CFHA 2019 Conference – Posters

Last updated September 15, 2019

PC01: Integration of telehealth into primary care practice for older adults

For Oak Street Health, providing quality mental health services is key to its integrated care approach. Founded in Chicago in 2013, the organization now serves 40,000 Medicare patients across five states – one-third of whom experience a mental health condition. As a value-based care provider, Oak Street is also incentivized to keep total healthcare costs down for each patient by focusing on preventive care. By delivering behavioral health services directly to patients, Oak Street sought to help them get the care they need, improve their overall health and reduce expensive – and sometimes avoidable – hospital admissions. As a rapidly expanding network based in underserved neighborhoods, Oak Street also needed a way to access high-quality mental health providers and scale its services quickly. Recognizing that telepsychiatry aligned with its mission to provide efficient, effective whole-person care, Oak Street launched its telepsychiatry program in 2016. Through its leading integrated telepsychiatry services, the telepsychiatry program empowers Oak Street Health Providers to bring quality mental health care services directly to patients, regardless of where they live.

Author(s):

- *Rebecca Murray, LCSW Clinical Behavioral Health Manager, Clinical Services Oak Street Health, Chicago, IL*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea Integration of telehealth into primary care practice for older adults

---

PC02: Shared Decision Making within the Primary Care Behavioral Health Model: A One-Visit Approach

There is a growing need for shared decision making (SDM) in the primary care setting as populations become increasingly more senior and present with greater medical complexity (Rotar et al., 2018). SDM is defined best by Elwyn et al. (2012) as a shared approach where patients are provided evidence for effective treatment options and supported by providers as they consider and make an informed choice on care. However, there are many barriers to the usage of SDM in the primary care setting. Friedberg et al. (2013) identified three main barriers in primary care which they identified as "overworked physicians, insufficient provider training, and inadequate clinical information systems". A recent study found that a team-based approach to SDM was affective, but time constraints created a barrier (Legare et al., 2011). These growing concerns and barriers in the primary care field provide a perfect avenue for the usage of Behavioral Health Consultants (BHCs) within a Primary Care Behavioral Health (PCBH) Consultation Model framework. An area of difficulty for BHCs in primary care is knowing how to begin the discussion with patients about the need to be "stepped up" to a higher level of care after treatment in the primary care setting is insufficient (i.e., referring to specialty mental health). BHCs may be able to utilize the

three-step model developed by Elwyn et al. (2012) with an emphasis on developing choice talk, option talk, and decision talk to engage in a collaborative conversation with the patient about the need for a higher level of care. Through SDM, BHCs can help educate the primary care team in the usage of SDM within a one visit model. A one visit, 30-minute model for SDM has already been piloted by Mott et al. (2014) to assist veterans in selecting specific treatment for PTSD within a traditional mental setting. BHCs are well positioned to use SDM to direct patients in the care of their behavioral health problems by providing a wide array of options. Currently, there is no literature or guidance on the usage of SDM within a PCBH framework. This poster will provide BHCs and other primary care team members with guidance on how to develop a step-by-step approach for implementing SDM in a one-visit intervention suitable for the PCBH model of care.

Author(s):

- *Alexander Young, M.A., Doctoral Candidate, Our Lady of the Lake University*
- *Sharon Mathai, Medical Student Year 1, UT Health San Antonio*
- *Brittany Houston, M.S., UT Health San Antonio*
- *Stacy Ogbeide, PsyD, MS, ABPP, UT Health San Antonio*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC04: Pathweigh: A workflow and disease state optimization tool for chronic weight management within an integrated primary care setting

PATHWEIGH is a novel clinical workflow and disease management tool developed to facilitate weight loss and weight loss maintenance. It is built as an optional application to EPIC with the intention of widespread use by primary care. The interface is quick and easy to use, but most importantly, tracks clinical information for the purpose of guiding clinical decision-making, future iterations of PATHWEIGH, and research. Pilot data will be presented on the efficacy of promoting weight loss in patients involved in PATHWEIGH vs. treatment as usual as well as the acceptability of its use for primary care providers.

Author(s):

- *Leigh Perreault, MD, Associate Professor, University of Colorado Department of Endocrinology*
- *Erik Seth Kramer DO, MPH, Senior Instructor, University of Colorado Department of Family Medicine*
- *Lauren W. Tolle, PhD, Assistant Professor, University of Colorado Department of Family Medicine*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC05: Practical Psychotherapy: Training in Evidence Based Practices for Primary Care Providers

Primary care clinicians working in rural and/or underserved areas often experience challenges in successfully referring patients for psychotherapy. While most are comfortable assessment and medication management these clinicians recognize that many patients would benefit from focused evidence based psychotherapy as well to manage distress, improve problem solving, reduce maladaptive behaviors and improve coping skills. Faced with patient reluctance, stigma and access challenges, a group of primary care providers and residents in a rural clinic affiliated with the University Of Iowa College Of Medicine are developing a focused, evidence based brief psychotherapy curriculum to develop skills in brief therapy techniques and associated resources for patient education and practice. The This curriculum and the associated patient education materials are designed to scalable and adaptable to other primary care settings.

Author(s):

- *Karla Hemesath, PhD, LMFT, Clinical Associate Professor Department of Family Medicine, University of Iowa Carver College of Medicine, Iowa City, IA*
- *Claire McKinley, MD, MS*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC06: Addressing Childhood Bereavement Through a Primary Care and Community Partnership

Research indicates the death of a parent or sibling places youth at increased risk for social, emotional, and behavioral problems, and early mortality. According to the Childhood Bereavement Estimation Model (CBEM) 1 in 15 children in the US will experience such a loss before age 18, with estimates more than doubling by age 25. Given the magnitude of the issue and the potential for grief to change developmental trajectories, primary care is a key setting for identification, education, and referrals to comprehensive, trauma-informed bereavement services. This presentation will provide a case example of a family referred from a pediatric care clinic to a community bereavement center that employs a systemic Comprehensive Grief Care approach focused on whole-family preventive services. Effective workforce development strategies that target integrated behavioral health will be offered.

Author(s):

- *Michaeleen Burns, PhD, Chief Clinical Officer, Judi's House/JAG Institute*
- *Ayelet Talmi, PhD, IMH-E® (IV-C), Associate Professor, Department of Psychiatry and Pediatrics, University of Colorado School of Medicine at Children's Hospital*
- *Brook Griese, PhD, Chief Executive Officer, Judi's House/JAG Institute*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC07: Integrated Mental Health Care System in a Socially Disadvantaged Community-Based Setting

The focus of this project was to address social determinants of health within a socially disadvantaged community-based setting. Our approach was multifaceted collaborating with a vascular clinic, school district and integrated healthcare system. In the vascular clinic, we focused on individuals going through amputations, conducted a social determinants of health survey, identified barriers, and referred high-risk adult patients to integrated healthcare system. With the school district, our approach was to focus on children with a social worker performing assessment; selected children were also sent to the integrated healthcare system. Results over the past 6-months had been promising.

Author(s):

- *Anil Mangla., PhD, MPH, Director of Public Health, University of the Incarnate Word, School of Osteopathic Medicine, San Antonio, TX*
- *Dr. Emma Santa Maria, Director of Faculty Development*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC08: The Rise of primary care psychiatry and the fall of the DSM-5

The DSM-5 is based on a traditional, categorical nosology, though the psychiatric conditions being defined are no more than arbitrarily chosen combinations of symptoms. The trend in primary care psychiatry has been to put less emphasis on these diagnostic entities and to instead treat the symptoms themselves based on patient reports, our understanding of neuronal pathways and neurotransmitters, and our estimation of illness severity. The fact that certain medications can be used to treat multiple conditions, while certain conditions respond to multiple classes of medication is leading to the reduction of hundreds of psychiatric diagnoses to a small number of elements shared by all of them - what the NIMH calls Research Domain Criteria. This switch from categorical to dimensional diagnosis brings psychiatric practice more in line with evidence-based treatment of other diseases that have both organic and behavioral causes, responding best to an interdisciplinary, holistic approach.

Author(s):

- *Hugh Blumenfeld, MD, Assistant Professor of Family Medicine, University of Connecticut Family Medicine Residency Program, Hartford, CT*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC09 - WAITING: Medicaid Managed Care Quality Case for Paraprofessionals in Pediatrucs

Problem: Only 30% of California's children under age six receive recommended developmental and behavioral screenings (First5LA, 2017). One barrier to adherence cited by Los Angeles area Medicaid-providers is limited clinician time (First5LA, 2017). Literature supports the inclusion of lower-cost paraprofessionals on pediatric teams in order to increase developmental screening and referral rates (Minkovitz et al., 2003; Warmels, Johnston, & Turley, 2017). Understanding the facilitators and barriers pertaining to the successful launch and incorporation of paraprofessionals in pediatric practices can guide providers and health plans seeking improvements in the quality of pediatric care. In addition, a decision-support model for embedding paraprofessionals in practices is needed to guide providers and payors with adoption considerations (Chapman & Miller, 2017). Methodology: This poster will share a literature review and early lessons from 10 pediatrician and 10 Medi-Cal health plan leaders' perceptions of facilitators and barriers of using paraprofessionals in pediatric care to support early identification of developmental and behavioral conditions. Additionally, the study will identify mediating factors and their influence on the ability of clinicians to shift select developmental screening tasks to paraprofessionals. The quantitative arm is a return on investment analysis on the impact of adding a paraprofessional to the pediatric care team, over a three-year time horizon. The analysis will incorporate the costs of any critical infrastructure investments required to support successful integration of paraprofessionals into a developmental screening and linkage workflow,

Author(s):

- *Lindsey Angelats, First 5 LA, South Pasadena, CA*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC10: fACT for Perinatal Depression: Proposal for a Hybrid Telehealth-Psychoeducational Intervention for Patients with Perinatal Depression

The proposed group program is a hybrid telehealth-psychoeducational intervention for patients with perinatal depression. The program was influenced by two specific studies, as well as the author's year-long internship experience at a Women's Health Clinic in the Southwest region of the United States (Bonacquisti, Cohen, &

Schiller, 2017; Feros, Lane, Ciarrochi, and Blackledge, 2013). The program combines Focused Acceptance and Commitment Therapy (fACT) and telehealth, as both interventions have shown success when working with postpartum mothers and patients who have experienced perinatal depression (Bonacquisti, Cohen, & Schiller, 2017; Macnab, Rojjanasrirat, & Sanders, 2012). The intervention includes nine visits that cover the following topics: Acceptance, Cognitive Defusion, Mindfulness, Value Identification, and Goal-setting. It is the author's intention that any Behavioral Health Consultant (BHC) with fACT training can reproduce the intervention and implement it in other Women's Health facilities.

Author(s):

- *Norma Balli-Borrero, MS, UTSA, San Antonio, TX*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC11: Deconstructing Descartes: Training the Future Professionals of Healthcare

The Center for Integrative Wellness at TCNJ is developing a unique and two-fold method for educating and training students who will be future healthcare providers, as well as providing affordable, community focused, healthcare services to the campus and local Trenton community. The CIW at TCNJ aims to be a leader in wellness and health promotion through practice, education, and community service. We intend to cultivate a new generation of compassion focused, integrative healthcare providers who share our passion for shaping the future of healthcare. The TCNJ School of Nursing, Health and Exercise Science, and Public Health, in conjunction with TCNJ's School of Education, are piloting a restructuring of the College's graduate-level, mental health training clinic. The CIW at TCNJ provides a unique and inverse example of integrated care by running nursing, exercise, and nutrition programs out of a mental health clinic that offers a training environment for mental health masters clinicians, and nursing students. The majority of integrated care models start in primary care settings and build in mental health. The CIW's mission is one that has logistic and strategic issues to dissect and resolve with few prototypes guiding our effort. We will speak to the success and growth our clinic has seen through community collaboration and grant funding. Additionally, we will address the ongoing barriers we continue to face which include resource allocation, funding, space constraints, staffing limitations, and legal issues related to FERPA/HIPPA. It is important to open a dialogue with colleagues regarding our pilot programming mission, logistics, strengths, challenges, as well as the opportunity our mission has to offer a unique approach to bridging the gap between primary care and mental health from the training level up.

Author(s):

- *Liza Woods MS, LPC, The Center for Integrative Wellness at The College of New Jersey, Ewing, NJ*
- *Jennifer Sparks, LMFT, PhD, The Center for Integrative Wellness at The College of New Jersey, Ewing, NJ*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PC12: Dental and Behavioral Health Integration: A Proposal for Program Development and Implementation

A small body of research explores integration of psychologists within dental settings to address dental anxiety, and other issues such as treatment compliance, nicotine dependence, and substance use concerns. Christ Community Health Services, a FQHC in Memphis, Tennessee, houses dental services within its primary care clinic, and has initiated a pilot program for integration of behavioral health within dental services. This poster will present findings from a review of the literature, and an initial proposal for integration of services. This proposal includes problems addressed, methods used, benefits to dental providers, and suggested workflow. Also

highlighted will be a discussion of successes and challenges evident in the first round of implementation. This discussion in particular may facilitate a dialogue for how to capitalize on successes and problem solve challenges. This presentation will target attendees who work in settings where dental services are offered in-house to their patient populations. Attendees will learn about problems currently being addressed by mental health professionals within dental settings, interventions for specific problems as informed by available research, as well as identified screening measures and benefits to dental providers.

Author(s):

- *Christopher Ferrand, PsyD, Licensed Clinical Psychologist, Christ Community Health Services, Memphis, TN*
- *Laura Schwent Shultz, PsyD, Director of Behavioral Health - Ambulatory Care, Methodist Le Bonheur Healthcare*

Poster Category: CONCEPTUAL: early-stage development of and proposal for new idea

---

PEP01: Building the Workforce through Implementation of a Telephone Health Coaching Intervention

ACTIVATE, a telephone coaching intervention to increase engagement in health behavior programs, has demonstrated positive effects on program enrollment, participation, and activation (Oddone et al., 2018). The poster will describe the implementation of this evidence-based practice with paraprofessionals in an interdisciplinary team setting. This mixed methods program evaluation presents results of a quality improvement project at a VA behavioral telehealth center to increase patient engagement in health behavior programs. The project used the RE-AIM framework to guide the evaluation (Glasgow & Estabrooks, 2018). Quantitative and qualitative analyses of electronic medical record data and interviews with patients, staff, and the facilitation team evaluate implementation and patient outcomes to understand program impact. Implementation facilitation strategies will also be described. In the first three months, 70 Veterans (80% male, 80% White, 96% non-Hispanic/Latino, mean age=56) have been offered the ACTIVATE intervention reflecting reach to 86% of the total eligible population; 33 Veterans completed ACTIVATE. Patient and staff interviews suggest high satisfaction. Veterans reported benefits including increased health awareness, increased motivation, and increased perceived support. All staff who were expected to implement the program did so, reflecting a 100% adoption rate. Staff interviews identified concerns regarding effect of the new program on the Veteran experience and current workflow; implementation facilitation team and leadership responses to resolve these concerns will be discussed. Program evaluation and implementation efforts are ongoing; additional data will be presented at the conference. Strategies and tools designed to help staff implement the intervention with high fidelity will be described. Implications for other sites implementing similar health behavior programs and expanding teams through addition of paraprofessionals and telephone services will be discussed.

Author(s):

- *Emily M. Johnson, PhD, VA Center for Integrated Healthcare*
- *Katharine Vantreese, LCSW, VA VISN 2 Behavioral Telehealth Center*
- *Eugene Z. Oddone, MD, MHSc, VA Center for Health Services Research in Primary Care*
- *Laura O. Wray*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP02: Can internship programs in Primary Care Behavioral Health help reduce mental health disparities for the Latino population? Initial Findings

Training opportunities for students and professionals have increased in response to a higher demand for integrated behavioral health services. As training proliferates, it is important to evaluate the impact of student interventions on patients. Through preliminary data, this poster will present how a Primary Care Behavioral Health (PCBH) internship program can have a positive impact on patients' health in a sample of Latino patients.

