What is a Balint Group?

"A Balint group is a group of physicians who meet regularly and present clinical cases in order to better understand the physician-patient relationship. Whereas physicians are usually trained to seek the "right" answer to medical problems, in a Balint group, the focus is on enhancing the physician's ability to connect with and care for the patient. A Balint group session begins with a physician presenting a case for the group to discuss. The group learns about the patient through the presenting physician's story. During the facilitated discussion, the group members uncover different and new perceptions about the patient and physician's feelings" (The American Balint Society, 2017).

Why Balint?

According to the American Balint Society (2017), "Physicians frequently feel 'stuck' with patients. Interactions with patients may leave the physician feeling frustrated, annoyed or just unsettled in some way. One way to better understand these challenging situations is to participate in an ongoing Balint group."

Balint groups aim to help physicians:

- Recognize they are not alone in having challenging interactions with patients
- Develop increased understanding and empathy for patients
- Explore how feelings and thoughts affect the physician patient relationship
- Become more aware and accepting of their conscious and unconscious responses to the patient
- Expand their capacity and repertoire for handling difficult situations with patients"

(The American Balint Society, 2017).

In spite of these aims, research supporting the efficacy of Balint groups remains modest at best. A review of 94 articles indicated some support that Balint groups may increase self-efficacy, reduce burnout, and increase emotional awareness. However, the current body of literature is diverse, scarce and often methodologically weak and therefore more research is needed (Van Roy, Vanheule, & Inslegers, 2015). Two possible reasons for the state of the literature include challenges associated with measuring related variables, such as empathy (Mahoney, et al., 2013), as well as the prevalence of informal "balint style" groups in the U.S. In a study of 159 Family Medicine Residency programs, more than half (54%) reported having at least one Balint group, however less than half of the group leaders reported going to formal training at the American Balint Society Leader's Intensive Workshop (Diaz, Chessman, Johnson, Brock, & Gavin, 2015).

Tools and Training

According to STFM's Behavioral Science Basics Library, "The American Balint Society (ABS) holds two Balint Leader Intensive Training Workshops a year in different locations around the U.S. These training sessions provide the first step in learning about the Balint group process and developing leadership skills. A leader credentialing process provides two years of supervision by an Approved Balint Leader Supervisor while a one-year Balint Leader Education Fellowship is conducted via Zoom conferences with a small group of beginning leaders and their mentor. More information is available on the ABS website www.americanbalintsociety.org." (Society of Teachers of Family Medince, 2016).

Getting Started

There is a high likelihood that a new Air Force behavioral scientist will be asked to facilitate a Balint group prior to formal training. This may occur for various reasons including staff turnover and budgetary constraints. This section provides a brief framework for support until you are trained and running. Here are some important notes from the American Balint Society (2017):

Essential Characteristics of a Balint Group:

1) A small group (between 6-12)
2) Group leader with formal training
3) A current case that raises thought/feelings in the resident
4) The discussion focuses on the relationship between the resident and patient
5) Groups are not for personal therapy
6) Standard rules for groups apply (confidentiality, honesty and respect)
7) The safety of the group is ultimately the responsibility of the facilitator
8) The group should be ongoing and generally include the same members
9) There is a co-leader

Leader Characteristics:

1) Creates a climate of safety, acceptance and trust: provides support, safety and divergent thoughts
2) Establishes and maintains group norms: facilitates self-reflection rather than problem-solving
3) Promotes movement towards the group's task (grappling with the presenter's case): encourages speculation and alternate perspectives
4) Understands group process: understands dynamics of case and Balint group
5) Personality/style of the leader: group-centered, comfortable with silence, curious and enthusiastic
6) Facilitates insight into the needs of the doctor (Daniel, 2013)
    - What kind of doctor can I be for this patient? (or, how can I most effectively manage transference and countertransference to encourage a more therapeutic encounter with this patient?) (Mahoney, et al., 2013)
    - Is this a tolerable position for me?
7) Increases insight into position of the doctor when working with similar patients (Daniel, 2013)

Format:

1) The leader asks "Who's got a case?

2) A typical or problematic interaction with a specific patient is presented; this should not be pre-planned.
3) The members ask clarifying questions just to fill in blanks where possible. Examples may include
   - What was the patient's reason for the visit?
   - How did you feel when you saw the patient's name on your list?
   - What kinds of thoughts did you have?
   - Are your reactions to this patient similar or different to your reactions to other patients?
   - How have you handled your reactions to the patient so far? (Daniel, 2013)
4) The presenter 'steps back' (literally and symbolically moves back from the circle)
5) The group 'takes' the case and begins tackles relational questions
6) What is it like to be this provider? What does the provider think/feel?
7) What is it like to be this patient? What is the patient thinking/feeling?
8) What is going on in this provider/patient relationship?

What Balint Group is Not (Daniel, 2013):

1) Didactic seminar
2) Psychotherapy for doctors
3) A support group to vent feelings
4) Forum for differential diagnosis
5) Opportunity to get advice from others
6) Opportunity to give advice to others

The following attachments have been added for your guidance:

Attachment 1: The Balint Group Process- A PowerPoint presentation outlines the general steps of a Balint group (Addison, Troll, Romm, Ghetti, & Sternlieb, 2013)

Attachment 2: Who Has a Case? Starting a Residency Balint Group- A thorough two-page handout covering the core aspect of Balint groups (Athyal, 2015)

Attachment 3: What to Expect as a Member of a Balint Group- A handout that provides a brief overview of Balint to new participants (The American Balint Society, 2017)

Avoiding Pitfalls

I learned an important lesson about avoiding pitfalls early in my behavioral science career. Shortly after attending my first conference, I eagerly raced home and implemented all of the process tips that I had learned. I spent little time explaining the rationale for the changes and dove in with my residents. As can be expected, my changes were met with frustration and the residents responded to my well-intended changes with something just short of a mutiny. Awareness of my story, along with these pitfalls provided by the American Balint Society (2017), may help you mitigate future challenges.

