# CFHA 2020 Conference – Sessions and Posters

*Last updated July 16, 2020 DRAFT* *All times listed are EDT*

## Plenary Sessions

### Health Policy After the Election and Covid-19

Instead of debating ACA+ vs. Repeal and Replace 3.0, Covid-19 and our nation's varied responses to it have altered many landscapes, some permanently. The weaknesses of employment-based insurance, the limits of rugged individualism, the dangers of anti-science agitation and the reverberating consequences of multi-dimensional socio-economic inequities are things that cannot be unseen. The political risk of government overreach is also dangerously heightened. How to fashion a broader American policy consensus out of these real time lessons coming at us relentlessly, for a polarized electorate, that is the question before us all.

Presenter(s):

- *Len Nichols, PhD, Non-Resident Fellow, Urban Institute, Emeritus Professor of Health Policy, George Mason University, President, NS Ideas, LLC, Arlington, VA*
- *Dan Gorenstein, Host and Executive, Tradeoffs, Philadelphia, PA*
- *Rodney Whitlock, Vice President, McDermott + Consulting, Washington, DC*

Date: TBD

Session Type: Plenary

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Explain how Covid-19 changed the health policy debate in our country
- Lay out the implications of the election and policy choices before us
- Identity some areas of policy consensus (not bi-partisan, but broader left-right consensus in the citizenry and in the health and social service sectors)

### Using Nudges to Improve the Delivery of Health Care

Medical decision-making is often suboptimal. Sometimes we conduct unnecessary tests and treatments and in other cases we fail to follow evidence-based guidelines. Nudges are subtle changes to the design of choices or the way information is framed that can have an outsized impact on behavior. The Penn Medicine Nudge Unit is the world's first behavioral design team embedded within the operations of a health system. This talk will describe how nudges can be used within the electronic health record to improve medical decision-making and highlight examples from different contexts in health care.

*Presenter(s):*

- *Mitesh Patel, MD, MBA, Director of the Penn Medicine Nudge Unit, University of Pennsylvania, Philadelphia, PA*

Date: TBD

Session Type: Plenary

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Learn the definition of a nudge
- Understanding principles of behavioral economics and how they can be used to design interventions
- Learn how nudges have been implemented to improve health care

## Our American Dilemma (temp title)

*Presenter(s):*

- *Will Ross, MD, MPH, Professor of Medicine, Division of Nephrology, Washington University School of Medicine in St. Louis, St. Louis, MO*

Date: TBD,

Time:

Session Type: Plenary

Objectives: *Coming Soon*

## Integrated Behavioral Health in the time of COVID19 (Temp title)

Presenter(s): *Coming Soon*

Session Type: Plenary

Content Level:

Keywords:

Objectives: *Coming Soon*

# Extended Learning Opportunities (ELOs)

## ELO 1: Clinician Rising: Transforming from Frontline Warrior to Large-System Change Leader

We are all change agents. But can we rise to be change leaders? In this ELO, five leaders in integrated healthcare, population health and large-system change will offer specific principles—including partnering, creating a value proposition, and developing an adaptive leadership stance--for applying skills gained as an integrated care clinician to wield influence on the large-system level. We will engage attendees in distinguishing between managing and leading change and in developing the personal and professional authority to foster--even force, at times--innovation. We'll talk specifically about building the communication, influence, and leadership skills to gain the attention and respect of prime decision-makers while remaining true to the values and best practices of integrated healthcare.

This ELO will expand upon a panel presentation at last year's conference, "Oh, the Places You'll Go!" When expert clinicians in integrated care try to bring their knowledge and best practices to the organizational level, they often encounter skepticism, resistance, and pressure to compromise. These experiences can dissuade them from ever again attempting to change the larger system. In this workshop, five clinician-population health leaders from medicine, psychology, and social work will describe the general principles of leadership development and their own challenges transforming from frontline warriors to effective organizational leaders. We will focus specifically on those skills from clinical care—including partnering and creating motivation to change through a demonstrated value proposition—that can be translated to the large-system level. Drawing on the work of organizational development guru Peter Senge, this highly participatory workshop will challenge participants to reflect on their personal development as leaders, including an examination of self-leadership, leading others and leading systems. The session will use group exercises to help attendees clarify their core work values, define their personal missions, and design future visions and immediate next steps. We will share our personal experiences to describe the gratification and frustrations of transforming from problem-solving clinician to innovation leader. Programmatic examples will be used throughout.

*Presenter(s):*

- *Suzanne Bailey, PsyD, Chief Operating Officer, Cherokee Health Systems, Knoxville, Tennessee*
- *Suzanne Daub, LCSW, Principal, Health Management Associates, Philadelphia, PA*
- *Jena Fisher, PhD, Executive Director of Innovation, Merakey, Wynnewood, PA*
- *Barry Jacobs, PsyD, Principal, Health Management Associates, Philadelphia, PA*
- *Andrew Valeras, DO, MPH, FAAFP Associate Program Director, Leadership Preventive Medicine Residency, NH Dartmouth Family Medicine Residency, Concord, NH*

**Date:** Thursday, 9/17/2020

**Time:** 2:00 PM - 5:00 PM

**Session Type:** ELO

**Content Level**:

**Keywords**:

- Mentorship
- Professional Identity
- Self-care/Self-management
- Skills building/Technical training
- Training/Supervision
- Workforce development

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Distinguish between authority, seniority, and leadership
- Define the meanings and importance of technical and adaptive leadership
- Understand current evidence regarding leadership style variation and effectiveness
- Develop a personal statement of vision and mission for leading self, others, and systems
- Communicate a value proposition for integrated care to their organization's senior leadership

## ELO 2: Toolkit for Sleep Concerns in Pediatric PCBH: Part 4

Sleep problems are among the most common childhood concerns providers face in primary care, and thorough understanding of how to assess and treat these concerns is essential for any pediatrics provider. Using a multidisciplinary approach and interactive teaching methods, this extended learning opportunity will provide participants with the knowledge, skills, and virtual toolkit needed to screen, assess,

**Date:** Thursday, 9/24/2020

**Time:** 2:00 PM - 5:00 PM

**Session Type:** ELO

**Content Level**:

and treat pediatric sleep concerns in integrated care settings. Emphasis will be placed on helping participants learn the practical skills needed to respond to the distinct needs of children and all participants will receive a virtual toolkit to use in their practices.

Abstract

Sleep is critical for healthy growth and development (Faruqui, Khubchandani, Price, Bolyard, & Reddy, 2011; Meltzer & Mindell, 2006; Owens, Rosen, & Mindell, 2003). Sleep issues can negatively impact a child's physical health, behavior, socioemotional functioning,

cognition, mood, academic performance and may even impact parental and family stress (Honaker & Saunders, 2018; Meltzer & Mindell, 2006; Owens et al., 2003). Further, sleep apnea has been linked to socioemotional difficulties as well as cardiac problems (Faruqui et al, 2011). There is a 25-40% prevalence rate for sleep issues in childhood and adolescence (Honaker & Saunders, 2018), with bedtime problems, insomnia, and night wakings among the most common complaints in pediatrics (Faruqui et al., 2011; Owens et al., 2003; Owens, Rosen, Mindell, & Kirchner, 2010). Despite this, sleep disorders are often underreported, under assessed, underdiagnosed, and untreated in pediatric patients (Faruqui et al., 2011; Honaker, & Saunders, 2018; Mindell & Meltzer, 2008; Owens et al., 2003). It is strongly recommended that all pediatric providers consider the impact of and assess sleep issues in their assessment of growth and development (Mindell & Meltzer, 2008). This extended learning opportunity will provide participants with the knowledge, skills, and a virtual toolkit to master the management of pediatric sleep concerns. Specifically, participants will be provided with a comprehensive background of the etiology, prevalence, and important developmental considerations of common pediatric sleep concerns as a foundational base for effective anticipatory guidance, education, and treatment planning. The workshop will emphasize evidenced-based interventions to apply in their practice.

Throughout the workshop, presenters will employ a variety of didactic and interactive methods of teaching including videos, live modeling, role-plays, and participant skill building activities that support the active learning of skills. For instance, participants will view sleep diaries and engage in diagnosing and role-playing treatment interventions.

***Presenter(s):***

- *Jodi Mindell, PhD, Associate Director of Sleep Clinic, Children's Hospital of Philadelphia, Pediatric Sleep Council*
- *Lesley Manson, PsyD, Assistant Chair of Integrated Initiatives, Clinical Assistant Professor*
- *Arizona State University, Phoenix, AZ*
- *Allison Allmon Dixson, PhD, Medical Director of Integrated Care & Psychologist, Gundersen Health System, La Crosse, WI*
- *Tawnya Meadows, PhD, BCBA-D, Co-Chief of Behavioral Health in Primary Care-Pediatrics, Geisinger, Danville, PA*
- *Cody Hostutler, PhD, Pediatric Psychologist, Nationwide Children's Hospital & Assistant Professor, The Ohio State University, Columbus, OH*
- *Catherine Wubbel, MD, Associate, Geisinger, Danville, PA*
- *Jeffrey Shahidullah, PhD, Assistant Professor of Psychiatry, University of Texas at Austin, Austin, TX*

Keywords:

- Adolescents, Behavioral Medicine Topics (e.g., insomnia, medication adherence), Evidence-based interventions, Pediatrics

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Build and utilize a toolkit of pediatric sleep resources for immediate implementation in medical settings
- Use screening measures/assessment strategies to identify and accurately diagnose sleep concerns in pediatric integrated care.
- Effectively implement a range of brief interventions for sleep concerns within a pediatric primary care visit

## ELO 3: Collaborative Care: An Advanced Implementation Workshop

***Presenter(s):***

- *Jürgen Unützer, MD, MPH, MA, Professor and Chair, University of Washington Department of Psychiatry, Seattle, WA*

**Date:** Thursday, 10/1/2020

**Time:** 2:00 PM - 5:00 PM

**Session Type:** ELO

**Content Level:**

**Keywords:**

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

## ELO Partnership with American Diabetes Association Diabetes Training

Registration separate from CFHA conference registration.

***Presenter(s):***

**Date:** Saturday, 10/11/2020

**Time:** 8:30 AM - 4:30 PM

**Session Type:** ELO

**Content Level:**

**Keywords:**

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Appreciate and articulate the value of implementing an evidence-based collaborative care program in primary care.
- Help adapt an evidence-based collaborative care program to unique primary care settings and populations served.
- Develop a training and implementation support program for unique primary care settings.

## ELO 4: PCBH Community Forum

***Presenter(s):***

- *Jeff Reiter, PhD, ABPP, Subject Matter Expert, Venesco, LLC / Defense Health Agency, Washington, DC*

**Date:** Saturday, 10/11/2020

**Time:** TBD

**Session Type:** ELO

**Content Level:**

**Keywords:**

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

## ELO 5: A New Take on Patient-Centered Care: Making Partnerships with High Utilizing Disadvantaged Patients

This workshop will be an introduction to a language for building partnerships in care with patients who cope with significant complexity (physical, psychological, and social). Participants will hear how current "patient-centered" approaches have difficulty making partnerships with these patients. They will practice reframing professional language for writing open notes and for having team clinical conversations in the presence of the patient. They will practice using empowering language as part of trauma-informed care, and learn attributions that support increased patient self-efficacy. Finally, they will practice creating patient-centered care plans in which patients are truly partners.

**Date:** Thursday, 10/15/2020

**Time:** 2:00 PM - 5:00 PM

**Session Type:** ELO

**Content Level:**

**Keywords:**

- Patient-centered care, team-based care, patient partnership, behavioral health integration, strength-based care.

The concept of "patient-centered care," along with its "sibling" concept "the medical home" were created to be guiding principles for positive transformation in medical care. Unfortunately, after all the time and money expended to bring about this transformation, the medical home effort, (changing practice patterns to improve information management, increase coordination of care, and promote access) has been more successful than the patient-centered care effort, (changing the doctor-patient relationships to improve transparency, accommodate to patient preferences and values, and make partnership with patients. This is especially true for patients we term "multiply-disadvantaged," (patients called "complex" in literature about high utilizing people with multiple chronic illnesses, also called "disadvantaged patients" who cope with poverty and bias, and finally, described in literature on victims of trauma. These are patients who tend to experience interaction with healthcare professionals more as encounters with authorities who want to control them rather than as time with highly trained benevolent helpers. The possibility of partnership with their doctor is not attractive to many of these people.

Using evidence-based methods, it is possible to create a process for interacting with these patients that builds their self-efficacy in regard to their health and their healthcare. These methods promote an experience of care for health team members and for patients that is transparent, empowering, activating and mutual. This workshop will be an introduction to language for building partnerships in care with multiply-disadvantaged patients. Participants will practice reframing professional language for writing open notes and for having team clinical conversations in the presence of the patient. They will practice using empowering language as part of trauma-informed care, and learn attributions that support increased patient self-efficacy. Finally, they will practice creating patient-centered care plans in which patients are truly partners. Time will be 1/3 lecture and 2/3 audience interaction.

*Presenter(s):*

- *Alexander Blount, EdD, Professor Emeritus of Family Medicine, University of Massachusetts Medical School, Worcester, MA*

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Communicate clinical information in language that is communicative to colleagues and non-stigmatizing to patients.
- Elicit information about patients' strengths and successes in caring for their own health.
- Transition information from patients about their successes into attributions toward the patient that promote more success.

## ELO 6: Mixed Methodologies in Research and Quality Improvement: At the Intersection of Numbers and Stories

Mixed method approaches to research and quality improvement include both quantitative and qualitative elements. When these components are combined in thoughtful and intentional ways, they add depth and context to our understanding of health settings. The workshop aims to introduce participants to the nuances of using mixed methods for research and quality/process improvement within integrated healthcare environments. It will include discussion of innovative designs, data collection methods, and cutting edge analysis. In small group exercises, participants will have the opportunity to work thorough elements of designing/conducting a mixed methods project around a chosen research or quality/process improvement topic.

Mixed method approaches to research and quality improvement include both quantitative and qualitative elements. When these components are combined in thoughtful and intentional ways, they add depth and context to our understanding of health settings. This workshop aims to introduce participants to the nuances of using mixed methods for research and quality/process improvement within integrated healthcare environments. Together presenters and participants will explore the synergy between quantitative and qualitative research design. This will

Date: Thursday, 10/22/2020

Time: 2:00 PM - 5:00 PM

Session Type: ELO

Content Level:

Keywords:

- Impementation science, Outcomes, Quality Improvement programs, Research and evaluation

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Understand how quantitative and qualitative data can be used synergistically within a mixed methods approach.
- Determine whether a quantitative, qualitative or mixed methods approach is best suited to answer a

include discussion of innovative designs, data collection methods, and cutting edge analysis. Presenters will begin with a broad overview of the two components of mixed methods research with more comprehensive focus on qualitative methods. Discussion will focus on four major types of mixed methods design (Triangulation, Embedded, Explanatory, and Exploratory). Examples will illustrate how when applied appropriately, mixed method approaches can yield results that are greater than the sum of their individual quantitative and qualitative parts. Presenters will end with introduction to techniques and considerations for data collection and analysis, with a focus on qualitative data. This will include an overview of strategies, advice on when to select one strategy over another, and how to use both the quantitative and the qualitative to tell a story of the data. At set time points throughout the workshop participants will engage in small group exercises designed to apply elements of designing/conducting a mixed methods project to a chosen research or quality/process improvement topic. To facilitate learning, participants will be asked to come prepared with a question they want to explore in their own practice or research. In the small group exercises participants will assist each other in identifying whether a quantitative, qualitative or mixed methods approach is best suited to addressing their question. This will lead into small group sharing of ideas for specific data collection and analysis methods.

*Presenter(s):*

- *Nyann Biery, MS, Manager of Program Evaluation, Lehigh Valley Health Network, Allentown, PA*
- *Allison Brenner, PhD, MPH, Director of Population Health Research and Innovation, Cascadia Behavioral Healthcare, Portland OR*
- *Casey Gallimore, PharmD, MS, Associate Professor, University of Wisconsin School of Pharmacy, Madison, WI*
- *Laura Gano, PhD(c), MPH, Indiana University School of Medicine, Indianapolis, Indiana*
- *Stephanie Trudeau, PhD, Postdoctoral Research Fellow, The Thrive Center for Human Development, Pasadena, CA & Faculty Associate, Doctor of Behavioral Health Program, Arizona State University College of Health Solutions*

specific research or evaluation question.

- Discuss the strengths and challenges of various quantitative and qualitative data collection methods.
- Describe mixed methods approaches to data analysis.
- Apply principles of mixed methods to guide design of a research or quality improvement project from their own practice site.

# Live Streaming Sessions

## A1: Reverse Engineering: Infusing Compassion into PCBH and Healthcare

Growing research is detailing the importance of healthcare being delivered in a compassionate manner. Unfortunately, and quite ironically, during this same time (i.e., increasing evidence detailing the importance of compassionate care), an equal amount of research is showing that healthcare in the US is becoming less compassionate. This decrease in compassion has correlated to worse health outcomes, lower treatment adherence, and provider burnout, among other healthcare outcomes. Integrated behavioral health models are not immune to this reality and while not empirically researched, one could posit that models such as Primary Care Behavioral Health (PCBH) are vulnerable to succumbing to the dearth of compassion in healthcare, and, at times, promoted an algorithmic and biomedical approach to behavioral health needs. To this end, this presentation will discuss the concept of "Reverse Engineering"and provide attendees actionable steps to help them infuse compassion within their PCBH and medical visits. Data will be presented regarding a clinic's patient satisfaction and provider engagement scores that support compassion being cultivated in the medical clinic through these initiatives. Further, this presentation will discuss how compassionate care can create a context where evidence-based/informed interventions can be "uptaken"by patients, especially patients that are coming from complex psychosocial contexts. Lastly, reflections from the three presenters will be discussed and how this "Reverse Engineering"and compassionate approach helps their clinical work become rewarding, engaging, and buffer against burnout.


***Presenter(s):***

- *David Bauman, PsyD, Behavioral Health Education Director, Community Health of Central Washington, Yakima, WA*
- *Bridget Beachy, PsyD, Director of Behavioral Health, Community Health of Central Washington, Yakima, WA*
- *William Summers, PsyD, Post-Doctoral Fellow, Community Health of Central Washington, Yakima, WA*


**Date:** Wednesday, 10/7/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level:** All Audience

**Keywords:**

- Patient-centered care/Patient perspectives
- Primary Care Behavioral Health Model
- Compassionate healthcare

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Describe the importance of compassionate healthcare as it relates to healthcare outcomes, patient engagement, and provider burnout
- Describe the concept of "Reverse Engineering"and how to apply this to healthcare visits to promote compassionate care
- Identify strategies to increase compassionate care to create contexts that allow evidence-based medicine/interventions to be uptaken

## A2: Integrative Medicine for Vulnerable Populations with Opioid Use Disorder

The American healthcare system has failed to address the needs of vulnerable patients with multiple, chronic, co-morbid conditions. We focus our attention on the opioid epidemic as it kills Americans by the tens of thousands and is currently the greatest threat to health. Decreased cost and improvements in treatment outcomes for complex patients demand that providers learn a new set of clinical skills. These skills are not given enough focus in current medical school curricula or post-graduate psychology training programs. This has never been more important than now, a time where the iatrogenic opioid epidemic has occurred along with the widening illicit use of fentanyl and fentanyl opioid derivatives. We have published a textbook on this subject entitled, Integrative Medicine for Vulnerable Populations: A Clinical Guide to Working with Chronic and Comorbid Medical Disease, Mental Illness, and Addiction. Our model of Integrative Medicine provides a methodology and a skill set that has been successful at treating individuals with co-existing chronic physical and mental health conditions including substance use, severe

**Date:** Wednesday, 10/7/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level:** Intermediate

**Keywords:**

- Complex Patient Care
- Interprofessional teams
- Opioid management

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Describe the syndemic of opioid use disorder, infectious disease, and severe mental illness that more frequently leads to poor health

mental illness, chronic pain, trauma, infectious disease, and other chronic conditions that are comorbid and syndemic, difficult or impossible to treat in isolation and occur more commonly in impoverished communities and people of color. We are currently focusing our attention in Kensington and North Philadelphia, areas of Philadelphia that have been most hard hit by the syndemic with high rates of overdose death, new HIV infection, and epidemic Hepatitis A. Our model focuses on comprehensive evaluation, an integrated formulation that adequately addresses all of the problems, and a rehabilitative holistic treatment plan that targets both physical and mental health conditions provided by a highly coordinated interdisciplinary team of providers. This practice requires that the team understands each discipline's role and that team communication is built into practice. At a time when "burnout"threatens the integrity of our field, this model improves outcomes, decreases costs, and improves staff and patient retention. We will describe the kind of patients who require this high intensity service, the essential elements of the method, empiric outcomes data, barriers and facilitators to effectiveness, the implications of the structure of the team, and the financial model that we have developed for our work. Finally, we will focus on an extended case study of a patient our team has treated for more than 10 years.

*Presenter(s):*

- *Trisha Acri, MD, Medical Director, Courage Medicine Health Center, Philadelphia, PA*
- *Kevin Moore, PsyD, Director of Integrative Medicine, Crossroads Treatment Centers, Philadelphia, PA*
- *Julia Hodgson, PsyD, Center for Integrative Medicine, AIDS Care Group, Sharon Hill, PA*
- *Glenn Treisman, MD, PhD, Johns Hopkins University, Baltimore, MD*

outcomes in impoverished communities and people of color
- Summarize the essential elements of a methodology that can be used to improve treatment outcomes in complex patients with opioid use disorder
- Apply integrative methodology for treatment of opioid use disorder and discuss the utility of an integrated whole-person and rehabilitative treatment plan with complex patients

## A3: How can ACEs, Self-Compassion, and Psychological Flexibility Impact Professional Quality of Life and Burnout?

Traumatic childhood events have the potential to shape later life experiences and choices (Layne et al., 2014). Felitti et al. (1998) found that higher numbers of adverse childhood experiences (ACEs) correlate to an increase in health risks and risky behaviors in adulthood. There is currently a lack of research regarding ACEs scores among graduate students in the helping profession. Thomas (2016) noted that graduate students in the helping profession have been overlooked in ACEs research although they tend to have higher rates of adverse childhood experiences than peers in comparable graduate programs. The current study sought to discover the rate of ACEs and if, among graduate students in the helping profession, self-compassion and psychological flexibility ameliorate the impact of ACEs on professional quality of life. Ninety-two participants were sampled from doctoral and master's programs at George Fox University. Data analysis shed light on how ACEs scores, level of Self-Compassion, and level of Psychological Flexibility predicted self-reported Professional Quality of Life. A strong positive relationship was found between the abilities of self-compassion and psychological flexibility. In this sample, 25.8% endorsed 4 or more ACEs. Overall, they reported significantly more ACEs than the Felitti et al. (1998) sample and were more likely to report emotional abuse, emotional neglect, parental separation or divorce, having a household member incarcerated, and a household member struggling with mental health concerns. These adversities should become a strong consideration in program development, student support systems, and early career guidance. The present findings suggest that psychological flexibility and self-compassion may be important antidotes to the adverse impact of childhood suffering. Level of psychological inflexibility was shown to predict burnout; a concerning element of professional work. These data point to

Date: Wednesday, 10/7/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Burnout
- Early Career Professionals
- Training/Supervision - Supervision and evaluation of trainees, providing feedback

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss the role of ACEs in a provider's own professional quality of life.
- Identify personally applicable strategies to combat burnout.
- Describe ways to foster the important skills of Self-Compassion and Psychological Flexibility in early career helping professionals.

the importance of strengthening responses characterized by psychological flexibility and self-compassion during the educational stage of early career. The results of this study have implications for individuals, organizations, and the populations served by helping professionals. Often, the focus of trauma-informed policies is on the consumer. These data indicate the need for increased awareness of the trauma histories of providers and the development of self-compassion and psychological flexibility skills.

*Presenter(s):*

- *Current Info: Heather Harris, MA, Doctoral Psychology Intern, Alaska Family Medicine Residency, Anchorage, AK*
- *Info in Oct 2020: Heather Harris, PsyD, Post-Doctoral Fellow, Cherokee Health Systems, Knoxville, TN*

## A4: "I don't see color"□: An Introduction to Race Equity and Cultural Humility in Health and Behavioral Healthcare

Have you ever wanted to talk about race in health and behavioral healthcare, but find it challenging for you or your organization to make real progress in this area? You are not alone. While most professional training programs and organizations emphasize the importance of cultural humility in practice, there are few opportunities to sustain conversations on race in healthcare. This session provides a "101"on race equity in healthcare and provides cultural humility and culturally responsive care frameworks for achieving race equity in this sector. We will provide clarification on major concepts such as race, racism, prejudice, internalized oppression, implicit bias, and equality versus equity. We will use an interactive, case-based, and discussion-based approach to ensure attendees leave the session with concrete steps they can take to begin or continue conversations on race equity at their home institutions.

*Presenter(s):*

- *Andrea Trejo, MA, Marriage and Family Therapy Trainee and Doctoral student, University of Georgia, Athens, GA*
- *Will Lusenhop, MSW, PhD, LICSW, Clinical Assistant Professor, Department of Social Work, University of New Hampshire, Durham, NH*
- *Stacy Ogbeide, PsyD, MS, ABPP, CSOWM, Associate Professor/Clinical, Dept. of Family & Community Medicine, UT Health San Antonio, San Antonio, TX*
- *Nida Emko, MD, FAAFP, Professor/Clinical, Dept. of Family & Community Medicine, UT Health San Antonio, San Antonio, TX*
- *Jeffrey Ring, PhD, Principal, Health Management Associates, Los Angeles, CA*

**Date:** Wednesday, 10/7/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Cultural Humility
- Population and public health
- Training Models
- Underserved populations (e.g. LGBTQ)
- Race Equity, Cultural Responsiveness

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Define race equity, culturally humility, culturally responsive care, and related terms.
- Describe at least two ways, institutional bias and implicit bias produce negative outcomes in health and behavioral healthcare
- Describe at least two actions one can take at the direct service and organizational levels toward improving race-equity in healthcare.

## A5: An Integrated Approach to Combating Provider Burnout: The Circle of Trust

Delaware Valley Community Health is a Philadelphia-based FQHC. In 2018, medical providers from our largest and busiest center brought to leadership some significant concerns around burnout. Looking at the issue from all angles, we decided to pilot a group for medical providers, over lunch, to discuss patient care and the challenges faced daily that contributed to burnout. Based on the principles of a Balint group, the Circle of Trust was created. The monthly group is led by the Director of Integrated Behavioral Health with significant support from the center's Medical

**Date:** Wednesday, 10/7/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Burnout
- Innovations
- Mentorship

Director. These discussions of patient care guided by both a licensed clinical social worker and a medical doctor, began to bring new perspectives to shared frustrations, as well as opening doors for organizational change. Starting with only a few attendees, the Circle of Trust now regularly has 100% attendance and participation. Together, we have structured a an opportunity to speak with and listen to one another, impart strategies for mitigating burnout, build skills around effective patient communication, boundary setting, and problem solving. In this session, we will share the foundation and structure of Circle of Trust, some of the topics covered, and the changes it has effected over the course of two years. We will provide tools and strategies to form this group in your organization.

*Presenter(s):*

- *Eric Elvanian, LCSW, Delaware Valley Community Health, Norristown, PA*
- *Naomi Walinsky-King, MD, Delaware Valley Community Health, Norristown, PA*
- *Noel Ramirez, DBH, MSW, MPH, LCSW, BCD, West Chester University, Philadelphia, PA*
- *Kelly Rembolt, PA-C, Delaware Valley Community Health, Norristown, PA*
- *Geraldine Pena, LPC, Delaware Valley Community Health, Norristown, PA*
- *Vincent Lamont, LPC, Delaware Valley Community Health, Norristown, PA*
- *Michelle Schweitzer, LCSW, Delaware Valley Community Health, Norristown, PA*

- Patient-centered care/Patient perspectives
- Primary Care Behavioral Health Model
- Quality improvement programs
- Self-care/Self-management
- Team-based care
- Training Models

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss staff burnout challenges faced in their own organizations, identify obstacles to satisfaction, and determine if a Circle of Trust group may be a solution.
- Describe the essential elements of a Circle of Trust group, write ground rules, and choose appropriate leaders and leadership approaches.
- Build a structure for a Circle of Trust group that aligns with the needs of your organization, as well as qualitative evaluation metrics.

## A6: Primary Care to Emergency Department Navigation for Patients with Suicidal Ideation: Barriers and Facilitators

45% of people who have died by suicide attended a primary care appointment in the month preceding (SAMHSHA-HRSA, 2019). As such, primary Care is the front line for assessment of patients presenting with SI. When a patient demonstrates that they are a threat to their own safety, the standard of care is to send the patient to the ED for evaluation. For systems following this standard protocol, ED providers are often called upon to be the "first responders"to mental health concerns in emergency care settings (Suicide Prevention Resource Center [SPRC], 2016). Unfortunately, what was particularly concerning is there has been a relationship between visits to the ED (for suicide ideation) and subsequent suicide deaths (within two months post ED visit) (Knesper, 2011). In order to provide effective and seamless care for this nuanced issue, the gap between primary care and ED systems must be bridged and providers trained accordingly. We plan to share clinical examples of 6 patients who presented to primary care with SI and were escorted to the ED for further evaluation and treatment. These examples highlight the complex systemic barriers both providers and patients face. We plan to share how these barriers have been addressed in two primary care clinic through interdisciplinary collaboration and systemic understanding.

*Presenter(s):*

- *Rebecca Levy, LMFT-A, PhD Candidate, Wake Forest Family Medicine, Winston-Salem, NC*
- *Aubry Koehler, PhD, LMFT, Director of Behavioral Science, Wake Forest School of Medicine, Winston-Salem, NC*
- *Carolyn Pedley, MD, FACP, Wake Forest Internal Medicine, Winston-Salem, NC*

Date: Wednesday, 10/7/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Collaborative Care Model of Integrated Care
- Primary Care Behavioral Health Model
- Suicide

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss clinical examples of patients who presented to primary care with SI and were escorted to the ED
- Explore solutions to improve provider collaboration and resolve systemic and operational barriers to ensure better care for patients with SI
- Elicit next steps among audience members for improving primary care and ED collaboration for patients presenting with SI in their home institutions

## A7: Expanding Integrated Health Care to Private Pediatric Practices

Mental Health America of Greater Houston's (MHAGH) Integrated Health Care Initiative works with over 50 organizational collaborators to expand and enhance integrated health care in greater Houston and Texas. A recent focus has been the expansion of integrated care to private practice, particularly private pediatric practices. Private pediatric practices that accept CHIP and Medicaid form a de facto part of the safety net, yet they have been largely left out of the movement towards greater integration of behavioral health in primary care. In 2018, in partnership with the Texas Children's Hospital system, MHAGH funded a pilot project to bring integrated behavioral health to two private pediatric practices and evaluate the financial sustainability of offering integrated behavioral health care in such settings. Since then, Texas Children's Hospital has expanded this pilot to several additional private pediatric practices. In response to barriers encountered during the pilot, MHAGH has developed capacity-building trainings such as How to Pay for Integrated Health Care in a Fee-for-Service Environment and Credentialing for Behavioral Health Providers in Integrated Health Care. To enhance provider skills, MHAGH is also partnering with The REACH Institute to provide mini-fellowships for private practice pediatricians to expand their knowledge and ability to address mental health conditions seen in their practices. Expansion to private practice strengthens integrated care to help meet complex needs in a greater variety of settings. To promote such expansion, this presentation will include original, empirical data from the pilot project, including data regarding financial sustainability. The presenters will also discuss the process of moving the private pediatric practices towards integrated behavioral health care, including training provided for the practices, as well as actions now being implemented in response to workforce- and payment-related barriers encountered.

*Presenter(s):*

- *Kara Hill, MHA, Director of Integrated Health Care, Mental Health America of Greater Houston, Houston, TX*
- *Alejandra Posada, M.Ed., Chief Operating Officer, Mental Health America of Greater Houston, Houston, TX*
- *Nancy Correa, MPH, Sr. Community Initiative Coordinator, Texas Children's Hospital, Houston, TX*

**Date:** Wednesday, 10/7/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Cost Effectiveness/Financial sustainability
- Pediatrics
- Workforce development

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify ways to leverage existing integrated health care efforts to expand to non-traditional providers of integrated care, such as private practices.
- Describe essential steps that support private pediatric practices in integrating behavioral health care.
- Discuss barriers to expansion of integrated health care to private practice, as well as approaches to mitigate such barriers.

## A8: Treatment Programming and Evaluation For Pregnant Women with Opioid Use Disorders: Coordinating Service Efforts

Substance use among pregnant women has seen recent growth because of the opioid epidemic (Patrick & Schiff, 2017). The Healthy Families Program (HFP), funded by SAMHSA, provides gender-focused, family-centered comprehensive and collaborative residential prevention, treatment and recovery support services to pregnant and postpartum women (PPW) who have opioid use disorders (OUD) and other substance use disorders (SUD), and their children, and families. The program utilizes a multidisciplinary team including substance use treatment center staff from two states, and a primary care clinic that provides comprehensive maternity care for PPW who are dependent on opioids and other substances. The goal of the HFP is to expand service provider capacity for PPW treatment services, and enhance services for PPW, their children, and family members. All clients are asked to complete evaluation interviews at intake, 6 months after intake, and discharge. Assessments include substance use, employment and housing status, mental health, and family functioning. Thus far 107 women have enrolled, with 6-month data collected from

**Date:** Wednesday, 10/7/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Interprofessional teams
- Opioid management
- Substance abuse management (e.g., alcohol, tobacco, illicit drugs)

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify unique treatment needs of pregnant and postpartum women

N=55. Most describe themselves as African American (40%) or White (49%), ages between 18 and 34 (79%). Preliminary outcomes indicate increased abstinence from substance use after six months, reduced substance use consequences, increased employment/education and stable housing. Statistically significant, positive outcomes are also observed for depression and trauma-related symptoms and family functioning. This presentation will begin by describing the HFP, key components and strategies for implementation and evaluation, evaluation findings and data limitations (20 minutes). The audience will then apply program implementation and evaluation strategies using a logic model worksheet (30 minutes). The presentation will conclude with a group discussion on the strengths and barriers of programming for PPW with SUDs and Q&A (10 minutes).