Author(s):

- *Nydia Cappas-Ortiz, PsyD, Primary Care Psychology Program Director, Ponce Health Sciences University, Ponce, PR*
- *Normarie Torres, PhD, Post Doctoral Fellow, Ponce Health Sciences University, Ponce, PR*
- *Viviana Hoyos, PsyD, Primary Care Psychology Program Coordinator and Supervisor, Ponce Health Sciences University, Ponce, PR*
- *Valerie Toro, PsyD*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP03: Relations between Patient Care Type and Psychological Symptoms in a FQHC in Rural Idaho

Prior studies indicate that patients are more likely to receive mental health services when offered in an integrated primary care setting, as opposed to a mental healthcare facility. This may be in part due to convenience, familiarity, and a less salient association with stigma often accompanying psychological services, particularly in smaller communities. Integrated healthcare programs have also been effective at improving mental healthcare quality, patient care satisfaction, and cost-effectiveness. However, there is still limited literature examining the extent to which FQHC services relate to improvements in common psychological outcomes (i.e., depression and anxiety) in rural, underserved settings. Therefore, archival EMR data were extracted utilizing a standard form and cleaned by a trained doctoral student under the supervision of a Licensed Psychologist at an integrated FQHC. Resultantly, 404 patients in rural Idaho were categorized as those receiving: (1) medical services (n=297), (2) behavioral health (BH) services (n=30), or (3) both (n=77). Each patient's depression and anxiety symptoms were examined via change scores from their initial and last scores on the Patient Health Questionnaire-9 and Generalized Anxiety Disorder Questionnaire from January to August 2018. The greatest percentage of patients were: 26 to 30 years old (13%), female (41%), and Caucasian (83%). Most had insurance coverage (53%), met criteria for a psychological disorder (81%), and received psychotropic medication (72%). Independent samples t-tests revealed that patients who received BH services alone or within the medical context had a significantly greater decrease in PHQ-9 scores, as did patients who received integrated care in comparison to those receiving just one form of care. These results further support the integration of primary care and BH services in FQHCs to improve patient outcomes, even in understudied rural settings where patients may have unique barriers to care.

Author(s):

- *Yaeeun (Joy) Lee, MS, Clinical Psychology Doctoral Student, Idaho State University*
- *Verena Roberts, PhD, Director of Behavioral Science, Idaho State University*
- *Nicki Aubuchon-Endsley, PhD, Assistant Professor, Idaho State University*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP04: Internships Aiding Perceptions of Integrated Care

This poster will present data examining the relationship being pre-professional training opportunities, degree of integration, and perceptions of integrated care which will help to guide and inform next steps for encouraging workforce development programs and goals.

Author(s):

- *Carrie Watson, MC, Lecturer, DBH Doctoral Student, Arizona State University, Tempe, AZ*
- *Colleen Clemency Cordes, PhD, Assistant Dean of Non-Tenure Eligible Faculty Success, Clinical Professor, Arizona State University, Tempe, AZ*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP06: Addressing Caregiver Stress in Primary Care: Evaluation of a Support Group Format

Caregiver can have many different meanings but is broadly defined as a friend or family member who provides unpaid care to an individual with a chronic or debilitating condition. As of 2015, there were approximately 43.5 million people in the U.S. serving as caregivers within the last 12 months. These caregivers face physical, psychological, and financial burdens that are often not addressed by the health care system and can become persistent, unpredictable, and uncontrollable, leading to one-third of caregivers describing a high burden. Support groups are a feasible way to reduce caregiver burden and positively impact psychological well-being. The purpose of the current project was to evaluate the implementation of a support group in response to caregiver burden within an integrated primary care clinic. This monthly support group for all caregivers covers topics including: self-care for physical and mental health, social support, communication, safety, and end of life decision making. Participants routinely complete the Short Form Zarit Burden Interview (ZBI-12) and an anonymous Caregiver Satisfaction Survey developed specifically for this program. Preliminary analyses of the first year of the project reveal that the support group has included 11 members (18.2% men, 81.8% women). Average age was 60.5 years (range 54-68). Members identified as Caucasian (63.6%), African American (27.3%), and Asian-American (0.9%). Preliminary analysis of satisfaction with the caregiver support group intervention revealed that on a scale of 1-5 (1=strongly disagree to 5= strongly agree), participants rated the intervention as helpful (M=4.44), were satisfied with the topics (M=4.66), and felt comfortable sharing their experiences and asking questions (M=4.77). More detailed information about group structure, content, complete results, implications, and future directions will be discussed.

Author(s):

- *Laura Haney, MA, East Carolina University Family Medicine Center, Greenville, NC*
- *Nichelle Huber, MA*
- *W. Miller Johnstone III, MD*
- *Marissa Carraway, PhD*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP07: Old Problem, New Solution: Engaging Patients with Group Medical Visits for Type-II Diabetes

Type II Diabetes is a medical condition in which the pancreas produces insufficient insulin (American Diabetes Association, 2018). Insulin is the primary hormone that allows the body to convert sugar into energy for the body. According to the CDC (2015), there are over 30 million Americans who have Type II Diabetes. This makes up over 9% of the American population. The American Diabetes Association (2018) reports that in 2017 alone there was an estimated $327 economic impact due to the cost of direct medical care, time off work, and

reduced productivity. Those who have diabetes are at increased risk for heart disease which is the CDC's (2016) top leading cause with diabetes being the seventh leading cause of death. Type-II diabetes mellitus (DM-II) is a condition that is generally slow progressing and allows for several points of intervention over time. The increasing prevalence of DM-II has caused a shortage in providers who are adequately resourced to treat the condition effectively with traditional individual visits. It is vital to support providers by finding more efficient and creative ways to treat DM-II while still providing high quality care (Blanc, 2014). A group visit or shared medical appointment (SMA) is a clinical encounter for multiple patients at one time. Kirsh et al. (2017) report that there is a growing interest in SMAs for common illnesses because they are not only cost effective, but also improve patient care and improve self-management. Blanc (2014) reports that patients who participate in group medical visit for DM-II are found to be more successful at managing their diseases and providers find it rewarding because they are able to see more patients without a decrease in the high standard of care provided. The current study evaluates patients (n=35) who are diagnosed with DM-II and are patients of a primary care clinic in the Portland area who participated in SMAs for DM-II management. This IRB-approved observational study reviews pre and post impacts of DM-II specific SMA participation. Data was collected from patients' medical records and include measures of BMI and A1c both before and after participation in DM-II SMAs. A matched sample t-test was used for data analysis and showed statistical significance to lower BMI after SMI participation. Results were not significant for A1c likely due to sample size. This study allows for better understanding the impact of SMAs for DM-II management. Implications, recommendations and effective implementation of the SMA model for DM-II in a primary care setting will also be discussed.

Author(s):

- *Martin Robison, MA, Providence Medical Group, Portland, OR*
- *Elisa Rudd, PsyD*
- *Roseann Getchell, PsyD*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP08: Teaching the Existing Workforce: A Community Based Collaborative Care Program

Few opportunities exist to assist mid-career psychiatric specialists (e.g. psychiatrists, psychiatric nurse practitioners) in repurposing their skills for primary care. This is essential for addressing the growing gap between mental health service need and the available behavioral health workforce. The suicide rate in the US has increased 30% since 2001 while nearly 60% of psychiatrists practicing today are 55 or older. Leveraging the skills of a psychiatric consultant to support generalist physicians and non-medical behavioral health providers in primary care maximizes the population impact of these specialists. The Community- Based Fellowship in Integrated Care trains community-based psychiatric specialists to provide consultation to primary care, thereby expanding access to specialist-informed care. This innovative program teaches the principles of Collaborative Care, including 1) patient-centered team care, 2) use of a registry that monitors treatment outcomes, 3) measurement-based treatment-to-target and proactive treatment changes when needed, 4) evidence-based psychotherapy and/or medications based on patient preference, and 5) accountability for quality of care. This year-long fellowship includes four in-person sessions, monthly videoconference mentor meetings, online and in-person monthly support to complete a Quality Improvement project at their clinic, and weekly online didactics focusing on psychiatric skills and core principles of Collaborative Care. Through this program, practicing clinicians apply new skills within their communities, many of them rural. To date, one cohort of 13 community-based fellows have completed the twelve month program. A second cohort launched in March 2019 with 16 trainees. Regular evaluation via surveys occurs throughout the 12 month program gathering demographics, participation in training sessions, activity attendance, feedback about the fellowship, self-assessed competencies, and attitudes about integrated care. We will present information from the first cohort, including

self- reported confidence in implementing changes learned through participation in the fellowship, topics for quality

Author(s):
- *Jennifer Erickson, DO, Acting Assistant Professor, Psychiatry and Behavioral Sciences, University of Washington*
- *Diane Powers, MBA, MA, Associate Director for Research, Psychiatry and Behavioral Sciences, University of Washington*
- *Betsy Payne, MA Integrated Care Program Analyst, University of Washington*
- *Deborah Bowen, PhD, Professor Bioethics and Humanities, University of Washington*
- *Ramanpreet Toor, MD Assistant Professor, Psychiatry and Behavioral Sciences, University of Washington*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP09: Behavioral health provider onboarding: Strategies to help you hit the ground running

Traditionally, the onboarding plan for a new provider is focused on the new employee. But what happens when the success of your role is largely impacted by the relationships you have with others on the interdisciplinary care team? Interprofessional relationships are a key element of Behavioral Health Consultant success in their role and the earlier they can start being developed the better. This presentation will identify strategies to help management teams create effective onboarding plans for the Behavioral Health Consultant that facilitate smooth adoption of integrated principles and launch successful interdisciplinary collaboration across the care team.

Author(s):
- *Vanessa Casillas, PsyD, Providence Health and Services, Portland, OR*
- *Ryan Dix, PsyD*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP10: Sweet Dreams for Care Managers: Improving Sleep and Wellbeing of Care Managers in Integrated Primary Care

Behavioral health providers (BHPs) play a critical role in supporting the quadruple aim by improving provider and staff wellness. A core competency for BHPs is to help improve the function and relationships of care teams (Miller et al., 2016). Given their clinical expertise, BHPs are uniquely suited to assist care managers (CMs), who report that their professional well-being is influenced by attention to self-care and availability of support from other care team members (Au et al., 2018; Friedman et al., 2016). At Salud Family Health Centers, an FQHC system operating 13 integrated clinics in rural and urban regions of Colorado, one way that BH supports inter-professional function and well-being of CMs is by facilitating a face-to-face, monthly meeting with CMs. This meeting, led by a BH postdoctoral fellow, provides a platform for CMs to express grievances, brainstorm solutions, and develop skills to better manage work-related challenges. This pilot project, developed with the intention to expand BH support to additional care team members, assessed the potential value of these CM meetings. Based on CMs' request for skill-building around sleep, the BH facilitator delivered a 45-min, interactive sleep hygiene (SH) intervention during one CM meeting. A total of 7 CMs (5 females; mean [M] age=48.7 years, standard deviation [SD]=15.7; duration in position M=3.4 years, SD=4.1) provided self-reported data at 3 time points: pre-invention, post-intervention, and at a 1-mo follow-up (1 additional CM excluded due to largely incomplete data). CMs completed the Insomnia Severity Index (Wong et al., 2017), the World Health Organization

Well-Being Index (Topp et al., 2015), a single-item question on burnout validated in primary care (Dolan et al., 2015), and a job satisfaction question at the pre- and follow-up time points. CMs also reported the utility of the intervention and their intention to implement SH techniques at post-intervention and reported whether they implemented and benefited from SH techniques at follow-up. Paired one-tailed t-tests were used to compare pre- and follow-up scores. All CMs reported utility of this intervention as "Very Helpful" or "Extremely Helpful," and 6 of 7 CMs reported intention to adopt at least 1 SH technique at post-intervention. Of the 5 CMs who reported implementing a SH technique at follow-up, all reported equivalent or improved insomnia scores (pre-intervention M=9.8, SD=3.6; follow-up M=7.6, SD=3.5, t(4)=0.01). These CMs also reported improved well-being at follow-up (pre-intervention M=15.8, SD=4.4; follow-up M=18.8, SD=2.5, t(4)=0.04). Measures of job satisfaction and job burnout were unaffected, both t(4)=0.09. Findings provide preliminary evidence that SH techniques may provide benefit to CMs that extend beyond sleep, and highlight ways in which BH can offer their expertise to support care team members. Qualitative data, limitations, and future directions to be discussed in the poster presentation. References Au, M., Kehn, M., Ireys, H., Blyler, C., & Brown, J. (2018). Care coordinators in integrated care: burnout risk, perceived supports, and job satisfaction. American Journal of Preventive Medicine, 54, S250-S257. Dolan, E. D., Mohr, D., Lempa, M., Joos, S., Fihn, S. D., Nelson, K. M., & Helfrich, C. D. (2015). Using a single item to measure burnout in primary care staff: A psychometric evaluation. Journal of General Internal Medicine, 30, 582-587. Friedman, A., Howard, J., Shaw, E. K., Cohen, D. J., Shahidi, L., & Ferrante, J. M. (2016). Facilitators and barriers to care coordination in patient-centered medical homes (PCMHs) from coordinators' perspectives. The Journal of the American Board of Family Medicine, 29, 90-101. Miller, B. F, Gilchrist, M. C., Ross, K. M., Wong, S. L., Blount, A, Peek, C. J. Core Competencies for Behavioral Health Providers Working in Primary Care. Prepared from the Colorado Consensus Conference. February 2016. Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: A systematic review of the literature. Psychotherapy and Psychosomatics, 84, 167-176. Wong, M. L., Lau, K. N. T., Espie, C. A., Luik, A. I., Kyle, S. D., & Lau, E. Y. Y. (2017). Psychometric properties of the Sleep Condition Indicator and Insomnia Severity Index in the evaluation of insomnia disorder. Sleep medicine, 33, 76-81.

Author(s):

- *Aimee R. Zisner, PhD, Postdoctoral Fellow in Primary Care Psychology, Salud Family Health Centers*
- *Yajaira Johnson-Esparza, PhD, Director of Medication Assisted Treatment, Salud Family Health Centers*
- *Jonathan Muther, PhD, Vice President of Behavioral Health Services & Training, Salud Family Health Centers*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP11: Effective Integration Using Electronic Detection and Assessment

An inclusive three-world view of integrated behavioral health is used to evaluate the effectiveness of electronic detection and assessment. Clinically, logic driven in-depth assessment detects the patients missed by simple depression measures like the PHQ-9 alone and reports actionable information for both the medical provider and behavioral health therapist. Automation, electronic processing and EMR integration reduces staff involvement to acceptable levels for operational needs and the labor savings combined with reimbursement meets the financial requirements.

Author(s):

- *Alan Malik, PhD, President, Patient Tools, Littleton, CO*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP12: The Utilization of the BHC to Prevent and Address Nursing Staff Burnout in an Underserved Rural and Remote Region

Workforce solutions for sustaining a nursing staff that is healthy and satisfied with their job can have a systemic impact on the quality of care provided in rural and remote regions. While this program focuses on presenting issues for healthcare workers, the overarching goal is to provide quality healthcare for the Alaska Native population of the Norton Sound region. The aim of this program development and evaluation was to identify and address current burnout, compassion fatigue and secondary traumatic stress symptoms among nursing staff and students serving a rural and remote region. Prevention of burnout was primarily considered for nursing students and was framed as a professional competency to learn and practice while training. In addition to gathering data to assess needs of current nursing staff, a seven-week program was developed and implemented in a nursing curriculum with the objective of utilizing self-care to create, stabilize and preserve a healthy and competent nursing workforce.