System Issues:

1) Attempting to start a Balint group without buy-in form the PD or other faculty
2) Supervision should be used when available. Also, facilitators should process sessions after their conclusion
3) Participant trust is critical for disclosure
4) Having continuity patients is important for the process

5) Cancelling sessions can interrupt continuity that may parallel the patient/provider relationship
6) Limited resources/staff (Penwell-Waines, 2017)
7) Program history "We don't do that there" (Penwell-Waines, 2017)

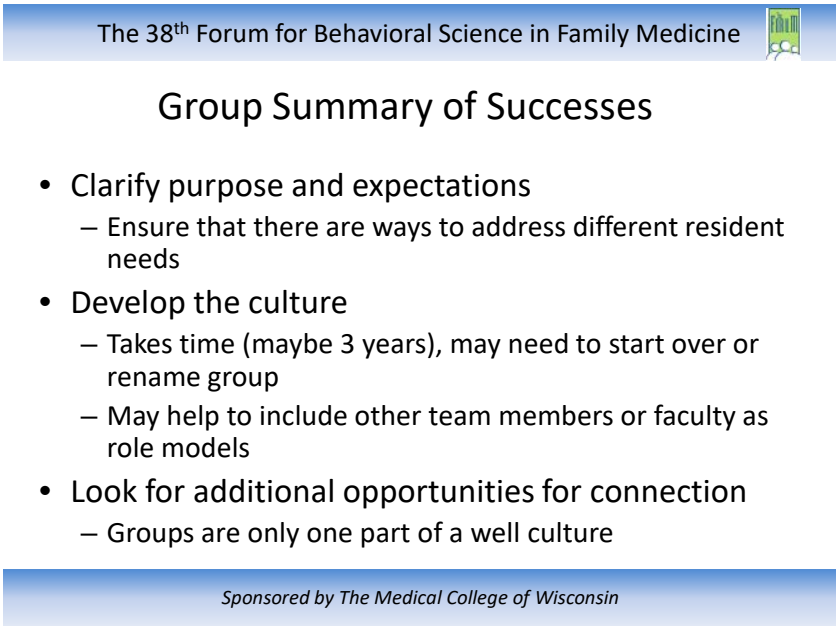
Group Issues:

1) Facilitators who talk too much and/or overdirect. Observe the process and try to limit involvement to when conversation gets bogged down by topic or dogmatic participant.
2) Ensure rules are established
3) Case-presenters who talk too much
4) Trying to "fix" the case rather than understanding the case or the experience of those involved
5) Overanalyzing group can lead to participants feeling self-conscious

Presenter Issues (Mahoney, et al., 2013):

1) "Being stuck" may be a manifestation of the physician's defensiveness or a lack of awareness of the transference and countertransference that is occurring in the interaction.
2) Another pitfall for the presenting resident physician is to find themselves engaging in a particularly heroic role when relating to "troubling" patients (over-identification). The disease has become more important than the illness; that the patient is, in fact, an onlooker at best, and at worst an annoying hindrance to the resident physician's well-conceived, scientifically driven treatment plan.
3) As a rule, Balint group cases often reflect the presenting resident's trouble staying in the role of physician and fulfilling those role expectations
4) The physician may be distracted by influences from the family, nurses, colleagues, or the persona of the patient causing objective assessments and management of the illness to be lost in an accepted social prejudice (a form of under-identification).

Penwell-Waines (2017) offers the following advice to further mitigate pitfalls:



“Key recommendations/things to consider for managing barriers and implementing groups successfully may include getting program and group member buy-in, protecting regularly scheduled time for the groups, clarifying the purpose of the groups and the facilitator's role(s), using adequately trained facilitators, creating a safe space for sharing, doing informal check-ins outside of the group time, other opportunities for connection (e.g., social gatherings, buddy system)” (Penwell-Waines, 2017).

I have chosen to focus on Balint groups in this section due to their rich history in family medicine residency training (Diaz, et al., 2015). However, Balint is not the only type of group available. Penwell-Waines (2017) provides the following comparison of Balint, Reflection, and Support groups:

The 38th Forum for Behavioral Science in Family Medicine

Types of Resident Groups

	Balint	Reflection	Support
Purpose	Promote patient-centered medicine and effective patient-physician relationships; cultivate empathy	Promote humanism, compassion, authenticity; develop trustworthy relationships; increase reflective capacity	Provide social support, decrease feelings of isolation; enhance culture of wellness; forum to discuss concerns and personal experiences as a physician
Structure	Small group with defined leader; focus on patient case; question-based	Prompt for reflection; question-based	Flexible
Needs	Leader training; ongoing process; confidentiality; respect	Open, safe space; confidentiality; willingness to engage in inner work	Supportive group members; confidentiality

This slide is not exhaustive, however, it demonstrates some of the options available for residency groups. Discussion of alternative groups is beyond the scope of this manual however it is encouraged for any behavioral scientist who does not feel that Balint groups are meeting the needs of their program.

ACGME

Understanding how Balint groups can support ACGME competencies may be important when getting “buy-in” from key stakeholders and residents. According to Steinlieb (2010), the following competencies are addressed in Balint groups:

1) Improves listening skills with both patients and colleagues

2) Allows you to sit with uncertainty (and complexity) without feeling the need to tease it apart
3) Encourages integrative thinking
4) Reveals group dynamics
5) Encourages empathy
6) Encourages reframing
7) Encourages thinking outside the box
8) Method for expressing frustration, pain and joy
9) Encourages camaraderie with group members
10) Encourages intimacy with group members
11) Improves observation powers
12) Shows value of being and not doing
13) Encourages reflection
14) Encourages self-evaluation
15) Improves satisfaction of all practicing clinicians

See attachment 4 for more detailed information on the relationship between the AGMCE core competencies and Balint (The American Balint Society, 2017).

Resources

Visit the American Balint Societies homepage for additional details:
http://www.americanbalintsociety.org/

And STFM's Behavior Science Basics webpage for balint found here:
http://connect.stfm.org/behavioralsciencebasics/professional-development/balint

Attachment 1: The Balint Group Process (Addison, et al., 2013)

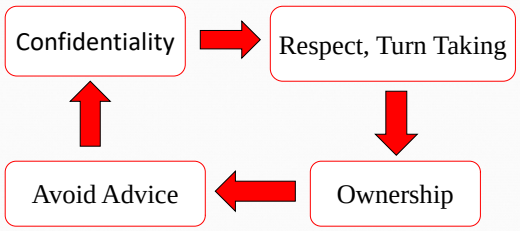
Balint Group Process

An Introduction to Balint Work
The American Balint Society
www.AmericanBalintSociety.org