*Presenter(s):*

- *Jessica Chou, PhD, Assistant Professor, Drexel University, Philadelphia, PA*
- *Catherine Williams, BS, CRAADC, Evaluation Coordinator, Missouri Institute of Mental Health, University of Missouri-St. Louis, MO*
- *Jeffrey Noel, PhD, Assistant Research Professor, Missouri Institute of Mental Health, University of Missouri-St. Louis, MO*
- *Sharon Spruell, MA, LPC, CCDP-D, CEO, Queen of Peace Center, St. Louis, MO*
- *Clara Stevenson, Chief Program Officer, Queen of Peace Center, St. Louis, MO*

with opioid use disorders and substance use disorders.
- Describe core strategies of program implementation for pregnant and postpartum women with opioid use disorders and substance use disorders.
- Identify components and outcomes of program evaluation for pregnant and postpartum women with opioid use disorders and substance use disorders.

## B1: Providing Medication Assisted Treatment in Primary Care using an Integrated Care Model--Bidirectional Warm Handoffs: Not Only Observed, But In Action!

Medication assisted treatment (also known as medication assisted recovery or MAT) for opioid use disorder (OUD) is an excellent example of a treatment plan that can involve bidirectional warm handoffs between medical providers and integrated behavior health (IBH) providers. In practices that have integrated MAT services within primary care, medical primary care providers (PCPs) can prescribe buprenorphine for their patients with OUD and potentially involve an IBH provider to help solidify the treatment plan, either through a warm handoff or a formal referral. In our practice, our IBH provider routinely screens for substance use disorder at initial intakes. If a client screens positive, it may be appropriate for the IBH provider to initiate a warm handoff with the medical provider to consider MAT treatment with buprenorphine. This workshop will introduce the concept of bidirectional handoffs/referrals, and attendees will have an opportunity to practice these handoffs in real-time using a standardized patient model. We will then have an opportunity to debrief how the experiences went, and discuss lessons learned. Basic Outline: 1. Introduction of MAT and discussion of methods of incorporating medical and behavioral health components (10 minutes) 2. Live simulation of bidirectional handoffs using our providers and standardized patient (20 minutes) 3. Breakout sessions where participants can practice the skills observed (15 minutes) 4. Debrief and discussion of lessons learned and any additional applications (15 minutes)

*Presenter(s):*

- *Bobby Kelly, MD, MPH, Family Physician, Core Physicians, Exeter, NH*
- *Alyssa Hamel, LICSW, Integrated Behavioral Health Clinician, Core Physicians, Exeter, NH*
- *Robin Marcotte, MFA, Co-Founder, Articine, Newfields, NH*

Date: Wednesday, 10/7/2020

Time: 12:15 PM - 1:15 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Primary Care Behavioral Health Model
- Substance abuse management (e.g., alcohol, tobacco, illicit drugs)
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the key components of an integrated MAT program, including the different ways the patient/client interfaces with professionals on the care team.
- Recognize opportunities to utilize bidirectional warm handoffs between members of their interdisciplinary teams.
- Share best practices with their colleagues at home regarding the application of bidirectional warm handoffs based on real-time experience.

## B2: Collaborative (Integrated) Mental Health Care in Canada - The Next 10 years

Guided by 2 position papers prepared by the Canadian Psychiatric Association and College of Family Physicians of Canada in 1997 and 2011, these two organizations have spearheaded the movement in Canada towards collaborative (integrated) care and have outlined a framework within which collaboration has evolved. The last 10 years have seen significant progress across the country, including a wide range of innovative projects and models of practice and increased collaboration between planners and funders, and it is now a greater expectation of patients as well as providers. To build on these successes the two organizations decided to produce a new position paper with the goal of setting the stage for the next 10 years of collaboration in Canada. The strategy outlined is based upon 3 core values - 1) Improve access and equity, 2) Enhancing the experience of care in a patient and family-centred approach and 3) sustainable high quality services and programs through innovation, adaptability and enhancing the provider experience. The paper discusses the principles that should guide collaboration between services and between providers, and the potential goals of any project. It outlines the key components of effective projects, the roles of all team members - including patients - and changes required to support these initiatives. It also addresses medical care for people with mental illnesses, the potential uses of newer technologies, competencies required by providers, a training strategy for learners and an approach to evaluation using a quality framework. It also looks at changes any mental health service can make in their relationship with local primary care providers to improve access, communication and care co-ordination and increase system capacity, Finally it looks at how better collaboration can address wider challenges facing any health care system


*Presenter(s):*

- *Nick Kates, MBBS FRCPS, Chair Dept. of Psychiatry McMaster University, Hamilton Ontario, Canada*
- *Maria Patriquin, MD CCFP, Family Physician, Living Well integrative Health Center, Halifax Nova Scotia Canada*
- *Nadiya Sunderji, MD, MPH, FRCPC, Psychiatrist in Chief, Waypoint Centre for Mental Health Care, Penetanguishene, ON, Canada*


Date: Wednesday, 10/7/2020

Time: 12:15 PM - 1:15 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Collaborative Care Model of Integrated Care
- Quality improvement programs
- Sustainability

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the components of effective collaborative care components
- Understand the principles to guide collaboration between both services and providers
- Know how better collaboration can address wider challenges facing health care systems

## B3: La Salud no Tiene Idioma: Using language to Address Healthcare Disparities in the Latinx Community

While the Latinx community continues to grow in the US (including workforce, small businesses, and college students), disparities in access and quality of healthcare have remained stable over the last two decades (Vega, et al., 2009). Research highlights low access to healthcare, low cultural sensitivity in health providers, and language differences as the main barriers to address health disparities (Velasco-Mondragon, et al., 2016). In East TN, Cherokee Health Systems (FQHC and CHC) provides services to the Latinx community across 11 counties. In the counties with the highest concentration of Latinx patients, CHS services 17.29 to 36.42% of the Latinx population. This study aims to address the role of cultural brokers, Spanish-speaking behavioral providers, and in-person interpreters in engagement of healthcare. The sample will consist of at least 150 individuals (including foreign- and US-born nationals) whose primary language is Spanish and receive services by CHS's interdisciplinary team. The study will compare two samples (those with cultural brokers as part of their care team and those without) using an independent-samples

Date: Wednesday, 10/7/2020

Time: 12:15 PM - 1:15 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Cultural Humility
- Primary Care Behavioral Health Model
- Special populations (e.g. disability)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Define health disparities in the Latinx population

t-test. It is hypothesized that having access to Spanish-speaking providers and cultural brokers increases patients' engagement in care (as measured by attendance to scheduled appointments) and helps discover needs that can be addressed by a culturally-sensitive integrated team (as measured by collaboration from multi-disciplinary team members).

*Presenter(s):*

- *Yolanda Rodriguez, PhD, Clinical Psychologist, Cherokee Health Systems, TN*
- *Eboni Winford, PhD, Director of Research and Health Equity, Cherokee Health Systems, Knoxville, TN*

- Identify interventions within the integrated care model to effectively address health disparities in the Latinx population
- Apply cultural humility skills in daily practice

## B4: Warm Hand Offs 2020: Refocusing on a Research Agenda

A warm handoff (WHO) in integrated care setting typically occurs when the primary care provider introduces the patient to the behavioral health provider in response to a mental or behavioral health concern identified as part of routine care. Anecdotally, WHOs are considered a beneficial, if not essential, component of integrated care models, including Primary Care Behavioral Health and Collaborative Care Management. However, like many other components of integrated care, there are varied descriptions of what constitutes a WHO and relatively limited empirical evidence to support the impact of WHOs on patient or system outcomes. This symposium will address the conference theme related to implementation of evidence-based practices by exploring the nature of WHOs and the extent to which they have empirical support across integrated primary care platforms. The target audience for this presentation is clinicians, administrators, and researchers who want to know more about the potential value and limitations of WHOs. A panel representing integrated care experts in research, implementation and clinical practice will discuss the nature of a WHO as a concept and process of care, research evidence regarding to date regarding WHOs, operational and clinical perspectives on why WHOs may be important and could benefit from future study. Through panel discussion and audience feedback, we will develop a tentative research agenda on this topic, including priorities for operationalizing WHOs and identifying appropriate methods for advancing the state of the science.

*Presenter(s):*

- *Gregory Beehler, PhD, MA, Associate Director for Research, VA Center for Integrated Healthcare, Buffalo, NY*
- *Jodi Polaha, PhD, Associate Professor, Department of Family Medicine, East Tennessee State University, Johnson City, TN*
- *Jennifer Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare Syracuse VA Medical Center, Syracuse, NY*
- *Kent Corso, PsyD, BCBA-D, Principal, National Capital Region Behavioral Health, Fairfax Station, VA*

Date: Wednesday, 10/7/2020

Time: 12:15 PM - 1:15 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional teams
- Primary Care Behavioral Health Model
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Define warm hand-offs as an element of integrated primary care practice
- Describe the empirical support for warm hand-offs based on current research
- Identify areas for future research to advance the state of the science on warm hand offs

## B5: The Impact of Integrated Care on Quality Metrics and Outcomes for CCBHO and FQHC Programs

Background: Launched in 2017, Certified Community Behavioral Health Organizations (CCBHO) are required to provide evidence-based, integrated care for patients with complex health and behavioral health problems. Unlike FQHCs, CCBHOs have not been well understood by the larger national integrated care community. As such, our presentation will describe, from the perspective of Compass Health Network, the nation's largest CCBHO as well as a multi-site FQHC: (1) CCBHO integration-related certification requirements, (2) evidence-based screening and treatment practices within the CCBHO/FQHC, (3) organization-wide CCBHO quality improvement metrics impacted by integrating care; and (4) improvements in quality measures and outcomes of patients receiving integrated care compared to those receiving exclusively primary care (PC) health services. Population sampled, procedure, measures, and design: Our data are pulled from two existing EHR systems, for a one-year window, and comprise the entirety of the patient population in the two programs (CCBHO/FQHC) that receive a single (PC) service (n=7,200) compared to the patients in both programs that receive PC and at least one additional integrated service (n=3,400; behavioral health, whether therapy, psychiatry, rehabilitation, and/or SUD treatment, is counted as one service). Our evaluation of CCBHO performance is based on required quality metrics, including SUD treatment engagement, medication adherence, hospitalization follow-up rates, and suicide risk assessment. Our FQHC analysis compares the standard UDS clinical measures defined by HRSA (e.g., BMI screening, tobacco screening and cessation, A1c, screening and follow up for depression, use of appropriate asthma medications). Patient ages for this analysis range from five to 65+, and include somewhat more females (55%) than males. The study design is an organization-wide quality improvement evaluation, assessing changes in a number of metrics longitudinally, corresponding to the implementation and ramp up period for CCBHO activities. Key results & conclusions: A comparison of the two groups on a set of 13 HRSA clinical metrics reveals that performance was significantly better for those patients receiving an additional service integrated with PC, according to a z-test for proportions ($p<.05$). Among that group five of 13 measures exceeded targets, whereas only one of 13 did so in the PC-only group. Additionally, each of the six CCBHO quality metrics exceeded targets by a statistically significant margin according to a series of z-tests ($p<.05$). Our conclusions are: (1) CCBHO standards are helping drive greater integration of services, (2) the organization is exceeding quality standards across the board, (3) a concerted focus on integration across CCBHO and FQHC appears to consistently lead to better outcomes, and (4) patients who engage in only PC are less likely to improve than those involved in more than one service line.


*Presenter(s):*

- *Paul Thomlinson, PhD, Psychologist, Executive Director, Research, Compass Health Network, Springfield, MO*
- *Alan Stevens, Executive VP, Chief Operations Officer, Compass Health Network, Jefferson City, MO*
- *Michaela Muehlbach, PsyD, Deputy CCO Outpatient & Psychological Services, Compass Health Network, Jefferson City, MO*
- *Jennifer Lee, Chief Quality Officer, Compass Health Network, St. Peters, MO*


Date: Wednesday, 10/7/2020

Time: 12:15 PM - 1:15 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Collaborative Care Model of Integrated Care
- Primary Care Behavioral Health Model
- Quality improvement programs

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Explain the significance, impact, and requirements of the Certified Community Behavioral Health Organization (CCBHO) movement regarding integration of care and deployment of relevant evidence-based practices (EBP).
- Describe the performance of a large CCBHO on a series of organization-wide quality improvement metrics including SUD treatment engagement, antipsychotic medication adherence, hospitalization follow-up rates, and suicide risk assessment.
- Describe the differences in outcome metrics at a large CCBHO between patients receiving integrated or collaborative care vs. relevantly similar patients receiving single-sector care.

## B6: PrEP In The Treatment Of Opioid Use Disorder: An Integrative Team's Perspective

People with Opioid Use Disorder (OUD) have complex healthcare needs that are best addressed by integrated care teams. Although the number of new HIV diagnoses in the United States decreased by 9% between 2010 and 2017, the rate of new infection among people with OUD is increasing. This is due not only to the sharing of needles, but because people with OUD being more likely to engage in high risk sexual behaviors. Additionally, these individuals face increased discrimination, have poor access to appropriate substance abuse treatment, and experience higher rates of incarceration, homelessness, and other socioeconomic factors that adversely impact their health. All of this places them at an increased risk for acquiring HIV. Although pre-exposure prophylaxis (PrEP) has been available to the public since 2012, the use of the medication has not been widely adopted, even among medical providers treating members of high risk groups. The Centers for Disease Control and Prevention estimates that PrEP is 99% effective at preventing the transmission of HIV, when used correctly. Therefore, we believe that the inclusion of PrEP navigation should be standard in primary care-based opioid use disorder treatment. Providing comprehensive care within an integrated healthcare team that includes mental health, medical, dental, nutrition, and social service providers is the most effective way to accomplish these goals. Attendees will be educated about the clinical utility of PrEP navigation as part of OUD treatment, as well as how to discuss sexual health and PrEP with patients in an open, thoughtful, non-judgmental manner. Using the results of a patient survey about attitudes toward PrEP along with clinic experiences providing integrated care to this population, the presenters will discuss the challenges and successes that we have faced in our own organization while implementing this as best practice. Data from the patient survey will also inform recommendations for overcoming barriers and best practices.


*Presenter(s):*

- *Dana Lehman, PsyD, Psychologist Supervisor, AIDS Care Group, Sharon Hill, PA*
- *Nicholas Wood, PsyD, Director Of Integrative Medicine, AIDS Care Group, Sharon Hill, PA*
- *Richard-Alan Mitteer, MS, MHS, PA-C, Physician Assistant, AIDS Care Group, Sharon Hill, PA*
- *Hector Colon, DC, MSHAPI, PrEP Director, AIDS Care Group, Sharon Hill, PA*


**Date:** Wednesday, 10/7/2020

**Time:** 12:15 PM - 1:15 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Interprofessional teams
- Opioid management
- Prevention

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Understand the role of PrEP navigation in an integrated care team
- Feel comfortable talking with patients about sexual health and behavior
- Develop ideas to enhance the provision of care for opioid use disorder

## B7: Practicing what we Preach is Easier-Said Than-Done: Preventing Burnout and Compassion Fatigue in Healthcare Teams

As biomedical and behavioral providers (alongside public health professionals, hospital/clinic administrators, and others), we know that attention to our own self-care and (inter)personal well-being is essential to maintaining balance and biopsychosocial/spiritual health. But we also know that doing this is easier-said than it is done vis-Ã -vis the time-demands that our jobs require, the political impasses that we must often navigate, and the intensity (and at times, heartbreaking nature) of the clinical presentations that we see. Drawing from on-the-ground efforts advanced by trauma-response teams (e.g., MRC, ICISF, RCF, FEMA), the presenters will introduce empirically-supported strategies in self-care that harness our resources across individual, family, social, and spiritual systems continua. Bridging these strategies to the everyday contexts of our "day jobs"in primary, secondary, and tertiary care will be outlined. Tangible resources / tools used in fieldwork and everyday practice(s) will be shared.

**Date:** Wednesday, 10/7/2020

**Time:** 12:15 PM - 1:15 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Burnout
- Prevention
- Self-care/Self-management

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- articulate common challenges in health care provision (e.g., crises of faith, scope of practice, role flexibility and clarity) that make burnout- and

*Presenter(s):*

- *Tai Mendenhall, PhD, LMFT, Associate Professor, University of Minnesota, Twin Cities, MN*

compassion fatigue- prevention challenging in contemporary care practices.
- describe empirically-supported strategies for preventing and/or repairing burnout and compassion fatigue that cut-across individual, family, and social systems continua.
- engage with tangible resources / tools for self-care (e.g., mobile app, worksheets, professional literature).

## B8: Strategies for Engaging Family in Managing Patients with Complex Care Needs using EMR/EHR Systems

This presentation directly addresses the conference theme regarding the needs of patients with complex care needs. It defines and describes a way to engage family members/support persons through the electronic medical record (EMR). The intention of this engagement strategy is to assist with meeting treatment plan goals, reduce medical and human communication error, and increase collaboration between patients, support persons/family members, and their healthcare team. To date, studies done have looked solely at patterns of utilization related to health outcomes of patients (e.g., Burke, Rossi, Wilner, et al., 2010; Goldzweig, Orshansky, Paige et al., 2013). Additionally, little to no research has been done including family/support persons and/or use of the proxy function in EMRs for improving patient engagement, family engagement, and comprehensive health outcomes. Findings from two qualitative studies conducted by the presenters address how use of the EMR patient portal system may improve the flow of communication between the treatment provider, patient, and patients' support system. Improved communication between patients, family members/support persons, and members of the healthcare teams may help to reduce hospital readmission rates. Over 20 participants representing patients, families, and providers contributed to these studies. Findings include themes that help understand high readmission rates for patients in DKA and strategies for increasing knowledge among family members/support persons to help improve patient health outcomes. Attendees who may benefit from this presentation include administrators and providers who utilize an EMR system. Attendees will learn how to: (a) create the infrastructure for piloting a similar EMR project in their settings, (b) expand inclusion of family members/support persons through the patient portals available in their EMR systems, and (c) track outcomes of its impact.

*Presenter(s):*

- *Jennifer Hodgson, PhD, Nancy W. Darden Distinguished Professor & Director, Medical Family Therapy Doctoral Program, East Carolina University, Greenville, NC*
- *Thompson Forbes, PhD, RN, Assistant Professor, College of Nursing, East Carolina University, Greenville, NC*
- *Melissa Welch, MA, Doctoral Student, Medical Family Therapy Doctoral Program, East Carolina University, Greenville, NC*
- *Emily Tucker, MS, Doctoral Student, Medical Family Therapy Doctoral Program, East Carolina University, Greenville, NC*
- *Joseph Pye, MD, Vice President of Medical Affairs, Regional and Associate Chief Medical Officer, Vidant Health, NC*

Date: Wednesday, 10/7/2020

Time: 12:15 PM - 1:15 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Complex Patient Care
- Electronic Medical Record
- Family centered care/Family perspectives

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Create the infrastructure for piloting a similar EMR project in their settings.
- Expand inclusion of family members/support persons through their EMR patient portal systems.
- Identify ways to track health outcomes through using the EMR portal as a method of engaging family members/support persons in their care.

## C1: The PCBH Mosaic: Training BHCs to Identify and Treat Complex Patient Needs

Date: Wednesday, 10/7/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Complex Patient Care
- Ethics
- Primary Care Behavioral Health Model
- Training Models

The Blueprint for Complex Care provides some key points to consider related to the ongoing development of complex care practices. Complex care is defined as "the care for people with complex health and social needs."One key issue the Blueprint targets is the need for training and professional development programs that support implementation of evidenced based models and solutions. The Blueprint recognizes there is not an adequate supply of professionals, namely primary care & behavioral health clinicians, to provide direct services on the front lines of complex care. The Blueprint also acknowledges that the existing professional workforce is not well prepared for addressing complex care needs. Complex care requires new skills and competencies, workflows, and knowledge of how to navigate systems and formulate sequenced responses to complex comorbid needs within a team. This panel presentation aims to discuss the challenges of training BHCs, vital members of integrated care teams, in a context that requires attention to multiple, complex healthcare needs and system variables. The PCBH model is a person centered approach which focuses on increasing access to whole-person care. When the care a person receives aims to target behaviors that are responsive and indicative of health, personality, situational state, context, culture, and social determinants of health, complexity is inherent in the decision making. Using SAMHSA's competencies for integrated care workforce, the panel will discuss the implications, challenges and frame some possible solutions, frameworks (i.e., the Four Point method; Jonsen, Siegler, and Winslade, 2010) and training tools that can help improve individual readiness for team-based integrated complex care.

Objectives: *At the conclusion of this presentation, participants will be able to...*

- The attendee will identify three tools that can be used in training to help a learner address complex care needs.
- The attendee will name three integrated care competencies to consider while onboarding or training in your clinical setting.
- The attendee will identify and address ethical situations typically encountered when working on an integrated primary care team.

*Presenter(s):*

- *Clarissa Aguilar, PhD, Director of Psychology & Training, The Center for Health Care Services, San Antonio, TX*
- *Yajaira Johnson-Esparza, PhD, Assistant Professor, UT-Health, Dept of Community & Family Medicine, San Antonio, TX*
- *Hayley Beth Van Serke, PsyD, Manager, Howard Brown Health, Chicago, IL*
- *Jonathan Novi, PsyD, Team Lead, Primary Care Mental Health Integration, Memphis VA Medical Center, Memphis, TN*
- *Tanya Vishnevsky, PhD, Co-Director of Primary Care Integration, Springfield Psychological, Springfield, PA*
- *Brittany Houston, PsyD, Postdoctoral Fellow, Community Health of Central Washington, Yakima, WA*
- *Daisy Ceja, PsyD*
- *Norma Balli-Borrero, LPC Intern, Behavioral Health Consultant, University Health System*

## C2: Making Friends: Forming partnerships between Providers and Payers

Date: Wednesday, 10/7/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Cost Effectiveness/Financial sustainability
- Innovations
- Opioid management

The opioid epidemic has impacted a viral hepatitis epidemic, HIV outbreak, and an increased prevalence of sexually transmitted infections increase among people who inject drugs. In order to move forward with integrated care strategies in a financially sustainable way, especially in an increasingly Value-based payment world, behavioral health providers need to look toward innovative reimbursement models and collaborations with payers. In this hour-long workshop, leaders in substance use disorder treatment, infectious disease care, and managed care organizations will present a unique partnership that has enabled a novel payment structure to support integrated care within a methadone maintenance clinic. This presentation will walk attendees through the current Medicaid carve-out payment structure in Pennsylvania; the goal for the physical health integration of a Methadone clinic in urban Philadelphia; and the development of organizational partnerships among the physical and behavioral health MCOs;. The current status and accomplishments

Objectives: *At the conclusion of this presentation, participants will be able to...*

resulting from this collaboration will be reviewed (e.g., metrics, access to data, novel reimbursement models, improved collaboration of care for individuals served). The target population for this program is program leaders and administrators who desire to move toward integrated service delivery models or policy makers who are interested in learning more about innovative approaches to reimbursement models.

*Presenter(s):*

- *Jena Fisher, PhD, Executive Director of Innovation, Merakey, Erdenheim, PA*
- *Laura Murray, DO, Chief Medical Officer, Merakey, Philadelphia, PA*
- *Chris Tjoa, MD, Chief Medical Officer, Community Behavioral Health, Philadelphia, PA*
- *Stacey Trooskin, MD, PhD, Physician and Director of Viral Hepatitis Program, Philadelphia FIGHT Community Health Centers, Philadelphia, PA*
- *Carol Larach, Director of Program Integration, Community Behavioral Health (CBH), Philadelphia, PA*
- *Kimberly Malayter, LCSW, Director of Innovation and Integrated Clinical Services, Merakey, Erdenheim, PA*

- Gain knowledge into innovative reimbursement models for integrated services
- Identify specific steps toward developing partnerships between providers and payers
- Define benefits to such collaborations, including financial, operational, quality, and data/analytics

## C3: Narrative Medicine Primer: Reading and Writing for Reflecting and Teaching

Narrative medicine is a powerful tool for reflection, wellness, team-building, and improved clinical services. A strong narrative practice assists faculty and supervisors in the teaching and clinical settings. During this session we will engage in a narrative medicine activity of reading, writing, and sharing, then explore model narrative medicine curricula that have been applied in clinical settings. Regarding clinical practice, the text "The Principles and Practices of Narrative Medicine"observes that: "Narrative Medicine began as a rigorous intellectual and clinical discipline to fortify healthcare with the capacity to skillfully receive the accounts persons give of themselves--to recognize, absorb, interpret, and be moved to action by the stories of others. It emerged to challenge a reductionistic, fragmented medicine that holds little regard for the singular aspects of a patient's life and to protest the social injustice of a global healthcare system that countenances tremendous health disparities and discriminatory policies and practices."(p. 1) In support of wellness, narrative medicine offers a format for reflection and professional development, and is at the heart of wellness for team-based education. As many supervisors and faculty lack formal education in close reading and group facilitation, the need for new skill and knowledge can present obstacles to implementing narrative medicine as a tool in a clinic or training program. This program will present a first exposure to narrative medicine and provide guidance and templates on how to implement this practice in personal, clinical, and teaching settings. Timeline: :00 - :05 Introductions and Overview :05 - :10 Small group outloud reading of either a poem or short story :10 - :25 Small group discussion of the poem or short story :25 - :35 5-minute prompted writing of a reflection (with intro) :35 - :45 Sharing of writing in small groups :45 - :60 Discussion of application to clinical and teaching settings / QA

*Presenter(s):*

- *Randall Reitz, PhD, LMFT, Director of Behavioral Medicine, Saint Mary's Family Medicine Residency, Grand Junction, CO*
- *Laura Sudano, PhD, LMFT, Associate Director of Integrated Behavioral Health, UCSD Family Medicine and Public Health, San Diego, CA*
- *Mark Knudson, MD, MSPH, Exec. Vice Chair, Wake Forest Family Medicine Residency, Winston-Salem, NC*

Date: Wednesday, 10/7/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional education
- Professional Identity, including development of
- Training/Supervision - Supervision and evaluation of trainees, providing feedback

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe benefits of narrative medicine practice in clinical and teaching settings
- Facilitate a brief narrative medicine activity of reading, writing, and sharing
- Develop a narrative medicine activity for their own personal practice or clinical setting

## C4: PCPs Face Complex Challenges Integrating Trauma-Informed Care and PTSD Screening/Management into Routine Patient Care

Recognizing and addressing adverse childhood experiences, exposure to lifetime trauma, posttraumatic stress, and posttraumatic stress disorder have increasingly been prioritized in primary care. While few would argue against expanding education and training medical providers on this topic, it is equally critical to understand the individual, relational, and system-level challenges practicing PCPs face in integrating trauma-informed principles and PTSD screening and management into routine patient care. This presentation will review qualitative survey data from a Department of Family Medicine and Community Health listserv of practicing primary care providers. PCPs were asked to consider the following question, "Think about your day-to-day practice as a primary care provider. Identify three specific challenges (individual or system level) you've encountered trying to integrate trauma-informed care into your routine patient care."Nearly 100 qualitative responses were collected and reveal nuanced and complex challenges that make it difficult for practicing PCPs to address this important component of their patients' health. The presenters will focus on examining themes across reported challenges, exploring individual and system-level root causes of challenges, and providing recommendations for acknowledging and addressing these challenges in training and practice.

*Presenter(s):*

- *Amber Cahill, PsyD, Assistant Professor, University of Massachusetts Medical School, Worcester, MA*
- *Bridget Beachy, PsyD, Director of Behavioral Health, Central Washington Family Medicine Residency, Worcester, MA*
- *David Bauman, PsyD, Behavioral Health Education Director, Central Washington Family Medicine Residency, Yakima, WA*
- *Sarah Pearson, PsyD, Behavioral Health Fellow, Dept. of Family Medicine and Community Health, University of Massachusetts Medical School, Worcester, MA*

**Date:** Wednesday, 10/7/2020

**Time:** 2:45 PM - 3:45 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Complex Patient Care
- Interprofessional education
- Trauma-Informed Care

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Recognize the nuanced and complex individual, relational, and system-level barriers PCPs face in their efforts to integrate trauma-informed care and PTSD screening
- Describe root causes for individual, relational, and system-level barriers
- Summarize approaches to acknowledge and address barriers to integration of trauma-informed care and PTSD screening

## C5: Psychopharmacology Review for Integrated Primary Care

The integrated primary care team is increasingly called upon to manage patients with a wide spectrum of psychiatric presentations often with co-occurring complex social needs. Psychopharmacology Review for Integrated Primary Care will provide an overview of drug classes, approach to common clinical presentations, and management of adverse effects. Psychopharmacology challenges related to social determinants of health, medication options for substance use disorders, and the role of non-prescriber integrated team members will be discussed. Case examples, clinical pearls and links to clinical drug resources will facilitate learning. Our target audience will be prescribers wishing to enhance their knowledge and non-prescribers wishing to add to their knowledge base. All disciplines are welcome.

*Presenter(s):*

- *Thomas Salter, MD, Psychiatry, Integrated Behavioral Health, Mayo Clinic, Rochester, MN*
- *Mark Williams, MD, Associate Professor, Integrated Behavioral Health, Mayo, Rochester, MN*
- *Patricia Gibson, MD, Medical Director, Arkansas Health Group Behavioral Health Integration Program, Fayetteville, AR*

**Date:** Wednesday, 10/7/2020

**Time:** 2:45 PM - 3:45 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Mood (e.g., depression, anxiety)
- Psychopharmacology

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify at least 3 different reasons for sub-optimal response to medication management of psychiatric disorders and describe associated strategies to manage.
- Identify at least 3 different medications used to treatment substance use disorders.

- Identify and have access to at least three clinical tools/resources related to clinical psychopharmacology.

## C6: Staying Up to Date on Eating Disorder Assessment and Treatment in Integrated Primary Care: Literature Review, Recommendations, and Case Study

Eating disorders (ED) can have a devastating impact on an individual's physical and mental health as well as on the larger healthcare system. EDs are associated with increased healthcare utilization, long-term health complications, and mortality. Detecting EDs early is vital, and research suggests that most individuals with EDs or subclinical ED symptoms present to primary care first. Behavioral health consultants (BHCs) within integrated primary care are uniquely qualified to assist primary care physicians (PCPs) and support staff in assessing and treating EDs in primary care and can be an integral part in the prevention of EDs more broadly. The purpose of this presentation is to synthesize the most up to date literature on preventing, assessing, and treating EDs in primary care, while also providing practical recommendations for translating research into clinical practice. First, a comprehensive literature review on preventing, assessing, and treating EDs will be presented. Time will be dedicated to discussing the intersection of EDs and social determinants of health (SDoH) with specific focus on challenging assumptions of 'typical' ED presentations. Next, recommendations for brief assessment and intervention of EDs in primary care will be provided (handouts will be used to summarize recommendations). These recommendations will also address how to assess for EDs while considering SDoH. Lastly, a deidentified case study will be presented on how these recommendations can be implemented within a Family Medicine Residency Clinic located within an underserved community. This case study will be based on a 40-year-old, African American patient who presented to primary care with angina, asthma, and insulin-dependent diabetes and was later diagnosed with binge eating disorder (BED). The BHC, PCP, and patient's perspective on the integrated care treatment approach to managing BED will be provided.

*Presenter(s):*

- *Jennifer Battles, MS, Doctoral Practicum Student, McLaren Health Care, Flint, MI*
- *Tamara Loverich, PhD, Associate Professor, Psychology, Eastern Michigan University, Ypsilanti, MI*
- *Jennifer Carty McIntosh, PhD, Associate Director of Behavioral Medicine Education, McLaren Health Care, Flint, MI*
- *Andrew Champine, PsyD, Director of Behavioral Medicine Education, McLaren Health Care, Flint, MI*

Date: Wednesday, 10/7/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Assessment
- Evidence-based interventions
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the most current literature on eating disorders in primary care and the advantages of utilizing an integrated team approach to prevent, assess, and treat eating disorders in primary care
- List current, evidenced-based recommendations for the assessment and treatment of eating disorders within primary care while considering the impact of social determinants of health
- Understand the application of these recommendations to a case study presentation to help generate future ideas for assessment and treatment effectiveness with other cases

## C7: Rising to the Challenge: Progress, Challenges, and Opportunities in Improving Population Behavioral Health in an Integrated Health System

Improving dissemination and implementation of evidence-based practices (EBP) in integrated behavioral health (IBH) is inextricably linked to the need to improve quadruple aim outcomes to compete in an ever-changing health care landscape. In our integrated health system, since 2011 we have expanded from 3 to 11 pediatric IBH sites since 2011 and from 0 to 8 adult IBH sites using a variation of the PCBH model to address local needs in access to high-quality behavioral health care. In 2017, we added embedded research to increase capacity for applied research and in 2019 we engaged in organizational restructuring to facilitate continued growth and collaboration between adult and pediatric IBH. In this presentation, we will briefly describe the evolution of our PCBH model related to improving EBP and illustrate aspects of our progress, challenges, and opportunities in improving

Date: Wednesday, 10/7/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Evidence-based interventions
- Implementation science
- Population and public health

Objectives: *At the conclusion of this presentation, participants will be able to...*

population behavioral health. The model is based on integrating complementary frameworks, including a) conceptualization of health care as a co-created service between patients, providers, and transdisciplinary researchers; b) extending the learning health care system approach to behavioral health; and c) leveraging contextual behavioral science principles to enable dissemination and implementation of innovations. Together, our framework supports both transformation and continuous improvement towards high value behavioral health care. We will also illustrate applications of this model by highlighting three projects: 1) A mixed methods project engaging patients and providers to develop and conduct preliminary user testing of a behavioral intervention technology platform to empower parents to take charge of their child's behavioral healthcare; 2) implementation of interdisciplinary primary care resident training in behavioral health; and 3) incorporation of a precision health youth advisory council into stakeholder feedback for quality improvement of youth suicide prevention efforts.