Author(s):

- *Cynthia Garza, PsyD, Norton Sound Health Corporation, Nome, AK*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP13: Medical provider satisfaction with integrated behavioral health services in a multi-site urban Federally Qualified Health Center

Utilization of the Primary Care Behavioral Health (PCBH) model is becoming more commonplace in settings seeking to integrate behavioral health within the primary care setting. This study seeks to add to the growing literature on how medical providers practicing within settings implementing PCBH view the usefulness of this model within their clinical practice. A brief, 7-item survey was given to medical providers (n = 33) from a healthcare system that had integrated behavioral health services approximately one to two years (depending on specific clinic location) prior to the administration of this survey. Survey items assessed medical providers' attitudes and perceptions about the Behavioral Health Consultants (BHCs) embedded within their practices. Perspectives about integrated behavioral health were largely favorable. For all items, 61% to 97% of participants endorsed agree or strongly agree. Chisquare analysis determined that the length of time working within the organization was significantly related to the frequency that providers referred to BHC, X2 = (3, N=33), 10.91, p=.012. A bivariate correlation determined that there was a negative correlation between length of time working within the organization (M = .67 SD = .85) and referral pattern (M = .79, SD =.42) , r =.56, p < .001, n = 33; suggesting that individuals who have worked within the organization longer refer less often to their BHC. Additional series of chi-square tests of independence were conducted and determined that professional role (physician or mid-level), frequency with which providers refer (low referrers or high referrers), and previous experience with integrated care (no or yes) do not significantly influence their perceptions of their BHC. It was also determined by a series of chi- square tests that previous exposure to integrated care and professional role do not significantly influence referral pattern. Overall, results suggest that medical providers are strongly satisfied with the integrated behavioral healthcare and their behavioral health consultants. Medical providers overall felt that working within an integrated care team with a Behavioral Health Consultant (BHC) improved their efficiency, enhanced their ability to provide quality care, helped them better address their patients' mental and physical health problems, increased their comfort in discussing mental health issues with their patients, and improved their overall job satisfaction as a medical provider. They also viewed their BHC as an important component of the medical team. These results are particularly promising given the relatively short duration of time that integrated behavioral health services have been offered within these sites, suggesting that such services are viewed as valuable by medical providers fairly quickly after launching, despite frequency with which

they refer, professional role, or if they had previous experience with integrated care. However, it should be noted that these results are reflective of the opinions of medical providers working exclusively within an urban Federally Qualified Health Center and as such, might not be representative of other settings. Future studies should include perceptions of medical providers working within settings integrating the PCBH model, but within perhaps more rural contexts as well as those within private healthcare settings. This presentation fits the conference theme as it demonstrates the overall appreciation medical providers have for integrated care and that this fosters their desire for additional behavioral health personnel, highlighting the limitation to expansion which is availability of a highly trained workforce. It also targets audience members interested in learning how integrated behavioral health services are viewed by medical providers shortly after adoption. Attendees will learn about the outcomes of a brief survey assessing medical providers' views on integrated behavioral health as it relates to their practice and professional satisfaction.

Author(s):

- *Kanesha Moore, MS, NCC, Counseling Psychology Doctoral Student, The University of Memphis, Memphis, TN*
- *Laura Schwent Shultz, Psy.D, Director of Behavioral Health- Ambulatory Care, Methodist Le Bonheur Hospital, Memphis, TN*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP14: Brief Interventions for Trauma-Informed Care in Pediatric Primary Care Settings

Introduction: Childhood trauma can have many short- and long-term consequences that impact both mental and physical health. Trauma can result in chronic stress which impairs the neuroendocrine and immune systems. This toxic stress often causes a prolonged activation of the HPA axis response which leads to abnormal patterns of cortisol in the body. Along with this, toxic stress can also cause issues with immune responses, gene expression, and neurodevelopment of the brain which may result in poorer physical health. Trauma-informed care focuses on recognizing and responding to trauma and therefore, should be included in healthcare assessments from primary care physicians (PCPs). In addition, brief interventions could be beneficial in encouraging healthy coping skills after trauma experiences in children. This systematic review will evaluate the utilization of brief interventions as a part of trauma-informed care in pediatric primary care settings. Methods: A literature search was conducted on Galileo using the key terms "trauma-informed care," "primary care," "child, youth," and "physicians, doctor." Exclusion criteria included full text, scholarly, peer-reviewed articles written in English that were published between 1999 and 2019. Results: A systematic review of the literature found that PCPs should regularly screen for trauma as this is a crucial first step in identifying children at risk for developing a toxic stress response. PCPs should be aware of risk factors and can promote resiliency, both before and after trauma has occurred, as these can work to prevent negative health outcomes. It is important for PCPs to understand how to assess for and handle disclosures of trauma since they can oftentimes be the only medical professional seen on a regular basis. In addition, behavioral health consultants (BHCs) are essential in the process of training and communicating with PCPs about intervening with patients who have a trauma history. Brief interventions that can be provided in pediatric primary care settings include providing psychoeducation, altering risky behaviors, teaching positive coping skills, reestablishing routines, enhancing feelings of safety, and decreasing distress. Conclusion: The literature showed that trauma-informed care and brief interventions should be regularly employed by PCPs before referrals to psychological services. Additionally, PCPs should be aware of the detrimental health effects that can occur after trauma. However, despite the need for preventative interventions, there is little research detailing specifics about how to implement treatments in pediatric primary care. Future research should focus on developing brief interventions useful for PCPs to utilize alongside providing trauma-informed care. Incorporating integrative assistance from BHCs within these primary care settings will be vital for beneficial implementation.

Author(s):

- *Kayla Killingsworth, BS, Clinical Psychology Doctoral Student, Mercer University, College of Health Professions, Atlanta, GA*
- *Mark Stillman, Ph.D.*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP15: Community Health Worker Home Visits For Geriatric Patients In Primary Care: An Impact Evaluation

Integrating multidisciplinary teams (MDTs) into primary care offices can extend care coordination and supports into the homes of community-dwelling older adults. In eastern Pennsylvania, a hospital system developed and deployed MDTs in six primary care offices. The MDTs consisted of a nurse care manager, clinical pharmacist, and community health worker (CHW) who addressed the complex needs of the geriatric patients in primary care. This poster presentation will primarily focus on the role of CHWs in geriatrics primary care. The CHWs performed home visits and patient outreach activities, including, referrals and linkages to community resources, patient education, and caregiver support. After more than 3 years of implementation, CHWs performed nearly 1,700 home visits among 355 patients. A one-group pretest-posttest evaluation of health care utilization was performed using data retrieved from the electronic medical record. Emergency department (ED) visits and hospitalizations were measured 180 days prior to and 180 days after initial patient outreach in patients who have had CHW home visits. The total number of ED visits and hospitalizations decreased by 18.9% and 5.8%, respectively, over six months. More results from patient interviews will be reported to describe the impact of CHW home visits on the individual needs of geriatric patients. This poster presentation will summarize both quantitative and qualitative findings on the impact of CHW home visits in geriatric patients' health outcomes and social needs.

Author(s):

- *Brenda Frutos*
- *Nyann Biery, MS, Manager of Program Evaluation, Lehigh Valley Health Network*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care

---

PEP16: Cultural Humility as a Clinical Competency in the Training of Integrated Primary Care Providers

Implicit biases exist toward minority populations among healthcare providers and in healthcare settings and negatively impact access to care, quality of care, and healthcare outcomes (Hall et al, 2015). For example, Latinos and immigrant populations, in particular, continue to have less access to healthcare delivery systems than whites, even after passage of the Affordable Care Act (ACA) (Alcala et al, 2017). In terms of quality of care, Hoffman, Trawalter, Axt, & Oliver (2016) found that a substantial number of providers believe that African-American patients experience less pain than white individuals, which influences healthcare provider response and intervention. Regarding healthcare outcomes, course and prognosis for black individuals with Diabetes are less optimal than for whites with the same disease, even when accounting for genetic and biological differences (Walker, Williams, & Egede, 2016). The majority of research conducted on racial and ethnic biases demonstrate a positive implicit bias on the part of healthcare providers towards whites and a negative implicit bias towards people of color (Hall et al., 2015). According to Richeson & Nussbaum (2004), most of these biases are implicit vs. explicit and are likely supported by both a lack of cultural knowledge and a fear of appearing racist by acknowledging that racial disparities exist. Hook, Davis, Owen, Worthington & Utsey (2013) hold that "cultural

humility" is able to break down cultural divides that contribute to and serve to maintain healthcare disparities by embracing differences rather than denying them. A culturally humble approach to patient care seeks to break down historical power imbalances in healthcare settings to provide better service. Yet, research reveals that implicit biases against minorities among healthcare professionals mirror those of the general population, suggesting a concerning deficit in mainstrream education and training of healthcare professionals (Hall et al., 2015). When training future healthcare providers to work in integrated primary care settings, instiling cultural humility as a clincal competency needs to be a main focus of training, both didactically and experientially, along with other skills sets unique to integrated healthcare service delivery. Models of integrating cultural humility into training of healthcare professionals are examined in terms of strengths, limitations, and efficacy, and the approach of a HRSA-funded behavioral health training program in integrated primary care for underserved minoirty populations aimed at instiling cultural humility is presented.

Author(s):

- *Steve Katsikas, PhD, Chair, Spalding University School of Professional Psychology; Director - Integrated Behavioral Health Scholars Program; President Elect - Kentucky Psychological Association*
- *Sarah Shelton, PsyD, MPH, MSCP, Spalding University School of Professional Psychology; Clinical Coordinator - Integrated Behavioral Health Scholars Program; Past President - Kentucky Psychological Association*
- *Harris, T., Nichelson, K., Bauman, J., Breedlove, T.,& Schager, J.*

Poster Category: PROGRAM EVALUATION: report on data collected and analyzed, focused on integrated care Training and Workforce Development

---

PO01: Image Empowerment: Healing from the Inside Out and the Outside In

Patients seen in a medical setting are often times addressing their physical well-being, but are not always mindful of their emotional and mental health. This poster presentation showcases a medical family therapist's role in a medical setting in which the therapeutic conversations carried out in sessions has made an impact in the patient's emotional system which then translated into their physical system. A shift in them internally has made shifts in their external appearance as well. This shows that patients can be healed from the inside out, but also from the outside in.

Author(s):

- *Melanie Hussain, CMC Therapy, Plantation, FL*

Poster Category: NOT APPLICABLE (being considered for oral presentation only)

PO02: Virtual Relationships: Applying Core Principles of Effective Integrated Behavioral Health to Serve Rural Clinics through Telehealth Offerings

As a new generation of behavioral healthcare providers enters the workforce, and as mid/senior career providers continue to grow and integrate new modalities, one area of impending growth is telehealth. Over the past year, CentraCare Health has worked at the micro, mezzo, and macro levels to implement a virtual integrated behavioral health program to serve the patients and providers in our rural clinic settings. In this presentation, we will explore the translation of an effective and successful integration program into a tele-communication based service in a rural area. We will examine barriers including the difficulty of forming relationships remotely, replicating the ease of provider accessibility that is found in a traditional integrated setting, and practical factors such as limited numbers of exam rooms in rural clinics and the benefits and pitfalls

of technology. We will discuss how core principals of effective integrated behavioral health were applied to ensure accessibility, communication, and supportive relationships by holding the structure of a Primary Care Behavioral Health model while adapting to the unique needs of a rural setting. From this presentation, attendees will get an overview of an innovative "tele-IBH" program and will learn practical tips for implementing a similar program within their own organization to further ensure access to quality behavioral healthcare for rural community members.

Author(s):

- *Rachel Delaney Geier, MSW, LICSW, Integrated Behavioral Health Provider, CentraCare Health*
- *Jody Kirchner, LICSW, MSW, Collaborative Care Manager, Integrated Behavioral Health Provider, CentraCare Health*

Poster Category: NOT APPLICABLE (being considered for oral presentation only)

PO03: Development and Pilot Evaluation of a Group-Based Standardized Patient Training in Behavioral Health Communication Skills

Improving behavioral health and communication skills of pediatric residents remains an important focus in medical education. In this poster, we present a preliminary evaluation of two novel standardized patient (SP) training experiences in which PGY1 residents observed and practiced behavioral health/communication skills within a group format, facilitated by an interdisciplinary team. Two separate trainings ("Working with a Challenging Patient" and "Breaking Bad News") were implemented at the beginning of the residency training year during intern orientation and retreat. Post-intervention surveys demonstrated that the trainings were received favorably by residents and were considered relevant and realistic learning opportunities. The outcomes from this pilot project suggest that group SP trainings for behavioral health and communication skills may be a promising option for pediatric resident training programs.

Author(s):

- *Rachel A. Petts, PhD, Assistant Professor, Wichita State University, Wichita, KS*
- *Jeffrey D. Shahidullah, PhD, Assistant Professor, Rutgers University - New Brunswick, NJ*
- *Michelle Jaques, PhD, Paul W. Kettlewell, PhD, & Kathryn Dehart, M.D.*

Poster Category: OTHER: any other topic/focus Interdisciplinary education and evaluation

---

PO05: Applying a Population Health Framework to Develop Integrated PCBH Programs in a Variety of Settings to Address Client Needs

You have heard about "population health" and generally know what it is, but how do you implement it for your setting? This poster will briefly describe how professionals from various backgrounds utilized a population health approach to managing chronic conditions such as diabetes, chronic pain, and hypertension etc. We will highlight how population health interventions vary by setting, client population, and presenting conditions and how to draw on the increasingly overlapping roles of the staff in your program to improve the health and well-being of clients and patients. The poster will highlight how this team has develop trainings and educational programming to address the physical and behavioral health needs of patients in integrated primary care settings.

Author(s):

- *Alexa Trolley-Hanson, MS, OTR-L, Clinical Assistant Professor Department of Occupational Therapy, College of Health and Human Services, University of New Hampshire*
- *Lesley Manson, PsyD, Assistant Chair of Integrated Initiatives, Arizona State University*
- *Sue Dahl-Popolizio, DBH, OTR/L, CHT, Clinical Assistant Professor, Doctor of Behavioral Health Program, Arizona State University*
- *Will Lusenhop, MSW, PhD LICSW, Clinical Assistant Professor Department of Occupational Therapy, College of Health and Human Services, University of New Hampshire*

Poster Category: OTHER: any other topic/focus Program Implementation

---

PO06: Behavioral & Family Health Systems: An Integrative Curriculum for Medical Education

An essential component of medical education is an introduction to the impact of family and social support on health and well-being. In traditional medical education, students are introduced to the varying systems that impact health within the body. However, a focus on family and social support systems, as well as larger contextual factors, is critical for effective and evidenced based patient centered care. In this presentation, an intensive week long curriculum designed for undergraduate medical education is described. Presenters will outline the primary educational objectives, topics, and varying pedagogical approaches to learning (such as small groups, large didactic, team based learning, and role plays). Medical students are invited to reflect upon the experience and share how the curriculum impacts their views on future patient care. Faculty and medical students will explore the impactful moments of the training and mechanisms for ensuring a continued focus upon a systemic approach to health. The presentation will end with a discussion regarding the benefits and challenges of integrating family systems and behavioral health into undergraduate medical education. The target audience will be providers and clinicians who work in medical education or individuals who are interested in advancing their knowledge of behavioral and family systems impact on health in adult and pediatric populations.