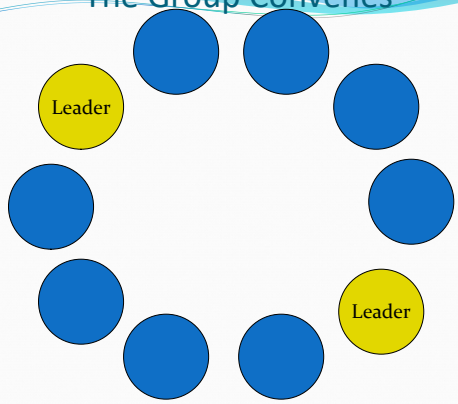
Characteristics of a Balint Group

- Ideally fixed membership
  - Closed Group
- Two co-leaders
- Focus on doctor-patient relationship
- Power of the group
- Preference for an ongoing case
- Less conscious aspects of relationship

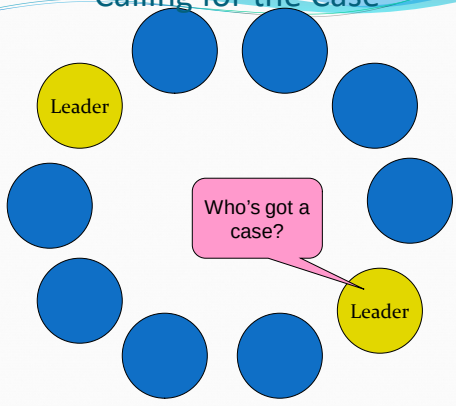
Ground Rules



The Group Convenes

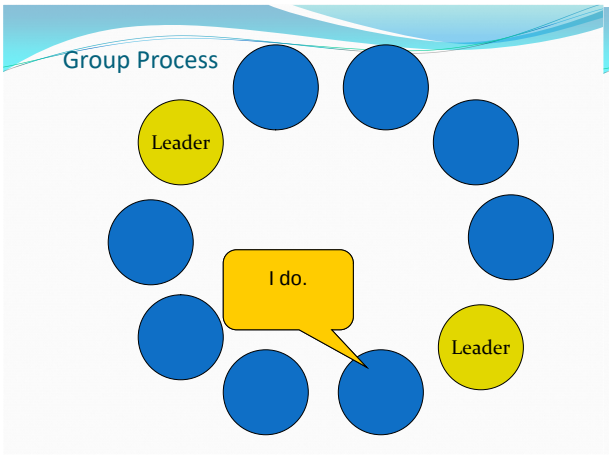


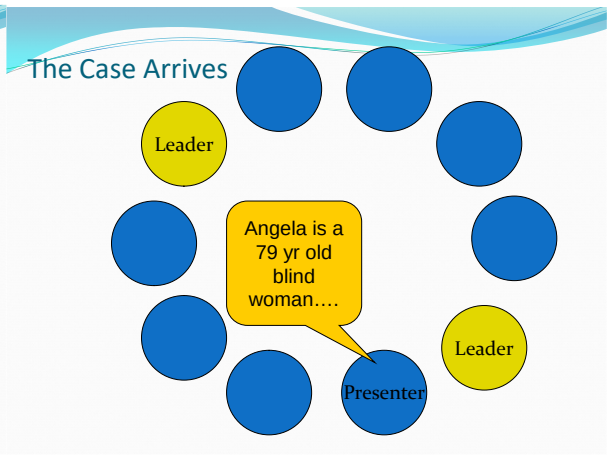
Calling for the Case

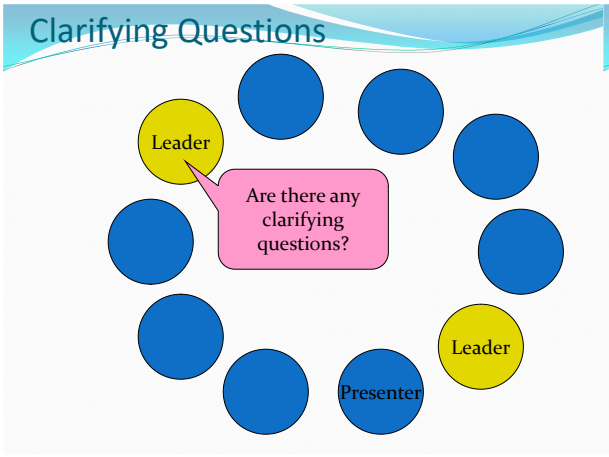


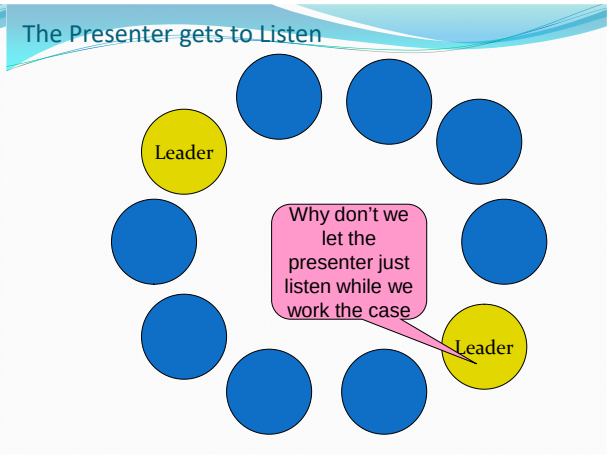
Cases

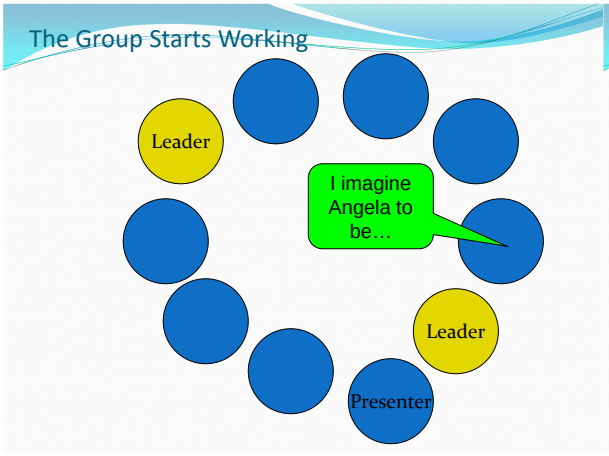
Presentations are spontaneous
Patients we have ongoing relationships with
Patients who we feel conflicted or strongly about
Patients that leave us feeling unfinished, who we lose sleep over
Patients who we "take home" with us
Patients that bubble up in the moment