*Presenter(s):*

- *Sean O'Dell, PhD, Clinical Assistant Professor, Geisinger Health System, Danville, PA*
- *Monika Parikh, PhD, Associate, Geisinger Health System, Danville, PA*
- *Kathy DeHart, MD, Associate Program Director, Pediatric Residency, Geisinger Health System, Danville, PA*
- *Caroline Spahr, Member, Precision Health Youth Advisory Council, Geisinger Health System, Danville, PA*

- Describe elements of a comprehensive framework contributing to growth and improvement within an integrated behavioral health program
- Rate progress and opportunities for growth and improvement in their setting
- Infer the extent to which a similar approach would enhance growth and improvement in their setting

## C8: Evidence-based AI Interviewing - Effective and Cost-effective Integrated Screening, Assessment and Practice-based Research

A practice-based research study to investigate integration of mental health in primary care was conducted generating a cohort of 2495 cases obtained from an FQHC in Montana during primary care visits. The results from electronic self-report administration of the PHQ-9 with a QPD in-depth psychological assessment administered randomly before or after the PHQ-9, are analyzed from multiple perspectives and used for training. First, using CJ Peek's three world view, the effectiveness and cost-effectiveness of the clinical depth, breadth, accuracy and automation used in the study are analyzed demonstrating the need for dynamic administration of latent trait measures. Second, the study dataset is analyzed to produce the evidence-based AI network weights used for probabilistic, higher accuracy, item-by-item scoring, enabling more effective dynamic administration. The evidence-based AI network weights are also generated between latent traits making the comorbid relationships in the dataset explicit and available to drive the AI interview process. Finally we will use the study dataset to analyze effective use of a data warehouse integrated with an EMR and how to automatically support practice-based research. Based on the information learned, attendees will then design a screening solution for their practice that covers detection, in-depth assessment, actionable results and potential research, outcomes and QI initiatives.

*Presenter(s):*

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

Date: Wednesday, 10/7/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Assessment
- Cost Effectiveness/Financial sustainability
- Innovations

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Able to design a cost-effective in-depth detection and assessment solution integrated with their EMR
- Extend the design to include practice-based research, outcomes and QI initiatives
- Explain the need for evidence-based AI interviewing using standard measures

## D1: Using a Behavioral Health App to Engage Patients and Reduce Administrative Pain Points

Behavioral health integration has many moving parts: collaboration across departments and with outside providers (ex: referral to BH specialist), documentation, billing, and patient and provider buy-in. Technology can be used to alleviate the most burdensome paint points (administering/scoring questionnaires), remotely monitor patients, provide 24/7 resources, and collaborate between care team members. Through the use of technology you can proactively identify urgent/at-risk patients with the resources they need in a timely manner and provide measurement-based care for patients. We have implemented this solution with a variety of clinics (primary care, OBGYN, Behavioral Health, Psychiatry, etc.) geographically (Pennsylvania, New Jersey) and have seen patients see symptom improvement for depression (82%; PHQ-9) and (77%; GAD-7). In this interactive session, we will provide a case study of implementation of a behavioral health app, NeuroFlow, in a large primary care health system. We will discuss incorporation into workflows, provider and patient uptake, and its return on investment. Audience members will then participate in an app "show and tell."We will walk participants through the app's provider features, including automatically scored questionnaires, automatic documentation for billing, remote monitoring patients, alerting providers of those in need, and billing documentation. It will also demonstrate highlights of the patient app, including its use of behavioral economics to facilitate behavior change and improved patient outcomes. The final portion of the session will be an audience brainstorm about barriers and facilitators to app integration in their practice settings. Participants will leave with resources and strategies for behavioral health app implementation.

*Presenter(s):*

- *Adam Pardes, MS, Chief Operating Officer, NeuroFlow, Philadelphia, PA*
- *Rachelle Rene, PhD, BCB, Clinical Assistant Professor, Director of Primary Care Integrated Behavioral Health, Jefferson University, Philadelphia, PA*
- *Phansy Chun, LCSW, Behavioral Health Consultant, Jefferson Health, Center City, Philadelphia, PA*
- *Mollie Cherson, LCSW, Behavioral Health Consultant, Abington-Jefferson Health, Abington, PA*
- *Matthew Miclette, RN, MPH, Sr. Clinical Operations Manager, NeuroFlow, Philadelphia, PA*

**Date:** Thursday, 10/8/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Collaborative Care Model of Integrated Care
- Primary Care Behavioral Health Model
- Technical assistance/practice facilitation for integrated care
- Digital Innovation

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Explain how behavioral health integration can be implemented in their care setting.
- Name a minimum of 3 ways technology can help reduce provider workload.
- Explain the basics of behavioral health integration.

## D2: Improv-ing our Practice Environments and Wellness: Using Medical Improv to Promote Resilient, Effective Primary Care Teams

Burnout is a national health crisis (Noseworthy et al., 2017), with PCP burnout rates ranging from 13.5-60% (Abraham, Zheng, & Poghosyan, 2019). Provider burnout is adversely associated with patient care, provider wellbeing, and organizational outcomes (West et al., 2018). In 2018, the National Academy of Medicine launched an Action Collaborative to advance initiatives to improve clinician wellbeing. Additionally, wellness is an increasing area of emphasis in medical education (AMA, 2018). Practice environment is the most common predictor of PCP burnout (Abraham et al., 2019). Modifiable environmental factors associated with lower burnout include defined team structures, goal-directed solution seeking, mutual support, and consistent, straightforward communication (Abraham et al., 2019; Salas, 2018). Simply put, teamwork is a foundation for building and sustaining resilient and effective primary care practice environments (Salas, 2018). As featured in Dr. Belinda Fu's CFHA conference plenary (2019), medical improv is "an emerging field in which the principles and training techniques of improvisational theatre are used to improve cognition, communication, and teamwork in the field of medicineâ€. Key tenets of improv include being present, flexibility, risk taking,

**Date:** Thursday, 10/8/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Burnout
- Interprofessional teams
- Self-care/Self-management

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Define medical improv, including key tenets
- Identify overlap across key tenets of medical improv and effective, resilient primary care practice environments

silencing the inner critic, and allowing imperfections. The proposed session explores how medical improv may be used to promote resilient and effective practice environments and to reduce provider burnout. The session aligns with 2020 CFHA conference aims to empower the integrated care workforce to meet complex social and patient needs. Further, interventions are needed to improve primary care practice environments and to help reduce provider burnout (Abraham et al., 2019). Using an "on stage"approach, attendees will gain familiarity with medical improv principles and how these intersect with goals and processes central to effective primary care teams. Attendees will also learn several basic improv games that can be readily integrated into a variety of primary care settings to promote teamwork and mitigate provider burnout. While a PowerPoint and reference handouts will be utilized, attendees should be ready to actively engage in this experiential session.

- Practice basis improv games that can be readily integrated into primary care teams to promote effective teamwork, resilience, and lower burnout

*Presenter(s):*

- *Jessica Lloyd-Hazlett, PhD, LPC, Assistant Professor, Department of Counseling, University of Texas at San Antonio, San Antonio, TX*
- *Stacy Ogbeide, PsyD, ABPP, CSOWM Associate Professor/Clinical, UT Health San Antonio, San Antonio, TX*

## D3: How to SUPERcharge your Supervision/Training with Integrated BHCs? A Brief Expert Panel

As the integrated behavioral health workforce continues to expand, with inherent complexities of care, additional supervisors and trainers will be needed to develop the core competencies of the PCBH role, such as GATHER (Reiter et al, 2018). Formal preparation training to become a clinical educator or supervisor of integrated behavioral health providers is not well-defined. The focus of this moderated clinical round table presentation is to share expert strategies in orienting, training, and developing new primary care behavioral health providers from a panel of experienced integrated supervisors and consultants. The session will include discussion of supervisory-level competencies on: --Onboarding: setting a training schedule, orienting to the model, training competencies and setting up shadowing experiences for the new clinicians. --Note-writing: helping shape primary care-specific, efficient integrated practice notes --Staff development: using supervision and reverse-shadowing to provide feedback and enhance competency skill-development --Ongoing support: growth identification, scaffolding development, chart audits, supervision, utilizing a lens of multiculturality and understanding complexity within the PCBH role, training, and continued shadowing. The presentation will include discussion of core competencies, provision of resources to the audience (e.g., BHC Core Competency Shadowing Rating Scale), case examples, and question/answer period. Discussion on managing up/down and advocating for supervisees with site leadership will also be addressed. Pilot data will also be shared on the use of a competency tool in BHC shadowing.

Date: Thursday, 10/8/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Primary Care Behavioral Health Model
- Skills building/Technical training
- Workforce development

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify supervisory core competencies in training new Primary Care Behavioral Health clinicians
- Describe strategies to use during clinical observation to enhance clinician skill-development
- Discuss the professional workforce needs of developing high-competence integrated behavioral health staff.

*Presenter(s):*

- *Travis Cos, PhD, Lead Network Clinician, Health Federation of Philadelphia, Philadelphia, PA*
- *Bridget Beachy, PsyD, Director of Behavioral Health, Community Health of Central Washington, Yakima, WA*
- *Meghan Fondow, PhD, Director of Behavioral Health, Access Community Health Centers, Madison, WI*
- *David Bauman, PsyD, Principal Member & Consultant, Beachy Bauman Consulting, Yakima, WA*
- *Neftali Serrano, PsyD, Chief Executive Officer, Collaborative Family Healthcare Association, Chapel Hill, NC (Moderator)*

## D4: Utilization of Smart Phone Applications to Assist in Depression Self-Management: An Underserved Primary Care Pilot Study

Depression is one of most common mental health conditions and the leading cause of disability worldwide, affecting about one in 10 adults in the US. Depression treatment is vital for underserved primary care patients who often experience multiple chronic medical conditions along with higher rates of health disparities. These challenges are very complex. Emerging evidence suggests mobile app technology can aid in the self-management of depression. Yet, there is limited research exploring the use of mobile health apps in this population with specific gaps concerning the feasibility of integrating these tools. Filling this gap is needed to inform evidence-based training, clinician tools, and educational material to facilitate the implementation of mobile apps with clinical care. Attendees, who could be at any stage in their education or careers, will learn about the process and results from a study that explored the feasibility of integrating depression self-management smartphone apps into primary care for an underserved patient population with depression. Adult patients with an active or previous depression diagnosis were eligible to participate. Participants were asked to complete measures which explored self-efficacy, and patient activation, along with questions pertaining to smartphone ownership, type of data plan, and willingness to use apps for self-management. Patient and provider/staff focus groups were conducted at clinic sites to explore the feasibility of using smartphone apps for depression management. Initial findings suggest that patients are likely to attempt app use for self-management when physicians make this suggestion. Results also suggest that giving patients an array of smartphone apps to choose from increases their likelihood of app use. The presentation will also include descriptive statistics, survey results, provider and patient perspectives of app integration into standard of care, and future directions.


*Presenter(s):*

- *Jennifer Caspari, PhD, Assistant Professor and Director of Behavioral Medicine, University of Nebraska Medical Center, Omaha, NE*
- *Maxine Notice, PhD, Behavioral Medicine Fellow, University of Nebraska Medical Center, Omaha, NE*
- *Margaret Emerson, DNP, Assistant Professor, College of Nursing, University of Nebraska Medical Center, Omaha, NE*
- *Shinobu Watanabe-Galloway, PhD, Professor and Vice Chair of Epidemiology, College of Public Health, University of Nebraska Medical Center, Omaha, NE*
- *Danae Dinkel, PhD, Associate Professor, University of Nebraska at Omaha, Omaha, NE*


Date: Thursday, 10/8/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Innovations
- Patient-centered care/Patient perspectives
- Technology (e.g. health informatics)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify strategies for selecting appropriate and useful self-management technology tools for use in primary care.
- Describe patient perspectives that are pertinent to the utilization of mobile apps in integrated primary care settings.
- Describe provider and clinic staff perspectives regarding the use of depression related mobile app technology within integrated primary care settings.

## D5: What is the Primary Care Behavioral Health Model? A Logic Model Helping Us Define It

Primary Care Behavioral Health (PCBH) is a popular service delivery model of integrated care; however, a key limitation to its growth in practice and research is the lack of understanding for how to define PCBH and ensure fidelity. To date, a majority of research and clinical work has focused on defining PCBH primarily as the presence of an embedded behavioral health consultant (BHC)and characteristics of the appointments conducted by the BHC (e.g., appointment length and number of appointments). However, this approach ignores other elements thought to be essential to PCBH practice and allows for wide variation in PCBH implementation. Such practice variability significantly limits the ability to identify PCBH outcomes. This presentation will describe the importance of assessing PCBH fidelity and shares a logic model developed and subsequently refined using expert consensus methods. This logic model elaborates and defines the structural components, activities, outputs, and outcomes of PCBH across the clinic, primary care team, primary care

Date: Thursday, 10/8/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Primary Care Behavioral Health Model
- Research and evaluation (e.g. data analysis methods)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand why fidelity is important

provider, behavioral health consultant, and patient levels. The discussion will focus on how this comprehensive set of relevant fidelity indicators of PCBH can be utilized by administrators and clinicians to improve practice as well as allow researchers to add rigor to any investigation of PCBH impact on outcomes.

- Identify Ways to Assess Whether a Clinic/Program Can be Characterized as PCBH
- Understand Potential Measures To Utilize to Assess Components of PCBH

*Presenter(s):*

- *Jennifer Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare Syracuse VA Medical Center, Syracuse, NY*
- *Jodi Polaha, PhD, Associate Professor, Department of Family Medicine, East Tennessee State University, Johnson City, TN*
- *Gregory Beehler, PhD, MA, Associate Director for Research, VA Center for Integrated Healthcare, Buffalo, NY*

## D7: Born this Way: Supporting Transgender Youth and Families Across Development in Integrated Primary Care

Transgender individuals experience significant health disparities associated with barriers to care, including lack of provider training, discrimination, system barriers, and financial barriers (Safer et al., 2016). Comfort with primary care services impacts health outcomes for transgender individuals (Clark et al., 2018). For example, affirming, integrated services for transgender youth that include early identification and family support improve psychological outcomes (Janicka & Forcier, 2016). Moreover, primary care services may offer connections to affirming medical interventions, such as puberty blockers and hormone replacement therapies; Turban et al. (2020) found that access to pubertal suppression during adolescence was associated with lower risk of lifetime suicidal ideation. Consistent with previous studies (Kano et al., 2016), this project used qualitative methods to develop gender-affirming programming based on input from patient stakeholders. This presentation describes the development of an intervention program for gender creative patients, including identification of patient population, needs assessment, patient-guided iterations, and the current state of the program. Study sample included youth aged 8-18 years and their families from two integrated primary care clinics located in central and northeastern Pennsylvania. Needs assessment procedures and data will be reviewed. Presentation will share details of the intervention and procedures, and patient experiences and outcomes will be captured in qualitative data. Quantitative data will include demographic data, diagnostic categories, and average length of care. Preliminary data suggests that patients report a high degree of satisfaction with the current program. Families identify the gender program as their "child's tribe" and "the best day of the month." Families also comment on the layers of support, mentoring, and education offered by the intervention.

*Presenter(s):*

- *Carrie Massura, PhD, Pediatric Psychologist, Geisinger Health System, Forty Fort, PA*
- *Shelley Hosterman, PhD, Pediatric Psychologist, Geisinger Health System, Bloomsburg, PA*
- *Megan Moran-Sands, DO, Primary Care Physician, Geisinger Health System, Bloomsburg, PA*
- *Samuel Faulkner, PhD, Pediatric Psychology Fellow, Geisinger Health System, Bloomsburg, PA*
- *Amanda Ferriola, PsyD, Pediatric Psychology Fellow, Geisinger Health System, Forty Fort, PA*

Date: Thursday, 10/8/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Family centered care/Family perspectives
- Pediatrics
- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the development process for an interdisciplinary treatment model for gender creative children, teens, and their families.
- Provide details of a multicomponent and stakeholder approach to affirming gender identity within integrated primary care.
- Highlight qualitative outcomes from patient groups at various stages of program development.

## D8: Research Rigor as a Critical Component of Integrated Healthcare: Development, Implementation, and Evaluation of a Diabetes Pilot Program

Individuals with a severe and persistent mental illness (SPMI) have over twice the risk of mortality than those without SPMI, which is partially attributed to a greater burden of chronic conditions. Individuals with SPMI are more likely to have diabetes, and suffer more severe consequences from diabetes than those with diabetes alone. Chronic disease self-management programs have been tested and used primarily within the general population. Individuals with co-occurring SPMI and diabetes, however, encounter additional barriers to managing diabetes that are not addressed in traditional programs. Self-management programs designed specifically for this population are critical in addressing health and health disparities among individuals with SPMI and diabetes. In this session the presenter will guide the audience through the elements of developing, implementing, and evaluating an innovative pilot intervention in an integrated healthcare setting, using our diabetes self-management pilot as a teaching tool. Session participants will learn, practice, and receive tools for successful pilot implementation and rigorous process and intervention evaluation, to enable them to successfully implement a pilot in an integrated healthcare context. During the session participants will brainstorm potential challenges they might encounter in the implementation and evaluation process. Then, utilizing a logic model to guide planning, participants will identify process measures and outcomes that would be critical in successful evaluation of an example pilot project. Lastly, participants will explore mixed methods analysis in the evaluation stage of their pilot project, and how evaluation methods guide reporting and communications. At the conclusion of the session participants will receive resources to supplement the information presented, including: logic model template, quick primer on mixed methods analysis tools, and additional links to resources on process evaluation and mixed methods analysis. Anticipated Session Outline 1. Overview of Cascadia Behavioral Healthcare and integrated diabetes care to develop context for the session and activities (3 min) 2. The basics on how to develop a pilot program, using Cascadia's work as an example to guide instruction and discussion (6 min) a. Using evidence and research b. Planning c. Implementation d. Evaluation 3. The logic model as a tool to guide steps a-d a. Didactic instruction (5 min) b. Exercise using a logic model to plan implementation and evaluation - Barriers and supports brainstorm and logic model development (15 min) 4. Evaluation of pilot program using mixed methods research a. Didactic instruction (7 min) b. Exercise developing measures/outcomes based on program goals, and guided by logic model (15 min) 5. You've evaluated your program, so now what? (7 min) a. Quick activity around creative approaches to reporting and communicating results 6. Questions/final remarks


*Presenter(s):*

- *Allison Brenner, PhD, MPH, Director of Population Health Research and Innovation, Cascadia Behavioral Healthcare, Portland OR*
- *Madi Knaub, Population Health Research and Innovation Project Manager, Cascadia Behavioral Healthcare, Portland OR*


Date: Thursday, 10/8/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Evidence-based interventions
- Research and evaluation (e.g. data analysis methods)
- Skills building/Technical training

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Develop awareness around identifying barriers and facilitators of implementation and evaluation of a pilot program
- Apply skills around implementation and evaluation, including developing a logic model to guide planning and implementation, and utilizing project management to support implementation
- Identify potential methods for evaluation of a pilot program, including benefits and drawbacks of different approaches

## E1: More than Core Competencies: What do Students Want in an Integrated Care Training Experience?

**Date:** Thursday, 10/8/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Training/Supervision
- Workforce development
- Student Perspective

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Understand basic core competencies for behavioral health integrated care
- Identify additional factors relevant to students in integrated care training
- Understand which student-centered factors are relevant to include in workforce development efforts in integrated care

As the field of integrated care continues to grow, the demand for well-trained, well-prepared behavioral health providers ready to work in complex health systems has also increased. There has been significant effort to identify core competencies for behavioral health providers working in integrated care models in recent years which can help shape training programs. However, the perspective of the student has not been included. While clinical skills, communication skills, consultant skills are typically emphasized by training programs, students are often looking for other factors when searching for training opportunities at various levels. These can include geography, diversity of patient population, diversity of faculty/staff, opportunities for research, opportunities for program development, understanding the complexities of the health care system and more. The goal of this session is to briefly review core competencies utilized in training programs, and then gather feedback from students in the audience. Presenters represent 3 training program sites across the country. Small group discussions will provide an opportunity for students to share with each other what factors they value in training programs. Groups will be asked to report out their findings, and audience members will be asked to rank their findings through an interactive poll. The results can be utilized by students to organize their thinking and decision making as they progress through graduate training, and by training directors to understand how students select training sites.

*Presenter(s):*

- *Meghan Fondow, PhD, Director of Behavioral Health, Access Community Health Centers, Madison, WI*
- *Elizabeth Zeidler Schreiter, PsyD, Chief Behavioral Health Officer, Access Community Health Centers, Madison, WI*
- *Arissa Walberg, PhD, Site Training Director, BHC, Community Health of Central Washington, Yakima WA*
- *Travis Cos, PhD, Lead Network Clinician, Health Federation of Philadelphia, Philadelphia, PA*

## E2: The Interprofessional Precepting Room - Preliminary Data to Support Novel Integration through Consultation and Bidirectional Learning

**Date:** Thursday, 10/8/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Interprofessional education
- Interprofessional teams
- Team-based care

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Describe the educational and clinical utility of an interprofessional precepting room setting
- Identify tools and outcomes for assessing learning and collaboration in these settings
- Identifying strategies of applying preceptor room science to unique interprofessional settings

One of the benefits of integrated primary care settings is the wealth of bi-directional learning that can occur through consultation and collaboration. In VA Connecticut's Center of Education (COE) in Interprofessional Primary Care, residents from clinical health psychology (CHP), medicine, nursing, and pharmacy work together to provide fully integrated and comprehensive care. In the precepting room, physician (MD) and nurse practitioner (NP) residents meet with an attending provider to review patient care and develop a treatment plan. During interprofessional precepting, CHP residents provide mental and behavioral health consultation, and in turn, are exposed to professional practices in primary care. This project is an extension of previous work done examining active and passive learning in the precepting room. The sample consisted of 2 CHP residents, 14 physician (MD) residents, and 6 nurse practitioner residents (NP) over a 12-month period. During precepting, CHP residents tracked the type of consultation provided, if a CHP referral was discussed, and if a "warm introduction"was performed. CHP residents qualitatively indicated what they learned from precepting and themes were identified by two CHP providers not participating in precepting. Of the 122 patient visits precepted (60 by MD residents, and 62 by NP residents), consultation was provided 90% of the time. Consultation included health behavior change (70%), patient-provider communication (30%), understanding psychiatric presentations (22%), cultural

considerations (11%), providing patient education handouts (10%), and mental health resources outside of the clinic (9%). Warm introductions were positively associated with health behavior change consultation (Ï‡2= 6.81, p = .009). CHP referrals were discussed 30% of the time and were inversely associated with consultation on psychiatric presentations (Ï‡2= 5.53, p=.019). Learning among CHP residents occurred 76% of the time and consisted of clinical/biomedical information (74%), profession-specific practices in primary care (19%), facility-related content (10%). MD and NP faculty identified coaching from CHP residents on communication techniques (e.g. motivational interviewing) as being particularly beneficial in MD/NP resident development. Other benefits of consultation included a greater appreciation for how mental health disorders impact care, alternative perspectives on clinical conceptualizations, and encouragement after multiple unsuccessful prior attempts to engage patients in changing health behaviors. Future directions include obtaining and examining qualitative data from MD and NP residents related to the impact of consultation with CHP residents on developing advanced competences in integrated care.

*Presenter(s):*

- *Noel Quinn, PhD, Health Behavior Coordinator, VA Connecticut Healthcare System, West Haven, CT*
- *Jocelyn Remmert, PhD, Postdoctoral Fellow, Corporal Michael J. Crescenz Philadelphia VA Medical Center, Philadelphia, PA*

## E3: Experiences of African American Men with Prostate Cancer: Engaging African American Men in Health Disparities Research

African American men are more likely to be diagnosed with and die from prostate cancer (American Cancer Society, 2016; Kreps, 2006). For those who survive, prostate cancer side effects, such as erectile dysfunction, impact the patient's quality of life and their romantic relationship. Sexual satisfaction seems to impact the perceived quality of life and overall health for African American men (Kinlock et al., 2017). When compared to white men with prostate cancer African American men are less likely to trust their physicians, this may be related to medical mistrust (Boulware, Cooper, Ratner, LaVeist, & Powe, 2016). The purpose of this study was to understand the association between trust and confidence in medical care, quality of life, sexual satisfaction, and couple's satisfaction for African American prostate cancer survivors. This study looked at African American men (n=24) who were in or had completed treatment and were in romantic relationships. A one-time, self-report survey was conducted. Surveys were web-based or in-person depending on the participants' preference. Participants were recruited nationally through prostate cancer support groups, medical and mental health listservs, social media (e.g. Facebook, Twitter, etc.), urology clinics and primary care clinics. Due to the difficulty of accessing the African American population for research, this study used non-random sampling such as convenience (i.e., quota or accidental) sampling (Etikan et al., 2015; Kumar, 2011) and snowball sampling (Kumar, 2011). Participants filled out questions from the following measures Functional Assessment of Chronic Illness Therapy-Treatment Satisfaction-Patient Satisfaction (FACIT-TS-PS), Functional Assessment of Cancer Therapy-Prostate Cancer (FACT-P), Couples Satisfaction Inventory (CSI-4), PROMIS SexFS. Due to the small sample size (n = 24), non-parametric correlations were conducted to test hypotheses. Positive associations were found between physician communication and quality of life, couples satisfaction, sex life satisfaction, and orgasm pleasure as expected. As well as confidence and trust in medical care, quality of life, couples satisfaction, sex life satisfaction, and orgasm pleasure. Recruitment of African American men for this study was difficult and the response rate was low. In healthcare research, one study found that older African American men who witnessed the Tuskegee disclosure

Date: Thursday, 10/8/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Social determinants of health (SDoH)
- Underserved populations (e.g. LGBTQ)
- Cancer

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify ways to engage African American men in health disparities research.
- Describe ways that researchers can engage community partners to help recruit minority research participants.
- Describe barriers to engaging African American men in prostate cancer research.

were less likely to engage in healthcare (Alsan & Wanamaker, 2017). Health disparities researchers face a conundrum, to change health disparities we must study a population that is hesitant to engage in research. To make an impact on health care disparities, researchers should understand barriers to engaging in research and how to gain trust in minority communities. This workshop will focus on the experiences that African American men with prostate cancer face. As well as how to engage African American men in health disparities research.

*Presenter(s):*

- *Kristin Ross, PhD, LMFT-Associate, Therapist, Stay the Course a Program of 22Kill, Dallas, TX*

## E4: Utilizing Interprofessional Education to Meet the Quadruple Aim in Skilled Nursing

Though significant attention has been paid to burnout in healthcare workers, the predominant focus has been on the physician experience with lesser attention to other members of the team. This is particularly concerning in long-term care (LTC), where thirty-seven percent of nursing staff report experiencing burnout, compared to just 22 percent of nurses working in other settings. Burnout has been linked to elevated turnover, absenteeism, and poorer mental and physical health outcomes for health care workers, but also poorer safety and quality for patients, and increased costs to employers. LTC staff report that one of the greatest contributing factors to burnout is challenging patient behaviors. This is particularly salient given that over the past ten years, adults ages 31 to 64 have been the fastest growing population in nursing homes, and they are more likely to have experienced additional social determinants of health--leading to more complex care needs--including developmental disabilities, trauma, psychiatric diagnoses, and inpatient stays in psychiatric facilities. At our facility, behavioral health specialists have long served as physician educators and delivered brief interventions to patients. Yet no supports to increase nursing knowledge or comfort working with behavioral challenges existed. As a result, a needs assessment was conducted with nursing staff in one multi-unit LTC to identify potential benefits of providing interdisciplinary teaching on these topics to support patient care and reduce rates of staff burnout. Nurses identified a need for additional training focused on addressing challenging patient behaviors and family interactions. In response, a twelve-month training program was created by a team which included medical family therapy, behavioral, and geriatric expertise and was delivered to all nursing staff of a 40-resident LTC unit. Pre-training, mid-point, and end-of-training-year measures were collected to determine training impacts on clinical and operational outcomes for patients, staff, and the facility, including staff burnout. The interdisciplinary healthcare team that designed and supported the program will describe the needs assessment design, development and implementation of the program, and evaluation methodology and results.

*Presenter(s):*

- *Jessica Goodman, PhD, LMFT, Postdoctoral Fellow, Departments of Psychiatry and Medicine, University of Rochester, Rochester, NY*
- *Lauren Decaporale-Ryan, PhD, Assistant Professor, Departments of Psychiatry, Medicine, & Surgery, University of Rochester, Rochester, NY*
- *Joseph Nicholas, MD, MPH, Associate Professor, Department of Medicine, University of Rochester, Rochester, NY, Medical Director, Highlands at Brighton Transitional Care Facility, Rochester, NY*
- *Marguerite Janto, RN, Unit Nurse Manager, The Highlands at Brighton Transitional Care Facility, Rochester, NY*

Date: Thursday, 10/8/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Burnout
- Complex Patient Care
- Interprofessional education

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the need for LTC nursing staff training to address challenging patient behaviors and family interactions
- Describe the didactic content and session organization associated with a novel training program to address these needs
- Discuss factors associated with the success of an interdisciplinary LTC team, incorporating members beyond physicians and behavioral health clinicians to include nurses, physical therapy, occupational therapy, and others

## E5: Correlates of Delivery of Evidence-Based Interventions for Anxiety in Primary Care Behavioral Health Routine Clinical Practice

Although anxiety is highly prevalent in primary care and a top reason for referral to Primary Care Behavioral Health (PCBH), understanding of anxiety interventions used in routine PCBH practice is limited. The objective of this study was to examine patient-level and provider-level correlates of delivering evidence-based anxiety interventions to inform research and practice on the implementation of evidence-based treatment in integrated primary care. In a cross-sectional survey, 209 PCBH providers recruited from national email listservs reported on use (yes/no) of various interventions in their most recent session with an adult patient referred for non-PTSD anxiety (e.g., generalized anxiety, social anxiety, panic, phobias). We used multivariate logistic regression to examine whether provider discipline and theoretical orientation, session type, likelihood of follow-up, and patient age, anxiety severity, depressive severity, comorbid concerns, treatment priority, and anxiety medication were associated with intervention delivery. Providers reported using an average of 5.77 (2.05) intervention techniques. Relaxation training was more likely to be used during initial (vs. follow-up) sessions, whereas cognitive therapy was less likely. Cognitive therapy and behavioral activation were less likely to be used for patients who prioritized treating anxiety (vs. other concerns), whereas relaxation training was more likely. Exposure and Acceptance and Commitment Therapy-based interventions were more likely to be delivered by psychologists (vs. other providers). Overall, PCBH providers seemed to consider the patient's priorities and likely course of treatment in selecting interventions, but their own training background may also factor in. The presenters and audience will discuss clinical, research, and training implications of the results as well as potential implementation strategies to increase the delivery of evidence-based anxiety interventions in integrated primary care.

*Presenter(s):*

- *Robyn Shepardson, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse, NY*

**Date:** Thursday, 10/8/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Evidence-based interventions
- Primary Care Behavioral Health Model

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify patient-level and provider-level factors associated with delivery of an array of evidence-based anxiety interventions in PCBH practice
- Discuss clinical, training, and research implications of low utilization of some evidence-based anxiety intervention
- Describe potential strategies to improve the implementation of evidence-based anxiety interventions in PCBH

## E6: Innovative Methods for Efficient Plan-Do-Study-Act Analysis in a Fast-Paced Integrated Primary Care Environment

Quality improvement is an area in which healthcare organizations strive to achieve; however, the realities of being in a fast-paced, safety-net primary care clinic often preclude the ability to efficiently evaluate the clinical utility of implemented quality improvement interventions beyond objective statistical measures. Although statistical measures may show significant improvements in outcomes, such as HbA1c scores, these measures may not accurately reflect the amount of labor that was required to affect change, thus calling into question the effectiveness of the intervention and opportunities for improvement. The Plan-Do-Study-Act (PDSA) Model for Improvement is a tool that was developed by the Associates in Process Improvement in order to track a test of change, and is used by numerous healthcare organizations. Although there are several PDSA worksheets available, these worksheets can be confusing to healthcare employees who have not received specific training in this area or lack experience with this process. Furthermore, lacking an advance plan to evaluate a test of change, such as tracking outcome measurements, can significantly increase the amount of time required to determine if the test of change was effective, thereby obfuscating the process of the PDSA in of itself. This presentation aims to provide a brief overview of the PDSA process, while taking a look at innovative methods that were utilized in an integrated family medicine residency primary care clinic to ensure the completion of PDSAs in a time-efficient manner. This presentation will provide PDSA examples ranging from implementation of new behavioral health services to the development of a new job

**Date:** Thursday, 10/8/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Quality improvement programs
- Research and evaluation (e.g. data analysis methods)

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Learn what a PDSA is and the purpose of utilizing a PDSA
- Identify how they may be able to utilize PDSAs in their work environment
- Develop skills for efficiently completing PDSAs in a fast-paced environment

position. Audience members will be encouraged to identify an intervention at their clinic for which they would like to complete and PDSA, recognize potential barriers to the PDSA, and develop solutions for overcoming these barriers.