Author(s):

- *Morgan Stinson, PhD LMFT, Assistant Professor of Psychiatry & Behavioral Sciences*
- *G. Bowden Templeton, PhD LMFT, Associate Professor of Psychiatry & Behavioral Sciences, Program Director Master of Family Therapy Program*
- *Andrea Meyer Stinson, PhD LMFT, Associate Professor of Psychiatry & Behavioral Sciences/Psychiatry, Associate Program Director Master of Family Therapy Program*
- *Medical student(s) (TBD)*

Poster Category: OTHER: any other topic/focus Training and curriculum for medical education

---

PO07: What about the other 60 million people?

60 million people in the United States live in rural areas. People who struggle with mental health issues already have a lack of access to health care. This issue is worse for those living in rural areas due to further lack of access but also stigma related to mental health. Integrated behavioral health can help to improve patient outcomes and limit some of these barriers. We will discuss how we have worked collaboratively to improve access to care and overcome these barriers. We will also discuss how this model is much different than previous models for delivering primary care in a rural setting with case examples, which has led to improved provider satisfaction. In addition we will address benefits and limitations to being a part of a large health care system. We can share our experiences with others so they may implement this into their practice with the goal of bridging the gap for the other 60 million people in the rural United States.

Author(s):

- *Jamie Hammerbeck, MD, CentraCare Health - Sauk Centre, Sauk Centre, MN*
- *Nicole Frie, MSW, LICSW*

Poster Category: OTHER: any other topic/focus The experience of IBH in a rural clinic as part of a larger health care organization after 2.5 years of implementation.

PO08: Simply Completing A Survey Can Induce Healthy Behavior Changes: Implications For Prevention And Population Health

Background: Inactivity and unhealthy diets contribute to poor physical and mental health outcomes. Few Americans engage in recommended levels of physical activity and most do not consume adequate amounts of healthy foods while overindulging in unhealthy foods. Interprofessional strategies to effectively address this pervasive public health problem are needed. Consistent with the conference theme, our presentation reflects the work of an interprofessional team (physicians, dietician/public health epidemiologist and health psychologist) that is providing clinical, research, and program development mentorship to a variety of learners (family medicine residents, medical students, psychology graduate students, pharmacy residents, and an undergraduate college student) as well as team-based care to our patients in a primary care setting. The findings presented in this poster have implications for prevention and population health. Population: Participants were 1137 adults in an integrated, family medicine residency primary care clinic serving an economically and ethnically diverse population. Participants ranged in age from 18 to 90. 66.6% were female, 19.6% identified as Latino, and 22.5% identified as being of Middle Eastern/North African descent. Study Design: This poster reflects the first phase of our project. A survey was created to assess current health behaviors, stages of change, and barriers to eating healthier, increasing physical activity and losing weight. The survey was designed to inform the development of team-based, patient-centered clinical interventions targeting healthy behavior changes. Feedback when piloting the survey led us to also ask about the impact of the survey itself. Surveys were given to potential participants as they checked in for their medical visits and completed as they waited for their physicians. Follow-up phone calls are in process to assess health behavior changes. Key Results: Half (50.8%) of participants reported that the survey made them think differently about the way they eat or their level of physical activity. Even more (62.8%) said they thought they would eat healthier or increase their physical activity level as a result of completing the survey. Preliminary results from follow-up phone calls to date confirm that 72.1% of those who said they would make changes reported making positive changes to their diet or activity level and sustaining those changes six months later. This poster will include details about our survey questions. It will also include predictive analyses of factors associated with health behavior changes along with descriptive analyses of the types of changes that occurred. Conclusions: A carefully constructed survey asking about health behaviors, motivation to change, and barriers to change, serves as an intervention on its own to promote positive and potentially lasting health behavior changes. This is a cost-effective way to impact a large population in a patient-centered way.

Author(s):

- *Lori Lackman Zeman, PhD, ABPP, Associate Director of Behavior Medicine, Beaumont -Troy Family Medicine Residency Program*
- *Sarah Wilson, MD, Faculty Physician, Beaumont -Troy Family Medicine Residency Program*
- *Melissa M. Reznar, PhD, MPH, Associate Professor Interdisciplinary Health Sciences, Oakland University*
- *Alysse Ashkar, DO, Family Medicine resident, Beaumont -Troy Family Medicine Residency Program*
- *Rianna Goetting, Oakland University*

Poster Category: OTHER: any other topic/focus Research focused on health behavior change.

PO09: If the Assessment Fits, Use It!

Organizations attempting to integrate behavioral health and medical care can use an assessment tool to measure their readiness on all of the core aspects of practice design and service delivery. They may also use these tools to track progress, assist with strategic planning, help determine operational gaps, train staff, establish links to community resources, and engage with other important clinical and operations components. This poster presents a comparison of three different integrated care practice assessment tools (MeHAF, IPAT, and AIMS BH Checklist). The researchers selected these three tools because they were designed to measure core components of the Primary Care Behavioral Health model, the Collaborative Care model, and variations of these models across the integrated care continuum. The researchers compared the tools on the core integrated care program implementation domains.

Author(s):

- *Casey Martinez, Arizona State University, Tempe, AZ*
- *Melody Olander*

Poster Category: OTHER: any other topic/focus

PO10: Development of a Competency-Based Curriculum for Interprofessional Warm Handoffs in the Integrated Primary Care Setting

Real-time behavioral health (BH) referrals, known colloquially as warm handoffs, are an essential, empirically supported component of BH care in the integrated primary care (IPC) setting. Still, many BH and primary care training programs do not incorporate such experiences into their curricula. The Centers of Excellence in Primary Care Education (CoEPCE) were established by the Department of Veterans Affairs (VA) with the aim of fostering the development of interprofessional curricula related to patient-centered primary care. In 2017, VA began requiring that all BH providers who practice in the IPC setting receive competency-based training on how to conduct warm handoffs. This curriculum has focused on development of the BH provider's competencies; we were unable to identify any such curriculum for non-BH providers in the VA setting. To address this need, the CoEPCE Curriculum Workgroup began the process of developing such a curriculum. This poster will address the process through which an interprofessional team of providers collaborated to develop this new curriculum. The resulting product was an off-the-shelf toolkit that includes (1) comprehensive teaching strategies that can be tailored to the learner's proficiency level; (2) a competency evaluation tool; (3) a competency worksheet to be used in the clinic for real-time assessment; (4) didactic lecture content; and, (5) informational handouts. Although there is substantial evidence that warm handoffs are effective, there is a dearth of evidence examining how the competency of the handoff's initiator contributes to the success and outcomes of the intervention. Future research could incorporate this curriculum to address this gap in the literature.

Author(s):

- *Joshua Ruberg, PhD, National Psychology Consultant, VA Centers of Excellence in Primary Care Education, San Diego, CA*
- *Elizabeth Painter, PsyD, Psychology Associate Director, VA Centers of Excellence in Primary Care Education-Cleveland Site, Cleveland, OH*
- *Joshua Felker, Bradford Poppe, Anne, The CoEPCE Curriculum Workgroup*

Poster Category: OTHER: any other topic/focus EDUCATION: Curriculum Development

---

PP01: Mapping Medication-Assisted Treatment Shortage Areas: A Colorado Case Study

Initiatives to increase access to treatment for opioid use disorder have grown rapidly in response to the opioid epidemic; however, significant gaps in access to treatment remain. Waivered providers often prescribe buprenorphine at rates below their allowed treatment capacity due to a variety of limitations, and some waivered providers do not prescribe buprenorphine. Given this evidence, determining gaps in treatment access based on prescribing capacity alone may not provide the clearest picture of where resources are needed most. This methodology for defining and mapping treatment shortage areas may support more appropriate targeting of resources.

Author(s):

- *Stephanie Gold, MD, Scholar, Eugene S. Farley, Jr. Health Policy Center, Aurora, CO*
- *Emma Gilchrist, MPH, Deputy Director, Eugene S. Farley, Jr. Health Policy Center, Aurora, CO*
- *Yuli Chen, Research Assistant, Eugene S. Farley, Jr. Health Policy Center*
- *Dionisia de la Cerda, MPA, Senior Professional Research Assistant, University of Colorado Department of Family Medicine, Aurora, CO*
- *Daniel Pacheco, MBA, Project Manager, University of Colorado Department of Family Medicine, Aurora, CO*
- *Anna Furniss, MS, Analytic Coordinator, Adult and Child Consortium for Health Outcomes Research and Delivery Science, University of Colorado, Aurora CO*

Poster Category: POLICY: proposal of new or analysis of current integrated care strategies

---

PP02: Patient-provider demographic matching: Increasing diversity among the behavioral health workforce

Health disparities for racial and ethnic minorities continue to persist in the current healthcare service fields and Black-White and Latino-White inequalities in mental health care access have not improved over time. Systems integrating behavioral health and primary care serve as the best means to reducing such health disparities and reducing barriers to care. The current behavioral health workforce perpetuates current disparities in mental health and substance use treatment and services because of the lack of diversity represented by providers. Intentional efforts to reduce this trend, specifically in integrated settings, is the best opportunity to reduce the disparities that exist related to racial, ethnic, and linguistic discontinuity. The demographic composition of the United States behavioral health workforce does not match that of the general population, nor the population of individuals seeking behavioral health treatment. Factors in workforce planning. Specific workforce strategies may improve the diversity and availability of behavioral health providers to serve minority and under resourced populations and better match the demographic composition of populations in need of behavioral health services. A rapid review was conducted to search the literature for patient and workforce related outcomes associated with patient-provider ethnic matching. Additionally, a case study was examined on Salud Family Health Centers' recruitment of Puerto Rican and other bilingual behavioral health clinicians that demonstrates how health agencies can recruit and retain a racially culturally and linguistically (Spanish) diverse workforce to meet patient need and match patient demographics. Pairing ethnic minority clients with therapists that share the same ethnic or linguistic background can increase treatment utilization, lower rates of dropout and facilitate greater privacy, sense of trust, and accuracy of communication more so than when there is not a patient/provider match. Finally, recommendations for recruitment of linguistically and culturally diverse behavioral health workforce include expanding educational pipeline programs to recruit and prepare students

from diverse backgrounds for behavioral health careers, and developing standards and training models and reimbursement strategies to increase cultural competence of interpreters.

Author(s):

- *Kathryn Scheyer Saldaña, MA, Farley Health Policy Center, Denver, CO*
- *Jonathan Muther, PhD*
- *Emma C. Gilchrist, MPH*

Poster Category: POLICY: proposal of new or analysis of current integrated care strategies Also OTHER: Workforce development recommendations

---

PP03: Psychological Treatments for Anxiety in Primary Care: What is the Best Current Evidence?

Primary care is often the site of initial presentation of the symptoms of psychiatric conditions and these symptoms are often missed and conditions left undiagnosed and untreated. Anxiety disorders are particularly challenging in primary care settings because the symptoms can mimic physical conditions and may require testing and additional services to rule out common conditions in a differential diagnosis. Research of primary care treatments of mental disorders is growing and systematic reviews of a variety of treatment methods are being published. This review was performed to review the currently available evidence on whether psychological treatments are effective for treating anxiety disorders in primary care patients (panic disorder, generalized anxiety, social phobia). The key questions this review attempts to address include: 1. Do psychological treatments reduce anxiety symptoms in primary care patients? 2. For which conditions are psychological treatments effective? 3. Which psychological treatments produce anxiety symptom reduction?

Author(s):

- *Karla Hemesath, PhD, LMFT Clinical Associate Professor, Department of Family Medicine, University of Iowa Carver College of Medicine, Iowa City, IA*

Poster Category: POLICY: proposal of new or analysis of current integrated care strategies Review

---

PP04: How can the research and expertise in collaborative integrated care, developed in the United States, be used in the new integrated primary and secondary mental health care teams in England?

This poster is targeted at marriage and family therapists, primary and secondary mental health professionals, primary care physicians, and those academics involved in training clinicians in collaborative integrated care. It describes current developments in primary and secondary mental health care in England. The new National Health Service 10 year Long Term Plan was launched in January 2019. It outlined healthcare priorities for the next 10 years, the aim being to achieve better outcomes by focusing more funding on mental health and primary and community services. Central to the plan is the creation nationally of integrated care systems and at local level primary care networks.

Author(s):

- *David Humphreys, MSc, Systemic Family Therapist & Postgraduate Researcher, University of Birmingham, Bishops Stortford, United Kingdom*

Poster Category: POLICY: proposal of new or analysis of current integrated care strategies

---

PQI01: Showing Our Worth: Tools for Behavioral Health Curriculum Program Evaluation

Having a behavioral health curriculum is a necessary component of medical residency training. Therefore, it is vital to ensure that efforts at increasing resident knowledge and skills are effective. Measuring the effectiveness of a curriculum can be done through regular program evaluation. Therefore, this poster presentation will focus on teaching audience members about the crucial tools and principles of education program evaluation.

Author(s):

- *Tyler Lawrence, PhD, Behavioral Health Faculty, Sea Mar Marysville Family Medicine Residency*
- *Jessica Koran, PhD, Behavioral Health Faculty, University of Nebraska Medical Center Family Medicine Residency*
- *Juliana Oliveiera, DO, Family Medicine Faculty, Sea Mar Marysville Family Medicine Residency*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI02: Evaluate the buprenorphine waiver training program to increase providers' implementation

Buprenorphine is an opioid medication approved for clinical use in 2002 by the U.S. Food and Drug Administration (FDA)1. Initially, only physicians were permitted to receive a Drug Enforcement Administration (DEA) x-waiver to treat opioid-dependent patients. In July of 2016, the Comprehensive Addiction and Recovery Act (CARA) extended prescribing privileges to qualifying nurse practitioners (NPs) and physician assistants (PAs)2. Given the prescribing requirements, the Psychological Health Center of Excellence (PHCoE) and the National Capital Region's Opioid Safety Program organized medication-assisted treatment (MAT) trainings for providers treating active duty military members, beneficiaries and veterans. This presentation will describe the major dissemination and implementation activities associated with the training. These include: 1) outreach efforts through social media, web-based platforms, online newsletters and list-serves; 2) track the number of trained providers; 3) enhance communication efforts with partners; and 4) address identified barriers at the organizational level that may hinder the success of the training program. The presentation will also discuss challenges when evaluating the implementation activities, which consist of goal setting for reaching the providers in transient environment without baseline data for each provider's category; changes in training policy, resources and organizational structure; and emerging issues (i.e. contract modifications, training format) during planning. The lessons learned will highlight both implementation challenges and successes of the training program in the military that are applicable to other medical systems in the communities. Reference: 1 Substance Abuse and Mental Health Services Administration, 2015. Buprenorphine Waiver Management. 2 Substance Abuse and Mental Health Services Administration, 2015. Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver.

Author(s):

- *Christine T. Nguyen, MHA, Technical Subject Matter Expert, ICF supporting Psychological Health Center of Excellence, Defense Health Agency*
- *Julie A. Chodacki, MPH, PsyD, ABPP, Clinical Care Branch Chief, Psychological Health Center of Excellence, Defense Health Agency*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI03: Interdisciplinary Approach to Complex Patient Care

Since the implementation of the Affordable Care Act in 2010, the number of patients previously uninsured or under insured has declined significantly. The U.S. healthcare system remains largely fragmented, inefficient and largely not cost-effective. With the influx of patients entering the system, there is an increasingly critical need for coordination of care, especially for patients with multiple chronic conditions and increased complexity. This poster describes one practice's quality improvement efforts to increase the quality of care for complex patients, many with a combination of multiple chronic conditions, polypharmacy, social and behavioral health needs and multiple providers involved in their care. The Champion Team (CT) Model is an evidence-based process of engaging various members of the healthcare team to address a quality initiative or need. The Champion Team Model was utilized to involved an interdisciplinary team in creating a process to improve the care provided to complex patients. Professions represented include pharmacy, medicine, behavioral health, nursing and administrative staff. As an interdisciplinary approach was already being utilized in an interprofessional transitions of care (IPTC) clinic, the creation of a dedicated complex patient clinic, later named VIP clinic, had a strong foundation to be built upon. This clinic provides time and resources to high risk, complex patients from an interdisciplinary team. A third interdisciplinary clinic, Medication Management clinic, is also utilized for complex patients to participate in, specifically if they have a complicated medication regimen. The IPTC clinic, VIP clinic and Medication Management clinic function as three tools available to the interprofessional healthcare providers in a residency teaching practice. This poster outlines the risk stratification process, obstacles and lessons learned and successes of the important quality improvement initiative.