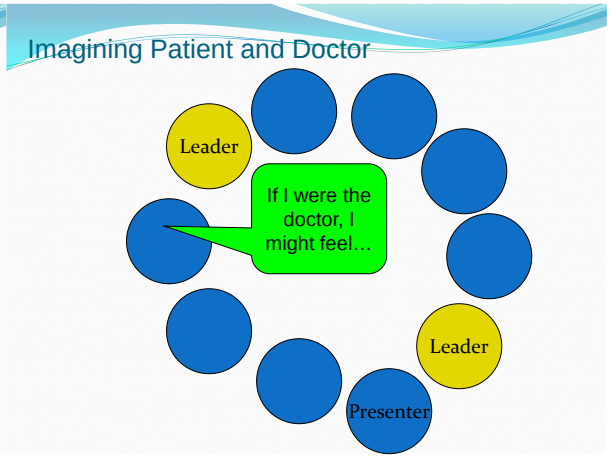

Group Process
Leader
I do.
Leader


The Case Arrives
Leader
Angela is a 79 yr old blind woman….
Leader
Presenter


Clarifying Questions
Leader
Are there any clarifying questions?
Leader
Presenter


The Presenter gets to Listen
Leader
Why don't we let the presenter just listen while we work the case
Leader


The Group Starts Working
Leader
I imagine Angela to be…
Leader
Presenter


Imagining Patient and Doctor
Leader
If I were the doctor, I might feel…
Leader
Presenter

Attachment 2: Who Has a Case? Starting a Residency Balint Group (Athyal, 2015)

WHO HAS A CASE? STARTING A RESIDENCY BALINT GROUP

Vidush P. Athyal, MD, MPH, FAAFP
Kaiser Permanente Family Medicine Residency, San Diego, CA

Introduction to Balint:

- Balint groups are a method of understanding the doctor-patient relationship leading to better communication and therapeutic outcomes.
- Started by Michael Balint, born in Budapest in 1896. He did psychoanalytical training in Berlin and Budapest, later immigrating to London. He started training-research seminars with his wife, Enid. These seminars were later known as 'Balint Groups'.
- Balint wrote his book, 'The Doctor, His Patient and the Illness'.
- Balint training became a world-wide phenomenon. In the US we have the American Balint Society (ABS). http://www.americanbalintsociety.org/
- The usual format of Balint training is a weekly meeting comprised of practitioners in health care. These are hour-long sessions led by a trained leader. Participants bring cases to discuss with their group. Average length of a group is about 3 years.

Balint versus Support Groups:

- Many residencies have a group experience which is called "Balint" but they are really support groups.
- Support groups help residents, especially interns, deal with the initial stressors of practicing medicine. They have flexible rules and may change with time. They often become a therapy group to help the residents.
- Unlike support groups, Balint groups are patient focused. Each session deals with one case.

Starting a Residency Balint Group:

- Ensure administrative support. Make sure your program director is on board. This is important for various matters, including scheduling time and resources to your group.
- Decide on a frequency. Either once or twice per month may be reasonable.
- Consider making this group mandatory, like any other rotation or residency experience.
- Determine who your leaders will be. Ideally two Behavioral Medicine faculty (even better if you have one physician and one therapist). The leaders could consider attending an ABS sponsored Balint Leadership Training Intensive. Consider having a back up leader, if needed.
- Determine who your audience will be. A support group may be helpful for the R1s. Balint groups may be more appropriate for R2s and R3s, who are hopefully more mature and have had some clinical experience. They will also have some continuity with their own patient panels. Most will present a case from their own panel or hospital experience.
- You may want to limit the size of each group to a maximum of 12 participants. Larger programs can consider running two separate groups. Members in each group should be consistent, for the sake of continuity and group dynamics.
- Choose a quiet location to meet regularly. This should be a place which can accommodate a circle of chairs with no barriers in between.

The First Session:

- Go over ground rules: confidentiality, punctuality, allow group members to leave if they are uncomfortable with a topic, ok with silence, no distractions (pagers, computers, etc).
- Introduce leaders and members of the group.

- "The success of a group depends on group members to be honest, respectful and supportive of divergent opinions."
- The goal of a Balint session is NOT to 'solve' a case, but rather to 'better understand' the doctor-patient relationship. Ask yourself, "What kind of doctor do I need to be to this patient today?"

The Group Experience and Basic Balint Structure:

- Leaders assign roles of doing time keeping and introduction. Leaders should sit opposite to each other, within the circle. Determine signals to keep time.
- Seat the group in an unobstructed circle.
- Leader begins with, "Who has a case?" Wait in silence for a case. Do not save the group!
- Presentation of a case: 3-5+ mins.
- Leader opens group to ask simple clarification questions to the presenter: 3-5+ mins.
- Presenter pushes back (wears the "cone of silence") for the main discussion.
- Case discussion for 20+ mins. Open to all for comment. Initial "dumping" of ideas. Encourage metaphors ("Let's fantasize or imagine…").
- Leaders to constantly assess safety in the group. Sit next to the problem resident.
- Leaders to guide the group through the three main signposts: Patient's feelings, Doctor's feelings and Patient-Doctor relationship.
- Leaders to encourage group to avoid prescriptive statements and "doing" dialogue.
- Allow presenter to share any comments, after the case discussion.
- Close group and allow members to disperse.
- Leaders debrief on their own: What stood out? Review the case summary. Name the case. Evaluate point of intervention or lack of intervention. Keep case notes – presenters, 1-2 lines about the case, attendees, patterns and metaphors.

Barriers to the Residency Balint:

- Scheduling issues. Beware of cancellations due to other responsibilities/programs. These cancellations lead to a lack of continuity, which is integral for a true Balint group.
- Difficult to get consistent group of residents monthly due to their rotation obligations.
- Introduction of new residents into the group each year may change dynamics and safety of the established group.
- Some residents may have little behavioral medicine background and can be insecure with psychosocial issues. Possibly less training in this with international medical graduates.
- Other residents may not care much for psychosocial medicine, even though they chose FM!
- Lack of funding to support a therapist leader in your residency.
- Think twice before including interns in a Balint group. They may not be ready to engage in this degree of the patient-doctor relationship discussion.
- General lack of trust in a program may lead to low self-disclosure and genuineness in a Balint group.
- Residents should have some continuity experience with their panel patients. R3s will likely have the best reservoir of patients to discuss.
- Leaders may push the group process. Allow the group to grow on its own. There is no perfect group – each will be different.
- Groups may have a problem resident who creates more tension and distrust in the group.

Attachment 3: What to Expect as a Member of a Balint Group (The American Balint Society, 2017)

What to Expect as a Member of a Balint Group

Why Balint?