*Presenter(s):*

- *Erin Iwamoto, PsyD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Virginia Parret, PhD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Sarah Sanders, PhD, Postdoctoral Psychology Fellow, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*

## E7: Screening and Treating Families for Adverse Childhood Experiences and Depression in a Safety-Net Pediatric Health Home Population

Research on Adverse Childhood Experiences (ACE) has demonstrated a significant association between childhood maltreatment and later life health and well-being. Other research has linked the impact of parental trauma and intergenerational trauma. Adults who experienced trauma as children are at higher risk incidence of parenting poorly. Additionally, mothers and fathers who experience postpartum depression are at greater risk for abusing or neglecting their children. The aim of this pilot study was to implement a screening process and intervention to address trauma, anxiety, and postpartum depression in parents with the intent of improving parental well-being. We conducted a brief pilot study implementing ACE, depression, anxiety, child quality of life and social determinants of health screening in our integrated behavioral health and primary care pediatric-focused health home, Jefferson Plaza Family Health Home (JPFHH) in Lakewood, Colorado. Medicaid was the predominant payer at this clinic and almost 50% of the population were of Latinx heritage. This health home is unique in that it is a bidirectional model providing a full range of both mental health services and medical services. The establishment of the health home was made possible by support and funding from the Colorado State Innovation Model (SIM), with the overarching goal of increasing access to integrated physical and behavioral healthcare services. Starting in January 2018, we implemented ACE Questionnaire, PHQ-9 depression screen, Edinburgh Postnatal Depression Scale (EPDS), Generalized Anxiety Disorder Screen 7 (GAD-7), and a self-scaled questionnaire on the Substance Abuse Mental Health Administration's (SAMHSA) 8 Dimensions of Wellness for the caregivers of infants as part of our intake process. Additionally, the child's quality of life was tracked using the age appropriate KINDL measure. Parents who screened positive on these tools were offered a variety of services from Jefferson Center, including, but not limited to, behavioral health assessment and education, individual therapy, navigation services, wellness services (health coaching), and family services . Patients received an average of 12 services. Of note, is that fathers who were screened appreciated being asked about their depression and trauma history and welcomed the opportunity to receive supportive services. Assessing and treating parental behavioral health may positively impact child well-being.

*Presenter(s):*

- *Shannon Tyson-Poletti, MD, Assistant Medical Director, Jefferson Center, Wheat Ridge, CO*
- *Meghan Pataky, DSW, LCSW, Manager of Integrated Care, Jefferson Center, Wheat Ridge, CO*
- *Megan Swenson, LPC, LAC, Director Integrated Care, New Directions, Overland Park, KS*
- *MaryAnn Shiltz, PNP, Westside Medical Director, STRIDE Community Health Center, Lakewood, CO*
- *Jeanette Waxmonsky, PhD, VP Integrated Care, New Directions & University of Colorado Dept. of Family Medicine, Denver, CO*

Date: Thursday, 10/8/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Family centered care/Family perspectives
- Multi-generational
- care
- Payment models
- Primary Care Behavioral Health Model

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe two ways parental well-being can influence children's quality of life.
- Describe the model components of assessment and intervention for parental well-being.
- Identify parental and child screening tools and describe how they can be used track program outcomes over time.

## E8: Reducing ER Utilization in Behavioral Health Patients

Existing literature has indicated utilizing current care teams marked an improvement in readmission and reduction in emergency department visits. Reducing Emergency Department visits is a system initiative within Geisinger Health System. Being integrated into the primary care setting, data was collected to determine if utilization could be decreased in those utilizing the emergency room for psychiatric related chief complaints (anxiety, depression, psych eval). Motivational Interviewing techniques were used by mental health professionals making the phone calls to patients. Reason for their visit, other options for care, and appointments were offered with the embedded behavioral health professional and/or their PCP. Data has been collected for 1 year to determine the impact of a mental health professional reaching out to those going to the emergency department with a mental health chief complaint. One year post intervention there was a 80% decrease in repeat ER utilization and a 14% decrease in overall ER utilization. There was shown to be a decrease in repeat patients and those using the emergency room and not being admitted for inpatient stays. Pre and post comparison will be included in the final presentation.

*Presenter(s):*

- *Kendra McKee, LCSW, MBA, Clinical Psych Specialist, Geisinger Health System, Lewistown, PA*

**Date:** Thursday, 10/8/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Cost Effectiveness/Financial sustainability
- Outcomes
- Primary Care Behavioral Health Model

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify ways to utilize motivational interviewing to decrease emergency room visits in behavioral health population
- Discuss with their team how to implement similar strategies
- Describe the reduction in nonemergent visits to the emergency department for behavioral health

## E9: The Eliminating Health Disparities Initiative (EHDI) in Minnesota: An Innovative Community-Based Program to Improve the Health of Native People

The EHDI is an innovative program that was created through the collaborative efforts of behavioral- and biomedical- healthcare professionals with local leaders (patients, families) in Minnesota's American Indian community. This workshop will describe the initiative's interactive, community-based, and educational efforts to engage Native people in addressing contemporary struggles with addition (opiods, ETOH), mental illness (depression, anxiety), obesity and diabetes, and social isolation. These efforts advance a multifaceted approach to reclaiming health-related activities that reflect traditional Indigenous culture(s), food/diet, and family members' (elders, men, women, youth) roles. Evaluative longitudinal data (quantitative) and qualitative accounts about participants' experience(s) in EHDI programming will be put forth.

*Presenter(s):*

- *Tai Mendenhall, PhD, LMFT, Associate Professor, University of Minnesota, Twin Cities, MN*

**Date:** Thursday, 10/8/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Family centered care/Family perspectives
- Underserved populations (e.g. LGBTQ)
- Community-based participatory research

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- describe the Eliminating Health Disparities Initiative (EHDI) as a community-engaged project created through the collaborative efforts of Western providers and American Indian community members to improve the lives of urban-dwelling adult AIs and their fa
- cite evaluative findings across biological- (BMI, metabolic control), psychological- (PHQ-9, GAD-7, key informant interviews regarding recovery/sobriety), and social- (Multidimensional Scale of Perceived Social Support) well-being.

- explain key lessons and strategies regarding how to get explore and initiate health-oriented interventions in partnership with minority and under-served populations.

## F1: The Many Faces of Psychiatry in Primary Care Settings

Background/Rationale: Traditional models of psychiatric care delivery have failed to keep up with patient demand. Psychiatrists offer expertise in several needed areas for population health including psychiatric diagnosis, psychopharmacology, access to specialty programming, and in helping to deal with complex medical and psychiatric patients. In primary care settings, behavioral health providers have had to adapt their approaches to the challenges and opportunities in those settings however in adding a psychiatric provider to a primary care team, there may not be awareness of the evidence based options available. We hope to introduce the audience to direct and indirect ways to leverage psychiatric care based on the literature and our own experience. We will include information on involving all psychiatric providers (not just MDs), use of telemedicine tools, the collaborative care model, project ECHO, measurement based care, and how to address financial barriers. Each of us has chosen this work at least in part because we appreciate working with a team involving behavioral health providers and primary care and as such we will highlight ways to make psychiatric providers a part of an integrated team.

*Presenter(s):*

- *Mark Williams, MD, Associate Professor, Integrated Behavioral Health, Mayo Clinic, Rochester, MN*
- *Lori Raney, MD, Principle, Health Management Associates, Denver, CO*
- *Thomas Salter, MD, Psychiatry, Integrated Behavioral Health, Mayo Clinic, Rochester, MN*
- *Patricia Gibson, MD, Medical Director, Arkansas Health Group Behavioral Health Integration Program, Fayetteville, AR*
- *Julie Le, DO, Assistant Professor of Psychiatry and Family Medicine and Public Health, UC San Diego Health, San Diego, CA*

**Date:** Thursday, 10/8/2020

**Time:** 2:45 PM - 3:45 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Collaborative Care Model of Integrated Care|Professional Identity, including development of|Suicide|Workforce development

**Objectives:** *At the conclusion of this presentation, participants will be able to…*

- Describe 3 ways to leverage psychiatric expertise in the primary care setting.
- Understand the role of measurement and stepped care in improving patient outcomes.
- Describe ways to employ psychiatric providers to raise capacity of the primary care team

## F2: Starting from Scratch: Developing PCBH Providers through Interdisciplinary Training

The fields of family medicine and behavioral health are stepping up to meet the growing demand for providers trained in the provision of team-based, integrated and interdisciplinary, healthcare. Each field has created competencies to guide their respective training programs and help ensure that trainees acquire the necessary skills to function in this collaborative environment. However, much of that training occurs separately, with the behavioral health and medical providers coming together only during the application of those skills to actual patient care. Because of this, each brings their own boxed recipe for patient care that they then must figure out how to mix together. Although some of this is necessary, given the unique value each field has to offer, at times it can lead to half-baked outcomes. When it come to the shared ingredients, what if we started from scratch when the providers are in their required training programs and integrated pieces of their training? Central Washington Family Medicine houses a family medicine residency, a predoctoral psychology internship, and a psychology postdoctoral fellowship. Since the inception of the psychology internship, we set out to integrate as many facets of the training

**Date:** Thursday, 10/8/2020

**Time:** 2:45 PM - 3:45 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Interprofessional education
- Team-based care
- Workforce development

**Objectives:** *At the conclusion of this presentation, participants will be able to…*

- Identify strategies implementing or enhancing integrated medical and behavioral health training

programs that have shared relevance as possible, starting from day one with a robust orientation and community medicine month. In this presentation the psychology internship training director, the chief medical resident, and former psychology intern/current postdoc will review details of the orientation, as well as the other integrated training experiences, and the impact of those experiences. Strategies for implementing or enhancing integrated medical and behavioral health training as well as added benefits, lessons learned, and ethical considerations will be identified.

- Describe benefits and lessons learned from integrating medical and behavioral health training
- Discuss ethical considerations and precautions for integrating medical and behavioral health training

*Presenter(s):*

- *Arissa Walberg, PhD, Behavioral Health Consultant, Central Washington Family Medicine, Yakima, WA*
- *Amelia McClelland, MS, Behavioral Health Consultant, Central Washington Family Medicine, Yakima, WA*
- *Josh Johnson, DO, Resident Physician PGY-3, Community Health of Central Washington, Yakima, WA*

## F3: Skills Versus Pills: A Novel Response to Vulnerable Patients with Low Mood

As many as 30% of primary care patients suffer from symptoms of depression, and many receive a diagnosis and an antidepressant medication as first-line treatment. People challenged by more social determinants of health are more vulnerable to development of depression symptoms, and they may experience harm from unnecessary use of antidepressant medications. In this presentation, participants will learn alternatives to using a depression symptom screening and prescribing broadly. The first alternative, informed by Focused Acceptance and Commitment Therapy (FACT), has a primary care provider or behavioral health consultant completing a brief functional assessment (love-work-play-health) and developing a behavioral health experiment to improve their quality of life in a first visit for depression. In a small randomized controlled trial, half of the patients that received this intervention were improved at a one-week follow-up. A second alternative is use of the Coping Strategy Use Scale (CSUS), a 6-item measure designed to rapidly identify the patient's needs for coaching on skills associated with mood improvement. A post hoc analysis of a randomized controlled trial found that patients seen by a behavioral health consultant recommending the skills demonstrated higher rates of use one month after diagnosis, as well as fewer symptoms of depression.

Date: Thursday, 10/8/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Complex Patient Care
- Evidence-based interventions
- Primary Care Behavioral Health Model

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss steps for completing an evidence-based first visit for depression in primary care.
- Describe a brief functional assessment for depressed primary care patients that generates a behavioral experiment to improve quality of life.
- Describe a 6-item screening for assessing patient rates of using skills associated with improving mood and energy.

*Presenter(s):*

- *Patti Robinson, PhD, Psychologist and President, Mountainview Consulting Group Portland, OR*
- *Professor Bruce Arroll MBChB, PhD, FRNZCGP (Distinguished), FRNZCUC (Honorary) Personal Chair and Elaine Gurr Chair of General Practice and Primary Health Care Head of Department Director of the Goodfellow Unit Department of General Practice and Primary*

## F4: Difficult Conversations: Assessing and Addressing Firearm Safety and Means Restriction in Integrated Care Settings

Research has clearly demonstrated that, irrespective of other risk factors, the presence of a firearm in the home greatly increases the risk of suicide. There is also solid empirical support for deploying means restriction as one of the most effective approaches to prevention of suicide among those who are actively suicidal or in a mental health crisis. Furthermore, we know from research and clinical experience that physicians, nurses, psychologists, psychiatrists, and other providers are very often uncomfortable and ill-equipped to have effective firearm safety and means

Date: Thursday, 10/8/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Population and public health
- Skills building/Technical training

restriction discussions with at-risk patients. This presentation is aimed at briefly reviewing the research, and then proposing multiple methods for healthcare providers to effectively screen for, discuss, and competently and ethically handle any information related to individuals' with both suicidal ideation or intent and access to firearms. Interactive activities and role-play will assist providers in practicing the language and interventions to increase confidence and allow attendees to leave with an actionable skill. We will discuss the initial implementation response and data of these recommendations in a multi-center health care network.

Due to the pandemic, the clinic we intended to utilize for gathering pilot data went all virtual, causing significant delays in data gathering. We still have a great deal of information and expertise regarding and discussing this topic, and the I/o's won't change. We are hoping to start data collection as restrictions are lifted over the next few months or we may need some way to utilize an online format.

*Presenter(s):*

- *Robynne Lute, PsyD, Licensed Psychologist, Director of Clinical Training, Kansas City University, Kansas City, MO*
- *Paul Thomlinson, PhD, Psychologist, Executive Director, Research, Compass Health Network, Springfield, MO*

- Suicide

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the importance and effectiveness of means restriction, particularly related to firearms, in preventing suicide.
- Identify barriers to psychologists and other integrated care team members engaging in effective firearms means restrictions.
- Demonstrate increased comfort and proficiency in discussing firearms means restriction with patients who are at high risk of suicide

## F5: When Clinicians Become Family Caregivers: Discovering the Joys and Acute Frustrations of Collaborating with the Treatment Team

Professional and family identities are often at odds when physical and behavioral health clinicians become family caregivers for their own ill or aging family members. Those clinicians have special knowledge about their loved ones' conditions and personalities but feel constrained in expressing their clinical opinions to the treating professionals who may regard them as a welcome resource or potential challenge to their authority. Or, conversely, clinician-caregivers may feel compelled to speak up to advocate for their loved ones and thereby risk multidisciplinary team members' resentment and avoidance. In this workshop, a family physician, nurse practitioner and clinical psychologist who have recently had experiences as family caregivers for parents with neurodegenerative diseases will share their own and others' personal experiences and stepwise advice for establishing trust and collaboration with primary care, specialty care and hospital teams.

*Presenter(s):*

- *Barry Jacobs, PsyD, Principal, Health Management Associates, Philadelphia, PA*
- *Katherine Mahon, MD, Crozer-Keystone Family Medicine Residency Program, Springfield, PA*
- *Kimberly McGuinness, CRNP, Nurse Practitioner, Inspira Health Network, Vineland, NJ*

Date: Thursday, 10/8/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Family centered care/Family perspectives
- Professional Identity, including development of
- Self-care/Self-management

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the conflicted feelings of healthcare professionals who become family caregivers to their own ill or aging relatives
- Define the ideal role of clinicians-caregivers as part of the collaborative healthcare team
- List 4 strategies for clinicians-caregivers to better partner with collaborative team members

## F6: Implementation of Primary Care Behavioral Health (PCBH) Model across 60 Comprehensive Primary Care Plus Practices in a Large Academic Health Network

The U.S. healthcare system has experienced a paradigm shift in the way it delivers care since the implementation of the Affordable Care Act. Its emphasis on improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities (the Triple Aim for populations)1 has created opportunities and challenges for numerous health care entities, especially for those that have not implemented an integrated

Date: Thursday, 10/8/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Innovations

behavioral health component. Providers have also faced challenges in fulfilling the Triple Aim, leading to calls for a Quadruple Aim that includes a focus on provider well-being.2 The benefits of integrating a behavioral health consultant in the primary care setting are well established. Sixty (60) Jefferson Health primary care practices were accepted into the Center for Medicare and Medicaid's (CMS) 5-year Comprehensive Primary Care Plus (CPC+) demonstration program (2017-2021). CPC+ selects practices that have demonstrated a solid track record of practice transformation and have demonstrated advanced capacity and readiness for enhanced care delivery. Through CPC+, Jefferson has had the opportunity to rapidly scale up system-wide primary care integrated behavioral health (PCIBH) model.3 This included the hiring and embedding over 25 Behavioral Health Consultants across four regional areas throughout Pennsylvania and New Jersey. Initial outcome metrics have reflected a fundamental transformation in how primary care providers at Jefferson understand and deliver integrated, team-based care within the practices, improved patient outcomes for depression and anxiety as measured by the PHQ9-and GAD7; improved physician well-being and expanded options for long-term program financial sustainability. This approach has fundamentally transformed how team-based care is delivered at Jefferson and could offer valuable lessons to other organizations looking to implement a similar model.

*Presenter(s):*

- *Rachelle Rene, PhD, BCB, Clinical Assistant Professor, Director of Primary Care Integrated Behavioral Health, Jefferson University, Philadelphia, PA*
- *Mollie Cherson, LCSW, Behavioral Health Consultant, Abington-Jefferson Health, Abington, PA*
- *Angelo Rannazzisi, PsyD, Behavioral Health Consultant, Jefferson Family Medicine Associate, Philadelphia, PA*
- *Lori Merkel, MSPH, RN, CPHQ, Population Health Business Analyst, Jefferson Medical Group, Abington, PA*
- *Christine Marschilok, MD, Clinical Assistant Professor of Family Medicine & Sports Medicine, Jefferson University, Philadelphia, PA*
- *Amy Cunningham, PhD, MPH, Jefferson Medical Group, Philadelphia, PA*

- Primary Care Behavioral Health Model
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Define CPC+ and implementation of the PCBH model at a large academic health center
- Define key metrics used in evaluating Jefferson's PCBH program.
- Discuss the impact, successes, challenges and early outcomes of embedding BHCs within 60 primary care practices

## F7: New and Aspiring Behavioral Health Consultants: Ask Us Anything!

This session is intended for new and aspiring behavioral health providers working in a primary care medical setting (although we heartily welcome interested colleagues and collaborators across all disciplines). Our panel of behavioral health consultants (BHCs) will provide an overview of 1) the Primary Care Behavioral Health (PCBH; Reiter, Dobmeyer, & Hunter, 2018) model and 2) BHC competencies as defined by Robinson and Reiter (2016), including 3) brief assessment and intervention approaches most useful to a BHC working in primary care. The above will provide some structure to the session, but our primary aim is to allow significant time for Q & A. Our panel includes BHCs with experience working in family practice, pediatrics, and geriatrics, in MAT programs, in both federally-qualified health centers as well as a large private non-profit healthcare organization, and with early experiences implementing a new integrated behavioral health program into a healthcare organization.

*Presenter(s):*

- *Michael Bruner, PsyD, Integrated Behavioral Health Program Coordinator, HealthSource of Ohio, Loveland, OH*
- *Chava Urecki, PsyD, Behavioral Health Provider & MAT Behavioral Health Provider, Cabin Creek Health Systems, Clendenin, WV*
- *Desiree Harding, PsyD, Behavioral Health Consultant, Bon Secours Mercy Health, Amberley Village & Mason, OH*

Date: Thursday, 10/8/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Novice

Keywords:

- Early Career Professionals
- Primary Care Behavioral Health Model
- Skills building/Technical training

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe & discuss the Primary Care Behavioral Health Model as defined by recent expert consensus (Reiter, Dobmeyer, & Hunter, 2018).
- Describe & discuss BHC competencies as defined by Robinson and Reiter (2015).
- Discuss brief assessment and intervention approaches useful to

- *Britni Ross, PsyD, Lead IPC Psychologist, Valley Health Systems, Huntington, WV*
- *Shelby McGuire, PsyD, IPC Psychologist, Valley Health Systems, Huntington, WV*

behavioral health consultants in a primary care setting.

## F8: Partnership for Academic Clinical Telepractice: Expanding Medications for Addiction Treatment in Integrated Practices Settings Throughout New Hampshire

Opioid Use Disorder (OUD) has impacted New Hampshire (NH); in 2016, the overdose death rate was 35.8 per 100,000, almost three times higher than the national rate. The presentation will describe how the Institute for Health Policy and Practice, NH Citizens Health Initiative and the University of New Hampshire's (UNH) Department of Nursing furthered the work of the NH Behavioral Health (BH) Integration Collaborative with the development of the Partnership for Academic Clinical Telepractice - Medications for Addiction Treatment (PACT-MAT). Eighteen community health care practices throughout NH and 64 students participated in the learning community; PACT-MAT demonstrated a 50% increase in patients' treatment for OUD and increased provider knowledge and confidence. The presentation will describe "how"to use the project ECHO® model, to link interdisciplinary teams and students developing a reflective and adaptive learning community guided by a continuous improvement approach to identify both clinical practice and policy issues. The presentation will include a community practice site provider who will discuss how they utilized the knowledge and confidence gained through participation to increase access to treatment at their community health center. Building on the integrated care approach, PACT-MAT was the first in the world to incorporate nursing students into an ECHO. The presentation will discuss best practices for onboarding students into this type of teaching modality as well as discussing augmentations to the ECHO format. An integral component of the program was the use of a person-centered approach to care in order to reduce stigma and bias. In addition to didactics specifically addressing stigma and bias, ECHO staff focused on redirecting and modeling language in each part of the ECHO process. Over the course of the sessions, the community developed a culture that understands addiction as a chronic disease and is prepared and capable to address a range of issues, including clinical management, compassion fatigue, stigmatization, and mental health conditions that emerge during the process of treatment. The presentation will share evaluation results and tools used for PACT-MAT to provide a framework for others to build a learning community that advances access to OUD treatment.

***Presenter(s):***

- *Marcy Doyle, DNP, MHS, RN, CNL, Quality and Clinical Improvement Director, New Hampshire Citizens Health Initiative, Institute for Health Policy and Practice, University of New Hampshire, Durham, NH*
- *Dayle Sharp, PhD, DNP, McPH, FNP-BC, APRN, Director of the Family Nurse Practitioner Program, Department of Nursing, University of New Hampshire, Durham, NH*
- *Susan Nichols, PA, Community Practice Site, Lamprey Health Care Community Health Center*

**Date:** Thursday, 10/8/2020

**Time:** 2:45 PM - 3:45 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Interprofessional teams
- Opioid management Telepractice Learning Community

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Discuss how to build an integrated behavioral health telepractice learning community that reduces stigma and bias while increasing access to medications for addition treatment at community practice sites.
- Describe "how"to use the project ECHO® model, to link community-based sites, providers, peer support specialists, Nurse Practitioner students, and Project ECHO faculty experts to teach and spread best practices in opioid use disorder treatment
- Understand how to measure an increase in provider and student confidence and knowledge of medications for addiction treatment. 3. Increase the number of patients with opioid use disorder at community practice sites

- *Marguerite Corvini, MSW Partnership for Academic Clinical Telepractice, New Hampshire Citizens Health Initiative, Institute for Health Policy and Practice, University of New Hampshire, Durham, NH*
- *Kelsi West, BS, Partnership for Academic Clinical Telepractice, Research Associate, New Hampshire Citizens Health Initiative, Institute for Health Policy and Practice, University of New Hampshire, Durham, NH*

## G1: The Quality of Life Matrix: An Intervention for Opioid Dependent PC Patients with Chronic Pain

Primary care opioid prescribing for patients with chronic non-cancer pain has increased over the last 20 years, even with a lack of evidence for effectiveness and concerns about long-term safety. High dose opioid prescribing may be more likely in high deprivation areas and long term use of prescription opioids is associated with dependence, addiction, and opioid-related deaths. Primary care patients with chronic non-cancer pain have responded favorably to low intensity interventions promoting non-medication treatment (Kanzler, Robinson, McGeary, Mintz, Potter, et al., 2018; Kesten, Thomas, Scott, Bache, Hickman, et al., 2020). This presentation introduces participants to a low intensity intervention from Acceptance and Commitment Therapy, The Quality of Life Matrix. This approach encourages sustained support of non-medication treatment for patients with chronic pain and continuity among members of the inter-professional team.

*Presenter(s):*

- *Patti Robinson, PhD, Psychologist and President, Mountainview Consulting Group Portland, OR*

Date: Friday, 10/9/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Evidence-based interventions
- Interprofessional education
- Opioid management

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss primary care patient interest in learning about non-medication treatment for chronic pain
- Promote patient focus on quality of life versus pain elimination
- Use The Quality of Life Matrix to talk with patients with chronic, non-cancer pain about who and what matters in their lives, identify internal and external behaviors that interfere with pursuit of a higher quality of life, and commit to small behavior ch

## G2: Culture is Context: Navigating a More Culturally-Informed Contextual Interview with the Foreign-Born Latinx Population

The Primary Care Behavioral Health (PCBH) model is associated with increased access to and utilization of behavioral health services and improved health outcomes. The benefit of an integrated model with racial/ethnic minorities and underserved populations remains poorly documented. However, an integrated model can meet the needs of this patient population by increasing patient contact and facilitating greater identification of behavioral health needs. Among these underserved populations is the rapidly growing, foreign-born Latinx community that endures adverse social/cultural/political factors which disproportionately affect their health and access to care and increase the complexity of their care in primary care settings. Being aware of these factors is critical in meeting their complex needs. Fortunately, inherent in PCBH is an appreciation for the complexity of patients' clinical presentations and an understanding that symptoms and behaviors do not occur in a vacuum but are a response to contextual factors. Thus, the contextual interview is essential in addressing the behavioral health needs of Latinx patients. However, with such complex psychosocial histories, inexperienced BHCs or those lacking a guiding cultural framework run the risk of missing relevant cultural information, going down a rabbit hole and deviating from the brevity of the model. This workshop seeks to provide clinicians a cultural framework to guide them in executing a more time-sensitive, culturally informed contextual interview. We will introduce the CAMINO framework (Silva, Paris, & AÃ±ez, 2017) which emphasizes

Date: Friday, 10/9/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Complex Patient Care
- Cultural Humility
- Primary Care Behavioral Health Model
- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the importance of listening for culturally significant responses while conducting the contextual interview.
- List pre/post-migration experiences affecting Latinx communities.
- Develop and hone a culturally informed contextual interview and

pre/post-migration experiences. We will guide participants through the integration of this framework into the contextual interview using case examples. A non-validated tool will be introduced to help BHCs apply this framework with patients. Additionally, participants will have the opportunity to engage in a hands-on activity applying this framework to the contextual interview.

discuss how it can be integrated into behavioral health visits.


*Presenter(s):*

- *Norma Balli-Borrero, LPC Intern, Behavioral Health Consultant, University Health System, San Antonio, TX*
- *Yajaira Johnson-Esparza, PhD, Assistant Professor, UT-Health, Dept of Community & Family Medicine, San Antonio, TX*
- *Gabriela Lopez, PsyD, Assistant Professor/Clinical, UT Health San Antonio, TX*
- *Clarissa Aguilar, PhD, Director of Psychology & Training, The Center for Health Care Services, San Antonio, TX*


## G3: A Novel Example of Using Mixed Methodology and Participatory Action Research to Examine Patient Experiences with PCBH at an FQHC


There is growing emphasis on utilizing novel methodological approaches to evaluate the primary care behavioral health model (PCBH; Hunter et al., 2018). In this project, we used mixed methodology guided by a participatory action research framework (PAR; Baum, MacDougall, & Smith, 2006) to examine patient experiences of PCBH at a Federally Qualified Health Center (FQHC) in an urban community. One hundred eighty-nine adult patients (M age = 44.18, 73.9% female, 44% black) completed a survey, which included general satisfaction with health care (i.e., the Patient Satisfaction Questionnaire-18, PSQ-18; Marshall & Hays, 1994) and satisfaction with integrated services at the clinic. Twelve patients also participated in four separate focus groups which sought to obtain more specific feedback on strengths and weaknesses of the clinic's model of care. The survey data indicated fairly high levels of satisfaction with the PCBH model, as indicated by the PSQ-18 (M = 70.96, SD = 12.44). Length of time attending the clinic and self-reported health status were not related to PSQ-18 scores, although self-reported ratings of mental health had a weak but significant correlation with the PSQ-18 ($r = -.2$, $p = .02$). The focus groups were analyzed via thematic analysis (Braun & Clarke, 2006) and 8 themes emerged related to strengths (convenience, affordability, health improvements, positive provider interactions, available resources, overall satisfaction) and challenges (issues with outside referrals, infrastructure challenges). While the quantitative and qualitative data were fairly consistent, the focus group content highlighted portions of PCBH that are particularly relevant to a lower income and higher needs population. The results can also be reviewed within the context of a PAR framework and the attempt to involve community partners throughout the implementation and evaluation process. This project highlights the use of unique methodology to evaluate PCBH with a diverse and underserved population.



*Presenter(s):*

- *Rachel Petts, PhD, Assistant Professor, Wichita State University, Wichita, KS*
- *Rhonda Lewis, PhD, Professor, Wichita State University, Wichita, KS*
- *Teresa Lovelady, MBA, MSW, President & CEO, HealthCore Clinic Inc., Wichita, KS*
- *Keyondra Brooks, MS, MA, Wichita State University, Wichita, KS*
- *Sarah McGill, BA, Clinical Psychology Doctoral Student, Wichita State University, Wichita, KS*


Date: Friday, 10/9/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Patient-centered care/Patient perspectives
- Primary Care Behavioral Health Model
- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the benefits of using mixed methodology and a participatory action research framework to evaluate PCBH models.
- Discuss themes related to patient experiences of PCBH at an FQHC.
- Discuss challenges of implementing community-based research and evaluation.

## G4: "We Can Talk for 5 Minutes Over Lunch, But It'll Probably Get Interrupted:" How To Engage Frontline Stakeholders in Research or Evaluation Efforts

In this presentation, which was supported by CFHA's REC Fellowship Program awarded to the first author, we will describe an ongoing research project wherein we aim to adapt Wittink's (2016) Collaborative Care intervention to VA integrated care teams. For this presentation we specifically focus on our methodology and recruitment strategies used to engage busy primary care teamlets (comprised of PCPs and nurses) in qualitative interviews. Engaging clinical providers in research and evaluation is key to using evidence-based methods to inform practice, including the development and treatment evidence-based treatments. However, care providers are among the most difficult individuals to recruit for research and to assist in data collection for evaluations, with primary care clinicians having some of the poorest recruitment outcomes. Though scant, there is empirical evidence describing some of the strategies known to improve engagement with clinical research and evaluation efforts. These include promoting buy-in and interest, developing front-office rapport, identifying champions, recruiting on-site rather than remotely, and using technology when possible. In this presentation, we will add our own experience with recruiting primary care teamlets (comprised of nurse and PCP), front-line admin staff, and administrative leadership in rural, remote clinics for brief qualitative interviews, and provide evidence-based tips and tricks to increasing provider engagement with research and evaluation projects. We will review the literature on the recruitment of busy healthcare professionals, and then describe our tips, tricks, and lessons learned in attempting to employ evidence-based strategies to optimize our study design and recruitment strategies. Participants will leave with a Provider Recruitment Flowsheet and a better understanding of the efforts we all need to take in order to engage key stakeholders in our research and evaluation efforts. We will first briefly describe the Collaborative Care intervention and our research aimed toward adapting it, in order to give the audience a framework to understand our recruitment efforts. Next, we will review the literature on recruiting healthcare professionals for research as well as to assist in evaluation projects, and will introduce the Provider Recruitment Flowsheet that will be developed for this presentation. We will then discuss the specific strategies that we used to enhance recruitment, including a staggered interview question format, use of instant messaging, oversampling, use of recruitment-enhancing informational materials, and in-person recruitment, and the success or failure rate of these strategies in our work. We will finish with a question-answer period and any audience feedback on their own recruitment strategies.