Author(s):

- *McKenzie Highsmith, PharmD, BC-ADM, Clinical Pharmacist, ETSU Family Physicians of Kingsport*
- *William Buselmeier, MD*
- *Jesse Gilreath, DSW, LCSW*
- *Jodi Polaha, PhD*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI04: Crisis evaluations: Comparing outcomes between integrated primary care clinics and the emergency department in a rural setting

This project compared short- and long-term outcomes of crisis evaluations completed in Integrated Primary Care (IPC) clinics to crisis evaluations completed in the emergency department (ED) at the main hospital of a large rural hospital system in North Central Pennsylvania. Participants were those patients seen for a crisis evaluation at one of the sites between 9/1/16 through 9/1/18. This study examined differences between IPC and ED on follow-up behavioral health utilization patterns, including, a) rate of inpatient hospitalization; b) wait time to subsequent behavioral health appointment; and c) appointment completion. We hypothesized that crisis evaluations completed in IPC would be associated with increased access to care and improved outcomes when compared to ED. Results and implications of the study relevant to enhancing patient care for youth experiencing mental health crises will be discussed.

Author(s):

- *Monika R. Parikh, PhD, Licensed Psychologist, Associate, Pediatric Integrated Primary Care, Division of Psychiatry and Behavioral Medicine, Geisinger Health System*
- *Sean M. O'Dell, PhD, Licensed Psychologist, HSP-P, Associate, Pediatric Integrated Primary Care, Division of Psychiatry and Behavioral Medicine Assistant Professor, Department of Epidemiology and Health Services Research, Geisinger Health System*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI05: Quality improvement around a screening program for depression and alcohol and drug use in multiple integrated university-based primary care clinics

Ample research supports screening for depression (Siu & USPSTF, 2016) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) efforts to identify and address alcohol and drug misuse (Babor et al, 2007) in primary care. We will provide an overview of a Quality Improvement (QI) project undertaken at multiple integrated university-based primary care sites to expand behavioral health screening (including depression and alcohol and drug use) and arrange appropriate follow-up care. The project was conducted across 3 Family Medicine (FM) and 3 Internal Medicine (IM) clinics, with an average of 7,500 patients per clinic. The clinics are in urban and suburban settings. Methods Our team implemented a program designed to increase screening rates for depression and alcohol and drug use and improve provider- and system-level response to patients with positive screens. An important step in the process was to identify appropriate collaborators prior to rolling out the protocol across the clinical sites. To track processes and outcomes we created a monthly report of screening rates and a patient registry to manage all clinical aspects of care related to this program. Continuous quality improvement was utilized to troubleshoot and improve procedures. Results Data will be presented demonstrating an increase in screening rates over time yet with high variability between clinics – IM clinics' rates increased for the PHQ2 from 10% in 2016 to 30% in 2017 to 76% in 2018, and for the PHQ-9 from 2% in 2016 to 5% in 2017 to 22% in 2018. Various steps were then taken to understand reasons for variations among clinics and solutions attempted to address the variability. The occurrence of a warm handoff when a patient had a positive screen was lower than expected (in 2018, the average occurrence of warm handoff was 16% in FM clinics, 7% in IM clinics). How often patients connected to services once referred was a focus of our QI efforts given the lower than expected rate (of positive screens with a warm handoff and referral, 50% connected after being referred to the BHP and 53% connected after being referred to psychiatry). Conclusion The process highlighted the importance of considering advantages and disadvantages of relying on people versus technology, with technology requiring significant investment in the initial phases to optimize its utility and people having many competing demands for their attention and time. Identifying and then addressing challenges of securing buy-in from stakeholders involved including representatives from various segments of the organization in the initial planning group as well as visiting clinics repeatedly to provide training and receive feedback on processes. The impact of staff burn-out and change fatigue, clarifying roles in the registry management process, and identifying the most appropriate staff/provider to complete tasks will also be discussed as lessons learned to support others in similar efforts.

Author(s):

- *Katrin Seifert, PsyD, ABPP, Assistant Clinical Professor, UC San Diego, San Diego, CA*
- *William Sieber, PhD, Clinical Professor, Director of Collaborative Care, UC San Diego, San Diego, CA*
- *Julie Le, DO, Assistant Clinical Professor, UC San Diego, San Diego, CA*
- *Renu Sugathan, Clinical Informatics Specialist, UC San Diego, San Diego, CA*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI06: Building Compassionate Collaboration: Facilitating the Successful Implementation and Practice of Integrated Care

This presentation will explore the importance of compassion for self and others in the implementation of quality, family-centered care in integrated settings. This presentation will explore a process of facilitation that is

informed by the need to create and hold a safe space in which partners are able to feel and reveal their vulnerability. Using facilitation that is informed by compassion, considers multiple stakeholders' perspectives including medical and behavioral health providers, community partners and patients and families. This presentation will include concrete examples from the facilitator's experience and the opportunity to try out new skills with hands on activities and group work. The presentation will be comprised of a didactic introduction to the concepts, case studies and activities. Quality improvement tools and Implementation Science will be introduced and practiced in this context and participants will have the opportunity to learn from each other's experiences.

Author(s):

- *Felicity Bernard, MA, LCMHC, UNH Citizens Health Initiative, Concord, NH*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI07: Assessing PCBH Competencies and Sustainability in a Fee For Service World: What Impact Does a Student Training Program Have?

In light of the recent development of training programs in settings not affiliated with academic institutions or federally qualified organizations, there is a growing importance to understand the benefits and challenges of incorporating a training program within a fee for service integrated primary care setting. At Swedish Medical Group, we have a three year old training program consisting of clinical psychology doctoral students and masters social work students that offer free services as an extension of BH services. Anecdotally, Swedish Behavioral Health Consultants (BHCs) have provided qualitative feedback to suggest that having students integrated within their home clinic increases supervisor PCBH knowledge and competencies/adherence to the model, as well as decreases risk for burnout. Using the Observation Tool developed by Drs. Olmer and Walberg, we will have students observe licensed BHCs as a component of their orientation, and review responses for impact to competencies and model adherence among BHCs operating with and without students under their supervision as well as discuss broader implications.

Author(s):

- *Shannon Albert, PsyD, Behavioral Health Student Program Lead, Swedish Medical Group, Seattle, WA*
- *Lindsay Olson, Student Behavioral Health Specialist*
- *Jennifer O'Donnell, PsyD, Clinical Program Director Primary Care Behavioral Health, Swedish Medical Group*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI08: Wake up Doc, Sleep is Important! What Primary Care Providers Know about Sleep Medicine

While most primary care providers believe it is their responsibility to counsel families on positive sleep practices, they receive very little formal training and guidance on how to apply evidenced-based treatment in primary care. This presentation summarizes the results of a survey regarding their practices and knowledge of pediatric sleep screening, behavioral interventions, and medication management. The survey was developed based upon previously published survey and additional items were added to learn about medical intervention knowledge and practices of the PCPs. These items were developed with assistance by pediatric sleep specialists across multiple disciples. Surveys were administered to over 10 clinics with and without integrated behavioral health providers across a large and mostly rural health care system. Descriptive analyses as well as comparisons between providers working in an integrated primary care setting and those working in clinics without onsite

behavioral health providers will be shared with the audience. Attendees will be able to describe content areas in which PCPs would benefit from additional training and how to apply evidenced-based interventions in a primary care setting. Survey results will then be used to develop training materials to disseminate across the health care system and measure change in knowledge and practice behaviors.

Author(s):

- *Tawnya Meadows Ph D BCBA-D Co-Chief of Behavioral Health in Primary Care - Pediatrics, Geisinger Health System, Danville, PA*
- *Monika Parikh, PhD, Licensed Psychologist, Associate, Pediatric Integrated Primary Care, Division of Psychiatry and Behavioral Medicine, Geisinger Health System, Danville, PA*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI09: Patients' Perspectives of Brief Cognitive Behavioral Therapy for Chronic Pain: Treatment Satisfaction, Perceived Utility, and Global Assessment of Change

Background: Chronic pain is a debilitating condition that significantly impacts millions of primary care patients every year in the US. Integrated primary care providers are in an ideal position to contribute to the biopsychosocial treatment of chronic pain. However, existing evidence-based psychosocial treatments, such as cognitive behavioral therapy for chronic pain, were developed for specialty care settings and are not consistent with the population-based treatment approach of integrated care models such as Primary Care Behavioral Health (PCBH). To address this gap in treatment options, Brief Cognitive Behavioral Therapy for Chronic Pain (Brief CBT-CP) was developed. Brief CBT-CP is an abbreviated version of the full-length evidence-based protocol for chronic pain developed in the Veterans Health Administration (VHA). Brief CBT-CP addresses core psychoeducation about chronic pain, behavioral activation and pacing, cognitive skills, and relapse prevention strategies. Brief CBT-CP was designed to be administered by PCBH providers in up to six, 30-minute appointments. After its initial development, the Brief CBT-CP manual was disseminated to select VHA PCBH providers as part of a clinical demonstration project. Embedded in this project was a pilot assessment of patients' experiences with Brief CBT-CP that aimed to characterize their perceptions of treatment acceptability and utility in order to identify potential areas for improvement. Method: Twenty-four PCBH providers across VHA volunteered to participate in the Brief CBT-CP demonstration project in 2017-18. Providers agreed to receive training from the study team via consultation teleconferences, deliver the CBT-CP protocol to patients in their local clinics, and distribute a brief survey to patients who completed the protocol anonymously. The one-page survey included a series of demographic questions (e.g., age, gender, racial background) and six questions on patient attitudes and perceptions of the Brief CBT-CP intervention. The survey also included a one-item global assessment of change in pain-related activities, the emotional impact of pain, and overall quality of life. Results: A total of 34 patients returned the survey. Participants reported a mean age of 55.8 (SD = 9.8) and primarily identified as male (68%; 26% female and 6% transgender). Participants were racially diverse although the majority were White (53%). All participants reported a history of taking medications for their pain; 71% reported being prescribed opioid medications. Most reported that they were very satisfied (71%) and found the treatment to be very useful (65%). Almost all participants reported that they received "just the right number" of appointments (88%) and that the length of each individual appointment was also acceptable (85%). Evaluation of the global assessment of change item indicated that 59% of respondents reported that their pain-related functioning was at least moderately better with 32% reporting definite improvement in functioning following treatment. Patients' self-reported treatment improvement was significantly correlated with treatment utility ($r = .52$, $p < .05$) and treatment satisfaction ($r = .53$, $p < .05$) providing support that Brief CBT-CP contributed to clinically relevant change. Discussion: Overall, the results of this patient survey suggest that Brief CBT-CP is a viable PCBH intervention to help primary care patients improve their pain-related functioning. Global measures

of change such as the one used in this study are easy to administer and function well in identifying clinically significant change in real-world settings (Kamper, Maher, & Mackay, 2009). Patients' treatment satisfaction and global assessment of change in this evaluation complement our prior findings that showed clinically-significant improvement in pain-related interference scores. Future research examining the effectiveness and clinical relevance of Brief CBT-CP will help to further establish this intervention as treatment resource for PCBH providers in VHA and non-VHA settings.

Author(s):

- *Travis Loughran, PhD, Psychology Postdoctoral Fellow, VA Center for Integrated Healthcare, Buffalo, NY*
- *Lisa Kearney, PhD, Associate Director-Education, VA Center for Integrated Healthcare, Buffalo, NY*
- *Gregory Beehler, Paul King, Katherine Dollar, Jennifer Murphy, & Wade Goldstein*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI10: The Heart of Integrated Care; Roadmap to Relationships

There is no single best model for integrating behavioral health and medicine. One required element across models is building relationships. No matter what model of integration is used, early stages of integration must support communication, training, and building shared collaborative practice models (Ratzliff et. al., 2016). The Center for Integrated Health Solutions defines a successful integrated care team as a multidisciplinary group of providers, working together with the patient, using a shared treatment approach and assisting the patient to achieve specific physical and behavioral health outcomes (Lardieri et. al., 2014). There are limited studies that specifically investigate team-building and relationship development in integrated primary care, particularly in pediatrics. In addition, articles that discuss interprofessional collaboration are not easy to access because there are no consistently defined keywords in the literature (Supper et., al, 2014). One review that discussed aspects of relationship building found that physicians and psychologists view collaboration as a mechanism to improve quality of care for patients, their own quality of work life, and opportunity to develop new professional skills (Supper et., al, 2014). However, several barriers were noted during collaboration in the field, including differing views on presenting problems as well as lack of definition, awareness and recognition of the role of each professional (Supper et., al, 2014). One way to clearly identify and establish roles is through the development and use of clinical pathways (Reiter et. al, 2018; Hunter et. al., 2018). Pathways prescribe routine involvement of the behavioral health provider in the care of patients through the use of formal clinic workflows. Pathways identify who provides what care, at what point, and for how long (Reiter et. al, 2018; Hunter et. al., 2018). This project describes the process of transformation from no behavioral health to full behavioral health integration of a large pediatric primary care practice, discusses the importance of relationship building and partnering with key stakeholders in the process of integration transformation, and identifies how workgroups can develop integrated care pathways to enhance recognition of behavioral health problems, promote referral to behavioral health, define treatment of specific conditions, and sustain continued co-management. Specifics are shared regarding how workgroups developed pathways to train staff on how to recognize and address specific conditions. Outcomes such as increased referral rates as well as patient and provider satisfaction are presented. References Hunter, C. L., Funderburk, J. S., Polaha, J., Bauman, D., Goodie, J. L., & Hunter, C. M. (2017). Primary Care Behavioral Health model (PCBH) research: Current state of the science and a call to action. Journal of Clinical Psychology in Medical Settings. Lardieri, Michael R., Lasky, Gina B. & Raney, Lori (2014). Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams; SAMHSA-HRSA's Center for Integrated Health Solutions. Ratzliff, A., Unutzer, J., Katon, W., & Stephens, K. A. (2016). Integrated care: Creating effective mental and primary health care teams. Hoboken, NJ: Wiley. Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2017). The primary care behavioral health (PCBH) model: An overview and operational definition. Journal of Clinical Psychology in Medical Settings.