Physicians frequently feel "stuck" with patients. Interactions with patients may leave the physician feeling frustrated, annoyed or just unsettled in some way. One way to better understand these challenging situations is to participate in an ongoing Balint group.

What is a Balint Group?

A Balint group is a group of physicians who meet regularly and present clinical cases in order to better understand the physician-patient relationship.

Dr. Michael Balint began working with burned out physicians in Britain after WWII to help develop the therapeutic potential of the physician-patient relationship.

Whereas physicians are usually trained to seek the "right" answer to medical problems, in a Balint group, the focus is on enhancing the physician's ability to connect with and care for the patient. A Balint group session begins with a physician presenting a case for the group to discuss. The group learns about the patient through the presenting physician's story. During the facilitated discussion, the group members uncover different and new perceptions about the patient and physician's feelings.

A Balint group usually has two leaders (often a physician and a psychologist, psychiatrist, clinical social worker or

counselor) who facilitate the process. The success of a group depends on group members to be honest, respectful, and supportive of divergent opinions. The content of the group is confidential. A Balint group may meet over the course of months or years, and group cohesion and trust develops over time.

Balint groups aim to help physicians:

- Recognize they are not alone in having challenging interactions with patients
- Develop increased understanding and empathy for patients
- Explore how feelings and thoughts affect the physician-patient relationship
- Become more aware and accepting of their conscious and unconscious responses to the patient
- Expand their capacity and repertoire for handling difficult situations with patients

For more information about Balint groups and training opportunities, the American Balint Society Website is: http://americanbalintsociety.org

Attachment 4: ACGME Competencies and Balint Work in Family Medicine Residency Programs

ACGME Competencies and Balint Work
In
Family Medicine Residency Programs
©American Balint Society

The ACGME and the American Board of Medical Specialties require that residents demonstrate competency and minimum skills in specific content areas. Under the ACGME plan, all medical specialties share the same six Core Competencies and twentyfive associated required skills. In order to meet these requirements, residencies use a number of teaching methods. Balint is a method that addresses many of the ACGME core competencies and associated skills. Because Balint work can train resident physicians in both ACGME core competencies and RRC curricular goals, the American Balint Society supports making Balint training a mandatory part of the Family Medicine residency curriculum.

1. What is a Balint group? The Balint group process is an experiential model in which residents meet regularly to examine the doctor-patient relationship. Group members listen to the presenting doctor's story and then discuss the case, with a concentration on the physician-patient relationship. The purpose of the group is to help the physician understand the physician-patient relationship rather than to advise the physician on treatment options. This process may also provide important information about the patient's feelings. Balint groups are a unique way to examine difficult situations in a non-threatening way. The group provides the opportunity to sit with uncertainty and complexity without pressure to arrive at an answer and without diminishing one's sense of self-worth as a physician. Being able to tolerate uncertainty is a necessary and important component of the maturation of physicians. In addition, resident-physicians frequently understand the doctor-patient relationship in a more empathic way, and so are able rekindle therapeutic efforts with patients. As a result of working in a group over a period of time, resident-physicians can recognize their habitual patterns of behavior with various types of patients. Balint work encourages self awareness and self reflection and helps residents to learn when to examine their reactions to an interaction with a patient.

2. How does the Balint Group satisfy the ACGME core competency requirements? The numbered list below enumerates the skills and attitudes enhanced or encouraged by Balint groups. The list of core competencies in the following table indicates the various ways these skills satisfy the ACGME core competencies.

1. Improves listening skills with both patients and colleagues
2. Encourages integrative, creative and divergent thinking leading to novel approaches to recurring problems
3. Encourages empathy; empathic skills are modeled; residents are able to experience themselves in the place of both the patient and the physician
4. Improves observation skills
5. Develops and encourages a repertoire of behaviors that may be therapeutic for a variety of patients
6. Increases sensitivity to and skill in addressing psychological aspects of the patient's illness
7. Improves ability to hear and react to difficult cases of colleagues in a gentle, supportive manner
8. Demonstrates a method for appropriately expressing frustration, pain and joy
9. Encourages camaraderie and intimacy among group members, thereby enhancing team work, communication and mutual support
10. Encourages self-reflection
11. Encourages self-evaluation

12. Improves satisfaction of practicing physicians

PATIENT CARE (1, 2, 3, 4, 5, 6, 10, 11, 12)
MEDICAL KNOWLEDGE (2, 5, 6)
INTERPERSONAL AND COMMUNICATION SKILLS (1-11)
PROFESSIONALISM (1-4, 10, 11, 12)
SYSTEMS-BASED PRACTICE (2)

	1	2	3	4	5	6	7	8	9	10	11	12
PC	X	X	X	X	X	X				X	X	X
MK		X			X	X						
ICS	X	X	X	X	X	X	X	X	X	X	X	
P	X	X	X	X						X	X	X
S-BP		X										

3. How does Balint meet the Behavioral Science curriculum goals required by the RRC?
Having a Balint Group experience in the curriculum satisfies curricular requirements listed in the program information form used to prepare for an RRC site visit. The following competencies are listed in the PIF and are part of the Balint group experience:

- components of family structure
- family structure and dynamics
- human development
- end-of-life issues
- role of the family in illness care
- emotional aspects of non-psychiatric disorders
- the physician-patient relationship
- normal psychosocial growth and development in individual and family
- stages of stress in the family lifecycle
- sensitivity to gender, race, age and culture differences in patients
- medical ethics including patient autonomy, confidentiality and issues concerning quality-of-life
- factors influencing patient compliance
- growth and development from newborn to adolescent
- management of emotional problems in children
- socio-cultural parameters in the older patient

The American Balint Society offers two pathways for training in Balint group leadership. A Balint Leadership Training Intensive is a four-day didactic, experiential and analytic course to introduce and refine the skills of Balint group leadership for physicians, residents and behavioral science educators. To develop more complete skills, leaders are encouraged to apply to the Balint Leaders Credentialing process, which provides developing leaders with supervision in the attainment of more in depth skills. The Council of the American Balint Society endorses leader training to ensure integration of the ACGME core competencies and the RRC curricular goals into Balint training for residents.

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CHAPTER IX: QUICK TIPS FOR NETWORKING AND CONTINUED EDUCATION

The clock is running. Your assignment as a behavioral scientist will likely last either three or four years. You will need to use your time wisely if you wish to do your job well. Your mission, should you accept it, is to gain competence as quickly and efficiently as possible in a profession to which some have devoted their entire careers. Here are some quick tips for networking and continuing education to get you started.