*Presenter(s):*

- *Julie Gass, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Buffalo, NY*
- *Jennifer Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare Syracuse VA Medical Center, Syracuse, NY*

**Date:** Friday, 10/9/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Interprofessional teams
- Research and evaluation (e.g. data analysis methods)
- Stakeholder engagement

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Learn to use the Provider Recruitment Flowsheet to develop strategies for improving provider engagement in research/evaluation
- Identify and respond to common barriers and pitfalls that providers face when asked to engage in research and evaluation
- Learn innovative, evidence-based strategies to improve provider engagement in research and evaluation

## G5: Social Determinants of Health as Critical Vital Signs: Investigation of Interprofessional Team-based Care for Addressing Patient Needs

Social determinants have a major impact on health outcomes, especially for the most vulnerable populations. Factors such as housing, food, transportation, and other social needs must be considered when providing treatment and care. In its work to improve the health of NH residents and create effective and cost-effective systems of care, the NH Citizens Health Initiative partnered with Connections for Health to provide a year-long practice facilitation opportunity for 8 practices in Seacoast NH. The goal was to expand upon the practice's knowledge and use of

**Date:** Friday, 10/9/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Cost Effectiveness/Financial sustainability

quality improvement science to initiate, improve, or maintain their integration efforts. Practices used the Maine Health Access Foundation's Site Self-Assessment (SSA) tool to evaluate their level of integration and a facilitated strategy meeting occurred at the practice to develop next steps and opportunities for improvement. Connections for Health used those results to request practice-level proposals to offer 12 months of practice facilitation to help move their goals for integration forward. This presentation will highlight the process of one primary care practice. An interdisciplinary care team comprised of a Primary Care Provider, Medical Assistant, and Integrated Social Work Care Coordinator at a primary care office in Seacoast New Hampshire have been working on addressing the social determinants of health of their patient population. The physician champion will share their confidence in addressing patient complexities and the impact these conversations have on the disease burden of their panel. In addition, this team has collected and utilized data to inform decision making and demonstrate the value of an MSW-level, non-billable clinician. It was apparent to the team that without the crucial role of an engaged and motivated Medical Assistant, implementing a change project would prove difficult. This presentation will highlight the importance of fostering a cohesive team-based approach that emphasizes the critical role each professional has on achieving whole-person care. The team has focused on the "how"to implement a SDOH screening process, build an organizational culture that normalizes SDOH as a standard part of care, and connect with organizations within the community to support patients. This presentation will demonstrate the importance of navigating across three scales to create change for their patients: 1). Micro - Screening patients for SDOH; Warm hand-off to Integrated Social Worker to address patient needs, 2). Meso - Building a culture of whole-person care in the organization; Coordination between Social Work and Nurse Care Coordination; Data collection to support QI efforts, and 3). Macro - Connecting with community based organizations via Community Care Team. The presentation aims to share how taking a measured approach to assessment, planning, implementing, and monitoring over time has been beneficial for a primary care practice at all levels.

*Presenter(s):*

- *William Gunn, PhD, Director of Clinical Integration, Integrated Delivery Network, Kittery Point, ME*
- *Katherine Cox, MSW, Project Director/Practice Facilitator, NH Citizens Health Initiative, Institute for Health Policy and Practice, University of New Hampshire*
- *Sandi Denoncour, BA, ASN, RN, Director of Care Coordination, Connections for Health*
- *Jason Howe, DO, Family Practice Provider, Core Physicians*
- *Angel Bilodeau, MSW, Social Work Care Coordinator, Core Physicians*
- *Elise Salvaneschi, CCMA, Medical Assistant, Core Physicians*

- Multi-sector partnerships
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss the importance of harnessing interprofessional team-based care and the community partnerships that advance integration and address the social determinant of health needs of patients.
- Consider engagement in quality improvement processes to address social determinants of health in a primary care setting.
- Understand how practice and patient data can be collected and utilized to inform next steps on implementing change projects.

## G6: Integration of Behavioral Health into Primary Care (IBHPC): Implementation of an Interdisciplinary Clinic Serving High Healthcare Utilizers

Date: Friday, 10/9/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Chronic Care Model of Integrated Care
- Complex Patient Care
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

The IBHPC study was an implementation and dissemination project funded by the Patient Centered Outcomes Research Institute (PCORI), of which the goal was to enhance the integration of behavioral health into the primary care setting. The University of California San Diego Lewis Family Medicine Clinic embarked on an ambitious plan to study how to best approach the care of patients deemed "high-utilizersâ€. Based on a needs assessment, a wrap-around clinic termed "Whole Person Health Clinic (WPH)"was developed for these patients, providing them much needed interdisciplinary care. The clinic team consists of a medical doctor, psychologist, social worker, and clinical pharmacist, of whom all see the patient during the same appointment to help address their multitude of needs. This presentation will review the financial, operational, and clinical barriers and factors

affecting implementation and sustainability of a model that provides interdisciplinary care in the same appointment. Data was collected pre and post implementation of the WPH clinic to assess impact and sustainability. Operational data will focus on how patients are identified, scheduled, and how follow-up is ensured. Financial aspects will include an overview of provider specific current procedural terminology (CPT) codes and funding related to Medicaid mandated measures and social determinates of health (SDoH). Financial data for the WPH clinic will be compared to general clinic outcomes. Clinical data will include biometric and psychometric data (e.g., A1C, number hospital visits, GAD, PHQ, etc.), as well as measures of health related quality of life (PROMIS-10) and discussion on how the clinic reduces physician burnout.

- Describe the clinical, operational, and financial challenges associated with the implementation and sustainability of an interdisciplinary clinic.
- Identify appropriate clinical outcome measures related to patient centered interdisciplinary care.
- Describe how to use a metric and registry driven process to identify a specific patient population (i.e., high utilizer) using electronic health record (EHR) system.

*Presenter(s):*

- *Lisa Black, PsyD, UCSD Family Medicine Residency Program, San Diego, CA*
- *Deepa Sannidhi, MD, UCSD Family Medicine Residency Program, San Diego, CA*
- *Melanie Fiorella, MD, UCSD Family Medicine Residency Program, San Diego, CA*
- *Christina Mnatzaganian, PharmD, UCSD Family Medicine Residency Program, San Diego, CA*
- *Willie Novonty, MD, UCSD Family Medicine Residency Program, San Diego, CA*
- *Crystal Chuk, LCSW, UCSD Family Medicine Residency Program, San Diego, CA*

## G7: Corporal Punishment: How Do Pediatricians Talk About it With Families? A Qualitative Study

Date: Friday, 10/9/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interpersonal violence
- Pediatrics
- Primary Care Behavioral Health Model

Child corporal punishment has been a widely debated topic in recent decades. Older research indicated that corporal punishment may or may not harm children, depending on the study. More recent research including meta-analyses, however, indicates a clear relationship between corporal punishment and negative outcomes for children. One negative outcome is increased risk of physical abuse. When caregivers have questions about child behavior and discipline, they tend to seek guidance from pediatricians. Over the years, the American Academy of Pediatrics (AAP) has recommended against corporal punishment. In December 2018, however, the AAP released an emphatic statement plainly recommending against corporal punishment because it harms children. This qualitative study explored how primary care pediatricians address corporal punishment, distinguish it from physical abuse, consider culture throughout the process, and whether they feel well-equipped to do so. Five participants, all primary care pediatricians in Oregon, completed semi-structured, in person interviews during mid-to-late 2018. After coding and interpretive phenomenological analysis of data, results revealed caregivers typically bring up concerns about behavior and discipline, including corporal punishment. Results also revealed participants' guidance to caregivers on corporal punishment varies from participant to participant and from case to case. Participants' guidance depended on personal and professional views, factors related to caregivers and children, type of discipline, and participants' interactions with families. Four out of the five participants did not report considering, following, or sharing with families the AAP's guidelines regarding corporal punishment. Participants reported that distinctions between corporal punishment and physical abuse tend to be obvious, and if a child's injuries, or other clinical information, raise suspicion of abuse, they notify authorities. Participants all reported their ability to consider aspects of multiculturalism in these cases but have little need to due to the homogenous patient population. Overall, participants reported feeling well equipped to address discipline and physical abuse, broadly, but received less training on corporal punishment, specifically. Furthermore, participants mentioned interprofessional collaboration with behavioral health consultants when addressing child behavior and discipline. Much like the topic of corporal punishment and associated research this study highlights the complex and evolving nature of primary care pediatricians'

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the complex and evolving issues pertaining to corporal punishment and how they arise in pediatric primary care.
- Consider research evidence examining pediatricians' current practices regarding corporal punishment.
- Discuss the implications of pediatricians' screening and guidance regarding corporal punishment in primary care.

guidance to families. Also highlighted is the use of behavioral health consultants in pediatric primary care to address topics of child behavior and discipline. Results from this study point to a need for standardized corporal punishment screening in pediatric primary care and for pediatricians to receive training on guidance on the topic.

*Presenter(s):*

- *Karlee McCoy, MA, Pacific University School of Graduate Psychology, Hillsboro, OR*

## G8: Pay it Forward: Using Your EHR Data to Make Data-Based Decisions and Demonstrate the Value of Integrated Behavioral Health

Date: Friday, 10/9/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Quality improvement programs
- Research and evaluation (e.g. data analysis methods)
- Sustainability

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify opportunities to use EHR data to answer empirical questions
- Apply foundational knowledge on electronic phenotypes to operational, clinical, and financial metrics
- Plan for empirical projects, including program evaluation, quality improvement, and research, using EHR data

The electronic health record (EHR) is ubiquitous in integrated behavioral health (IBH). Unbeknownst to many, usable data on many dimensions of IBH are already captured in the EHR as a part of routine care. This represents a largely untapped resource for improving data-based decision making in IBH and demonstrating the value of IBH services. Reasons for this disconnect include lack of additional knowledge and skill required to determine how to leverage EHR data for research and quality improvement purposes in IBH. This presentation will illustrate actionable strategies for the practicing clinician to conceptualize electronic phenotypes for EHR data and collaborate with Health Information Technology analysts and researchers at your institution. We will present for 5 minutes on foundational information in a didactic lecture to orient the participant to key concepts in secondary data analysis and electronic phenotypes. We will use 15 minutes to reinforce key concepts using a case example of a retrospective cohort study of a crisis evaluation service in a pediatric IBH setting compared with consults obtained in an emergency department within the same health system. By combining IBH program evaluation data on identified crisis cases with existing EHR data, we learned about key outcomes, including: a) a higher proportion of youth were hospitalized from the IBH service; b) the IBH service demonstrated shorter latency to the next behavioral health appointment; and c) there was higher proportion of IBH patients who engaged with any follow-up treatment in the year after the evaluation. Next, participants will engage in 20 minutes of exercises using a project conceptualization worksheet to develop operational, clinical, and financial indicators available in the EHR, from data that easily captured manually by practitioners, or both. Ample time will remain for questions and illustration, and electronic handouts of these resource and a reading list will be provided.

*Presenter(s):*

- *Sean O'Dell, PhD, Clinical Assistant Professor, Geisinger Health System, Danville, PA*
- *Monika Parikh, PhD, Associate, Geisinger Health System, Danville, PA*
- *Laura Cook, PhD, Associate, Geisinger Health Syste, Danville, PA*

## H1: Sexual Functioning and Preferences for Discussing Sexual Health Concerns among Primary Care Patients

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)

Sexual health is a complex yet often overlooked aspect of overall health. As the entry point to the healthcare system, primary care is an ideal setting for identifying sexual health concerns, and integrated behavioral health providers (BHPs) can assist the primary care team with assessment and treatment. The objective of this study was to assess the prevalence of sexual dysfunction and examine preferences for discussing sexual health concerns in primary care. We conducted a cross-sectional survey of a random sample of Veteran primary care patients from 3 VA medical centers across Central and Western New York. Of 1500 surveys mailed, 313 were

returned (21% response rate). Participants (M age=50.4 years, SD=13.4, range: 25-85) were mostly White (88%), female (60%), and married (76%). They completed a brief measure of sexual functioning (Arizona Sexual Experiences Scale) and items on preferences for discussing sexual health concerns (1=strongly disagree to 5=strongly agree). Overall, 36% of men and 63% of women screened positive on the ASEX for sexual dysfunction, with low sex drive being the most common issue. Participants indicated that if they were having sexual problems, they preferred that the primary care team ask about it (M=3.68, SD=1.12) rather than wait until they brought it up on their own (M=2.96, SD=1.21), t(304)=6.32, p<.001. Most participants (86%) were willing to meet with a BHP to discuss sexual dysfunction if their primary care team recommended it. The preferred format for help with sexual health concerns was meeting with the PCP (33%), followed by meeting with the BHP (16%). Findings suggest sexual functioning difficulties are common among primary care patients, and patients are receptive to being asked about and discussing sexual health concerns with their primary care team, including BHPs. Patients may benefit from PCPs and BHPs addressing their sexual health concerns in primary care using a biopsychosocial, integrated team approach.

*Presenter(s):*

- *Luke Mitzel, PhD, Postdoctoral Fellow, VA Center for Integrated Healthcare, Syracuse, NY*
- *Robyn Shepardson, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse, NY*

- Patient-centered care/Patient perspectives
- Sexual health

Objectives: *At the conclusion of this presentation, participants will be able to...*

- State the prevalence of sexual dysfunction in a sample of primary care patients
- Describe patient preferences for discussing sexual health concerns
- Explain why the integrated primary care setting is well-suited for addressing sexual health concerns

## H2: Interprofessional Day: A Collaborative Exercise Between Nursing and Counseling Graduate Students

This presentation will detail the development, execution, and evaluation of a collaborative exercise between nursing and counseling students in a small state university. The students used SBIRT and Motivational Interviewing to work collaboratively with simulated patients. Students and faculty were surprised at the different approaches used to achieve the same objectives. The exercise fostered a new understanding of collaboration between students in two different health professions.

*Presenter(s):*

- *Gabriel Lomas, PhD, Professor Clinical Counseling, Western Connecticut State University, Danbury, CT*
- *Andy Hull, MS, RN, Simulation Coordinator, Western Connecticut State University, Danbury, CT*

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional education
- Patient-centered care/Patient perspectives
- Primary Care Behavioral Health Model
- SBIRT Model of Integrated Care
- Substance abuse management (e.g., alcohol, tobacco, illicit drugs)
- Team-based care
- Training Models
- Training/Supervision - Supervision and evaluation of trainees, providing feedback
- Workforce development

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify how to implement collaborative training exercises with students in two different health professions.
- Identify how addiction screening and SBIRT can be used in a primary care setting.

- Identify how to use simulated patients to achieve collaborative learning goals.

## H3: Using A SBIRT Model to Meet the Biopsychosocial Needs of Prenatal Patients within a Family Medicine Residency Primary Care Clinic

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional teams
- SBIRT Model of Integrated Care
- Social determinants of health (SDoH)
- Special populations (e.g. disability)
- Prenatal

Objectives: *At the conclusion of this presentation, participants will be able to...*

- identify one model of integrated OB biopsychosocial care that aligns with a SBIRT framework.
- learn how an interdisciplinary chart review process can be developed to identify gaps in prenatal care, provide brief teaching points to residents, and encourage interprofessional communication among providers regarding patient care.
- receive a copy of the maternal psychosocial needs assessment used at the Alaska Family Medicine Primary Care Clinic

Research has shown the effects of social determinant of health (SDoH) in pregnancy for both the patient and the child; however, the ability to adequately assess for the areas can be difficult. Often in residency, residents struggle to adequately address all the medical and psychosocial needs that can arise during pregnancy; however, family medicine residents are in a unique position to provide integrated prenatal care in a primary care setting. In this presentation, participants will learn how the Alaska Family Medicine Residency (AKFMR) successfully implemented strategies to helped patients receive access to integrated prenatal care in a primary care setting through a biopsychosocial framework. An overview is provided of how AKFMR expanded their OB curriculum to provide prenatal care utilizing a biopsychosocial framework delivered by an interdisciplinary team. Based on the 2016 recommended AAFP guidelines for maternity care, AKFMR used an SBIRT model to implement a maternal psychosocial intake and needs assessment to improve provider awareness of SDoH variables impacting women during their pregnancy and gather baseline mood screening using the EPDS. Based on the information gathered, pregnant patients are offered brief interventions and referrals to appropriate interdisciplinary resources. In addition, an interdisciplinary chart review led by family medicine residents was implemented for all patients between 28-32 weeks gestation to assure prenatal care and increase team communication around patient care and needs. An evaluation of the overall OB curriculum expansion process will include data that has been gathered since August 2016 from maternal psychosocial intakes which includes: demographics, social support system, maternal health risk factors, psychiatric and substance use history, SDoH concerns, lifestyle practices, and an initial perinatal mood disorder screening using the EPDS. Additionally, explanation of how the interdisciplinary OB chart review is conducted and tracked will be reviewed.

*Presenter(s):*

- *Virginia Parret, PhD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Erin Iwamoto, PsyD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Sarah Sanders, PhD, Postdoctoral Psychology Fellow, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*

## H4: The Family Health Scale: Developing an Instrument to Assess Family-Level Processes, Lifestyle, Resources and Ssocial Capital in Primary Care Settings

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Family centered care/Family perspectives
- Population and public health
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

Families are the most powerful and proximal determinant of health prevention, promotion, and disruption across the life course (Haskins et al., 2014). Indeed, the economic value that families provide in caring for their individual members far exceeds that of the medical care system (Leiter et al., 2004). Primary care has been identified as an ideal setting to deliver preventative, family-based interventions (Leslie, et al. 2016). Experts define family health as "a resource at the level of the family unit that develops from the intersection of the health of each family member, their interactions and capacities, as well as the family's physical, social, emotional, economic, and medical resources"(Weiss-Laxer et al., 2020). However, a standard instrument to assess family health in clinical settings does not exist. To fill this gap,

our interdisciplinary team composed of public health researchers, family scientists, mental health providers and a primary care physician developed and validated a Family Health Scale (FHS), based on responses from N=2050 U.S. adults, representing a range of family structures (Crandall et al., under review). In this presentation, we describe the potential clinical application of a 10-item version of the FHS and its four subscales, which include: 1) Family social and emotional processes, 2) Family healthy lifestyle, 3) Family health resources and 4) Family external social capital. An example item includes: "In my family, we help each other in seeking health care services when needed (such as making doctor's appointments)."A screening instrument assessing family health could be highly valuable in clinical settings where many health outcomes are driven by social determinants. In addition, integrated care providers may benefit from such a scale when developing treatment plans and delivering their holistic care (Berg et al., 2017). Recommendations for applications of the FHS in clinical settings, including opportunities and challenges, will be discussed. Examples will be drawn from the fields of primary care pediatrics, family medicine, and obstetrics.

*Presenter(s):*


- *Nomi Weiss-Laxer, PhD, MPH, MA, NRSA Postdoctoral Fellow and Research Assistant Professor, Department of Family Medicine, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo, The State University of New York, Buffalo, NY*
- *Jerica Berge, PhD, MPH, Professor and Vice Chair for Research, University of Minnesota, Minneapolis, MN*


- Describe the importance of assessing "family health"in primary care settings.
- Identify the core components of Family Health.
- Discuss opportunities and challenges for future clinical applications of the Family Health Scale .

## H5: Optimizing Clinician Coaching in Primary Care Residents: Moving from Learning to Behavioral Transfer of Skills

BACKGROUND: Effective patient-provider communication is critical to optimizing patient health and well-being [1]. Clinician coaching directly targets these skills [e.g., 2,3]. The current project builds on an established coaching approach used with MD/NP residents in an integrated VA primary care setting. Coaching is delivered by clinical health psychology (CHP) staff and targets: Motivational Interviewing (MI), Shared Decision Making (SDM), and Trauma-Informed Care (TIC). Based on the New World Kirkpatrick training evaluation model [4], the project used previous learner/coaching data [5] and current literature to revise this approach to promote behavioral transfer of skills. METHOD: Population included 24 residents (NP=6, MD=18) who received clinician coaching and feedback from CHP staff during the 2018-2019 academic year. Residents completed a pre-planning session, observation, and coaching in MI, SDM, and TIC. Skills were evaluated on empirically supported checklists. Forms were reviewed by another CHP staff for trends and inconsistencies in ratings and use. Resident satisfaction data were examined. RESULTS: Items observed 100% of the time were removed from the checklists. Low frequency items were starred and coaches are now encouraged to highlight them with residents pre-observation. Residents are now asked to identify an observation appointment where MI is likely to be paramount (e.g., smoking cessation) and one where SDM is likely to be emphasized (e.g., medication changes); TIC continues to be evaluated at all appointments. A self-reflection component was added, prompting learners to rate the extent to which they were guided by MI, SDM, or TIC-based principles during the appointment. The new approach has now been implemented. Formal evaluations will be completed at the end of the academic year. CONCLUSIONS: The updated form/coaching approach, promotion of MI and SDM-specific case selections by residents, and addition of a self-reflection component all serve to support the behavioral transfer of patient-centered communication skills. The presentation will highlight data, present changes, and elicit feedback from conference participants.

*Presenter(s):*

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional education
- Patient-centered care/Patient perspectives
- Training/Supervision - Supervision and evaluation of trainees, providing feedback

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe an evidenced-based approach to MD/NP resident communication skills coaching used in an integrated VA primary care clinic.
- Identify factors involved in moving this type of educational tool from targeting learning (Level 2) to directly promoting behavioral transfer of skills (Level 3).
- Discuss implications for utilizing this type of learning tool to promote medical education and patient-centered care.

- *Amanda Gehrke, PhD, Clinical Health Psychology Resident, Center of Education (COE) in Interprofessional Primary Care, VA Connecticut Healthcare System, West Haven, CT*
- *Noel Quinn, PhD, Health Behavior Coordinator, VA Connecticut Healthcare System, West Haven, CT*

## H6: IPC at the Vanguard of Value: A Continuous Quality Improvement Approach to Primary Care Behavioral Health Services in Medical Education

**Date:** Friday, 10/9/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Cost Effectiveness/Financial sustainability
- Outcomes
- Primary Care Behavioral Health Model

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify opportunities to utilize formal change processes (e.g. CQI/Kotter's 8-Step Model) to shape the culture and attitudes toward IPC/PCBH.
- Describe how to systematically link PCBH services to physical health and quality outcomes in a community based medical education ambulatory health setting.
- Discuss value based opportunities such as using time driven activity based costing (TDABC) to increase the viability of IPC/PCBH models.

The Primary Care Behavioral Health (PCBH) model continues to garner support and acclaim, and has demonstrated vast potential for not only mental health but also physical health related outcomes. Contemporary focus on PCBH has begun to shift toward the identification of operational efficiencies and the testing of best practice applications in a variety of settings. The purpose of this presentation is to explicate such elements from a unique PCBH model positioned in the context of a medical education setting, linked to HEIDS quality health outcomes, and which is using a continuous quality improvement (CQI) format to provide further innovation. This presentation will specifically explore core components of the project including the inception of an integrated primary care taskforce using Kotter's 8-Step Change Model, strategies for service evaluation that have linked behavioral interventions to physical health metrics, and examination of new directions in the context of value and time driven activity based costing methods (TDABC). To begin, the presentation will set the context for how PCBH was developed in the novel environment of an internal medicine residency clinic via use of an IPC taskforce. This taskforce utilized models from the business world to expand the work of existing health system's IPC efforts. Briefly, we will delineate the Kotter's 8-Step Change Model and discuss how this successfully impacted the framework of our PCBH services. Second, the focus of the presentation will turn to the specific CQI principles employed and the aim of linking health outcomes and IPC interventions. The project included a standard screening process, and provided a number of opportunities to compare pre and post intervention data. Metrics of interest in the presentation will explore readiness to change scores, the iterative effects of PCBH related to successive visits, and comparisons of top physical health outcomes as connected to HEIDs quality metrics and IPC. Concluding, this presentation will highlight developing initiatives for the CQI project including the value stream components of IPC in the education setting. Highlights of this section will explore efforts to utilized contemporary costing strategies such as TDABC, examining value associated with prospective revenue capture, and map both upstream and downstream costs savings.

***Presenter(s):***

- *Andrew Champine, PsyD, Director of Behavioral Medicine Education, McLaren Health Care, Flint, MI*
- *Jennifer Carty McIntosh, PhD, Associate Director of Behavioral Medicine Education, McLaren Health Care, Flint, MI*
- *Jennifer Battles, MS, Doctoral Practicum Student, McLaren Health Care, Flint, MI*

## H7: Origin Storytelling: Fostering Understanding, Collegiality, and a Culture of Well-Being

**Date:** Friday, 10/9/2020

**Time:** 12:30 PM - 1:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Burnout
- Interprofessional teams
- Professional Identity

Background: Burnout, usually defined as a personal stress reaction of individuals resulting from their perceptions of the workplace, is associated with impaired clinical care, increased attrition and turnover of professional staff, and increased costs for health care systems. For physicians, professional burnout can contribute to broken relationships, alcoholism, and suicide. High level of burnout is one reason that accounts for high physician turnover and decreased productivity. This presentation will depict an origin story-telling initiative targeted at promoting understanding,

collegiality, and a culture of well-being for physicians. Objectives - Provide an opportunity for Family Medicine faculty physicians to engage in an origin writing group. - Promote understanding, collegiality, and a culture of well-being for faculty physicians. Population Sampled - Family Medicine Residency - 12 Family Medicine Faculty Members Methods: Study Design - Cross-sectional, Pre-Post - Mixed methods - Mini-Z Data Analyses - Phenomenological analysis - Paired sample t test for Mini-Z scores Results: Demographic Information - Participants - N=12 - 25% Male, 75% Female Quantitative Results - Participants were: - Satisfied with their job - Had moderate levels of stress - Identified as approaching burn out - Felt they had adequate control over their workload - Felt they had adequate time for documentation - Felt their workplace was calm - Felt there was good teamwork - Felt proficient with the EHR, and that it did not intrude on their off-work hours - Only variable on Mini-Z that changed was the perception of their values aligning with the clinic leadership's values - "High"values alignment pre-intervention - "Moderate"values alignment post-intervention - However, no significant differences between participants pre- and post-intervention on the Mini-Z Qualitative Results - 6 themes - Genuine curiosity - Safety for reflection and vulnerability - Insight of lived experiences - Life is not a linear trajectory - Creative empowerment - Strengthened collegiality Presentation: We will first provide an introduction & background of the study (4min). Second, we will offer a small group reflection activity & discussion (10min). Third, we will describe the study implementation (2min). Fourth, we will share the study findings (5min). Audience participation will include breaking into small groups to discuss how to implement similar initiatives within primary care settings (5min). We will conclude with Q & A (4min).

*Presenter(s):*

- *Ruth Nutting, PhD, LCMFT, Director of Behavioral Health, Via Christi Family Medicine Residency Clinical Assistant Professor, University of Kansas School of Medicine-Wichita*
- *Kari Nilsen, PhD, Director of Residency Research & Assistant Professor, University of Kansas School of Medicine-Wichita, KS*

- Physician Well-Being

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the outcomes of physician burnout on the U.S. health system.
- Identify the value of fostering understanding and collegiality among physicians.
- Describe how to develop initiatives that receive buy-in and promote a culture of physician well-being.

## H8: Successes and Lessons Learned Integrating Psychiatry and Primary Care: A Collaborative Care Pilot

In 2018, Boulder Community Health (BCH) started a Collaborative Care Management pilot in primary care to better serve patients facing barriers of timely access to behavioral health and psychiatry. Collaborative Care is a population health model addressing barriers of psychiatry shortage by bringing psychiatric consultation into enhanced primary care paired with robust care management. This delivery model leverages existing provider-patient relationships, and people receive services within their familiar and convenient primary care medical home setting at a lower cost than specialty psychiatry. It amplifies scarce resources by allowing providers to consult on a panel of 40 or more patients weekly rather than dedicating 1 hour/patient.

In the first 12 months of implementation, BCH found increases in primary care provider satisfaction and capacity as well as encouraging treatment outcomes for patients. Pre/post staff surveys showed pilot clinics had statistically significant increases in provider and staff ratings of comfort treating behavioral health conditions and increased satisfaction with resources, outreach, and follow up when Collaborative Care was offered.

At the same time, implementation presented many challenges. Provider turnover and a system-wide priority of transitioning electronic medical record systems limited resources and capacity.

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Collaborative Care Model of Integrated Care
- Evidence-based interventions

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the evidence-base rationale for Collaborative Care vs. care as usual
- Identify care team members and their roles, especially the key social worker role and relevant competencies
- Understand implementation challenges and tips for success

During this interactive presentation, social workers will have an opportunity to review patient case studies and dialogue around lessons learned from implementing innovative behavioral health programs within a complex and fragmented health care system.

*Presenter(s):*

- *Julie Jungman, LCSW, Boulder Community Health, Boulder, CO*
- *Diana Lin, LCSW, Boulder Community Health, Boulder, CO*

## H9: Implementing Integrated School Based Health in a Non-Profit Rural Setting

In October, 2019, Community Health of Central Washington (CHCW) embarked on a health care journey to improve access to medical and behavioral health care to the students at Davis high school in Yakima, Washington. Yakima is a rural, medically underserved, low income county with 85% of the 2,400 students at Davis high on Apple Health Care. The clinic was opened knowing that funding would continually be a struggle, but that it was the right thing to do, we needed to address the disparity of medical and behavioral health care to the adolescent community. The Davis Health Clinic is a fully functioning medical clinic located inside Davis high school that offers integrated behavior health care to work with patients with multiple adverse childhood experiences (ACE's) and social determinants of health (SDoH). While our model of care is proving successful within the school setting, we continue to search for ways to expand with limited to no external funding. In this presentation, we will discuss our successes and struggles in opening an integrated health clinic in a rural, central Washington town.

Explaining challenges related to telehealth with adolescents and navigating the challenges of COVID-19 and the school district

*Presenter(s):*

- *Amelia McClelland, MEd, Behavioral Health Fellow, Davis Health Clinic, Yakima, WA*
- *Staci George, Clinic Manager for the Davis Health Clinic, Yakima, WA*
- *Ginny Shelton, MD, Medical Provider, Davis Health Clinic, Yakima, WA*

Date: Friday, 10/9/2020

Time: 12:30 PM - 1:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Patient-centered care/Patient perspectives
- School-based
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the utility of PCBH in a school-based health center
- How to assess SDoH in a high school setting with the support of a school-based health clinic
- Understand budget challenges that may arise in developing a school-based health clinic in an area without a tax levy

## I1: Implementation of a Single Session/Brief Intervention Clinic in a Family Medicine Rresidency Primary Care Clinic: A Program Evaluation

Alaska Family Medicine Residency's (AKFMR) continuity care clinic, Providence Family Medicine Center (PFMC), is a patient centered medical home located in Anchorage, AK. Identified as one of two safety-net clinics in Anchorage, PFMC primarily serves underserved populations with significant social determinants of health needs and the substantial majority of PFMC's patients are enrolled in Medicaid, Medicare, or are uninsured. Due to insurer and billing challenges in Alaska, patients often experience barriers in their ability to access mental health and/or behavioral health (MH/BH) services. Multiple surveys of PFMC's providers and clinic staff identified a gap in terms of their patients' ability to expediently access MH/BH services, despite the integration of BH providers at PFMC. Prior to this study, PFMC offered MH/BH services through BH consultation -- where patients are able to meet with a BH provider during their medical visit -- and psychotherapy for 8-12 sessions. However, regardless of these services, PFMC was experiencing similar wait-times, with patients waiting 9-12 months to establish services. Given that research has shown a mode of 1 for MH/BH sessions attended by patients, the authors looked into the single-

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Evidence-based interventions
- Primary Care Behavioral Health Mode

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Explain how the single session/brief intervention model differs from behavioral health consultation and traditional psychotherapy

session models as an evidence-based practice to address this gap, and implemented a single-session/brief intervention (SBI) pilot in addition to the current BH services offered. Based on the success of the pilot, the SBI clinic was implemented in full. This presentation will focus on the implementation process as well as a program evaluation of this clinic. The current sample size is n = 97 and will continue to increase over time. The mean and mode sessions attended was 2, and a 77.14% reduction in the number of patients on the waitlist was demonstrated. Preliminary data analysis is being conducted and paired sample t tests will be utilized to analyze scores on screening measures, such as the PHQ-9 and GAD-7, as well as descriptive statistics analysis for the Session Rating Scale and Outcome Rating Scale.

*Presenter(s):*

- *Erin Iwamoto, PsyD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Virginia Parret, PhD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Sarah Sanders, PhD, Postdoctoral Psychology Fellow, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*

- Learn how to implement a single session/brief intervention clinic in a primary care setting from pilot to full implementation
- Learn how to conduct a program evaluation of a single session/brief intervention clinic to determine the sustainability and feasibility of continuing this service

## I2: New Psychotherapeutic Techniques in Chronic Pain and Functional Syndromes

Physical symptoms, including chronic pain, that are not linked to organ disease or structural abnormality are the reason for 30-40% of visits to primary care. These medically unexplained symptoms and chronic functional syndromes, collectively known as Psychophysiologic Disorders, have led to development of several new (and related) psychotherapeutic techniques in recent years. These include Pain Reprocessing Therapy, Emotional Awareness & Expression Therapy and Intensive Short-Term Dynamic Psychotherapy. The goal for these is relief of physical symptoms rather than merely helping the patient manage or cope with their condition. A developing evidence base documents the success of these overlapping approaches. These concepts will be introduced with emphasis on PRT and EAET, the evidence base will be presented and the benefits to the quadruple aim of teaching these concepts to behavioral and medical staff will be reviewed. This presentation is a concise, practical version of courses taught in two doctoral programs and many primary care practices since 2013.

*Presenter(s):*

- *David Clarke MD*

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Evidence-based interventions
- Medically unexplained symptoms
- Chronic Pain

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Diagnose the causes of Psychophysiologic Disorders (PPD) particularly non-organic chronic pain but also MUS and chronic functional syndromes.
- Understand the evidence base supporting new therapeutic approaches to these conditions.
- Apply new psychotherapeutic techniques for relief of (not merely coping with) PPD. These include Pain Reprocessing Therapy and Emotional Awareness and Expression Therapy.