Author(s):

- *Amy A. Signore, PhD, MPH, Connecticut Children's Medical Center and The Village, Hartford, CT*
- *Lisa L. Backus, PhD, Connecticut Children's Medical Center, Hartford, CT*
- *Catherine Wiley, MD, Karen Rubin, MD, Larry Scherzer, MD, MPH, Steven D Moore, PhD*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PQI11: Learning Collaborative Care and Curriculum Design as a Resident: An Opportunity to Build Educational Skills

Background/Significance: As the evidence base supporting collaborative care approaches for the delivery of mental health services grows, healthcare systems are increasingly utilizing collaborative care models. A critical need for psychiatrists trained in collaborative care has motivated psychiatry residency programs across the nation to expand their collaborative care offerings. This transition represents a valuable training opportunity for residents to participate in clinical education, working with training faculty to develop multimodal curricula including didactics, clinical supervision, and inter-professional simulation. Here we discuss opportunities for development of clinical educational skills through participation in development of a resident collaborative care rotation. Methods: We examine University of California San Diego's (UCSD) progress in integrating collaborative care training into residency education and highlight opportunities for trainee educational leadership and mentorship. This includes a review of patient care opportunities, didactics and existing resources relating to this topic, faculty development, and resident roles to date. Results: A gap in training about collaborative care, including specific approaches to therapy and team integration, was identified. A review of UCSD trainee placement sites also revealed that psychology trainees were learning to practice in collaborative care models, while psychiatry trainees were not. Subsequently, a half-day VA-based collaborative care elective rotation is being transformed into a required clinic experience for categorical psychiatry residents. The new core rotation will include a didactic component, mentoring in specialized skills required to practice collaborative care psychiatry, inter-professional education, and co-therapy experiences. A joint internal medicine, psychiatry, and psychology collaborative care simulation training is also planned. The development of the core rotation curriculum also offers opportunities for residents to learn about resident education and gain experience in creating training experiences. The primary obstacle identified in both expanding training and including residents in these initiatives was resident service obligations. Discussion: Despite the need for psychiatrists trained in collaborative care models, we found that training opportunities for psychiatry residents in collaborative care at UCSD was inadequate. We summarize our plans for an expanded and required collaborative care rotation, focusing on resident involvement to provide training in curriculum design. Conclusion/Implications: Many psychiatry residency programs are in the process of determining how to optimize education about collaborative care models. Expanding collaborative care offerings is an opportunity for educational innovation. Involving residents in these efforts is an ideal opportunity for engagement in scholarly projects and curriculum development, preparing residents for continued involvement in psychiatry education post-training. Incorporating collaborative care rotations into psychiatry residency training will also lead to a broader understanding of integrated care among psychiatrists.

Author(s):

- *Keren Friedman, MD, UC San Diego Health Department of Psychiatry , San Diego, CA*
- *Alan Hsu, MD Kristin Beizai, MD Alana Iglewicz, MD Joshua Ruberg, PhD Autumn Backhaus, PhD Cortney Mauer, PhD Jeanne Maglione, MD, PhD*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement
Conceptual

PQI13: Increasing Integrated Primary Care Utilization in Two Ambulatory Residency Primary Care Health Centers: A Continuous Quality Improvement Project

Integration of behavioral medicine into primary care is a well-supported method for symptom management and improved care for common behavioral and mental health disorders. Integrated primary care (IPC) typically involves brief (15-30 minutes, 1-6 sessions) assessment, intervention, and care coordination by a behavioral health consultant (BHC). This model of care is of particular importance in primary care residencies where educating primary care providers to obtain competency in behavioral science is a priority. Despite being an evidence-supported practice, optimization of IPC within primary care residencies continues to be a challenge. The current continuous quality improvement (CQI) project sought to examine barriers and implementation of an IPC model into two ambulatory residency health centers (Family Medicine (FM) and Internal Medicine (IM)) with varying previous experience with integrated care. The FM residency has been integrated with behavioral medicine for over two decades and includes a postdoctoral fellowship and practicum students in clinical health psychology, as well as behavioral medicine faculty. On contrast, the IM residency has been introduced to IPC for less than 18 months and has fewer BHCs. Therefore, this project developed strategies to improve implementation and utilization of IPC within these two unique residency health centers, with a focus on specific strategies for training environments and health centers with varying familiarity with the IPC model. The initial phase of this project involved creation of a taskforce with key stakeholders and engagement in a self-assessment process using subjective (SWOT analysis) and objective (Practice Implementation Profile; tracking log) tools. The project analyzed and compared strategies cumulatively and between health centers. In the four months prior to the initiation of the IPC taskforce in February 2019 there was low utilization of IPC, with an average of 15.25 consults per month (FM avg. = 13.5; IM avg. = 1.75), consistent with historical trends of IPC utilization. Initial barriers identified during the self-assessment period were: lack of knowledge of IPC from faculty, residents, and staff; perception of increased length of visit; work space and visibility of BHCs; availability of BHCs; yearly residency turnover; and standardized processes to identify and engage patients. As a result, we implemented three major strategies: 1) education, 2) visibility and availability, and 3) identification of automatic triggers for IPC. Strategic education sessions with faculty and residents in both health centers, and with staff in IM, were held. Additionally, we added two partial coverage sessions for IPC by behavioral medicine faculty and instructed BHCs to increase visibility during huddle, throughout clinic sessions, and with their physical location. Last, we identified "automatic triggers" (e.g., A1C > 6.5, current smoker, PHQ9 >10) for IPC based on chart review, BHC or PCP clinical knowledge, and/or scores from a newly developed behavioral health screening form (currently in use in IM only). Since the implementation of these changes, utilization of IPC saw an increase of 86.69%, to an average of 28.5 IPC consults per month (avg. FM = 25; avg. IM = 3.5). In particular, implementation of the behavioral health screening form resulted in an increase in IPCs in the IM residency from two in May to nine in June. Increased visibility and access appeared to have the largest effect in the FM residency. Despite prior stagnation, improved enthusiasm, knowledge, and workflow resulted in promising increases in utilization rates. Future PDSA cycles will examine additional strategies to improve utilization and link use of IPC to health outcomes.

Author(s):

- *Jennifer Carty, PhD, Associate Director of Behavioral Medicine Education Family Medicine , McLaren Flint/Michigan State University, Flint, MI*
- *Andrew Champine, PsyD, Director of Behavioral Medicine Education Internal Medicine, McLaren Flint/Michigan State University, Flint, MI*

- *Alyssa Vela, PhD Lucetry Dalton, PhD Julie Thai, MD Ebrahim Abdelrazzak, MD Arunima Dutta, MD Parul Sud, MD*

Poster Category: QUALITY IMPROVEMENT: formal approach to performance assessment and improvement

---

PSR01: Is Population Health Management Even a Thing? A National Survey of Primary Care Clinics

A comprehensive population health approach is designed to improve patient outcomes and reduce costs by increasing disease management, improving patient decision making, and closing care gaps. Although there is considerable incentive to adopt these strategies, the level of adoption among primary care clinics is unclear. We surveyed 128 clinics in states across the US to measure the utilization level of population health management strategies. One in five participants (21.1%) reported using all five population health strategies, almost one in three (31.4%) reported using all five care management strategies, and one in ten (11.43%) reported all ten strategies. The least commonly reported strategies for population health and care management were non-clinical data aggregation and team meetings, respectively. The most commonly reported strategies for population health and care management were patient registries and treatment follow-up, respectively. The most commonly reported electronic health record product was Epic. These survey results suggest that many clinics may not be using a comprehensive population health management approach for patients. Future studies should profile high performing clinic systems and identify those structural components that support a comprehensive strategy.

Author(s):

- *Matt Martin, PhD, LMFT Clinical Assistant Professor Arizona State University*
- *Stephanie A. Brennhofer Research Specialist Arizona State University*
- *CR Macchi, PhD, LMFT Clinical Associate Professor Arizona State University*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR02: Families, Trauma & Health: The Role of Relationships on Adult Health

Childhood trauma has been linked to increased incidence of both mental (Charlotte et al. 2017) and physical health disorders in adulthood (Dube, Felitti, Dong, Giles & Anda, 2003). Though it is difficult to determine the exact prevalence rate, some estimate that as many as 60% of adults report having experience trauma in the first 17 years of life (National Center for Mental Health Promotion and Youth Violence Prevention, 2012). Previous research has indicated the systemic ways in which adult family and partner relationships can affect a person's mental and physical health as well (Priest et al., 2015). The biobehavioral model (Wood, 1993) posits that supportive families can act to protect individuals from negative mental and physical health outcomes. The poster presentation will discuss the results of study in which the mediation pathway between childhood trauma, a supportive family or partner environment, mental health, and physical health has been analyzed. The hypothesis tested postulates that a supportive family or partner environment will reduce biobehavioral reactivity (anxiety/depression) in individuals who have experienced childhood trauma, as well as, reduced the incidence of chronic illness as measured by symptomology and number of medications. The findings will focus on the importance of utilizing a biopsychosocial approach to understanding health outcomes and the clinical importance of screening for childhood trauma.

Author(s):

- *Jennifer Kendall, Texas Woman's University, The Colony, TX*

- *Veronica Kuhn*
- *Sarah Woods*
- *Mary Hannah Key*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR03: Assessing complex behavioral health needs of primary care patients in the patient-centered medical home (PCMH)

Behavioral health (BH) concerns are common and can result in significant disability. Despite increases in integrated primary care BH services, physicians continue to manage most BH needs. Through analysis of physicians' management of patient BH concerns, referral of patients to BH services, and patient utilization of BH services, we aim to better understand how physicians and patients engage with BH services in a patient-centered medical home (PCMH). Resident and faculty physicians from an academic residency PCMH with a co-located BH service were recruited. Physicians were surveyed on their confidence diagnosing and managing depression, anxiety, and bipolar disorders in patients. A referral and utilization tracking system for the BH service was developed. Electronic Health Record data were extracted to examine patient and provider engagement with BH services. Differences in referral and utilization data by patient demographics were explored. Results from repeated measures general linear models indicated main effects of disorder ($F(2, 42)=24.5$, $p<.001$) for confidence diagnosing. Physicians reported more confidence diagnosing depression and anxiety than bipolar disorders ($F(1, 21)=29.8$, $p<.001$). A main effect of disorder was found for confidence personally providing therapy ($F(2, 42)=19.4$, $p<.001$), with more confidence providing therapy for depression and anxiety than bipolar disorders ($F(1, 21)=25.6$, $p<.001$). Referral and utilization data demonstrated similar patterns. 479 referrals were made to the BH service with significant differences in patient diagnoses ($\chi^2(96)=162.7$, $p<.001$). The majority of referrals to therapy were for patients with either depression or anxiety diagnoses, while the majority of referrals to psychiatry were for bipolar disorder, or comorbid depression and anxiety. The BH needs presented at this PCMH are indicative of the issues facing primary care. Providers are challenged with treating complex behavioral health issues. Recommendations for improved integrated BH are discussed.

Author(s):

- *Chariz Seijo, University of California San Diego, La Jolla, CA*
- *Justin Nash, PhD, Department Head, Allied Health Sciences, University of Connecticut*
- *Melissa R. Hatch, Marisa Sklar, Cara Fuchs, Daniel Evans, Lisa Uebelacker*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR04: The ins and outs of providing obesity services in primary care settings: The Making Obesity Services and Treatments work (MOST) study

Background: Obesity is a prevalent and challenging public health issue. Primary care (PC) providers and staff are tasked with screening and counseling for obesity, which includes intensive behavioral therapy (IBT). This study explored the provision of obesity services in a convenience sample of 85 PC practices from 14 US states. Population: Clinicians and staff of PC practices. Some were identified because they submitted >10 claims for the Medicare IBT for obesity benefit as reported in the Medicare Provider Utilization and Payment Data files between 2012-2015. Some were identified through practice-based research networks. Study Design: Descriptive, qualitative study. Procedures: Individual, semi-structured telephone interviews were conducted between July

2017–December 2018. Transcripts were analyzed using a qualitative thematic analysis (data triangulation and a constant comparative technique). Key Results: Among those who previously or currently provide and bill for comprehensive obesity services (n=38), at least one provider in each practice expressed a strong passion for the provision of obesity management in primary care and described great joy in helping patients lose weight. However, all participants were frustrated with low reimbursement rates for obesity services and those experienced with IBT Medicare billing found it to be burdensome and difficult. Providers in practices that specialize in weight loss often added or reverted to self-pay in addition to using various insurance billing codes. Practices self-described as "successful" established a protocol for obesity services, included multidisciplinary staff (physicians, advanced practice providers, registered dietitians) and had a specified plan for approaching weight loss (e.g., type of diet, plan for success). Conclusion: Clinicians and staff are motivated to address obesity in PC can experience joy providing obesity care, but also often encounter significant

Author(s):

- *Phoutdavone Phimphasone-Brady, PhD, University of Colorado, Anschutz Medical Campus, Aurora, CO*
- *Andrea Nederveld, Lauri Connelly, Rowena Dolor, and Jodi Summers Holtrop*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR05: Role of behavioral health providers in the provision of diabetes care in integrated primary care settings: the Invested in Diabetes study.

Background: Diabetes is a significant burden in primary care. Patients benefit from comprehensive self-management education and support emphasized in a shared medical appointments (SMA). Our research with patient stakeholders revealed that ideally, SMAs should be led by a team including behavioral health providers (BHPs). Our objective is to describe the role and experiences of BHPs in diabetes care in integrated care settings prior to a comparative effectiveness trial of diabetes SMAs called Invested in Diabetes (i.e., Invested). Population: Primary care practices (n = 22; 45.5% private practices and 54.5% federally qualified health centers) in Colorado and Kansas that serve 55% Latino and 4.6% American-Indian patient populations. Study Design: Descriptive, qualitative study Procedures: Individual, semi-structured interviews were conducted with MDs, RNs, medical assistants, health educators, and BHPs. Transcripts were analyzed using a qualitative thematic analysis (data triangulation and constant comparative technique). Key Results: Baseline results from BHPs revealed experiences with primary care integration, role in diabetes care, and expected role in this project. Practices varied by degree of integration, from involving BHPs in all new patient visits to BHPs are on site but not fully integrated. BHPs provided brief psychotherapy, collaborated with providers, and coordinated outpatient mental health for cases with severe mental health diagnoses. Diabetes-specific care included stress management or self-management interventions. Some BHPs hesitated to assist with diabetes care and expressed the need for greater training. While BHPs were unclear of their role in Invested, the support for collaborative models of treatment for diabetes and enthusiasm for this project was universal. Conclusion: BHPs can greatly enhance the diverse needs of patients with diabetes. Invested in Diabetes serves as an example to expand the role of BHPs in integrated settings.

Author(s):

- *Phoutdavone Phimphasone-Brady, PhD, Postdoctoral Fellow, University of Colorado, Anschutz Medical Campus*
- *Andrea Nederveld, Jodi Summers Holtrop, Jeanette Waxmonsky, and Bethany M. Kwan*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR06: Suicide treatment anxiety: How do we help providers to help others?

Background/rationale: Suicide is a growing cause of death in the United States (Hedegaard, Curtin, & Warner 2018). Therapists who treat people with suicidal ideation (SI) frequently experience anxiety (Moerman, 2012). Physical health care providers and systems also struggle with treatment of suicide as well as coordination of care (Knesper, 2011). Description of population sampled: In our current study, we interviewed 9 participants from various behavioral health disciplines (e.g., LCSW, or LCSW-A, LMFT or LMFT-A, LPC or LPC-A) and with different backgrounds and years in practice (age range from 24 to 49 [M = 34.44, SD = 8.8]; years in clinical practice from 2 to 21 [M= 10.25, SD=7.99]). Procedures/measures: We used a phenomenological qualitative approach to understand therapists' experiences of what it is like to work with patients with SI and what therapists do when working with patients who have SI. Study design: We used a semi-structured interview guide with a grand tour question and supporting questions to elicited therapists' experiences of working with patients with SI. Key results: Results indicated three major themes for therapists working with patients with SI: (a) self-of-the-therapist issues, (b) issues relating to power, and (c) issues relating to treatment. These results indicate the need for further training and supervision of therapists and other health care providers to manage provider anxiety/emotional reactions to patients with SI and to balance provider expertise/power and client autonomy in risky situations. Conclusions: As the findings suggest, more supervision should be available to therapists (especially therapist-in-training) and other health care providers working with patients experiencing SI. Further, providers should use clear and direct language to screen/assess for SI and to discuss treatment options with patients who have SI.