1) Attend the ***Forum for Behavioral Science in Family Medicine*** as soon as possible.

Finding mentorship as a behavioral scientist can be a challenge, particularly if you are the lone representative for your team. Here is a summary of "The Forum" from the Medical College of Wisconsin's website:

"First held in 1980, The Forum for Behavioral Science in Family Medicine has served to stimulate the advancement of behavioral science in family medicine for 36 consecutive years. At the core of The Forum's success are three objectives: promote professional networking, provide high quality professional development opportunities, and advance the integration of behavioral science in family medicine training." (Medical College of Wisconsin, 2017)

I was 15 months into my assignment the first time I went to The Forum. I remember how thrilling it was to be amongst "my people." I felt tremendous relief knowing that I was not alone and there was an entire community of professionals with whom I could share my thoughts, feelings, and questions. Ideally, new Air Force behavioral scientists should attend the conference during the October immediately following their arrival to their new duty station. Unfortunately, this is a challenge for most as registration deadlines are in mid-August and this is typically a busy time for house-hunting and in-processing. Don't be afraid to lean forward and ask your gaining leadership or consultant about the feasibility of attending. Although never accomplished to date, another option may be for new behavioral scientist to attend the Forum during their third year of PhD training. Funding may be tricky, however, everyone benefits from a new behavioral scientist that "hits the ground running."

Please note that social work continuing education units (CEU's) are available at the Forum through the Illinois Department of Professional Regulation, but not directly through the National Association of Social Workers. My state is rather stringent regarding CEU's and I had to argue assertively to gain credit for my attendance. The staff at the Medical College of Wisconsin was very helpful throughout the process.

2) **Network:** During my first year at The Forum, I attended a presentation on building networks within your geographical area. I learned that it's common of behavioral scientists from surrounding programs to gather periodically to discuss current events and best practices. This network can provide a valuable support structure for those who are new to the field. Upon returning from the conference, I immediately built two email distribution lists. The first was composed the behavioral scientists within my geographical area (I was able to gain this from the conference attendance listing), and the second list included all the current and past Air Force behavioral scientists I knew. In my personal experience, behavioral scientists have been very willing to help.

3) **Read:** This recommendation may seem obvious, however, the emphasis on evidence-based practice is particularly high in residency programs. As a behavioral scientist and practitioner of the "soft sciences," your credibility will be enhanced by having knowledge of the literature. The Society of Teacher of Family Medicine offers a fantastic library here: http://resourcelibrary.stfm.org/home

Also, don't be afraid to ask faculty or residents for reading recommendations about the culture of family medicine. You will get plenty of great recommendations like *When Breath Becomes Air* by Paul Kalanithi, and some eye-brow raising suggestions like *House of God* by Samuel Sherm. These books are at the heart of the profession's culture and are critical for gaining competency. Further, discussing books with colleagues and residents is a great way to convey respect and interest in their field, all while building relationships too. See attachment 1 for a list of additional suggested readings.

4) Apply for STFM's ***Behavioral Science/Family Systems Educator Fellowship (BFEF)*** during the second November of your assignment. Taken directly from their webpage:

"This competitive, yearlong fellowship is for family medicine faculty who have responsibility for coordinating or teaching the behavioral science/family systems curriculum. Preference is given to applicants with 1 to 5 years of experience as a faculty member.

The BFEF uses a structured learning curriculum of core content and formalized mentoring. The fellowship will help you:

- Better understand the medical culture
- Build a personalized professional development plan
- Integrate behavioral science and family systems core principles into the practice of family medicine
- Plan, create, and present a scholarly project at a national conference
- Grow professionally through strong mentoring relationships with seasoned behavioral science/family systems educators and physicians

Schedule

Fellows attend three events:

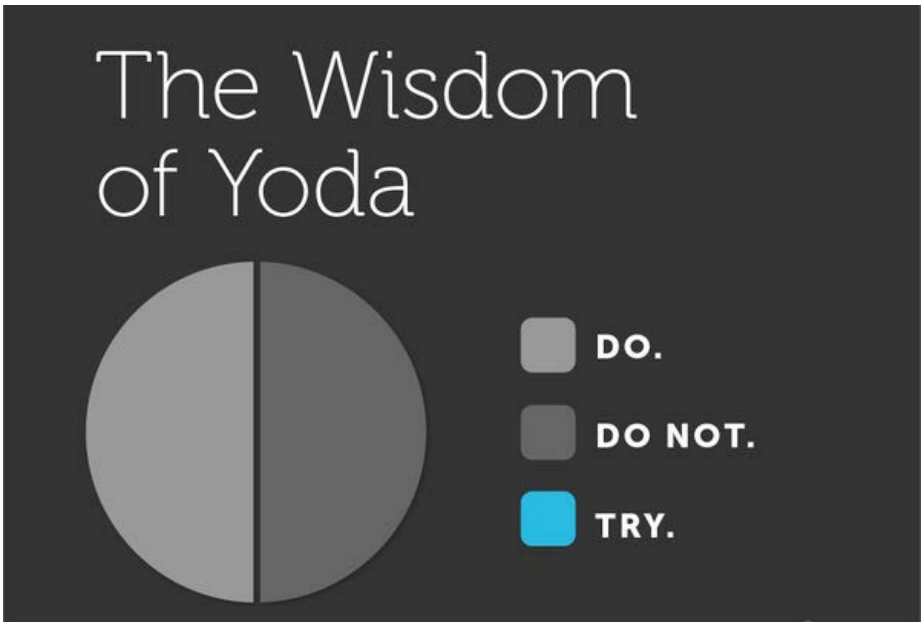
- 2018 and 2019 STFM Annual Spring Conference
- 2018 Forum on Behavioral Science in Family Medicine Conference

In addition to attending these great conferences, the fellowship experience includes:

- A mentoring relationship with two seasoned behavioral science educators
- Participation in a mentored group of 4 fellows, who will meet at designated times during the conferences and by phone monthly through the remainder of the fellowship year
- A Professional Learning Contract that will include a mentored scholarly project to be completed and presented at the second STFM Annual Spring Conference
- An opportunity to have your work highlighted in STFM publications and/or website
- Being honored at a formal fellowship graduation ceremony at the second STFM Annual Spring Conference

Cost

The program fee is $1,500 and covers program materials and expenses plus registration fees for one STFM Annual Spring Conference and the Forum for Behavioral Science in Family Medicine. Participants pay travel expenses" (Society of Teachers of Family Medince, 2018). Obtaining unit funding can be challenging in the current fiscal climate. I was fortunate to gain support for this scholarly activity through my GME office.