## I3: Come for the Pizza...Stay for the Medical, Mental Health, and Social Support Services

Mazzoni's "Drop-in clinic" for patients ages 14-24 began as a resource for patients with complex care needs; LGBTQ HIV positive youth who had a difficult time maintaining scheduled appointments and were prone to falling through the cracks and often lost to care. From humble roots we have grown into an interdisciplinary team consisting of medical providers, social workers, psychiatry fellows, lawyers, insurance coordinators and educators. Patients may access medical care, housing supports, legal resources, behavioral health, education re: sexual health and

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Adolescents
- Complex Patient Care

relationships, insurance navigation, food, travel passes and gender affirming services and surgery navigation. Come join us for a panel discussion where we will explore our successes and failures and demonstrate through case examples and data gathered from the past year how this flexible and extensive model creates access to services for underserved LGBTQ youth who might not otherwise engage with medical care and social support services. How does changing the model and working creatively and collaboratively shift who accesses medical care and social support services?

*Presenter(s):*

- *Amelia Smith, MSW, LSW, Behavioral Health Consultant, Mazzoni Center, Philadelphia, PA*
- *Hilary Rosenstein, MD, Assistant Medical Director, Mazzoni Center, Philadelphia, PA*
- *Anna Kiesnowski, MSW, LSW, Gender Affirming Services Manager, Mazzoni Center, Philadelphia PA*
- *Alexander Krausman, PA, Physicians Assistant, Mazzoni Center, Philadelphia, PA*
- *Jerome Hollomon, MSW, LSW, Care Coordinator, Mazzoni Center, Philadelphia, PA*
- *Andrew Gudzelak, Data Analyst, Mazzoni Center, Philadelphia, PA*

- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the complex care needs of LGBTQ youth.
- Discuss medical and social support services centered on LGBTQ Youth self determination.
- Evaluate programs and develop models to better serve LGBTQ Youth.

## I4: The Joy in Practice: Shifting the Conversation from Burnout to Wellbeing

The case no longer needs to be made that burnout is a syndrome with far-reaching implications (Koenig, 2018). We now exist in a time where innovative programs and interventions have been and continue to be developed to combat the systemic influences of burnout and enhance clinician wellbeing. Based on a review of cross-disciplinary literature and lessons learned through the development of an existing physician wellness program, this presentation aims to engage participants in learning novel approaches to foster clinician wellbeing. In lieu of the traditional view of burnout as a set of deficits and wellbeing as the antithesis of burnout, we will highlight burnout as moral injury and loss of purpose and will highlight strategies for promoting "The Joy in Practice"rather than strategies for solely ameliorating burnout or promoting wellness. We'll convene our attention on joy as a mode of "assets-based thinking"that harnesses strengths to be developed rather than problems to be solved (Johnson, 2020). Interventions focused on joy, purpose, and hope broaden attention and thinking, and as an emotion, joy persists longer than negative emotions and is shown to increase one's capacity for affective empathy. Joy is so much more than just the experience of, or the state of happiness. It is a discreet positive emotion, and there are ways to assess it, foster it, teach it, and embody it (Watkins, 2018). Building upon the IHI's framework (Perlo, 2017) to "Improve the Joy in Workâ€, this presentation will offer evidence-based practices, validated assessments, and practice transformation tools from cross-disciplinary philosophies (e.g., medical sciences, developmental and positive psychology, and improvement science).

*Presenter(s):*

- *Stephanie Trudeau, PhD, Postdoctoral Researcher, Thrive Center for Human Development, Fuller Theological Seminary, Pasadena, CA*
- *Jennifer Caspari PhD, Assistant Professor and Director of Behavioral Medicine, University of Nebraska Medical Center, Omaha, NE*

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Burnout
- Prevention
- Self-care/Self-management

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the utility of and strategies for shifting the focus on clinician burnout and wellbeing from deficit-focused to strengths-based joy-promotion.
- Learn ways to assess for joy and purpose as an indication of clinician wellbeing.
- Identify steps to engage leadership in demonstrating that joy in practice is a systemically shared responsibility.

## I5: Equipping the Next Generation of Behavioral Health Trainees: A Clinical Supervision Primer

As Behavioral Health (BH) Integration in primary care settings steadily becomes the standard of care it has never been more important to build up the BH workforce with skilled new professionals ready and able to work such settings. Despite an increasing number of trainees who are interested in receiving training primary care settings, there is a dearth of competent clinical supervisors to execute this task. Therefore, it is imperative to support clinical supervisors in order to mitigate this imbalance. The purpose of this presentation is to provide a clinical supervision primer for those who currently serve as clinical supervisors or who plan to provide clinical supervision to BH trainees in the primary care setting. This presentation will review evidence-based clinical supervision approaches, the differences between clinical supervision in mental health settings versus primary care settings, the infusion of evidenced-based teaching practices from medical education into clinical supervision for behavioral health trainees, and the importance of understanding macro versus microsystem issues that occur within clinical supervision in primary care settings. Qualitative examples from a current HRSA Behavioral Health Workforce Education Training Grant will be discussed as well as recommendations for supporting community-based clinical supervisors as well as faculty members who serve as clinical supervisors from training programs.

*Presenter(s):*

- *Stacy Ogbeide, PsyD, ABPP, CSOWM Associate Professor/Clinical UT Health San Antonio San Antonio, TX*
- *David Bauman, PsyD, Behavioral Health Education Director, Community Health of Central Washington, Yakima, WA*
- *Bridget Beachy, PsyD, Director of Behavioral Health, Community Health of Central Washington, Yakima, WA*
- *Gabriela Lopez, PsyD Assistant Professor/Clinical UT Health San Antonio San Antonio, TX*

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Early Career Professionals
- Primary Care Behavioral Health Model
- Professional Identity, including development of
- Skills building/Technical training
- Training/Supervision - Supervision and evaluation of trainees, providing feedback
- Workforce development

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Understand the differences between clinical supervision in mental health settings versus primary care settings
- Identify at least one, evidence-based teaching strategy that can be used within clinical supervision
- Implement at least one recommendation to provide support to clinical supervisors working in primary care within training programs or in the community

## I6: When Stuck Add People: Stepped Family Consultation in Primary Care Behavioral Health

As applications and accomplishments of the Primary Care Behavioral Health (PCBH) model proliferate (Reiter, Dobmeyer & Hunter, 2018), possible contributions of a family systems perspective in this arena seem conspicuously absent. Understandably, population health priorities such as accessibility, high productivity, and brief, team-based episodic care may leave little time for systemic formulations of problem maintenance or interventions that target social units and processes beyond the patient. Here we describe an adaptation of strategic-systemic family consultation (FAMCON), originally developed as a specialty approach for change-resistant health and behavior problems (Rohrbaugh & Shoham, 2011, 2017), to primary care. Stepped FAMCON complements the pragmatic, time-efficient PCBH model by reserving family involvement for complaints that do not respond to first-line individual-focused medical or behavioral interventions. This generalist approach addresses behavioral aspects of chronic medical conditions (e.g., non-adherence to diabetes regimen, unexplained physical symptoms) as well as persisting behavioral complaints (e.g., depression, anxiety, SUD). It also (a) formulates problem maintenance, including helper involvement, in a systemic framework not dependent on psychiatric diagnosis; (b) optimizes indirect (non-prescriptive) behavioral intervention framed as assessment; (c) leverages PCP influence to promote patient/family engagement and adherence to behavioral interventions; and (e) enhances response to post-consultation follow-on procedures, including evidence-based individual interventions. FAMCON embodies the systemic themes of circularity

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Complex Patient Care
- Family centered care/Family perspectives

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Identify gaps in knowledge regarding family-focused assessment and intervention methods in primary care.
- Describe systemic patterns of problem maintenance, including ironic processes and symptom-system fit, and the role of communal coping in clinical change.
- Describe stepped FAMCON assessment and intervention approaches for primary care

(locating problems in current cycles of interaction), context (looking beyond the patient), and pattern interruption (breaking problem-maintaining cycles), with key constructs including ironic processes (when 'solutions' maintain problems), symptom-system fit (when problems stabilize relationships), and communal coping (when 'we-ness' facilitates change). Procedures include a warm handoff meeting with PCP and systemic BHC followed by 30-60 minutes with BHC; an assessment phase consisting of 1-4 BHC meetings with patient and family members; an opinion/feedback session incorporating observations and recommendations, both medical and behavioral; and a PRN follow-up phase adjusting strategies and tactics to patient/family response. During the assessment phase, with indirect intervention framed as assessment, the BHC remains overtly neutral about behavior change, offering no direct suggestions or advice prior to the opinion/feedback session with the PCP. In addition to highlighting exportable clinical tools (e.g., social network interview; family engagement scripts; communal coping intervention; assessment and opinion planning templates), we discuss promises and pitfalls of stepped FAMCON in light of recent pilot work by first author MR in the rural Virginia primary care practice of third author CM.

complaints that do not respond to first-line medical and behavioral interventions focused on the individual patient.

*Presenter(s):*

- *Michael Rohrbaugh, PhD, Clinical Professor of Psychiatry and Behavioral Sciences, George Washington University, Washington, DC*
- *Florencia Lebensohn-Chialvo, PhD, Assistant Professor, Marital and Family Therapy Program, San Diego State University, San Diego, CA*

## I7: Screening, Referral and Linkage for Social Determinants of Health: Health Care and Early Childhood Systems Integration in Practice

Background. Child health practitioners and managers frequently support recommendations to screen for and provide social determinants of health (SDOH) resources to families. They also report reluctance to implement screening guidelines because they perceive community services to be limited or unavailable. Thus, forging effective partnerships across health care and community service systems is a promising, but still little understood, tool for addressing SDOH. Methods. This paper reports findings from one component of a mixed methods, longitudinal study of nine pediatric health care clinics in five U.S. communities implementing innovations to address SDOH among families of infants. The study reports the results of interviews at two time points with early childhood organizations and health care providers overseeing the innovations. In interviews (n = 60 at t1, n = 18 at t2), participants reported on their partnerships between community service systems and health care; experiences implementing screening, referral, and linkages in pediatric primary care; and key aspects to sustainability. We analyzed qualitative interviews thematically and developed cross-site summaries of emergent findings. Results. Early childhood and health care participants reported that embedding screening in pediatric health care, that includes team-based care, yielded important cross-sector knowledge that did not exist prior to implementing the innovations. Participants also said that the lack of clear financial mandates for the work influenced sustainability, as did a lack of role clarity about which system supported families to support access to community services. Implications. Screening, referral, and linkage for SDOH has promise to increase access to resources for individual families and as well as inform local and state advocacy efforts. However, current funding models, infrastructure, evidence, and will among leadership pose important constraints on scaling innovations to address SDOH.

Date: Friday, 10/9/2020

Time: 2:45 PM - 3:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Innovations
- Multi-sector partnerships
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe pediatric primary care perspectives to partnering with community-based services to address social determinants of health (SDOH).
- List challenges to sustainability of innovations in health care and early childhood systems partnership to address SDOH.
- Describe the value of team-based care in innovations to address SDOH.

*Presenter(s):*

- *Julie McCrae, PhD, Senior Researcher, Chapin Hall at the University of Chicago, Chicago, IL*
- *Angeline Spain, PhD, Researcher, Chapin Hall at the University of Chicago, Chicago, IL*

## I8: Benefitting from the Single Case Research Design: How Anyone Can Use It

This is a 60-minute oral presentation for the research and evaluation track. It reviews the distinct value of the single case research design before delving into various methods of using this research strategy across various real and hypothetical data sets. Because there is such rapid change in our healthcare system, healthcare and community stakeholders need feasible and accessible methods for analyzing the outcomes of programs and treatments including complex patients and those tapering off of opioids. Since there is a scarcity of research on how to influence the social determinants of health, the single case design uniquely offers the most immediate way to demonstrate positive change in an individual or system in a short amount of time. This means that community leaders or various healthcare and nonhealthcare agencies within a system could use these tools to measure their program or intervention. Likewise, the methods can be used by physicians or behavioral health providers at the clinic level. Finally, the author presents data on how this research methodology can be used at the system level to make programmatic decisions about meeting the needs of patient populations. Learners will ascertain information about how to conduct these analyses upon completing the session (e.g., the basics of analyzing trend, level and variability on linear charts; using reversal and withdrawal designs and conducting analyses on the standard celeration chart).

*Presenter(s):*

- *Kent Corso, PsyD, BCBA-D, Principal, National Capital Region Behavioral Health, Fairfax Station, VA*

**Date:** Friday, 10/9/2020

**Time:** 2:45 PM - 3:45 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Outcomes
- Research and evaluation (e.g. data analysis methods)
- COVID-19

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Describe the three ways to analyze data within the single case research design.
- Analyze data using reversal and withdrawal designs.
- Apply your knowledge to use the standard celeration chart to analyze data on a semi-logarithmic scale.

## J1: Coordinated Medicated Assisted Treatment for Opioid Use Disorder: Collaborative Care between Community Organizations and Health Care Access Points

Background: Integrated primary care for opioid use disorder (OUD) increases access to addiction treatment in rural and urban communities. By reducing stigma, providing medication assisted treatment (MAT), and addressing medical, behavioral and social complexity, primary care contributes to the addiction care continuum. We describe preliminary successes and challenges of a collaborative initiative to support primary care practice implementation of integrated care for patients with OUD. Population: Patients with OUD at participating primary care practices across 7 Pennsylvania counties. From 2015-18, the area saw increasing overdose deaths, driven largely by fentanyl, rising hepatitis C infections, high burden of chronic pain, unintended pregnancies, and limited access to behavioral health and addiction services. Study Design: Combined narrative and case series describes partner engagement to build a coordinated support system for primary care, practice experiences, and patient outcomes. Procedures: Descriptive data about development of the model collected through participatory narrative process. Practices mapped to describe integrated care processes Background: Integrated primary care for opioid use disorder (OUD) increases access to addiction treatment in rural and urban communities. By reducing stigma, providing medication assisted treatment (MAT), and addressing medical, behavioral and social complexity, primary care contributes to the addiction care continuum. We describe preliminary successes and challenges of a collaborative initiative to support primary care practice implementation of integrated care for patients with OUD. Population: Patients with OUD at participating primary care practices across 7 Pennsylvania counties. From 2015-18, the area saw increasing overdose deaths, driven largely by fentanyl, rising hepatitis C infections, high burden of chronic pain, unintended pregnancies, and limited access to behavioral health and addiction services. Study

**Date:** Saturday, 10/10/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Chronic Care Model of Integrated Care
- Interprofessional teams
- Substance abuse management (e.g., alcohol, tobacco, illicit drugs)

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Discuss and analyze how Interprofessional teams across agencies come together to break down silos in order to build a model of integrated care that moves patients through high risk settings (i.e. emergency department, addiction treatment, criminal justice
- Describe evidenced based practices that can assist with implementation of medicated assisted treatment in primary care such as flexible integrated behavioral health support, ProjectECHO "hub and spoke"model,

Design: Combined narrative and case series describes partner engagement to build a coordinated support system for primary care, practice experiences, and patient outcomes. Procedures: Descriptive data about development of the model collected through participatory narrative process. Practices mapped to describe integrated care processes and partnerships as they enroll in project. Practice experiences described through team debriefs and training evaluations. Patient data re behavioral/addiction diagnoses, interventions, engagement and effectiveness at each location collected through electronic health records and from structured intake and follow up interviews. Results: Key practice/system parameters, team roles and support measures that facilitate/inhibit change, preliminary patient outcomes.

*Presenter(s):*

- *Abby Letcher, MD, Addiction Medicine Doctor, Neighborhood Centers of the Lehigh Valley, and Lehigh Valley Health Network, Allentown, PA*
- *Angela Colistra, PhD, LPC, CAADC, CCS Director of Behavioral Sciences, Lehigh Valley Health Network, Allentown, PA*
- *Gillian Beauchamp, MD, Emergency Medicine, Lehigh Valley Health Network, Allentown, PA*
- *Kevin McNeill, MD, Primary Care, Lehigh Valley Health Network, Allentown, PA*
- *Regina Hills, BA, Neighborhood Health Centers of the Lehigh Valley, Allentown, PA*
- *Jazmine Irizarry, BSN, Neighborhood Health Centers of the Lehigh Valley, Allentown, PA*
- *Paige Roth, MSW, Emergency Medicine, Lehigh Valley Health Network, Allentown, PA*

and real-time consultations with addiction
- Synthesize information focused on the management of opioid use disorder in primary care through the shared experiences from the primary care practice teams and the patients they serve along with the existing data

## J2: Understanding Family Decision-Making about Healthcare Utilization: Methodology Development for Measurement at the Relational Unit-Level

In 2015 there were 136.9 million visits to the Emergency Department (ED) in the United States equaling 43.3 visits to the ED per 100 persons for that year. This number represents a substantial increase in ED usage in this country, outpacing population growth. As a result of the increasing number of annual ED visits, the Institute of Medicine described the state of emergency care in the U.S. as "at the breaking point"□. Historically, research, policy, and practice have focused on reducing ED visits without understanding the biopsychosocial, systemic, relational needs of patients and those that care for and about them. In a previous stage of the lead author's research, she and colleagues operationalized frequent ED use employing population health data and machine learning to identify an empirically-grounded definition of ED use and clinically-relevant patient subpopulations. Yet while prior research has shown that couple, family, and relational systems are social determinants of health, there is a dearth of research on how relational systems engage in and make decisions about health care utilization. Given that people that utilize the ED and other healthcare services more frequently have more complex care needs, understanding decision-making about whether to utilize the ED for care is both a prominent public health issue and one of health equity and social justice. Thus, our team conducted a study exploring the role and contribution of relational (i.e., family, friends, health care team members) decision-making in utilization of the ED for health care. Presenter(s) will describe the methodology for development and delivery of a survey administered to 256 relational groups (i.e., the patient and individuals that present with them to the ED) at the point of care in the emergency department. Results and implications for assessment and intervention at the practice level, as well as research, and policy focused on health care utilization will be discussed. Special considerations for conducting relational research in the ED will be described.

*Presenter(s):*

- *Jessica Goodman, PhD, LMFT, Postdoctoral Fellow, Departments of Psychiatry and Medicine, University of Rochester, Rochester, NY*

Date: Saturday, 10/10/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Family centered care/Family perspectives
- Social determinants of health (SDoH)
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the need for research, policy, and practice that incorporates a family- and relational-based understanding of decision-making about emergency department utilization
- Describe a novel survey methodology used to understanding relational decision making in ED and health care utilization
- Discuss the results and implications for assessment and intervention at the practice level, as well as research, and policy focused on health care utilization

## J3: General Hospitals and Integrated Care: Paging the Behavioral Health Consultant

The integration of behavioral health providers (BHPs) in general hospital settings is potentially advantageous because hospitalized patients can have complex care needs and have high rates of psychosocial problems. However, there is a paucity of literature on the topic, including best practices for integrating BHPs and outcomes generated by inpatient BHP treatment. We will describe findings from our scoping review of the literature on BHPs in general hospital settings. Attendees will learn about the results of the scoping review including common collaborative practices and communication strategies. Presenters will describe multiple facilitators and barriers to BHP integration and will discuss the wide varieties of problems treated by BHPs and their extensive array of treatment modalities. The lack of outcome data and patient and providers perspectives reported in the literature will also be highlighted along with ideas about strategies to fill this gap. Using extant literature, presenters will highlight factors that may guide BHPs practicing or interested in practicing in general hospital settings. Hospitalized patients frequently have very complex biopsychosocial-spiritual needs. Thus, the focus of this presentation is directly in line with the conference theme. Presentation content will be applicable to a wide audience; especially providers and administrative professionals whose roles have or will include work in the hospital setting.


*Presenter(s):*

- *Tyler Lawrence, PhD, Behavioral Health Faculty, Sea Mar Marysville Family Medicine Residency, Marysville, WA*
- *Matt Martin, PhD, Clinical Assistant Professor of Behavioral Health, Arizona State University, Phoenix, AZ*
- *Jennifer Caspari PhD, Assistant Professor and Director of Behavioral Medicine, University of Nebraska Medical Center, Omaha, NE*
- *Rae Witt, MD, Assistant Professor, Associate Program Director, Internal Medicine Residency Program, University of Nebraska Medical Center, Omaha, NE*


Date: Saturday, 10/10/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Complex Patient Care
- Interprofessional teams
- Hospital setting

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the importance of integrating behavioral health providers into general hospital settings.
- List the barriers and promoters to integrating behavioral health providers into general hospital settings.
- Evaluate patient and medical provider outcomes from behavioral health integration within general hospitals.

## J4: Training PCBH Trainers: A Story of Diligence, Detail, and Diversity

Providing high quality services consistent with the Primary Care Behavioral Health (PCBH) model requires professionals to develop a new professional identity and to master a broad range of skills over a sustained period of time. In order to train others effectively, Behavioral Health Consultant (BHC) trainers need to demonstrate excellent in clinical, consultation, team-based care, and practice management competencies and to learn to be effective teachers. Presenters include three BHC trainers who have worked together in a 3-year project to develop Primary Care Behavioral Health services for a diverse country with a primary concern of achieving health equity. They will introduce a tool for training PCBH trainers and detail lessons learned about training trainers.


*Presenter(s):*

- *Patti Robinson, PhD Psychologist and President Mountainview Consulting Group Portland, OR USA*
- *Bridget Beachy, PsyD Director of Behavioral Health Community Health of Central Washington*
- *David Bauman, PsyD Behavioral Health Education Director Community Health of Central Washington*


Date: Saturday, 10/10/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional education
- Primary Care Behavioral Health Model
- Workforce development

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe core competences for working as a Behavioral Health Consultant (BHC)
- List additional core competencies needed for becoming a BHC trainer and reference a BHC Trainer Core Competency Tool
- Discuss key components for developing a diverse group of BHC trainers who are engaging,

enthusiastic, and committed to PCBH sustainability and evolution

## J5: Implementation of an Ambulatory Pharmacy Program through Team-based Care

Introduction: Polypharmacy, medication costs, and physician burnout are complex issues at the forefront of American healthcare delivery.1-3 An Ambulatory Pharmacy Program (APP) can help as pharmacists are poised to assist with precisely these issues and remove barriers that providers and patient encounter when navigating the prescription drug market.4-5 This solution can be costly to initiate for already cash-strapped healthcare entities but with value-based, population health movement in full swing, it may not be out of reach. A Medicare demonstration project called CPC+ focuses on evolving primary care teams and encourages pharmacy integration. CPC+ enables infrastructural innovation through grant funding that created the APP.6 Method: The APP was designed to cover nearly 60 practices with three pharmacists. EMR workflows were designed to enable pharmacists to receive referrals directly from providers and nurse care coordinators. Clinical documentation mirrored the Pharmacy Quality Alliance's (PQA) Medication Therapy Problem Categories Framework to streamline and standardize care delivery. The PQA focuses documentation on medication indication, effectiveness, safety, and adherence. Pharmacists readily use clinical and payer data to evaluate their impact using standardized metrics and payer reports. Initially, program success metrics were process-oriented but have since evolved to evaluate clinical quality outcomes. Results: APP measures include evaluations of process, interventions employed, and clinical outcomes, like Hemoglobin A1c trends in pharmacist-managed diabetics. Discussion: Pharmacists have been able to assist patients and providers through a variety of medication-related issues. Medication expertise, along with the ability to manage chronic disease states, are essential to reduce medication-related costs, and provide the most safe and effective medication therapy management to the patient.


*Presenter(s):*

- *Darren Mensch, PharmD, BCPS, BCACP, Ambulatory Care Pharmacist - Population Health, Jefferson Medical Group-Abington, Abington, PA*
- *Corrine Young, PharmD, BCPS, Ambulatory Care Pharmacist - Population Health, Jefferson Medical Group-Abington, Abington, PA*
- *Steven Spencer, MD, MPH, Medical Director of Population Health, Jefferson Medical Group-Abington/Jefferson Northeast, Rydal, PA*
- *Lori Merkel MSPH, RN, CPHQ, Population Health Business Analyst, Jefferson Medical Group, Abington, PA*
- *Julia Lees, PharmD, BCPS, Ambulatory Care Pharmacist - Population Health, Jefferson Medical Group-Jefferson Northeast, Abington, PA*


**Date:** Saturday, 10/10/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Burnout
- Cost Effectiveness/Financial sustainability
- Outcomes

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Define the pharmacist's potential roles in population health and value-based care.
- Describe the implementation of an Ambulatory Pharmacy (APP) program
- Discuss evaluate implementation of program and early outcomes

## J6: An Interdisciplinary Team Approach to Multiply Disadvantaged Patient Populations in a Geriatric Primary Care Setting

Multiply disadvantaged patients, particularly older adults, often present with complex combinations of medical, functional, social, and psychiatric factors that often cannot be full addressed with fast-paced outpatient visits (Buhr et al., 2019). The objective of this session is to share outcomes from effective team-based practices that particularly benefit multiply disadvantaged patients, and to help attendees identify ways they can collaborate with other team members as well as patients to address complex issues. At Iora Health, the structure of in-office visits and definition of care team member roles allow for deeper relationships with patients and understanding of their needs. Behavioral health staff, transitions nurses, medical providers, team nurses, and health coaches work together via

**Date:** Saturday, 10/10/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Complex Patient Care
- Geriatrics
- Team-based care

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

multiple collaborative efforts to identify patients with complex social needs, medical conditions, and behavioral health concerns and then address them in a patient-centered, team-based manner. Using a risk stratification approach, team members focus on patients considered at highest risk of hospitalization or increased morbidity and mortality. At regular intervals, team members develop a care plan to address social determinants of health, provide the needed level of medical intervention, and behavioral health care as indicated. Focus on advanced care planning and clarifying patient wishes for medical decision-making and end-of-life care helps care teams honor patient values and wishes, particularly in transitions between outpatient, hospital, and institutional settings. In the session, presenters will review team-based processes that have been effective, and then work through case vignettes as small groups with discussion as a larger group to learn to apply a patient-centered, team-based lens to stratifying patient subpopulations, identifying social determinants of health, and planning team-based collaborative follow-up.

*Presenter(s):*

- *Weston Donaldson, PhD, ABPP, Behavioral Health Lead, Iora Health, Denver, CO*
- *Laura Wiese, LCSW, Behavioral Health Specialist, Iora Primary Care, Denver, CO*
- *Jenny Hubbard, LCSW, Behavioral Health Specialist, Iora Primary Care, Denver, CO*
- *Jessica Castaño, PsyD, Behavioral Health Specialist, Iora Primary Care, Denver, CO*
- *Emily Yebra, RN, team nurse, Iora Primary Care, Denver, CO*
- *Shannon O'Connor, PhD, Behavioral Health Specialist, Iora Primary Care, Lakewood, CO*

- Participants will be able to describe how a risk stratification model can focus outreach and intervention in complex patient populations.
- Participants will be able to think creatively about complex cases in ways that involve team members from multiple disciplines.
- Participants will have increased self-efficacy for planning team conversations about patient care.

## J7: Schools, Medicine, and Families - Bridging the Gap

Within primary care, children only come through the medical office door one time a year for well child checks or if there is a problem. Although some speciality clinics may see children and teens more than once a year, these visits are often focused on complex symptom management and care among different specialities. The majority of children's time is spent in the school environment. However, school is a complex system that is often difficult for parents to navigate on their own, which may lead to a disconnect between family and school. This often leads parents to reach out to medical providers first if they are concerned about school difficulty. Sometimes, school staff even request that children see their pediatrician or present proof of a medical diagnosis if there is a concern. Some school concerns that families often share include: learning difficulties, behavioral concerns at school, difficulty concentrating, anxiety and school avoidance, fatigue, and sleep concerns. Often medical providers may feel ill-equipped to manage these concerns and systems (Burka, Van Cleve, Shafer, & Barkin, 2014). With the integration of behavioral health in primary care and speciality clinics it reduces some of the burden on medical providers to help navigate school difficulties and concerns that the family may share and help improve student functioning. Integrated behavioral health providers with school psychology training have an advantage in helping pediatricians and families navigate the complexities of the school system given their experience with multi-disciplinary collaboration and their understanding of academic and behavioral supports. Presenters will discuss important school jargon, legal considerations for care coordination communications, and methods of connecting with school systems as behavioral health providers within integrated settings and a school-based mental health clinic. Successes and barriers to collaboration with school settings will be discussed.

*Presenter(s):*

- *Maribeth Wicoff, PhD, Psychologist, The Children's Hospital of Philadelphia, Philadelphia, PA*
- *Maria Golden, PhD, Psychologist, The Children's Hospital of Philadelphia, Philadelphia, PA*
- *Christine Rivera Gonzales, MA Intern, Milton Hershey School, Hershey, PA*
- *Jennifer Mautone, PhD, Assistant Professor in Psychiatry, Children's Hospital of Philadelphia/University of Pennsylvania School of Medicine, Philadelphia, PA*

Date: Saturday, 10/10/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional teams
- Pediatrics
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify important considerations for care coordination between schools and behavioral health providers within primary care settings.
- Discuss successes and barriers to collaboration with school settings.
- Understand important school lexicon and legal considerations that integrated behavioral health providers need to be aware of when trying to help families navigate school-based concerns.

- *Chim Okoroji, MA Psychology Fellow, The Children's Hospital of Philadelphia, Philadelphia, PA*

## J8: Raising the Ceiling: An Advanced Workshop on Publishing for Integrated Care Researchers

Publishing work in a peer-reviewed journal disseminates ideas widely and can contribute to the evolution of the field. This interactive workshop, facilitated by the Co-Editors, will engage researchers in co-producing impactful research for publication in Families, Systems, & Health. We will define the opportunity to advance integrated care science through the journal, share exemplars that highlight the journal's strategic direction, distill themes the editors have encountered in handling submissions from experienced authors, and identify practical strategies for success. Participants will workshop one manuscript that they are working on (which may be at any stage of development) that they might shape for submission to FSH. Finally, they will also have an opportunity to provide the Co-Editors feedback on what would make FSH their journal of choice for disseminating leading edge research on effective integrated care interventions.

*Presenter(s):*

- *Nadiya Sunderji, MD, MPH, FRCPC, Psychiatrist in Chief, Waypoint Centre for Mental Health Care, Penetanguishene, ON, Canada*
- *Jodi Polaha, PhD, Associate Professor, Department of Family Medicine, East Tennessee State University, Johnson City, TN*
- *Jennifer Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare Syracuse VA Medical Center, Syracuse, NY*
- *Dan Mullin, PsyD, MPH, Associate Professor, University of Massachusetts Medical School, Worcester, MA*
- *Ian Bennett, MD, PhD, Professor, University of Washington, Seattle, WA*

**Date:** Saturday, 10/10/2020

**Time:** 11:00 AM - Noon

**Session Type:** Live streaming

**Content Level**: Advanced

**Keywords**:

- Outcomes
- Research and evaluation (e.g. data analysis methods)
- Skills building/Technical training

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Engage with a collegial community of Co-Editors and other academics in co-producing impactful research for publication in Families, Systems, & Health.
- Describe common pitfalls that experienced authors encounter during the peer review process and identify strategies for successful publication.
- Tailor and advance a manuscript they are working on for potential publication in FSH.

## K1: Who's Assisting Whom? Dovetailing Medication Assisted Treatment and PCBH to Address Opioid Use Disorder within a Family Medicine Residency Program

As the treatment model for chronic/relapsing substance use disorders in the United States continues to shift from episodic treatment to continuing care, primary care is uniquely positioned to serve those struggling with Opioid Use Disorder, both with Medication Assisted Treatment (MAT) and with the support of Primary Care Behavioral Health (PCBH). The CentraCare Family Health Clinic adopted the PCBH model in the fall of 2015 and began prescribing buprenorphine-naloxone for Opioid Use Disorder in the summer of 2016. As the programs developed and grew concurrently, behavioral health providers have been involved with the MAT program since its beginning. Since 2016, the program has grown from one waivered prescriber to six, along with a group of 11 second- and third-year family medicine residents, increasing the need for structured support. The next phase in our program is to adjust policy, practice, and workflow in our clinic to further integrate behavioral health providers into MAT. This presentation will focus on the current literature around behavioral health support of MAT, the need for a greater base of evidence-based practice, and the progress that one clinic has made in utilizing MAT and PCBH to address the opioid crisis. It will also invite open conversation amongst attendees to promote learning through shared experiences. Special consideration will be given to the implications for rural communities - both through the training of Family Medicine residents, many of whom will further their careers in rural clinics, and the utilization of established tele-IBH services within our organization's rural

**Date:** Saturday, 10/10/2020

**Time:** 1:45 PM - 2:45 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Interprofessional teams
- Opioid management
- Primary Care Behavioral Health Model
- Rural

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- discuss the role of primary care in treating opioid use disorder.
- describe strategies for interdisciplinary collaboration within policy, programming, and clinic workflow.
- identify areas needing more specific research for informing evidence based practice.

clinic settings.