Author(s):

- *Rebecca Levy, MMFT, East Carolina University, Greenville, NC*
- *Aubry Koehler, PhD, LMFT*
- *Quintin Hunt, PhD, LMFT*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR07: Identifying Intimate Partner Violence: A Review of Three Measures for Implementation in Primary Care Settings

Introduction. Recent survey data report that more than 27% of women and 11% of men have experienced violence (e.g., sexual, physical, psychological) and/or stalking by an intimate partner in their lifetime. It is estimated that the lifetime cost of intimate partner violence (IPV) is $103,767 per female victim and $24,414 per male victim, with a population economic burden of $3.6 trillion over victims' lifetimes. Studies have suggested that one of the major barriers for IPV disclosure is a lack of universal screening for violence in mental health and medical settings. Therefore, it is imperative for health-service providers to integrate IPV measures that are empirically, psychometrically sound. This review examined the existing research on the psychometric properties of evidence-based IPV screening mechanisms for administration in primary care. Methods. Three hundred sixty articles written between 1995 and 2018 were reviewed and identified the Women Abuse Screening Tool (WAST), the Conflict Tactics Scale Revised (CTS2), and the Hurt, Insult, Threaten, Scream (HITS) as the most commonly used IPV screening tools. From this list, a second review was conducted to obtain psychometric data for each measure. Reliability and validity estimates were recorded and compiled to identify any significant differences across measures. Articles that used a translation/back-translation of instruments in foreign languages were included as well as shortened versions. Results. Twenty-one studies (Total participant N = 11,521) were identified that examined the psychometric properties of the WAST, CTS2, and/or HITS. All instruments demonstrated high reliability in both internal consistency and test-retest. The HITS and WAST reported higher internal consistency

than the CTS2 (HITS α=.61-.90; WAST α=.75-.95; CTS2 α=.18-.95). The HITS demonstrated strong convergent validity and was highly correlated with CTS2 total and its sub-scales, the WAST, and the ISA-P. Finally, the HITS correctly classified 96% of self-identified abused women and 91% of non-abused women. Conclusions. This review suggests that the HITS is the shortest, most reliable, and valid measure compared to the WAST and CTS2, indicating that it takes the least amount of time for patients to complete, with significant accuracy of IPV incidence, and for health-service providers to score, which can be attractive in fast-paced medical environments. The data from this review provides further evidence in support of the HITS as an effective measure for identifying IPV in primary care. Limitations and future directions of this research are discussed.

Author(s):

- *Matthew W. Henninger, BA, Counseling Psychology PhD Student, Department of Counseling, School, and Educational Psychology, University at Buffalo*
- *Andrea D. Clements, PhD, Professor, Department of Psychology, East Tennessee State University*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR08: Obtaining Provider and Patient Feedback to Refine the Treatment Manual for a Brief Primary Care Anxiety Intervention

Anxiety is common, yet under-treated, in primary care. Evidence-based anxiety interventions that are patient-centered and designed specifically for integrated primary care (IPC) are critically needed. We developed a modular anxiety intervention by adapting evidence-based, cognitive-behavioral intervention techniques (e.g., exposure, relaxation training, mindfulness meditation) for delivery in a brief format compatible with IPC practice. We sought feedback from IPC providers and primary care patients to refine the treatment manual to enhance provider feasibility and patient acceptability, respectively. We conducted semi-structured interviews (M=42 minutes) with IPC providers (N=5, 100% female, 60% psychologist, 40% social worker), who rated the feasibility of the number, duration, frequency, and format of sessions as well as of delivering a manualized intervention in IPC and collaborating with patients to select modules. They also shared strengths, concerns, and suggestions regarding the overall intervention and specific modules. We conducted a pilot open trial with patients (N=6, 33% female, 100% White, age M=55.2 [18.9] years) who completed all 9 possible modules. Patients completed the Generalized Anxiety Disorder-7 and Patient Health Questionnaire-9 at baseline, prior to every session, and at post-assessment. After each session, they rated the helpfulness, relevance, and their intention to try the skills taught in each module. At post-assessment, they completed an acceptability interview assessing likes, dislikes, and most/least helpful components. We will use descriptive statistics for quantitative data and summarize common themes from qualitative data. This project illustrates a feasible process for collecting pilot data from key stakeholders to refine an intervention prior to large-scale evaluation or implementation in IPC settings.

Author(s):

- *Robyn L. Shepardson, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse, NY*
- *Jennifer Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse, NY*
- *Risa B. Weisberg, PhD, Assistant Chief of Psychology & Internship Director, VA Boston Healthcare System*
- *Stephen A. Maisto, PhD, Professor of Psychology, Syracuse University*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR09: Family Support and Barriers for Physical Activity in Children of Parents Participating in Medically Assisted Weight Management

The purpose of this study was to explore the associations of child exercise and sedentary activity, contextual and demographic factors, and family exercise participation to identify specific areas of intervention for children (ages 2-18) with parents engaging in medically assisted weight management. Family exercise participation was significantly associated with participant race, child mild physical activity, and child exercise video game use. Future work should determine methods to engage children in parental MWM, and to explore ways to engage families in PA to ensure changes in MWM are sustainable, and to prevent the onset of obesity in a high-risk group of children.

Author(s):

- *Catherine "Katie" Van Fossen, MS, PhD Candidate, Department of Human Sciences; The Ohio State University*
- *Keeley Pratt, PhD, Associate Professor, Department of Human Sciences; Department of Surgery; The Ohio State University*
- *Haley Kiser, MA, MFT, Department of Human Sciences; The Ohio State University*
- *Callie Lambert Brown, MD, MPH, Wake Forest University*
- *Joseph Skelton, MD, MS, Wake Forest University*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR10: Behavioral Health Integration Within Division I Collegiate Athletics: A Disparity Between What It Is Now and What It Should Be

Collegiate and elite athletes, or athletes who are engaging in physical activity for their sport with extreme intensity, are highly susceptible to behavioral health issues, which include mental health and substance use disorders (Hughes & Leavey, 2012; Hunt & Eisenberg, 2010). Recent Studies have found that there is an increased prevalence of poor behavioral health among the student-athlete population (Sudano, Collins, & Miles, 2017; Watson & Kissinger, 2007). Recognizing the importance of whole-person care, the National Collegiate Athletic Association (NCAA) published mental health best practices guidelines (NCAA, 2016). These guidelines recommend the integration of behavioral health into the medical care of student-athletes (NCAA, 2016). Yet, there are few studies that provide insight into the current level of behavioral health care integration in collegiate medical settings. Sudano and Miles (2017) conducted a survey of head athletic trainers regarding behavioral health services within NCAA Division I institutions. Consequently, researchers were able to approximate the current state of integration using the Substance Abuse and Mental Health Services Administration's (SAMHSA) standard framework for levels of integrated healthcare (Heath, Wise Romero, & Reynolds, 2013).

Author(s):

- *Casey Martinez, BS, Graduate Student, Arizona State University*
- *Laura Sudano, PhD, LMFT, Associate Director, University of California San Diego*
- *Christopher M. Miles, MD, Associate Director, Wake Forest Sports Medicine Fellowship*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR12: Characteristics of OEF/OIF/OND Veterans Related to Symptom Severity in a VA Post-Deployment Clinic

This poster presents the results of analyses conducted on initial evaluations of veterans presenting to the post-deployment clinic at the James A. Haley Veterans' Hospital in Tampa, FL. This clinic functions as a specialized primary care clinic that incorporates behavioral health providers as well as other specialty professions. Given

that previous research suggests a link between deployment characteristics (particularly deployment length) and various psychiatric concerns, this study focused in particular on evaluating relationships between deployment characteristics and symptom severity on multiple behavioral health screening questionnaires. Results suggest that although there are statistically significant relationships between deployment length and symptom severity, these relationships are weak relative to the associations that have been established by previous research with servicemembers. Implications for working with Veterans in integrated healthcare systems are discussed.

Author(s):

- *Matthew Baker, PhD, Psychology Resident, Department of Veterans Affairs*
- *Stephanie N. Miller, PhD, Daniel Agliata, PhD, & Ronald J. Gironda, PhD*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR13: Eudaimonic Well-Being, Close Family Relationships, & Health for African Americans with Hypertension

Hypertension is a leading cause of coronary heart disease and stroke (Fongwa et al., 2008), and recent prevalence data indicates that African American men and women are significantly more at-risk for hypertension than other racial/ethnic groups (Fryar et al., 2017). Because recent research suggests that psychological and relational health may be important predictors of hypertension, this study examined the interactive effects of eudaimonic well-being and family stress for African American adults with hypertension. We drew on the eudaimonic model of well-being (Ryff, 2017) to specify pathways by which specific aspects of psychological well-being (specifically, environmental mastery and self-acceptance) impact cardiovascular health for African Americans, as moderated by the quality of close family relationships. This study used data from the Midlife Development in the U.S. (MIDUS), a national study of biopsychosocial pathways to aging. Data were pooled from three distinct MIDUS projects, conducted between 2011-2014, to derive a sample of 309 African American adults who reported having experienced or having been treated for high blood pressure or hypertension in the past 12 months. Two multiple moderator models were tested, one for each measure of eudaimonic well-being, with family strain and family support entered as moderators of these effects. Results indicated that family support was associated with a significantly reduced likelihood of heart attack risk, and significantly moderated the effect of environmental mastery. Neither family strain nor self-acceptance directly predicted heart attack risk, nor did they predict risk in combination. Results suggest that family support may be a meaningful predictor of health for African Americans with hypertension. Directions for future research and clinical implications will be discussed.

Author(s):

- *Angela R. Hiefner, PhD, Post-Doctoral Fellow, Department of Family and Community Medicine, UT Southwestern Medical Center*
- *Sarah B. Woods, PhD, Director of Behavioral Health, Department of Family and Community Medicine, UT Southwestern Medical Center*
- *Liz Arnold, PhD, Vice Chair for Research, Department of Family and Community Medicine, UT Southwestern Medical Center*
- *Nida Zahra, MD, Medical Clinic Director, Department of Family and Community Medicine, UT Southwestern Medical Center*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR14: Race/Ethnicity as a Moderator of Weight Status Misperception and Sociodemographic Factors in Diverse Young Adults.

Data from 4,825 young adults aged 18-26 years from the 2005-2014 National Health andNutrition Examination Survey (NHANES) were examined for diet, weight history, and anthropometric measures to explore associations of weight status and dietary misperception and sociodemographic factors. Weight status misperception was significantly predicted by age, BMI, gender, and depressive symptoms. Poverty status and household size were only predictors in Non-Hispanic African American young adults. Race/ethnicity fully moderated the relationship between weight status misperception and household size, but only partially moderated the relationship between income and misperception. This study provides evidence that race/ethnicity is a moderator of weight status misperception and socioeconomic factors in U.S. young adults, highlighting that integrated care should include a focus on cultural influences (i.e. race and household size) in weight prevention and intervention efforts for young adults.

Author(s):

- *Catherine "Katie" Van Fossen, MS, PhD Candidate, Department of Human Sciences; The Ohio State University*
- *Keeley Pratt, PhD, Associate Professor, Department of Human Sciences; Department of Surgery; The Ohio State University*
- *Christopher Taylor, PhD, RDN, Associate Professor, School of Health and Rehabilitation Sciences; The Ohio State University*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR15: Measuring Success: A Review of Implementation Outcomes for Brief Alcohol Interventions in Medical Settings

Risky alcohol use is associated with a variety of health concerns (Room, Babor, & Rehm, 2005). Medical settings such as primary care clinics and emergency departments are prime locations to address risky alcohol use, as 30% of patients that present to primary care clinics endorse hazardous alcohol use (Kaner et al., 2013). Furthermore, previous studies have shown that brief alcohol interventions (BAI's) provided in these settings are effective in reducing alcohol use (Kaner et al., 2009). However, for BAI's to have the greatest public health impact, they must be successfully implemented into the real world healthcare system. Therefore, the purpose of the current study was a narrative review of the existing literature regarding BAI implementation outcomes. A search of articles published prior to October 11, 2018 was conducted using PubMed. Forty-two articles describing studies that were from the United States, focused on screening and brief intervention for alcohol use in medical settings, and reported implementation outcomes consistent with the Proctor et al. (2011) taxonomy were included in the review. Proctor et al. (2011) categorized implementation outcomes into eight domains (acceptability, adoption, appropriateness, costs, feasibility, fidelity, penetration, and sustainability) that are considered unique from service and client outcomes. Despite inconsistency in the language used to describe implementation outcomes in the literature, the results of the current review revealed that acceptability, penetration, feasibility, and appropriateness outcomes were commonly reported, while other implementation outcomes were reported less frequently. Based on these results, existing themes and recommendations for future research related to BAI implementation are discussed.

Author(s):

- *Travis Loughran, PhD, Psychology Postdoctoral Fellow, VA Center for Integrated Healthcare*
- *Jennifer Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse, NY*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR16: Integrated Behavioral Health Implementation at a FQHC along the US-Mexico Border: Results from an Implementation Study

Nuestra Clinica del Valle (NCDV), an FQHC, implemented an integrated behavioral health (IBH) program at four clinics. NCDV primarily serves uninsured, medically indigent residents and migrant/seasonal workers and their families. NCDV is a subgrantee of Methodist Healthcare Ministries' Sí Texas project (Social Innovation for a Healthy South Texas), a Social Innovation Fund program. The study used a non-randomized quasi-experimental design to evaluate NCDV's program aimed at improving the health of patients with obesity, diabetes, and/or depression through a multidisciplinary team approach. This poster presentation focuses on the implementation of an IBH model that strengthens a team-based care approach to improve patient care.

Author(s):

- *Veronica Gonzalez, MS, LPC, Behavioral Director, Nuestra Clinica del Valle, San Juan, TX*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR17: Just one more question? The added value of assessing impaired function or desire for information of more broadly defined emotional problems

Primary care screening for depression and anxiety symptoms is well established as having high utility (O'Connor, Whitlock, Beil, & Gaynes, 2009). The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) for depression and the Generalized Anxiety Disorder-7 (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) are the most commonly utilized, valid measures for such screening. High concomitant or lifetime rates of comorbidity suggest that few suffer from a single mood or emotional disorder (Kennedy & Barlow, 2018). The use of single screening questions in the form of subjective report of impaired function and/or information seeking due to and regarding more broadly defined emotional problems can provide a valuable conduit to identification of patients who may benefit from Behavioral Health intervention (Robinson & Reiter, 2015). Participants (Ppts) and Procedure: Ppts (N = 501) completed an online survey including a multidimensional screen and commonly used behavioral health measures. In our sample [Age M=39.02(SD=11.39)], 85.8% visited primary care >=1x/yr, 51.7% were female, 77.8% Caucasian and 34.9% had a previous mental health diagnosis. Ppts completed PHQ-9 and GAD-7 with corresponding items "how difficult have these [problems] made it for you to do your work, take care of things at home, or get along with other people?" from Not at all-to-Extremely and one Functional Impairment item: "How LIMITED are you in any activities because of any emotional problems (such as feeling depressed or anxious)?" 0=Not at all-to-10=Completely. Ppts answered yes/no to separate items "If you could receive more information … would you want more information on treatment for… Anxiety, Depression?" Results Of those who completed PHQ-9 (n=347) and GAD-7 (n=354) 61.7% and 55.6% (respectively) endorsed having No Difficulties related to problems. Of these, however, approximately one third in each group indicated they felt at least somewhat limited in activities due to "emotional problems." Similarly, 36.9% of the PHQ-9 and 44.6% of GAD-7 group citing No Difficulties indicated that they would like information on Anxiety/Depression treatment. Among PHQ-9 and GAD-7 total scores of ppts who wanted information versus those who did not, those who wanted information had higher overall scores [PHQ-9: $t(346)=8.59$, $p<.0001$; GAD-7: $t(353)=9.09$, $p<.0001$]. Conclusions Given the degree of comorbidity among emotional disorders, when screening for emotional problems and related functional interference, use of single items assessing greater breadth of problems or concern (e.g., emotional problems vs one symptom set) may identify patients who feel affected but not necessarily identified by unidimensional symptom assessment (Robinson & Reiter, 2016). Additionally, if patients indicate an interest in

receiving information regarding treatment of emotional problems, it may likewise help to identify those in need of further assessment for behavioral health intervention.