(Edutopia, n.d.)

Attachment 1: Additional Suggested Readings (Ayres & Myerholtz, 2016)

Augustyn, et al. *Zuckerman Parker Handbook of Developmental & Behavioral Pediatrics for Primary Care*

Bolte-Taylor. *My stroke of insight.*

Clabby, J. *Two Minute Talks to Improve Psychological and Behavioral Health*

Feldman & Christensen. *Behavioral Medicine: A Guide for Clinical Practice*

Fortin, A. *Smith's patient-centered interviewing: An evidence-based method*

Gawande. *Being mortal*

Groopman. *How doctors think*

Guerrasio, J. *Remediation of the struggling medical learner*

Hunter & Goodie. *Integrated Behavioral Health in Primary*

Care Kalanithi. *When breath becomes air*

Levinson, et al. *Understanding Medical Professionalism*

Lipson & Dibble. *Culture and Clinical Care*

McDaniel, et al. *Family oriented primary care*

McDaniel, et al. *Medical family therapy*

McDaniel. *Shared experience of illness*

Medina, J. *Brain rules*

Pink, D. *Drive*

Remen. *Kitchen table wisdom & my grandfather's blessing*

Ric, et al. *Clinical Handbook of Psychotropic Drugs*

Rider & Nawotniak. *Teaching and Assessing the ACGME Core Competencies*

Robinson, et al. *Real behavior change in primary care*

Robinson & Reiter. *Behavioral Consultation and Primary Care*

Rollnick, et al. *Health behavior change*

Sahler & Carr. *The behavioral sciences & health care*

Sanders. *Every Patient Tells a Story- Medical Mysteries and the Art of Diagnosis*

Sanford. *Waking*

Schneider & Levenson. *Psychiatry Essentials for Primary Care*

Seaburn, et al. *Model of collaboration*

Searight. *Behavioral medicine*

Sahler & Carr. *The behavioral sciences & health care*

Sanders. *Every Patient Tells a Story- Medical Mysteries and the Art of Diagnosis*

Sanford. *Waking*

Schneider & Levenson. *Psychiatry Essentials for Primary Care*

Seaburn, et al. *Model of collaboration*

Searight. *Behavioral medicine*

Stewart, M, et al. *Patient-Centered Medicine.*

Strosa hl, et al. *Brieftnterventions for Radical Change*

Stuart & Lieberman. *The 15 minute hour*

Stuart & Lieberman. *Five-Minute Talk: Therapeutic Talk in Primary Care* Whitman and Schwenk. *The Physician as Teacher, 2nd Edition*

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(Chernett, 2018).

CHAPTER X: FAMILY MEDICINE ALPHABET SOUP:

Faculty Field Guide to Acronyms in Family Medicine Residency Education
(Society of Teachers of Family Medince, 2017)

AACH. Academy of Communication in Healthcare. Seeks to improve healthcare through education, research, and practice that focuses on communication and relationships with patients, families, and healthcare teams. Supports DocCom, a video resource on doctor-patient communication. http://www.aachonline.org/

AAFP. American Academy of Family Physicians. The American Academy of Family Physicians is the national association of family doctors. www.aafp.org

AAMC. Association of American Medical Colleges. The AAMC serves and leads the academic medicine community to improve the health of all. www.aamc.org/

ABFM. American Board of Family Medicine. Through certification and maintenance of certification programs the ABFM pursues its mission by establishing, maintaining, and measuring high standards of excellence in the specialty of Family Medicine. www.theabfm.org

ABSAME. Association for the Behavioral Sciences and Medical Education. An interdisciplinary professional society dedicated to strengthening behavioral science teaching in medical schools, residency programs, and in continuing medical education. Publishes *Annals of Behavioral Science and Medical Education.* http://www.absame.org/

ACGME. Accreditation Council for Graduate Medical Education. The Accreditation Council for Graduate Medical Education (ACGME) is a private professional organization responsible for the accreditation of about 9,200 residency education programs. www.acgme.org

ACO. Accountable Care Organizations are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

ADFM. The Association of Departments of Family Medicine (ADFM) is the organization of departments of family medicine and is devoted to transforming care, education, and research to promote health equity and improve the health of the nation. www.adfammed.org

AFMRD. The Association of Family Medicine Residency Directors (AFMRD) inspires and empowers family medicine residency program directors to achieve excellence in family medicine residency training. www.afmrd.org

AFP. American Family Physician. A journal of evidence-based reviews published by the AAFP.

AHRQ. The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. It is 1 of 12 agencies within the Department of Health and Human Services. The National Integration Academy Council

(NIAC) supports integration of the behavioral health and primary care fields. Extensive behavioral health integration resource list and Atlas of qualitative measures. http://www.ahrq.gov/

AOA. American Osteopathic Association. The professional family for osteopathic physicians (DOs) and osteopathic medical students; the primary certifying body for DOs; the accrediting agency for all osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities. www.osteopathic.org/

CAFM. Council of Academic Family Medicine. Comprises ADFM, AFMRD, STFM and NAPCRD. http://academicfamilymedicine.org/

CAQ. Certificate of Added Qualifications. CAQ's are earned after completion of a fellowship or other advanced training following Family Medicine Residency. They are similar to subspecialties. CAQ's for Family Physicians are available in Geriatrics, Hospice and Palliative Care, Adolescent Medicine, Sports Medicine and Sleep Medicine

CBE. Competency Based Education. A concept in the ACGME Next Accreditation System. Competency-based education targets standardized levels of proficiency to guarantee that all learners have a sufficient level of proficiency at the completion of training.

CCC. Clinical Competency Committee. Part of the ACGME Next Accreditation System. Composed of core faculty members who make a consensus decision on the progress of each resident. http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf

CERA. is the CAFM's Education Research Alliance. CERA conducts approximately four surveys per year of CAFM members. Individuals who submit specific questions for study are given 3 months to analyze the data from the survey prior to release of the data to the general membership. The expectation is that investigators will write and submit a paper within those 3 months. http://www.stfm.org/initiatives/CERA.cfm

CFHA. Collaborative Family Healthcare Association. Promotes a comprehensive and cost-effective model of healthcare delivery that integrates body and mind, individual and family, patients, providers and communities. http://www.cfha.net/

CLER. Clinical Learning Environment Review. A component of the next accreditation system. The ACGME has established the CLER program to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites. http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf

CMS. Centers for Medicare & Medicaid Services. http://www.cms.gov/

COGME. The Council on Graduate Medical Education (COGME) provides an ongoing assessment of physician workforce trends, training issues and financing policies, and recommends appropriate federal and private sector efforts on these issues. http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/index.html

CPCI. Comprehensive Primary Care Initiative (of the Center for Medicare and Medicaid). Partnership between Medicare and other insurance programs/organizations to help selected PCP's

provide additional resources to improve quality of care. Fall 2012 launch with 500 practices in 7 states. http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/

DIO. Designated Institutional Official; the institutional officer charged with oversight of all of an institution's ACGME approved training programs.