*Presenter(s):*

- *Rachel Delaney Geier, LICSW, Integrated Behavioral Health Provider, CentraCare Family Health Clinic, St. Cloud, MN*

## K2: Implementing C.H.A.N.G.E.: Strengthening Resiliency in Pregnancy

Pregnancy and childbirth is one of the most biologically, socially, and psychologically complex periods in a woman's life (Anda, 2010). Carrying an infant in the womb is made even more difficult if a mother has endured her own trauma, potentially transmitting a vulnerability to her child's development through maternal behavior and emotions (Hudziak, 2018). Additionally, the transition to parenthood is a general life stressor which often activates her attachment system. Symptoms of depression, anxiety, and trauma may also interfere with her ability to bond with her child (Main, 2000). Although the complexity of pregnancy and motherhood can be daunting, a mother's resilience may mitigate the impact of these risk factors. Resilience involves being able to face challenging circumstances while also maintaining a positive mental health status (Steen, 2015). This study seeks to describe the risk of adverse birth outcomes associated with antenatal trauma and insecure attachment, as well as the impact of resilience through the incorporation of a resiliency-based intervention early in pregnancy. The intervention will target the risk of developing mood symptoms, identify positive coping strategies and highlight meaningful resources. Participants include expectant mothers in their first trimester at a rural obstetric healthcare clinic enrolled in a "New Mom's"class. While attendance is not required, all newly expecting women enrolling in the clinic for obstetric care are strongly encouraged to attend. Mean age of participants is 28.1 years (SD = 2.03) with 44.4% of participants including first time mothers. Study design: A quasi-experimental design due to the inability to use random assignment. The study looks to assess the feasibility and acceptability of a multidisciplinary group visit to address health behaviors, presence of emotional health concerns, assess for risk of adverse experiences and initiate resiliency development for pregnancy health. Methods: Participants will complete the following measures before the class begins: Adverse Childhood Experience Questionnaire, Revised Adult Attachment Scale, the "New OB: Women's Health History form including the Edinburg Depression Scale, and the Integrating C.H.A.N.G.E. pre-assessment. Participants will attend a 90min new mom's class covering medical and emotional concerns associated with pregnancy, and the role adverse childhood experiences can play in coping and emotional wellbeing. Participants will complete a newly developed resiliency-based intervention (My C.H.A.N.G.E. Plan) to identify positive and protective coping strategies that they can use to support biopsychosocial wellbeing both during and after pregnancy. While early in the pilot phase, physician, clinic and patient feedback has been overwhelmingly positive. At the conclusion of the intervention, 100% of participants strongly agreed that they would access behavioral health services to support their perinatal healthcare.

*Presenter(s):*

- *Joanna Harberts, MA, MS, Behavioral Health Consultant, Newberg, Oregon*
- *Jeri Turgesen, PsyD, ABPP, MSCP, Psychologist, Providence Medical Goup, Newberg, OR*
- *Ryan Dix, PsyD, MS, Psychologist, Providence Medical Goup, Newberg, OR*
- *Mary Peterson, PhD, ABPP, Psychologist, Newberg, OR*

Date: Saturday, 10/10/2020

Time: 1:45 PM - 2:45 PM

Session Type: Live streaming

Content Level: Intermediate

Keywords:

- Collaborative Care Model of Integrated Care
- Population and public health
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss the impact of ACEs and attachment styles on antenatal healthcare.
- Identify team-based approaches to early intervention and resiliency building in maternity care.
- Demonstrate the acceptability and effectiveness of a group-based intervention for pregnancy health.

## K3: The Great Debate 5.0: Integrated Care's Questions and Controversies

Some of America's most important debates were contested in Philadelphia. In that tradition, we present 3 debates at the heart of integrated care. We will strive for robust empiricism, but might settle for strong rhetoric where we lack solid data. Regardless, you will leave informed of the latest science and most relevant policy advances. As participants in an emergent and largely untested healthcare model, our leaders and practitioners face daily quandaries for which we lack data for making an informed decision. By convening the leading researchers and thought leaders of our field, we aim to shed light on some of the most important dilemmas. These will be actual debates using recent research and important policy advances for supporting arguments. They will be adjudicated by the audience and the debater who made the most compelling case will be awarded a signed copy of his or her opponent's most important literary work. DEBATE 1: IS TRAUMA-INFORMED CARE AN EVIDENCE-BASED PRACTICE? In the years since the publication of the ACEs research, trauma-informed care has brought major re-consideration to our clinical environments and services. While the client-centeredness of these changes is not in dispute, can it be said that the scientific literature endorses these approaches as evidence-based practices? Cara Pozun will debate the affirmative, Stacy Ogbeide the negative. DEBATE 2: ARE THE PHQ AND GAD OVER-UTILIZED? No quality metric has been more widely adopted than universal screening for depression, with screening for anxiety often done concurrently. We rely on the 2/9 AND 2/7 to identify need and assess outcomes. And yet, the United States Preventive Services Task-Force is mixed in support of their utilization. Additionally, as they are so embedded into EMRs, they crowd out other tools that might be more useful. Deepu George will debate their prominence is merited and CR Macchi will counter that they are over-utilized. DEBATE 3: DOES THE EMR INHIBIT OR FACILITATE COLLABORATION? Few innovations have changed healthcare more than the EMR. This revolution has brought many advantages (easy access to records, metrics and data, asynchronous communication), they have also disrupted much of what clinicians value most in their careers (human interaction, efficiency, unimpeded time away from work). What has been the overall impact of the EMR on interprofessional collaboration? Paul Simmons will highlight the benefits of the EMR and Barry Jacobs will convince us of the challenges. Each debate will last approximately 15 minutes, with 4 minutes for each of the opening statements, 2 minutes for each rebuttal, and 1 minute for closing statements


*Presenter(s):*

- *Randall Reitz, PhD, LMFT, Director of Behavioral Medicine, Saint Mary's Family Medicine Residency, Grand Junction, CO*
- *Stacy Ogbeide, PsyD, ABPP, CSOWM Associate Professor/Clinical, UT Health San Antonio, San Antonio, TX*
- *Cara Pozun, MA, MFTC, Medical Family Therapist, Saint Mary's Family Medicine Residency, Grand Junction, CO*
- *Barry Jacobs, PsyD, Principal, Health Management Associates, Philadelphia, PA*
- *Deepu George, PhD, Associate Professor of Family Medicine and Director of Integrated Behavioral Health, University of Texas Rio Grande Valley School of Medicine, McAllen, TX*
- *CR Macchi, PhD, Clinical Associate Professor, Academic Program Lead, Arizona State University, College of Health South, Phoenix, AZ*
- *Paul Simmons, MD, FAAFP, Faculty Physician, Saint Mary's Family Medicine Residency, Grand Junction, CO*


**Date:** Saturday, 10/10/2020

**Time:** 1:45 PM - 2:45 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Complex Patient Care
- Electronic Medical Record
- Patient-centered care/Patient perspectives
- Research and evaluation (e.g. data analysis methods)

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- To present the current status of the evidence-base for trauma-informed care
- To critically analyze the role and prevalence of the PHQ and GAD in primary care settings
- To distinguish advantages and disadvantages of the EMR and describe ways to maximize their advantages

## K4: Integrated Care Coordination for Adult Depression: Lessons Learned Over the Course of 20 Years That Can Inform Implementation and Expansion Efforts

Background: Depression is the most common mental health condition with prevalence rates ranging from 8-14% in primary care (PC) settings [1]. While evidence-based treatments are available, access to these services can be challenging. Moreover, many patients do not attain remission and are vulnerable to a relapsing-remitting course [2]. Consequently, there has been a call for increased services in PC [3]. While collaborative care programs have been shown to help patients achieve and maintain remission over time, they have not yet been employed on a national level [4]. This presentation details an integrated care coordination (ICC) program for depression delivered in PC, focusing on lessons learned over time to improve future implementation and expansion efforts. Methods: Multiple iterations of the ICC program have been employed. Across iterations, nurses serve as the primary liaison between patients and providers to enhance engagement and enhance engagement in evidence-based care. Psychiatrists provide weekly supervision and consultation to a panel of depressed patients. Qualitative information about the program was obtained from multiple stakeholders. Results: In all iterations, there has been a focus on training and supervision to ensure fidelity. The first iteration was a quality improvement process and the second iteration was the Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program. Both exemplified the importance of obtaining reimbursement for sustainability. The third, fourth, and fifth iterations included depressed patients diagnosed with anxiety disorders, bipolar disorder, or medical conditions respectively. In these iterations, it was challenging to standardize services, define outcomes, and determine readiness for discharge. Consequently, the DIAMOND program foundations have been re-implemented. Conclusion: The ICC program has been integral to serving the needs of the PC population. Lessons learned include identifying clear measures and workflows, establishing evidence, maintaining fidelity, reporting outcomes, and collaborating with stakeholders for sustainability, which have been echoed in the literature [5]. These lessons have informed efforts to improve and expand the ICC program across a wider region, especially clinics in rural areas.

*Presenter(s):*

- *Olivia Bogucki, PhD, Postdoctoral Fellow, Mayo Clinic, Rochester, MN*
- *Mark Williams, MD, Associate Professor, Integrated Behavioral Health, Mayo, Rochester, MN*
- *William Leasure, MD, Division Chair/Consultant, Mayo Clinic, Rochester, MN*
- *Scott Breitinger, MD, Senior Associate Consultant, Mayo Clinic, Rochester, MN*
- *Angela Mattson, DNP RN NE-BC, Nursing Administrator, Mayo Clinic, Rochester, MN*
- *Craig Sawchuk, PhD, Division Chair/Consultant, Mayo Clinic, Rochester, MN*

Date: Saturday, 10/10/2020

Time: 1:45 PM - 2:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Care Management
- Collaborative Care Model of Integrated Care
- Tertiary care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Discuss the evidence supporting integrated care coordination programs as an effective and efficacious treatment for depression.
- Identify challenges associated with implementing integrated care coordination programs in primary care settings.
- Describe the ways in which integrated care coordination programs can be improved and implementation can be increased.

## K5: Addressing Perceived Stress and Burnout in Healthcare Providers: Piloting a Low Dose Guided Self Help Intervention in an Inpatient Hospital Setting

Medical and mental health professionals are among the top five professions who are most prone to burnout in the United States. Burnout is characterized by emotional depletion and loss of motivation resulting from prolonged exposure to chronic emotional and interpersonal stress. Burnout among helping professionals is associated with poorer quality of healthcare delivery and reduced patient safety. Efforts to address workplace burnout have been mixed. One challenge often reported is finding effective interventions that fit the needs of a busy clinical setting that has limited time for broad-based staff training. One model that has received increased attention over the past decade is the Community Resiliency Model (CRM).

Date: Saturday, 10/10/2020

Time: 1:45 PM - 2:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Burnout
- Prevention
- Professional Identity, including development of
- Self-care/Self-management

CRM is a 30-hour low dose guided self-help intervention aimed at teaching health workers a set of skills geared toward increasing resiliency and reducing distress both of which are significant components of burnout. Previous use of the CRM model has focused on first responders working in the aftermath of disaster and traumatic situations. However, in this study, the Community Resiliency Model (CRM) training was adapted into a single 3-hour session training session with an additional 1-hour booster session delivered 3 months after the initial training. The training focused on the same six CRM skills that have been found to promote individual resilience and stress reduction. Participants included nurses, social workers, physical therapists, residents, and other care providers. Respondents were ethnically diverse and primarily female, highly educated, and married. An adapted version of the Physician Vitality Measure (PVM) 4-item burnout subscale was used to measure burnout. Paired sample t-tests were conducted to explore differences between the pre and immediate post and the pre and after booster posttest burnout scores. Although there were no significant mean score differences between the pre and after program post-test, there was a significant decrease in burnout and perceived stress scores between the baseline and after the booster session. Our results suggest that a low dose resiliency intervention that teaches wellness skills is a promising and sustainable approach that fits within the demands of clinical settings and can be used to address perceived stress and burnout among helping professionals.

*Presenter(s):*

- *Brittany Huelett, MS, AMFT, PhD Student, Loma Linda University, Loma Linda, CA*
- *Zephon Lister, PhD, Director of Systems, Families and Couples PhD Program, Loma Linda University, Loma Linda, CA*
- *CarmeneomiAngela Reyes, MS, AMFT, PhD Student, Loma Lina Univeristy, Loma Linda, CA*

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Participants will be able to identify factors that contribute to burnout in mental health providers and health care providers working in a healthcare setting.
- Participants will be able to identify the skills of the Community Resiliency Model a low dose self-help intervention aimed at reducing burnout.
- Participants will be able to identify the utility of implementing CRM to be utilized as a sustainable approach that fits within the demands of clinical settings and can be used to address perceived stress and burno

## K6: Zero Suicide - Working Towards Integrating Behavioral Health and Primary Care

National figures estimate that over 83% of people who died by suicide saw their primary care provider at least once within the year prior to their suicide death.1. In order to address this most preventable cause of death and with the goal of integrating behavioral and primary care, the Health System has implemented the Zero Suicide model. This evidenced-based approach aims to raise awareness, establish referral processes, and improve care and outcomes for the complex care needs of patients at-risk for suicide.2 As the mandated safety net hospital system for the region and a Level 1 Trauma Center, Bexar County Hospital District, dba University Health System, serves 22 counties through its teaching hospital and ambulatory clinics. University Health System is implementing a comprehensive, multi-setting suicide prevention and intervention approach under the framework of the seven essential elements of the Zero Suicide Model. This workshop will review the Zero Suicide model to include organizational assessments measuring primary care staff competencies related to suicide prevention and care. Additionally, we will review evidenced-based trainings related to screening (Patient Health Questionnaire - PHQ 3/9), assessment (Columbia Suicide Severity Rating Scale - C-SSRS), best practices (Question, Persuade, Refer - QPR3), and treatment interventions (Collaborative Assessment and Management of Suicidality - CAMS4 & Counseling on Access to Lethal Means - CALM5). This innovative approach of the Zero Suicide model is one of the first applications to implementing a comprehensive, universal, suicide prevention program across a regional health system. As a safety net hospital, our primary population encounters complex social needs which can best be addressed by strengthening integrated primary care services. To remain relevant and sustainable, the Health System has incorporated feedback from leadership, community members, leading agencies/organizations in suicide prevention, survivors of suicide, and crisis organizations. We will present findings on barriers to

Date: Saturday, 10/10/2020

Time: 1:45 PM - 2:45 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Implementation science
- Prevention
- Suicide

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Participants will learn about a practical framework for system-wide transformation toward safer suicide care in primary care settings.
- Participants will learn practical evaluation tools which can assess workforce development related to suicide prevention in primary care, in the context of implementation science.
- Participants will learn about the various evidenced-based trainings (QRP, CALM, CAMS, CASE Approach) for suicide assessment, prevention, and care.

implementation including resistance to change within the system, lack of knowledge and positive attitudes towards suicide prevention, and the efforts made to address these issues.

*Presenter(s):*

- *Mercedes Ingram, PhD, LPC, Evaluator, University Health System, San Antonio, TX*
- *José Gonzalez, MS, Program Manager, University Health System, San Antonio, TX*
- *Laura Farley, MA, Director of Community Initiatives and Population Health & Zero Suicide Project Co-Director, University Health System, San Antonio, TX*

## K7: Should We Screen for ACEs? - Yes. No. Maybe?

More than twenty years of research has confirmed a relationship between Adverse Childhood Experiences (ACEs) and poor health outcomes. Associations of ACEs and future suicide attempts, problematic drug use, sexually transmitted infections, mood and anxiety disorders, and respiratory disease are particularly strong. In response to this finding, primary care stakeholders have proposed screening children and adults for ACEs. Unfortunately, the impact of these screening programs on health outcomes has not been well established. As with all screening programs in primary care it is necessary to establish the expected benefits and potential harms of ACEs screening, prior to establishing policies and workflows for routine screening. This presentation will briefly review the evidence and gaps in evidence associated with universal and targeted screening for ACEs. The evidence for primary care interventions for addressing ACEs will also be reviewed. Small and large group discussions will clarify the expected benefits and potential harms associated with screening for ACEs. The presentation and discussions will explore the relative risks and benefits of screening for ACEs in adult vs. pediatric populations. Additional considerations, for clinicians working in diverse settings with diverse populations. Finally, the presenters will compare and contrast a universal education approach to addressing trauma with a screening approach to identify patients with ACEs.

*Presenter(s):*

- *Dan Mullin, PsyD, MPH, Associate Professor, University of Massachusetts Medical School, Worcester, MA*
- *Joan Fleishman, PsyD, Behavioral Health Clinical Director, Oregon Health & Science University, Portland, OR*
- *Sarah Pearson, PsyD, Behavioral Health Fellow, Dept. of Family Medicine and Community Health, University of Massachusetts Medical School, Worcester, MA*

**Date:** Saturday, 10/10/2020

**Time:** 1:45 PM - 2:45 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Across the Lifespan
- Interpersonal violence
- Social determinants of health (SDoH)

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Describe the evidence supporting screening for Adverse Childhood Experiences.
- Describe the potential benefits and harms associated with screening for Adverse Childhood Experiences.
- Compare and contrast a universal education approach to addressing trauma with a screening approach for Adverse Childhood Experiences.

## K8: Translating Research into Meaningful Use of Assessments in Practice

This workshop exemplifies ways to maximize the use of the assessments you already collect to inform treatment planning and progress monitoring. Too often, assessments are required by administrators or reporting agencies which are not implemented in ways which help inform individuals at the point of care. When this happens, assessments feel like an unnecessary burden to staff and individuals and the information collected suffers in quality and consistency. The burden is even greater in rural communities where assessments are often captured on paper. It is important to make sure that the individuals who contribute to and collect assessment information find value for use of the information being collected so that they invest in the quality of that information for their own goals. Nobody wins if we use valuable time to fulfill administrative requirements which are not found useful in practice. Many of the assessments we use in the field were developed and validated in research settings. While research implements measures for the sake of research, practice need implement measures for the sake of practice. The measures we found helpful in research must be transformed into tools for practice without changing the

**Date:** Saturday, 10/10/2020

**Time:** 1:45 PM - 2:45 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Assessment
- Implementation science
- Outcomes

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Describe how assessments can be used to visualize a client's story and share information across a multidisciplinary team.

validity and reliability of the assessment itself. Research often uses measures to evaluate performance after the program is complete. However, in practice we must consider ways in which we can implement these tools to inform practice during practice. This workshop presents specific examples on different ways in which assessment information you already collect can be meaningfully used within an individual's period of care in addition to building a knowledge base within and across programs. The workshop will discuss the use of assessments to inform level of care determination, capturing an individual's story of need and strength, and identifying staff strengths and training needs to increase staff success and retention. The workshop will provide examples of how to test and measure effectiveness of existing level of care algorithms for success in placement. I will demonstrate how assessments can be used to visualize an individual's story and share information across a multidisciplinary team. The workshop will explore simple approaches and solutions as well as provide an overview of more advanced data visualization and machine learning techniques, as applicable to the task.

- Measure the effectiveness of their existing level of care algorithms for success in placement.
- Use assessment data to identify staff strengths and identify peer leadership opportunities for staff based on their strengths.

*Presenter(s):*

- *Kate Cordell, PhD, MPH, Mental Health Data Alliance, Folsom, CA*

## L1: De-Colonizing the FQHC, Unpacking Enactments and Striving Towards the Quadruple Aim of Primary Care

This seminar will explore and discuss the toxicity in FQHCs, racial enactments and the process of decolonizing practice, agency, and leadership. Through an interactive healing-centered approach, participants will learn about colonialism and critical theory frame works, develop understanding decolonization as a practice tool and philosophy towards liberation practice, and will create a community with one another through storytelling and processing past experiences and struggles with power, subjugation, and the non-profit industrial complex. This seminar will deconstruct concepts like productivity, gatekeeping, organizational gaslighting, exploitation of the other, and the profits over people mindset that has plagued many of our community-based agencies and discuss white supremacy, racism and the internalized colonizer syndrome (Villanueva, 2018). The seminar will end with healing-centered exercises to allow for participants to use developmental frame works, behavioral frameworks and decolonizing theory to find meaning, connection, belonging and action that is aligned with the individual's true subjectivity. This seminar is meant to be a beginning of an unapologetic conversation about the profession, power dynamics, and liberation in integrated health care.

*Presenter(s):*

- *Noel Ramirez, DBH, MSW, MPH, LCSW, BCD, West Chester University, Philadelphia, PA*
- *Katherine Huynh, PA-C*
- *Rachel Fox, PA-C*
- *Tanajsia Mason, BA*
- *Blessy Mathew, MSN, CRNP*
- *Elliot Goodenough, PhD, MD*

Date: Saturday, 10/10/2020

Time: 3:00 PM - 4:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Burnout
- Chronic Care Model of Integrated Care
- Complex Patient Care
- Interprofessional teams
- Policy

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Enhance understanding of intersectional integrated-care practices in FQHC settings.
- Develop understanding in the non-profit industrial complex and decolonization framework as a tool for leadership, supervision and clinical practice.
- Develop skills in critical theory and decolonization as it relates to practice, supervision, leadership, and advocacy. Increase skills in identifying enactments of oppression, healing-centered skill-building, and professional self-restoration.

## L2: Creating Radical Ripples: A Training Curriculum for Quality Improvement Projects

As medical organizations continue to adapt to the ever-changing healthcare landscape, quality improvement initiatives are vital for these organizations to meet patient needs, quality metrics, and financial demands. Indeed, one would be hard-pressed to find a health center that does not have a department and/or significant resources related to quality improvement (QI). Integrated behavioral health providers (IBHPs) are in a unique position to support health centers in this realm, as many IBHPs receive extensive training in research and program design, survey development, and statistics. However, there appears to be a lack of acknowledgement regarding an IBHPs vital role in QI projects and even a greater lack of specified training during clinical internships and fellowships for future IBHPs in the QI process. Often, IBHPs may not even consider QI as part of their role. This presentation will give an overview of how a teaching health center (Community Health of Central Washington) incorporates QI into their behavioral health training program. Specifically, the presentation will detail the curriculum for doctoral interns and fellows on the PDSA cycle of QI, how to collaborate and work with medical residents and leadership on QI initiatives, and the completion of a QI project. Additionally, two doctoral fellows who have completed the internship training and subsequent QI projects with the program will share their experience, as well as an overview of their two projects and outcomes. One of the projects is on improving cognitive screening in primary care and the other on the patient experience in the clinic waiting room.

*Presenter(s):*

- *Arissa Walberg, PhD, Site Training Director, BHC, Community Health of Central Washington, Yakima WA*
- *Hilary Richardson, PhD, BH Doctoral Fellow, Community Health of Central Washington, Yakima, WA*
- *David Bauman, PsyD, Behavioral Health Education Director, Community Health of Central Washington, Yakima, WA*
- *William Summers, PsyD, Post-Doctoral Fellow, Community Health of Central Washington, Yakima, WA*

Date: Saturday, 10/10/2020

Time: 3:00 PM - 4:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Interprofessional education
- Quality improvement programs
- Training/Supervision - Supervision and evaluation of trainees, providing feedback

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the important role that integrated behavioral health providers have in assisting health centers in QI initiatives
- Outline curriculum used to train future psychologists in the QI process in a primary care setting
- Discuss the results of two QI projects related to improving cognitive screening in primary care and patient experience in waiting rooms

## L3: Hospital to Rehab: A Medical Resident Education Program Focused on Addressing Complex, Post-Acute, Biopsychosocial Care Needs in Patient Transitions

The transitions of care from hospital to post-acute rehabilitation and then to home are complex, particularly given the biopsychosocial stressors of aging and social determinants of health that are often present for those with numerous underlying chronic conditions. While psychosocial factors are known to impact success with discharge, unmet needs and concerns are frequently voiced by patients and their families during transitions of care. At the same time, limited physician education and training experiences have historically been available in geriatrics, particularly with older adults transitioning between clinical settings. Previously, our facility ran the Hospital to Home Program as a model of geriatric training for internal medicine residents emphasizing the complicating role of psychosocial factors, including social determinants of health, and importance of interdisciplinary collaboration. In 2018, our facility shifted focus to address another high-risk transitional area, hospital to rehabilitation. The post-acute rehabilitation setting offers a unique opportunity to gain feedback around clinical skillsets necessary for collecting psychosocial information to support effective discharge planning, communication between care teams, and shared decision-making with patients to address complex care needs and social determinants of health. This presentation will outline the structure of the

Date: Saturday, 10/10/2020

Time: 3:00 PM - 4:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Complex Patient Care
- Social determinants of health (SDoH)
- Teaching family-centered care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the impact of social determinants of health on transitions of care across clinical settings.
- Describe the biopsychosocial interview and coaching component of the Hospital to Rehab program and thematic feedback from medical resident participants

Hospital to Rehab program, as part of a university internal medicine residency.. Particular emphasis will be given to the psychosocial interview portion of the rotation, which serves multiple purposes, including (a) collecting baseline information on residents' communication skills with patients and families; (b) providing modeling and feedback to residents around the psychosocial factors that play an important role in discharge planning; (c) how to facilitate a collaborative conversation around these factors with patients and their families; (d) an opportunity for residents to contribute to successful discharges through documentation that provides a biopsychosocial picture of the patient and their needs. Qualitative data from residents' reflections on their experiences with the program overall and psychosocial interview in particular will be shared. Recommendations for building interdisciplinary support to facilitate a program such as this will be offered.

*Presenter(s):*

- *Jessica Goodman, PhD, LMFT, Postdoctoral Fellow, Departments of Psychiatry and Medicine, University of Rochester, Rochester, NY*
- *Lauren Decaporale-Ryan, PhD, Assistant Professor, Departments of Psychiatry, Medicine, & Surgery, University of Rochester, Rochester, NY*
- *Joseph Nicholas, MD, MPH, Associate Professor, Department of Medicine, University of Rochester, Rochester, NY, Medical Director, Highlands at Brighton Transitional Care Facility, Rochester, NY*

- Establish ideas for how to build teaching/training protocols to enhance physicians' communication and biopsychosocial interviewing skills at audience members' facilities

## L4: Chronic Conditional Love: Integrating Care in a PCMH including Dental, Optometry, and Primary Care

This presentation will explain our fully integrated care model utilizing how we obtained our Behavioral Health Integration Distinction from NCQA. This will include staffing and billing information. Our presentation will showcase how we utilize Masters-level Social Workers in our model to help identify patients who need assistance with creating goals for their chronic conditions, including diabetes and hypertension. We will also discuss how we implemented our MAT program and what techniques and tools we utilize for this. Our presentation will also ensure participants get to practice using tools and techniques, allowing audience members to participate in a problem solving exercise regarding two case studies.

*Presenter(s):*

- *Kaitlin Boger, EdD, LMSW, LMAC, Director of Integrated Care, Hunter Health, Wichita, KS*
- *Ben Benson, LMSW, LMAC, Integrated Care Consultant, Hunter Health, Wichita, KS*

Date: Saturday, 10/10/2020

Time: 3:00 PM - 4:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Chronic Care Model of Integrated Care
- Complex Patient Care
- Innovations

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Create a plan to implement Behavioral Health Distinguished PCMH model at their own location
- Explain two techniques to manage complex chronic conditions
- Identify tactics to engage all levels of staff in integrated care

## L5: Huddle Up! The Inter-Professional Team at Its Best

Primary care patient care models are shifting from lone primary care provider (PCP) decision making to shared responsibility for patient panels, with other team members empowered to provide significant portions of chronic and preventive care across the lifespan (pediatric through geriatric populations). Interprofessional health teams are equipped with a broad range of skills and expertise to address health and wellness needs of patients with complex medical conditions. For example, the interprofessional team can best serve patients with chronic pain and opioid use disorder (OUD), who have an elevated risk of mortality and higher health care costs, compared with the general population. These disparities have been linked to sub-optimal management of co-occurring chronic conditions in primary care, resulting in

Date: Saturday, 10/10/2020

Time: 3:00 PM - 4:00 PM

Session Type: Live streaming

Content Level: All Audience

Keywords:

- Across the Lifespan
- Complex Patient Care
- Team-based care
- Interprofessional Teams

high costs of care and functional impairment of the patients. In addition, high burnout rates in primary care are rising and can be ameliorated through medical home models that emphasize team-based participatory decision making. One evidence-based strategy to address these issues is the inter-professional team huddle. Another evidence-based approach is Situation, Background, Assessment and Recommendation (SBAR) communication. These strategies can be combined to optimize communication and outcomes. This presentation includes discussion of evidence-based communication techniques and identification of specific roles and responsibilities for each team member to improve coordination of care healthcare team satisfaction and patient outcomes. An interactive interprofessional huddle demonstration will teach how to apply these techniques in a primary care setting. Common comorbid, real world case examples, including a patient with opioid use disorder (OUD), will be discussed by the team during the simulated huddle. Huddle and communication competency guidelines and tools will be applied in the demonstration and shared with participants to encourage application in practice.

*Presenter(s):*

- *Lisa Tshuma, PA-C, DBH, MPAS, MPA, Assistant Professor, A.T. Still University, Mesa, AZ*
- *Sue Dahl-Popolizio, DBH, OTR/L, Clinical Associate Professor, Arizona State University, Phoenix, AZ*
- *Lesley Manson, PsyD, Associate Chair of Integrated Initiatives, Arizona State University, Phoenix, AZ*
- *Alexa Trolley-Hanson, MS, OTR/L, Clinical Assistant Professor, University of New Hampshire, Durham, NH*
- *Will Lusenhop, MSW, PhD, LICSW, Clinical Assistant Professor, Department of Social Work, University of New Hampshire, Durham, NH*

- Care Coordination
- Opioid Use Disorder
- Evidence-Based Practice

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the roles, and overlap of roles, for interprofessional team members in primary care.
- Explain how a huddle is used to determine treatment approach and plan of care.
- Provide at least 3 examples of how the interprofessional team can address the needs of complex patients.

## L6: Medical-Legal Partnership: Integrating Lawyers into Health Settings to Address Social Determinants of Health

Background: The Legal Clinic for the Disabled, a civil legal aid agency, has four Medical-Legal Partnerships (MLP) across seven diverse sites in low-income communities and developed best practices to implement and sustain MLPs. LCD's partnership with St. Christopher's Hospital for Children (SCHC) is a case example of MLP's effectiveness. SCHC is in an epicenter of poverty where 66% of the children in the surrounding zip code live in poverty. SCHC and LCD established an MLP in 2011. The MLP embeds an attorney in SCHC's primary care practice to address social determinants of health (SDoH) including housing and habitability, food insecurity, immigration, public benefits, domestic violence, and family law. Attorneys and healthcare personnel combine law and medicine to mitigate negative SDoH. Objective: Systematize screening in an outpatient practice to proactively identify legal issues and connect families with resources or immediate legal intervention to mitigate negative SDoH. Methods: Families received a 14-item SDoH screener during the visit. Providers reviewed the screeners, gave resources and/or referred to an onsite attorney. The attorney regularly trains healthcare staff on screening and substantive legal issues. Screening tools were collected and results compiled. Results: 39833 families were screened for unmet legal needs from August 2011 through December 2019. The number of screens increased each year (year 1=895, year 9=7591). Overall, 40% (10480) self-identified at least one unmet need. From 2011 to 2019, the rate of self-reported unmet need decreased (year 1= 74%, year 9 = 19%) while the service rate (legal assistance and/or resources) increased (year 1 = 27%, year 9 = 63%). Conclusions: The MLP successfully implemented SDoH screening in a busy outpatient practice. With this holistic approach, each team member's role best utilizes time and capabilities. With efficient screening, triage, and referrals, many families have their issues addressed during the visit.

Date: Saturday, 10/10/2020

Time: 3:00 PM - 4:00 PM

Session Type: Live streaming

Content Level: Novice

Keywords:

- Interprofessional teams
- Multi-sector partnerships
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- At the conclusion of this presentation, participants will be able to describe the innovative MLP model to address social determinants of health that are legal in nature.
- At the conclusion of this presentation, participants will be able to identify common issues for low-income clients that are especially ripe for MLP intervention.
- At the conclusion of this presentation, participants will be able to identify approaches to implementing and sustaining an MLP or similar interdisciplinary

*Presenter(s):*

- *Theresa Brabson, Esq, Legal Director, Legal Clinic for the Disabled, Philadelphia, PA*
- *Linda Peyton, Esq, Executive Director, Legal Clinic for the Disabled, Philadelphia, PA*
- *Daniel Taylor, DO, FAAP, FACOP, Associate Professor, Drexel University College of Medicine, Director Community Pediatrics and Child Advocacy, St. Christopher's Hospital for Children, Philadelphia, PA*

partnership to address social determinants of health.

## L7: Strategic Implementation Planning for Integrated Behavioral Health Services in Pediatric Primary Care

Delivering physical and behavioral health services in a single setting is associated with improved quality of care and reduced health care costs. Few health systems implementing integrated care develop conceptual models and targeted measurement strategies a priori with an eye toward adoption, implementation, sustainment, and evaluation. Without this foundation, it is difficult to disentangle why implementation is or is not successful. The purpose of this presentation is to discuss strategic implementation and evaluation planning for a pediatric integrated care initiative in a large health system. A logic model, which defines resources and community characteristics, program components, evaluation activities, short-term activities, and intermediate and long-term patient-, provider-, and practice-related outcomes will be described. The model was designed based on research and stakeholder input to support strategic implementation and evaluation of the integrated primary care program. For each aspect of the logic model, a measurement battery was selected. These measures will be presented to highlight how a logic model can inform targeted measurement selection. Additionally, initial implementation data and intermediate outcomes from a pilot in five practices in a 31-practice pediatric primary care network will be presented to illustrate how the logic model and evaluation plan has been used to guide the iterative process of program development. This model provides a template for future projects integrating behavioral health services in pediatric primary care and can be used broadly to provide structure to implementation activities.