Author(s):

- *Julia L. Ratchford, MA University of Denver Counseling Psychology*
- *Shandra Brown-Levey, PhD University of Colorado Department of Family Medicine*
- *Lauren Tolle, PhD University of Colorado Department of Family Medicine*
- *Desiree Green, PsyD Dayton VA, Dayton OH*
- *Abbie Beacham, PhD University of Colorado Departments of Psychiatry Family Medicine*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR18: Chronic Pain & Decreased Depression: Case Reports from an Underserved Pain Clinic Population

Based upon an earlier pilot study aimed at understanding changes in mental health (MH) status in a pain clinic within an urban, underserved environment, the current study presents an in-depth examination of three patients with comorbid chronic pain who demonstrated improved PHQ-9 scale depression scores over time1. Studies show that comorbid pain and MH disorders are negatively impacted by economic and social disparities frequently seen in underserved populations2. Despite the prevalence of comorbid pain and MH disorders, little is known about how chronic pain treatment affects MH status over time and how treatment efficacy concomitantly affects depression. Successful clinical outcomes have been achieved using the biopsychosocial model in care of chronic pain patients with comorbid MH diagnoses3. Using this care model as part of an integrated multidisciplinary approach within a primary care setting is an effective, evidence-based approach for treating comorbid chronic pain and MH disorders4, 5. These case reports are derived from academic Family Medicine pain clinic records using the biopsychosocial model within an integrated setting that is focused on underserved care. Three patients showed decreased PHQ-9 categorical scores during their tenure as pain clinic patients during the study period. Data from the retrospective, cross-sectional pilot study examining comorbid pain and MH disorder prevalence were reviewed to discern improvement in depression as evidenced by a downward change in PHQ-9 scores. A case report study design was utilized to provide granular understanding and detailed analysis of factors influencing the downward trend. Variables considered were: pharmacology (drugs/dosages), hospital utilization (emergency department/inpatient); changes in comorbid conditions; changes in psychosocial factors; MH services utilization (referrals/treatment); specialty provider utilization (physical therapy).

Author(s):

- *Emilee J. Delbridge, PhD, LMFT, Indiana University School of Medicine, Indianapolis, IN*
- *Laura Gano, MPH*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR19: Are We Fast Enough?: An Exploration of the Relationship Between Time to Initial Pediatric Consultation-Liaison Consult and Hospitalization Length

Youth with comorbid psychiatric and medical issues tend to have higher health care costs and more difficult health outcomes than youth who do not have psychiatric and medical comorbidity (Steiner, Fritz, Mrazek, Gonzales, & Jensen, 1993). Limited information exists regarding hospitalization length and amount of time between hospital admission and initial pediatric consultation-liaison (CL) consult visits. The current study

examines the relationship between time-to-initial consult (TTIC) and hospitalization length to test the hypothesis that delayed initial consult lengthens overall hospital stay through a retrospective one-year chart review of the CL service at a large pediatric hospital in Central Texas. Results indicated a statistically significant relationship between TTIC and hospitalization length, suggesting that medical providers should refer patients to CL services earlier within their hospital stay. Possible confounding variables are discussed.

Author(s):

- *Amanda A. Bowling, M.A., Doctoral Student, Educational Psychology Department, University of Texas at Austin, Austin, TX*
- *Weixi Wang, University of Texas at Austin; Leslie A. Guzman, University of Texas at Austin; Sarah Kate Bearman, PhD, University of Texas at Austin*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR20: Perceptions of a Medicaid Managed Care Roll-Out Among Stakeholders of Children and Youth with Special Health Care Needs: The STAR Kids Program in Texas

This research focuses on the experiences and perceptions of families and care providers of children and youth with special health care needs (CYSHCN) as they transition from fee-for-service Medicaid to Medicaid managed care through a process evaluation of the implementation of the new Medicaid managed care program and assessment process for CYSHCN. It is vital to address issues around information accuracy, dissemination, and understanding any new program or assessment process through public outreach. Suggested solutions and recommendations to the issues and concerns raised are provided, which are germane to other state public health insurance programs considering micro and macro changes. The results provide clear indications for practice and policy, as well as critiques and directions for change.

Author(s):

- *Melissa L. Welch, MA, LMFT, Medical Family Therapy PhD Student, East Carolina University*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR21: The Impact of Trust in Medical Care on African American Men with Prostate Cancer

African American men are experiencing prostate cancer at significant rates, though little research exists investigating their experiences (American Cancer Society, 2016; Center for Disease Control and Prevention, 2015; Powe et al., 2007). African Americans are more likely to be diagnosed with prostate cancer when compared to other races (U.S. Cancer Statistics Working Group, 2018). Recent research gives evidence for African American men being more likely than their white counterparts to experience a lower quality of life after prostate cancer treatment (Matthews, Tejeda, Johnson, Berbaum, & Manfredi, 2012). Lower quality of life has been linked to poor patient-provider communication (Li et al., 2017); and medical mistrust (Kinlock et al., 2017). This poster will present the relationship between trust and confidence in medical care, quality of life, sexual satisfaction and the couple relationship for African American prostate cancer survivors.

Author(s):

- *Kristin Ross, MS, LMFT, Doctoral Candidate, Saint Louis University, St. Louis, MO*
- *Katie Heiden-Rootes, PhD, LMFT, Assistant Professor, Saint Louis University, St. Louis, MO*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR22: The Collective Experiences of Counseling Trainees Working in Primary Care Behavioral Health: A Qualitative Analysis

Primary Care Behavioral Health (PCBH) has become an emerging area of interest for counselors in training. Despite the growing need for counselors in primary care, many Council for the Accreditation of Counseling and Related Educational Programs (CACREP) accredited training programs provide minimal training in this promising field. Counselors entering the primary care field are likely to experience a multitude of challenges including provider buy-in, competing identities, educating primacy care staff, adjusting to brief (< 30 minute) behavioral health visits (Cox, Adams, & Loughran, 2014; Gleuck, 2015), and adopting a population health-focused approach to care (Robinson & Reiter, 2016). A major goal of this pilot study was to qualitatively examine the collective experiences of counseling trainees working in PCBH. Twelve counseling trainees enrolled in a CACREP accredited master's program completed a two-semester internship in primary care. Trainees then participated in a post-internship focus group at the end of each semester. Thematic analysis of the interviews' uncovered three major themes (advocacy, barriers to clinic integration, and benefits) and 8 sub-themes (personal advocacy, professional advocacy, unique skills and knowledge, competing identities, onsite BHC Supervision, trainee satisfaction, benefits to primary care providers, and benefits to patients). Consistent with previous findings (Cox et al., 2013; Gleuck, 2015) our focus group data indicate that counselors working in PCBH must become advocates for their services, adapt to the primary care workflow, develop skills and knowledge unique to primary care, and address potential barriers, such a PCP buy-in and available on-site supervision. Trainee satisfaction with the experience and perceived benefits were also highlighted. Finally, our data suggest the need for PCBH training programs to address multiple barriers prior to implementation.

Author(s):

- *Cory Knight, MS, Counseling Student, University of Texas at San Antonio, San Antonio, TX*
- *Jessica Lloyd-Hazlett, PhD, Assistant Professor, University of Texas at San Antonio, San Antonio, TX*
- *Stacy A. Ogbeide, PsyD, MS, ABP, Associate Professor, UT Health, San Antonio, TX*
- *Dr. Linda Strano-Burton*
- *Ashley Morgan*
- *Dr. Mercedes Ingram*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR23: Path Analysis of Adverse Childhood Experiences and Developing Diabetes

Introduction: Childhood trauma is an ongoing problem that has many debilitating consequences, including poor outcomes of both mental and physical health. Trauma can result in chronic stress which impairs the neuroendocrine and immune systems. This stress often leads to an abundance of cortisol in the body which can have detrimental effects on the body, specifically a higher risk of developing chronic illnesses. Due to the implications of chronic stress on the body, childhood trauma should be assessed when appropriate to assist in possibly preventing long-term health effects. The following path analysis was conducted to assess whether certain types of traumatic experiences in childhood could predict the development of diabetes. We hypothesized that (I) one or more ACE's will predict the development of diabetes and (II) various types of ACE's will yield different effect sizes in predicting the development of diabetes. Methods: Archival data was obtained from the 2017 National Survey of Child Health, which included parent/caregiver self-reports concerning 21,599 children, ages 0-18. Demographic (age, gender), clinical (diabetes diagnosis), and ACE variables were reported at

one time point. A path analysis was used to examine this data and evaluate the predictive relationship of adverse childhood experiences on diabetes. Results: Results showed that the only significant direct effect on the presence of diabetes was experiencing low income (B = 0.305, p = .001). Cohen's d for this relationship was 0.0465, which is a small effect size. Conclusion: These findings show the importance of assessing for adverse childhood experiences in primary healthcare settings so that brief interventions can be provided to help in the prevention of development of chronic illnesses. It is important to further evaluate potential moderators between this relationship.

Author(s):

- *Kayla Killingsworth, BS, Clinical Psychology Doctoral Student, Mercer University, Atlanta, GA*
- *Jane Sutcliff, BS, Clinical Psychology Doctoral Student, Mercer University, Atlanta, GA*
- *Craig Marker, Ph.D.*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR24: Exposure to Adversity and Childhood Obesity

Background: Exposure to 4 or more environmental adversity factors in childhood is associated with a 1.4-1.6 fold increase in obesity and myocardial infarction in adulthood and a 1.4 increase in coronary artery disease and stroke. Specifically, experiencing sexual abuse in childhood is associated with an elevated risk of being obese in adulthood. However, few studies have investigated adversity exposure and elevated weight in childhood. The aim of this study is to characterize the relationship between environmental adversity, pediatric obesity, and cardiovascular risk factor diagnoses. Methods: A retrospective medical review of electronic medical records of 295 children aged 1 to 17 years old with elevated BMI was conducted. Records were obtained from Child Health Clinic at Children's Hospital Colorado, selecting for patients who received a mental health consultation following a weight measurement of BMI greater than the 85th percentile. Data collected included: demographics, cardiovascular risk related diagnosis, BMI and behavioral health flowsheets. Following EHR abstraction encounter data were manually coded for adversity using ATLAS.ti. Results: The sample was predominately Latino/Hispanic (67.7%) and publicly insured (85.7%) patients. There were equal percentages of males and females (50.5% and 49.5%, respectively). On average, there were1.5 adversity factors reported per child with 72.5% of patients reporting at least one adverse experience. The most common adversity factor reported was family separation (38%) followed by abuse (15%). Weight diagnoses were evenly distributed between overweight (25.8%), obese (40.3%), and morbidly obese (33.9%). There were 38 patients with cardiovascular risk factor diagnoses including: essential hypertension, hyperglycemia, hypertriglyceridemia, and dyslipidemia. After correcting for age, race, gender, insurance, and financial factors families who reported housing instability were more likely (p=0.002) to have children who were morbidly obese (61.3%) than families who did not report housing instability (30.7%). Conclusion: This study demonstrated a high percentage of Latino/Hispanic and publicly insured children had elevated BMI relative to the given patient population. Additionally, the most common environmental adversity factor in the overweight or obese pediatric population was family separation. Finally, it demonstrated a dose dependent relationship between elevated weight in childhood and housing instability.

Author(s):

- *Colleen Long, MD, University of Colorado School of Medicine , Denver, CO*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR25: Integrated Care, Team-Based Care, and Physician Burnout

Physician burnout is common, and its consequences for physician's health and quality of care have been discussed. Some research suggests that collaborative team work and integrated care may help reduce the risk of the physician burnout. However, it is still unclear whether working in integrated care/ or team environment actually results in less burnout for primary care providers. To explore this, we conducted literature searches and identified four articles for a systemic review. In the review, we found that although there were inconsistent definitions of "team - based" and "integrated care", team -based/ or integrated care was associated with lower burnout and greater well-being for primary care providers and other outpatient staff. Understanding how integrated care can be related to the outcomes that concerns primary care providers' well -being would help further inform development of integrated behavioral health services in primary care setting. This poster describes current evidence of the effects of the integrated/ team - based care on primary care providers' burnout and well-being.

Author(s):

- *Seonhwa Lee, PhD Postdoctoral Fellow, University of California, Davis/ Center for Healthcare Policy and Research*
- *Angie Hood-Medland, M.D. Postdoctoral Fellow, University of California, Davis, Center for Healthcare Policy and Research*
- *Sarah Kahle, Ph.D.*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

PSR26: Factors that Influence Workforce Quality of Work Life and Well-being in Two Family Medicine Residency Clinics: Developing a Committee and Mixed-Methods Approach to Mobilizing Staff and Leadership

Preparing a healthy workforce who operate effectively in an integrated care setting and the current health care environment inherently starts in academic medical settings. Yet in these settings, the quality of work life and well-being of the workforce is especially strained due to the competing demands that are unique to the residency clinic structure and model of care. In our integrated family medicine residency practice we created an interprofessional Well-being Committee. The Committee's mission is to help create a culture by design that supports our workforce's well-being and quality of work life amidst the competing demands inherent to providing patient-centered care in a residency clinic. This presentation will discuss the development of the Well-being Committee and our mixed-methods approach for: 1) conducting on-going assessment and monitoring of exacerbating and protective factors that affect workforce quality of work life and well-being, 2) serving as liaisons between staff and leadership and, 3) monitoring the effectiveness of interventions that are aimed at improving quality of work life and well-being for our workforce.

Author(s):

- *Laura Daniels, PhD, Clinical Psychologist, Associate Program Director, Carilion Clinic Family Medicine Residency, Roanoke, VA*
- *Katherine Lee, LPC, Behavioral Health Provider, Carilion Clinic Family Medicine Residency, Roanoke, VA*
- *Erika Snyder, DO, Family Medicine Physician, Carilion Clinic, Roanoke, VA*
- *Nallienne Chavez, MD, Family Physician, Carilion Clinic, Roanoke, VA*

Poster Category: RESEARCH: systematic investigation exploring key issues related to integrated care

---

ID# PSR27: Multidisciplinary Community-Engaged Global Health: Challenges and Facilitators from a Student-Led Experience and Research Project in Rural Nicaragua

This poster presentation highlights the experiences of a multidisciplinary team of learners and professionals during a medical outreach trip to Nicaragua. The poster describes the process and outcomes for a biopsychosocial needs assessment that was conducted by the team. This comprehensive needs assessment focused on risk factors for cardiovascular disease. This poster also highlights the collaboration process as well as challenges and facilitators experienced surrounding the needs assessment.

Author(s):

- *Jennifer Harsh, PhD, LIMHP, CMFT Assistant Professor and Director of Behavioral Medicine, Internal Medicine, University of Nebraska Medical Center*
- *Jessica Ern, MPHc, College of Public Health, University of Nebraska Medical Center*
- *Mariela Bahena, MPHc, College of Public Health, University of Nebraska Medical Center*