EBM. Evidence Based Medicine. http://en.wikipedia.org/wiki/Evidence-based_medicine

EPA. Entrustable Professional Activities. A concept in the ACGME Next Accreditation System. Units of professional practice, defined as tasks or responsibilities to be entrusted to the unsupervised execution by a trainee once he or she has attained sufficient specific competence.

FMEC. Family Medicine Education Consortium. Organization focusing primarily on Northeastern US. Working to achieve the full potential of Family Medicine and primary care as critical to improving health of the nation. http://www.fmec.net

FMRCR. Family Medicine Residency Curriculum Resource. The Association of Family Medicine Residency Directors (AFMRD) and Society of Teachers of Family Medicine (STFM) have launched a multi-year collaboration to build an online resource of peer-reviewed, competency-based curriculum content organized by post-graduate year (PGY). When complete, the Family Medicine Residency Curriculum Resource will comprise case-based presentations, quizzes, and facilitators' guides for the core content of family medicine education. The site currently includes a core topic list for PGY1 with recommended readings. This content is available at no charge to AFMRD and STFM members. http://www.fammedrcr.org/

FQHC. Federally Qualified Health Center. Qualifies for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html

GME. Graduate Medical Education.

HRSA. Health Resources and Services Administration; makes grants to organizations to improve and expand health care services for underserved people. They also provide funding for residency teaching innovations. With SAMHSA co-sponsors the Center for Integrated Health Solutions.
http://www.hrsa.gov/

IHI Institute for Healthcare Improvement; training and resources to improve patient safety and quality of care. Http://www.ihi.org

IPCS. Interpersonal communication skills - it is one of the 6 the ACGME competency areas for all residents.

ITE. In-training exam. All ACGME-accredited Family Medicine programs are eligible to take the In-Training Examination, which is given annually during the last week of October. The purpose of the examination is to provide an assessment of each resident's progress, while also providing programs with comparative data about the program as a whole. https://www.theabfm.org/cert/ite.aspx

IPC. Integrated Primary Care.

LCME. The Liaison Committee on Medical Education (LCME) is the nationally recognized accrediting authority for medical education programs leading to the MD degree in the United States and Canada. The LCME is sponsored by the Association of American Medical Colleges and the American Medical Association. www.lcme.org/

MAC. Medicare Administrative Contractor. The Centers for Medicare & Medicaid Services (CMS) uses a network of contractors called Medicare Administrative Contractors to process Medicare claims, enroll health care providers in the Medicare program and educate providers on Medicare billing requirements. MACs also handle claims appeals and answer beneficiary and provider inquiries.

MI. Motivational Interviewing. Frequently used behavior-change intervention in health care. http://www.motivationalinterview.org/

MOC. Maintenance of Certification. ABFM. American Board of Family Medicine.

MOL. Maintenance of Licensure. ABFM. American Board of Family Medicine.

NAPCRAG. The North American Primary Care Research Group (NAPCRG) is a multidisciplinary organization for primary care researchers. www.napcrg.org/

NAS. ACGME's Next Accreditation System. http://www.acgme-nas.org/

NCQA. The National Committee for Quality Assurance is a private, not-for-profit organization dedicated to improving health care quality. Offer six accreditation programs, five certification programs and five physician recognition programs. PCMH "recognition". www.ncqa.org/

OSCE. Objectively Structured Clinical Examination. An OSCE usually comprises a circuit of short (the usual is 5–10 minutes although some use up to 15 minute) stations, in which each candidate is examined on a one-to-one basis with one or two impartial examiner(s) and either real or simulated patients (actors or electronic dummies).

P4 – Preparing the Personal Physician for Practice. Initiative sponsored by ABFM and FMRD. Purpose is to learn more about how to improve GME of family physicians working in new models of practice. http://www.transformed.com/p4.cfm

PCMH. The patient-centered medical home—one of modern health care's most important innovations—is a model of care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." http://www.pcmh.ahrq.gov/

PCOF. Patient-Centered Observation Form. Assessment tool to improve resident physician-patient communication. https://catalyst.uw.edu/webq/survey/mauksch/107123

PDSA. Plan-do-study-act. A simple, yet powerful tool for accelerating improvement by testing changes on a small scale. http://www.ihi.org/knowledge/Pages/HowtoImprove/

PDW. Program Directors Workshop. One of two workshops at annual AFMRD meeting: Workshop for Directors of Family Medicine Residencies (PDW) or the Residency Program Solutions (RPS) Workshop.

PIF. Program Information Form (PIF). Part of ACGME certification process, which is being phased out with the implementation of the NAS

RPS. One of two workshops at annual AFMRD meeting: Workshop for Directors of Family Medicine Residencies (PDW) or the Residency Program Solutions (RPS) Workshop.

RRC. Residency Review Committee. The RRC for Family Medicine is a part of the ACGME. The RRC is responsible for developing the program requirements for Family Medicine Residency training, and for accrediting decisions for individual Family Medicine Residencies. RRC members are nominated by the AAFP, the ABFM and the AMA.

SAM. Self-Assessment Module (SAM). https://www.theabfm.org/moc/part2.aspx

SAMHSA. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. The Center for Integrated Health Solutions offers integration training, policy updates and funding of primary care integration in Community Health Services. Training grants. http://www.samhsa.gov/

SDSA. Study-do-standardize-act. See PDSA.

STFM. The Society of Teachers of Family Medicine. The academic society of Family Medicine.

USMLE. The United States Medical Licensing Examination (USMLE) is a three-step examination for medical licensure in the United States and is sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners® (NBME®). www.usmle.org/

WONCA. World Organization of Family Doctors. The unusual, yet convenient acronym comprising the first five initials of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. WONCA's short name is World Organization of Family Doctors. Global not-for-profit professional organization representing family physicians and general practitioners from all regions of the world. www.globalfamilydoctor.com/

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