*Presenter(s):*

- *Jennifer Mautone, PhD, Assistant Professor in Psychiatry, Children's Hospital of Philadelphia/University of Pennsylvania School of Medicine, Philadelphia, PA*
- *Courtney Benjamin Wolk, PhD, Assistant Professor of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA*
- *Zuleyha Cidav, PhD, Assistant Professor of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA*
- *Jami Young, PhD, Director of Psychosocial Research, Children's Hospital of Philadelphia; Associate Professor of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA*

**Date:** Saturday, 10/10/2020

**Time:** 3:00 PM - 4:00 PM

**Session Type:** Live streaming

**Content Level**: Intermediate

**Keywords**:

- Implementation Science
- Pediatrics
- Sustainability

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Understand the importance of logic models to guide program implementation activities
- Describe the iterative process of program development for a pediatric integrated behavioral health program
- Select measures to evaluate program development activities

## L8: Developing an Integrated Community to Treat Addiction in Homeless Populations.

In the summer of 2017, Cabin Creek Health Systems entered a scope change to support a robust Syringe Service Program. They were able to provide direct, integrative primary care services to participants actively engaged in intravenous drug use. In addition to primary care, relationships with participants were established that worked to motivate participants through the stages of change supporting their transition to Medication Assisted Treatment. social determinants of health were quickly identified as barriers to treatment with an active use population, and successful transition from use to Medication Assisted Treatment was mostly unsuccessful. Since that time Cabin Creek Health System has been in collaboration with Community-Based Organizations to address the social determinants of health. The collaboration includes, a large meal services, multiple shelters, the City of

**Date:** Saturday, 10/10/2020

**Time:** 3:00 PM - 4:00 PM

**Session Type:** Live streaming

**Content Level**: All Audience

**Keywords**:

- Care Management
- Co-morbidity
- Complex Patient Care
- Cultural Humility
- Evidence-based interventions
- Innovations
- Interprofessional teams

Charleston, WV, and the local Continuity of Care agency. Through collaboration participants are identified and supported as they are transitioned to a person-centered substance use treatment program. Interested participants receive housing support, ancillary items such as identification, and birth certificates, transportation to resources and appointments, meal support, and integrative primary care. Modifications to traditional substance use treatments were required to better meet the needs of the population, this has increased retention, and decreased the negative impacts of other social determinants of health. Adoption of a program involving eight or more agencies has yielded communication difficulties, however having increased connection to resources is improving provider moral and decreasing burnout within Cabin Creek Health System, and for the partners. The target population are individuals who use IV substances, face housing difficulties, homelessness, and struggle with social determinants of health. Initial pilot hopes to track 25 participants of mixed age, race, gender, and sexual orientation. Recruitment continues to be open, and more participants are being induced routinely. Participants will be monitored monthly for continued motivation, attrition, and adherence to program. Providers will be asked to measure their felt work stress and burnout in relation to this participant group. It is expected that participant adherence, attrition, and motivation will be improved in comparison to past referral attempts. A comparison group is unavailable due to poor referrals previously. After collecting this initial data, a more robust research design can be developed for further research. This program aims to establish a community ecosystem of care that activates multiple community agencies into an integrative team to address social determinants of health for an often forgotten, at risk population.

*Presenter(s):*

- *Jake VanHorn, PsyD, Special Projects Director, Cabin Creek Health System, Charleston, WV*
- *Josh Carter, PsyD, Medication Assisted Treatment Program Director, Cabin Creek Health Systems, Charleston, WV*
- *Traci Strickland, Executive Director, Kanawha Valley Collective, Charleston, WV*

- Opioid management
- Patient-centered care/Patient perspectives
- Population and public health
- Primary Care Behavioral Health Model
- Social determinants of health (SDoH)
- Special populations (e.g. disability)
- Substance abuse management (e.g., alcohol, tobacco, illicit drugs)
- Sustainability
- Team-based care
- Tertiary care
- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Participants will be able to identify the partnerships to address social determinants of health.
- Participants will be able to discuss the impact of poor partnerships on provider and participant outcomes.
- Participants will be able to identify possible community relationships to improve practice.

# Webcasts

## Webcast 01: Implementing Integrated Behavioral Health In Low-Resource Settings

It is estimated that one in seven individuals in the world today have a mental health or substance use disorder. Most of these individuals live in low-resource settings. Low resource mental health settings are typically characterized by a lack of funds, limited access and availability of services and/or shortage of trained personnel on an individual or societal basis to adequately address mental health needs. In response to this reality, organizations such as the National Institutes of Health and World Health Organization have called for the development of resource conservative and low dose interventions to scale up mental health access and services. Resource conservative and low dose interventions refer to interventions that are low frequency, short duration and/or low intensity. Low intensity interventions are designed to use fewer resources, in terms of healthcare professional time and expertise than conventional psychological therapies. These interventions are often delivered and/or supported by health workers without formal mental health professional training, who have been specifically trained to deliver low-intensity interventions. One model that has received increased attention over the past decade is the Community Resiliency Model (CRM). CRM is a low dose guided self-help intervention aimed at teaching lay health workers to provide individuals, groups and communities a set of skills geared toward increasing resiliency, regulating the nervous system and reducing distress. This presentation reports on a recent pilot project where community health workers were trained to provide CRM as part of an integrated behavioral health service to medical staff and patients in a hospital in Sierra Leone.


*Presenter(s):*

- *Zephon Lister, PhD, Director of Systems, Families and Couples PhD Program, Loma Linda University, Loma Linda, CA*
- *Cintia Alfonso, Student, Systems, Families and Couples PhD Program, Loma Linda University, Loma Linda, CA*
- *John Lou, Student, Systems, Families and Couples PhD Program, Loma Linda University, Loma Linda, CA*
- *Sona Topalain, Loma Linda Univeristy, Loma Linda, CA*
- *Brittany Huelett, MS, AMFT, PhD Student, Loma Linda University, Loma Linda, CA*


**Date:** Asynchronous Content

**Time:** Available throughout conference

**Session Type:** Webcast

**Content Level:** All Audience

**Keywords:**

- Implementation science
- Special populations (e.g. disability)
- Underserved populations (e.g. LGBTQ)

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify the factors that contribute to challenges in mental health access and services in low resource contexts
- Describe the Community Resiliency Model as a potential scale up integrated behavioral health intervention in low resource settings
- Discuss challenges and lessons learned from implementing integrated behavioral health services in a low resource setting

## Webcast 02: Beyond the Borders of Gender and Immigration: Strategies for Transgender Inclusive Integrated Care

The permeation of the two-gender system in our healthcare system is painful, at best, and life-threatening, at worst. Transgender and nonbinary patients experience serious health injustices and limited healthcare quality and access. Patients tend to delay healthcare utilization due to inadequate insurance coverage and past experiences of microaggressions, discrimination, non-affirming practices, and pressure to de-transition from healthcare providers (Hudson, 2019; James et al., 2016). Such experiences are problematic as these patients often experience worse physical and mental health outcomes compared to cisgender patients (Burgwal et al., 2019; James et al., 2016). In addition, transgender and nonbinary patients have significantly higher rates of suicidal ideation and suicide attempts (James et al., 2016). Although negative experiences negatively impact the health outcomes for all

**Date:** Asynchronous Content

**Time:** Available throughout conference

**Session Type:** Webcast

**Content Level:** Novice

**Keywords:**

- Complex Patient Care
- Patient-centered care/Patient perspectives
- Underserved populations (e.g. LGBTQ)

transgender patients, patient documentation status creates complexity. Transgender Latinx immigrant patients experience additional unacknowledged stress and risk due to persecution, immigration status, and fear of deportation (Hwahng et al., 2019). Providers' lack of education on transgender inclusive healthcare practices is associated with discrimination, harm, and poorer health outcomes (Kattari et al., 2020). In this session, presenters will provide foundational concepts for transgender inclusive healthcare to help professionals strengthen their practice. Attendees will learn important terminology regarding transgender inclusive practice in Spanish and English. Next, presenters will discuss the health inequities that transgender patients experience, which will focus on accessible and quality healthcare legislation and policy. Throughout the session, presenters will specifically contextualize the experiences of undocumented Spanish-speaking Latinx transgender patients. To solidify action steps, presenters offer strategies to promote awareness, knowledge, and advocacy with transgender inclusive healthcare.

*Presenter(s):*

- *Joshua Boe, MS, LAMFT, Doctoral Candidate, University of Georgia, Athens, GA*
- *Andrea Trejo, MA, Marriage and Family Therapy Trainee and Doctoral student, University of Georgia, Athens, GA*
- *Émilie Ellis, MA, LAMFT, Doctoral Student, University of Georgia, Athens, GA*

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Define important terminology related to transgender inclusive healthcare
- Identify how cisnormative ideology influences the healthcare system and healthcare settings
- Develop and apply strategies for building a transgender inclusive healthcare practice

## Webcast 03: Addressing Organizational Complexity: Everyday Implementation Strategies for Practitioners

Integrated care is widely accepted as an evidence-informed strategy aimed at improving whole-person health. Positive outcomes have been demonstrated at patient, clinic, and systems level. Healthcare landscape, major healthcare reforms seek to modify billing, health information technology, and the workforce, among other change initiatives are shifting towards integrated care models. Through this rapid decade of growth, many clinics have nurtured flourishing integrated healthcare programs. However, some clinics have struggled to maintain or grow the program after the initial funding has evaporated, in spite of positive outcomes and a general sense of satisfaction with the programs. To optimize the uptake and progression towards sustainability, we can assess and amend organizational factors that are known to support the use of the innovation. This is known as implementation science. Focusing on implementation and capacity building for scale-up across an organization increases the chances that an evidence-based program, practice or policy (EBP) will be delivered with integrity and will achieve intended outcomes. The time it takes from research to move from trial to full implementation can be reduced from 17 years to about three years when implementation best practices are delivered via technical assistance. Organizations optimize their outcomes when they: 1) Build organizational readiness for an initiative, 2) explore and build necessary capacities to support the use of a new innovation, and 3) allocate time and effort to adequately attend to programmatic elements that will result in systematization and its precursor, routinzation -key elements in sustainability. Medical settings often have implementation needs that are unique to their context, such as capacity for informatics and health information technology, workflow analysis, and attention to billing and coding. The implementation of integrated healthcare programming is even more complex. Beyond these technical components, clinics must first shift their culture toward the foundational tenants of team-based approaches to treatment and patient-centered care while simultaneously selecting a programmatic model and fully operationalizing that model. Therefore, one must choose the approach (e.g., Primary Care Behavioral Health Model or Collaborative Care Model) and clinical

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Webcast

Content Level: All Audience

Keywords:

- Administration
- Implementation science
- Innovations

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe ten implementation best practice strategies they can use to promote sustainability of their integrated care program
- Describe the crossover among implementation strategies, effectiveness research, and quality improvement
- Apply one or two applied implementation strategies that promote programmatic uptake or sustainability

foci and related practice modalities (e.g., ADHC clinic, socioemotional screening and brief intervention, brief anxiety treatment, healthy weight clinic) that is the best fit for their clinic. There is some literature on implementation strategies related to integrated care implementation. However, there is a growing base of best practices, many of which are program agnostic. In this session, we will compile and share lessons learned across the fields of implementation science and integrated care. We will also provide tangible strategies learned from the presenters' experience providing technical assistance to organizations.

*Presenter(s):*

- *Julie Austen, PhD, Implementation Specialist, University of North Carolina, Chapel Hill, NC*

## Webcast 04: Training Medical Residents and Behavioral Health Learners to Manage High Risk Situations in Primary Care & Outpatient Care

When it comes to identifying and managing high-risk situations in primary care and outpatient care settings, there are many missed opportunities. Forty-five percent of people who have died by suicide attended a primary care appointment in the month preceding (SAMHSHA-HRSA, 2019), despite recommendation by the US Preventive Services Task Force (2016) to screen all adults for depression and validation of Questions 9 on PHQ-9 as a robust predictor of suicide attempts and deaths (Rossom, 2017). In terms of child abuse and neglect identification and management, primary care physicians' and pediatricians' reporting rate is very low with over a third of cases physicians classified as very likely to have been caused by child abuse not reported (Flaherty at al., 2008). These care gaps indicate a need for training and education of medical residents and BH learners to adeptly manage these high-risk situations and provide good patient care to those experiencing them (Foster et al., 2017; Hymel at al., 2018). High-risk BH-related situations in a primary care and outpatient care settings include suicidality and homicidality, duty to warn/report, child and elder/incapacited adult abuse and neglect reporting, and domestic and criminal violence reporting. Additional layers of complexity include different state-to-state requirements for medical and BH providers in terms of management and Department of Health and Human Services and/or law enforcement reporting and also related ethical considerations and nuances (Jordan & Pritchard, 2018). During this session, we will (a) identify medical resident and behavioral health learner training/education needs related to high-risk situations in primary care and outpatient integrated behavioral health care settings, (b) share and discuss one Family Medicine residency program's curriculum for training medical residents in managing these situations, and (c) explore ways in which participants can take steps towards identifying and addressing high-risk situation training needs at their home institutions.

*Presenter(s):*

- *Aubry Koehler, PhD, LMFT, Director of Behavioral Science, Wake Forest School of Medicine, Winston-Salem, NC*
- *Linda Nicolotti, PhD, Director of Pediatric Psychology, Wake Forest Baptist Health, Winston-Salem, NC*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Webcast

Content Level: Intermediate

Keywords:

- Ethics
- Interprofessional education
- Team-based care
- Pediatrics

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify medical resident and behavioral health learner training/education needs related to high-risk situations in primary care and outpatient integrated behavioral health care settings.
- Share and discuss one Family Medicine residency program's curriculum for training medical residents in managing high risk situations in primary care and outpatient care settings.
- Explore ways in which participants can take steps towards identifying and addressing high-risk situation training needs for medical residents, behavioral health learners, and medical/behavioral providers and staff at their home institutions.

## Webcast 05: Building an Integrated Behavioral Health Note for Efficiency and Clinical Quality

Southcentral Foundation (SCF), an Alaska Native customer-owned health care system, has implemented a new electronic note for charting behavioral health care provided in its primary care clinics. SCF had been using electronic charting for some time, but this charting was too difficult and was taking Behavioral Health Consultants (BHCs) too long. SCF also wanted to capture utilization patterns, clinical data, and intervention data from the note. The goal was to identify trends happening with patients, which interventions were being used and why, and if they were making a difference. To do this, SCF's behavioral health integration leadership spent six months creating the note SCF currently uses. The note is made to prioritize/capture population data in addition to individual symptoms, with the patient-centric data being free text, while the population-based data is entered through discoverable fields. This helps SCF to know at a systems level what percentage of the population has been seen by a BHC and which clinical areas. SCF also wanted to know how many times BHCs were seeing patients, because this allows SCF to look at referrals to behavioral health and determine availability of behavioral health consultants in primary care, and effectiveness of clinical interventions. It also helps providers to stay on top of trends and patterns at the population level, and determine what other behavioral health resources need to be developed. SCF has been using the new note for approximately one year. Since the note has been used, approximately 18% of SCF's 68,000 patients have been seen by a behavioral health consultant, with approximately 73% of those patients having 3 visits or less in the last calendar year. Charting time for BHCs has decreased from an average of 6 minutes per note to an average of 3.5-4 minutes per note, improving clinical efficiency. Through the data collected in the note, SCF is currently measuring the impact on the number of follow-up visits, symptom reduction, and improved functioning. The note also provides data on which interventions and clinical topics SCF needs to devote training resources and time to.

*Presenter(s):*

- *Melissa Merrick, LCSW, MSW, CDC I, Clinical Director of Brief Intervention Services, Southcentral Foundation, Anchorage, AK*
- *Shane Coleman, MD, MPH, Medical Director, Southcentral Foundation, Anchorage, AK*
- *Jerrad Anderson, MHRM, Primary Care Manager, Southcentral Foundation, Anchorage, AK*

**Date:** Asynchronous Content

**Time:** Available throughout conference

**Session Type:** Webcast

**Content Level**: All Audience

**Keywords**:

- Across the Lifespan
- Administration
- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Evidence-based interventions
- Population and public health
- Primary Care Behavioral Health Model
- Quality improvement programs
- Technology (e.g. health informatics)
- Training Models
- Training/Supervision - Supervision and evaluation of trainees, providing feedback
- Workforce development

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Identify the key elements of SCF's integrated behavioral health consult note.
- Analyze how SCF developed the note as an iteration of previous charting systems.
- Identify the successes and lessons learned by SCF throughout the first year of the note's usage.

## Webcast 06: Developing the Workforce: Successes, Challenges, and Outcomes of Training Doctoral-Level Psychology Students in Integrated Primary Care

Primary care often serves as the front line for both mental health and health behavior change issues, resulting in an increase in of integration of behavioral health into primary care. Despite the successes of integrated primary care (IPC) and increased training opportunities at the internship and post-doctoral level in IPC, there continues to be a deficit of skilled behavioral health consultants. Further, limited opportunities exist to engage in IPC as a doctoral level practicum student, which is an opportune time to increase excitement and skills in this area of clinical psychology. The current project examined the training and utilization of doctoral-level clinical psychology practicum students in the involvement of IPC in two ambulatory primary care residency-based health centers (Internal Medicine (IM) and Family Medicine (FM)) with established IPC services. Specifically, we examined the model of training, particularly related to training in an underserved, urban, patient

**Date:** Asynchronous Content

**Time:** Available throughout conference

**Session Type:** Webcast

**Content Level**: Intermediate

**Keywords**:

- Team-based care
- Training Models
- Training/Supervision - Supervision and evaluation of trainees, providing feedback
- Underserved populations (e.g. LGBTQ)

population, and trends in IPC consults for practicum students compared to expected competencies. The practicum consists of doctoral level psychology students (N=4; 2 per year) engaged in IPC services for at least 8 of 16 hours per week. The training model focuses on a developmental, experiential approach, and utilizes well-supported guidelines for competency in IPC (McDaniel et al., 2014). In addition to traditional supervision, training often mimics that of the medical learning setting, including an emphasis on shadowing, direct observation, modeling, "on-the-fly"supervision, and didactic training, focused on moving practicum students at their developmental rate from observer to independent learner. Due to the setting of the training experience, particular emphasis is placed on social determinants of health in all aspects of training. Throughout the training year considerable movement toward competency in IPC are often seen in practicum student's abilities including: detecting patient needs appropriate for the IPC setting, engagement of brief interventions, understanding of medical language and culture, and communication with medical providers. Challenges identified in this setting included: variability in skill level; ability to influence factors less likely to change (e.g., personality); theoretical resistance to brief intervention; and time constraints on faculty schedules. Data will be presented examining changing trends in IPC visits by practicum students throughout their training year and will compare performance to postdoctoral fellows. Observations suggest that practicum students see a wider variety of patients as the year progresses, become more efficient, and have increased professionalism. This suggests that training practicum students in IPC is achievable and worthwhile, and may serve to improve the workforce imbalance in the future.

*Presenter(s):*

- *Jennifer Carty McIntosh, PhD, Associate Director of Behavioral Medicine Education, McLaren Health Care, Flint, MI*
- *Jennifer Battles, MS, Doctoral Practicum Student, McLaren Health Care, Flint, MI*
- *Andrew Champine, PsyD, Director of Behavioral Medicine Education, McLaren Health Care, Flint, MI*

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Define competencies in Integrated Primary Care specifically related to doctoral level practicum students.
- Discuss the specific training model utilized for a practicum in IPC in an underserved patient population.
- Describe the challenges and successes in training practicum students in IPC

## Webcast 07: The Birth of a New Pathway: Behavioral Health in Obstetric Care

We know behavioral health is important in obstetric care and that pregnant and perinatal women have unique needs. But with behavioral health practitioners entering the field from a variety of training modalities, how do we upskill ourselves for work with special populations? This presentation will review findings from a quality improvement project focused on enhancing knowledge and skills for work with OB patients among our behavioral health intern and post-doctoral fellows at a Primary Care clinic. Learn about basic core competency areas for behavioral health with OB patients, including those related to mental and physical health. We will also discuss successes and challenges in using Behavioral Health as part of an OB pathway and explore opportunities for assessing social determinants of health in obstetric care.

*Presenter(s):*

- *Emily Faust, MS, Behavioral Health Consultant, Community Health of Central Washington, Yakima, WA*
- *Ruth Olmer, PsyD, Behavioral Health Consultant, Community Health of Central Washington, Yakima, WA*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Webcast

Content Level: Intermediate

Keywords:

- Primary Care Behavioral Health Model
- Skills building/Technical training
- Social determinants of health (SDoH)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify key competency areas for providing safe and effective behavioral health care with perinatal patients.
- Discuss how to identify and address social determinants of health in perinatal patients.

- Understand the benefits and challenges of implementing a clinical pathway to increase integration between behavioral health and obstetrics care.

## Webcast 08: Reflections on Integrating Marriage and Family Therapists and Mental Health Counselors into A Primary Healthcare Practice

Collaboration between mental health and behavioral health has been identified as a best practice in the treatment of patients by the World Health Organization (WHO, 2010). It has been shown to lead to improved patient outcomes and save money on healthcare costs (WHO, 2010); however, creating an integrated healthcare practice can be challenging, especially in established practices. This presentation will discuss the multifaceted process of integrating Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) into a primary care practice using a Medical Family Therapy integration framework. Specifically, Medical Family Therapy identifies five levels of integration: 1) minimal collaboration, 2) basic collaboration at a distance, 3) collaboration on-site, 4) close collaboration in a partly integrated system, and 5) close collaboration in a fully integrated system (Doherty, McDaniels, & Baird, 1996). This program will have four components. The first component will be to provide an overview of the integrated healthcare program the presenters are a part of. The second component will be to discuss how the presenters moved through the levels of integration to the point at which the integrated healthcare program is currently. The third component will be to provide reflections on the strengths and challenges encountered throughout the process. Finally, this presentation will discuss specific case examples to elucidate reflections learned. The presentation will utilize a mixture of didactic lecture with visual aids and audience participation in the form of discussion questions and reflections.

*Presenter(s):*

- *Heather Katafiasz, PhD, Assistant Professor, Program Director & Clinical Training Director: Master's Program in Marriage and Family Therapy, The University of Akron, Akron, OH*
- *Rikki Patton PhD, Associate Professor, Co-Program Director: PhD Program in Counselor Education and Supervision with a specialization in Marriage and Family Counseling/Therapy, The University of Akron, Akron, OH*
- *Jessica Chou, PhD, Assistant Professor, Drexel University, Philadelphia, PA*
- *Gloria Gonzalez-Kruger, PhD, Associate Clinical Professor, Director of Clinical Services, Drexel University, Philadelphia, PA*
- *Laura Lynch, PhD, Assistant Clinical Professor, Program Director: Doctor of Couple and Family Therapy Program, Drexel University, Philadelphia, PA*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Webcast

Content Level: Novice

Keywords:

- Collaborative Care Model of Integrated Care
- Interprofessional education
- Interprofessional teams
- Primary Care Behavioral Health Model

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the five levels of Medical Family Therapy Integration.
- Discuss the strengths and challenges related to integrating behavioral health into primary care.
- Apply the content of the presentation to specific case examples.

## Webcast 09: Making Metrics Matter (and fun!): How to Engage your Providers to Springboard Productivity Tracking

When most providers hear the terms "metrics,""data,""productivity,"what reaction might it elicit? Is it positive? Not likely. And, yet, for growth, sustainability and myriad other operational factors, having (accurate and meaningful) program metrics is critical. Many leaders do not engage their providers in the metrics conversation as they fear it can further highlight the divide or tension that often exists between "admin"and "front line providers"regarding productivity expectations. In this presentation, we discuss an alternative way that directors and managers can approach their team, which actually helps engage their providers with metrics (and dare we say that engaged providers helps to buffer burnout). Having your team engaged in this process can produce more than just better financials - it can be a process that is foundational to your sustainability. This is especially salient in this healthcare climate where we have lofty goals to address the ever-growing complex biopsychosocial needs of our patients. This presentation reviews what one primary care behavioral health program did to engage their BHCs in metrics/data review and collection. We know as behaviorists that what we measure, gets our attention. The principles that are discussed can be translated to providers and teams of all types (not just behavioral health). The key factors of this approach were to only track what was most important (as the old business adage recommends: the "KISS method"or "keep it simple stupidâ€) metrics to keep it streamlined and to make it positive, reinforcing and fun! The leaders worked with their team to develop "clubs"and awards that are reviewed at every monthly team meeting. Once, again, the clubs and awards are easy to understand and highlight what the team is aiming for - completed billable encounters, including total visits and warm hand off visits and providers with the highest patient satisfaction to name a few. This presentation will outline principles that participants can use to start developing their own metric gathering system that is streamlined, meaningful, engaging and fun! Additionally, presenters will provide their program metrics before and after the implementation of the clubs and awards as well as employee engagement numbers.

*Presenter(s):*

- *Bridget Beachy, PsyD, Director of Behavioral Health, Community Health of Central Washington, Yakima, WA*
- *David Bauman, PsyD, Behavioral Health Education Director, Community Health of Central Washington, Yakima, WA*

**Date:** Asynchronous Content

**Time:** Available throughout conference

**Session Type:** Webcast

**Content Level**: All Audience

**Keywords**:

- Primary Care Behavioral Health Model
- Sustainability
- Provider/employee Engagement

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- describe the importance of gathering metrics to build and establish sustainable integrated behavioral health care in primary care.
- list the clubs and awards that were used to highlight core data points in a behavioral health program.
- develop their own metric/data gathering approach that highlights engagement from its team members.

## Webcast 10: Screening and Treatment for STIs in a Philadelphia Methadone Clinic: The Hows, Whys, and Whats.

People living with substance use disorders are at significantly increased risk of death and negative health consequences due in large part to the higher prevalence of sexually transmitted infections (STI) than the general population. The opioid epidemic has contributed to an outbreak in HIV and viral hepatitis infections among people who inject drugs, due to a variety of risky health behaviors including shared needles, transactional sex, and non-sterile tattoos. When left untreated, these health conditions can have significant negative health consequences. In recognizing that recovery encompasses the whole person, SUD treatment providers are uniquely poised to address sexual health issues in the population they serve through integrated care. Leaders in integrated care, addictions, and managed care will discuss the transition in a large Methadone Clinic in Philadelphia to one addressing holistic needs of the clients. This presentation will review specific steps that SUD

**Date:** Asynchronous Content

**Time:** Available throughout conference

**Session Type:** Webcast

**Content Level**: Intermediate

**Keywords**:

- Innovations
- Interprofessional teams
- Opioid management

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Gain knowledge into how sexually transmitted infections and infectious

treatment providers and programs can take to identify, treat, and reduce risks in the population they serve by examining the implementation of infectious disease and sexual health services. These interventions include: opportunities for directly observed therapy; providing sexual health psychoeducation and taking sexual health histories; incorporating STI screening; providing Hep A/B vaccinations; expanding access to PrEP/PEP and HCV treatment; developing collaborative relationships with community partners. The target population for this program is program leaders and clinicians who work with people who live with SUD or policy makers interested in learning more about innovative approaches to outreach and life-saving treatment in a population who often does not otherwise seek care. Participants will walk away with a comprehensive understanding of how STIs disproportionately affect the SUD population, and they will be able to identify specific strategies that they can implement in their programs.

*Presenter(s):*

- *Kimberly Malayter, LCSW, Director of Innovation and Integrated Clinical Services, Merakey, Erdenheim, PA*
- *Laura Murray, DO, Chief Medical Officer, Merakey, Philadelphia, PA*
- *Chris Tjoa, MD, Chief Medical Officer, Community Behavioral Health, Philadelphia, PA*
- *Stacey Trooskin, MD, PhD, Physician and Director of Viral Hepatitis Program, Philadelphia FIGHT Community Health Centers, Philadelphia, PA*
- *Jena Fisher, PhD, Executive Director of Innovation, Merakey, Erdenheim, PA*
- *Carol Larach, Director of Program Integration, Community Behavioral Health (CBH), Philadelphia, PA*
- *Joshua Vigderman, LPC, Executive Director of Addictions Services, Merakey, Philadelphia, PA*

diseases, including HIV and Hepatitis C, disproportionately affect the substance use disorder population
- Identify specific interventions that clinicians and substance use disorder treatment programs can implement into their existing programs to expand access to sexual health services
- Recognize how substance use disorder programs can develop community partnerships to enhance the holistic wellness of the populations they serve

## Webcast 11: Dental Integration: How Do We Do It?

In an effort to increase much needed access, we work to the idea that there is no wrong door to access services. This multi-site FQHC has integrated medical, dental, and behavioral health to provide optimal whole-person care and strengthen services to meet the complex social needs of our community. As we know, the mouth is the "gateway to the body."However, most dental providers are not trained in an integrated care approach. This presentation will walk the audience through the steps of how to develop and implement team-based dental services. We will describe workflows and address potential obstacles to success. Our journey to implementation across three years of grant funding allowed for 1694 unique patients to be seen to date by Behavioral Health and subsequently services rolled out into additional clinics with increased levels of integration between medical, dental, and behavioral health. Get motivated with practical tools to guide innovation!

*Presenter(s):*

- *Sherri Sharp, PhD, Vice-President of Behavioral Health, Peak Vista Community Health Centers, Colorado Springs, CO*
- *Mindy Tygar-Boyd, LCSW, Behavioral Health Provider, Peak Vista Community Health Centers, Colorado Springs, CO*
- *Sarah Brown, PhD, Behavioral Health Director, Peak Vista Community Health Centers, Colorado Springs, CO*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Webcast

Content Level: All Audience

Keywords:

- Collaborative Care Model of Integrated Care
- Innovations
- Interprofessional teams
- Dental

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe program implementation in this FQHC.
- Identify obstacles and tips for success.
- Discuss how to apply to your own setting.

## Webcast 12: Improving fidelity to PCBH through measuring GATHER: G is for Diagnostic Variability

Primary Care has served as the first line of care within the US Healthcare system. This means that regardless of symptom or condition severity patients often come to primary care first. While primary care can treat a wide array of conditions, referral to specialty care providers are common. In the last few decades behavioral health has become more adapted to primary care and several models aim to mimic the medical primary care system to become the front line of behavioral health as well as reducing the known barriers to the specialty behavioral health system. Primary Care Behavioral Health (PCBH) is one of these integration models and by definition the PCBH model of integration sees a large variety of patient presentations. This often ranges from mild stress, adjustment, and health changes, but can also include more chronic and severe conditions such as cancer, psychosis, PTSD, and Eating disorders. In many behavioral health models patient diagnoses or symptoms presentation create barriers to access care. Exclusion criteria, insurance acceptance, and lack of rigorously studied treatment protocols can leave some of the most vulnerable patients without needed behavioral health services. The PCBH model at the Yakima Valley Farms Workers Clinic (YVFWC) sees patients as they are: Complex. BHCs within this system conduct visits within the PCBH model of behavioral health integration and ongoing efforts are made to track and ensure fidelity to this approach. The GATHER acronym provides clear guidelines about what PCBH is, but how to measure these goals remains unclear. While some aspects of GATHER are objective such as seeing 10 patients per day, other aspects of PCBH are more nebulous. The presenter will discuss how YVFWC is striving to measure all aspects of GATHER and how the presenter took additional steps to improving reporting, tracking, and advocacy for the PCBH model through the development of a Diagnostic Variability statistic to more objectively measure and define the G (Generalist) of GATHER. This measure has helped determine a range of what G should be and when a BHC may need coaching due to falling short in regards to being a Generalist. Conversely this measure allows us to recognize and learn from those BHCs with the highest G performance. The presenter will show reports, tables, and charts which help calculate these numbers and how aggregate data has allowed us to give empirical meaning to G. Additionally the presentation will also provide several examples of the variety of conditions, diagnoses, and symptoms that present in primary care. These case examples will provide a real world look at how BHCs within the PCBH model can provide meaningful care to complex patients. By exploring these presentations the presenter hopes to validate and normalize the difficulty faced by working in primary care and also to instill hope and confidence that the skills utilized by BHCs can be effective to many conditions deemed "too difficult" for PCBH work

*Presenter(s):*

- *Phillip Hawley, PsyD, Primary Care Behavioral Health Director, Yakima Valley Farm Workers Clinic, Yakima, WA*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Webcast

Content Level: Intermediate

Keywords:

- Administration
- Assessment
- Complex Patient Care
- Electronic Medical Record
- Evidence-based interventions
- Population and public health|Primary Care Behavioral Health Model
- Quality improvement programs
- Team-based care
- Technology (e.g. health informatics)
- Training/Supervision - Supervision and evaluation of trainees, providing feedback

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Presenter will explore the PCBH model and ways that PCBH teams can monitor fidelity to this model utilizing the GATHER acronym
- Presenter will highlight difficulties in GATHER as some aspects are difficult to measure through quantitative data.
- Presenter will teach audience members a process to improving tracking, reporting, and administrative support by creating a metric which can be used to coach PCBH BHCs. This will also set a benchmark for what G means in quantitative language.

## D6: Decreasing Provider Stress in the Treatment of Complex Patients: A Brief Collaborative Training Program for PCPs and BHCs

As the demands on primary care providers (PCPs) are increasing, addressing the stress levels of PCPs, specifically daily stressors, is crucial (Bodenheimer & Sinsky, 2014). These stressors lead to burnout and are affecting PCPs at alarming levels. Bodenheimer and Sinsky (2014) report "...46% of US physicians experience symptoms of burnout...68% of family physicians would not choose the same specialty if they could start their careers anew"(p.574). While much of this frustration is associated with administrative work, this has had a ripple effect in leaving little time and energy for engaging with more difficult complex patients who present as some of the most draining of patient encounters (Babbott et al., 2014). Physicians report this is primarily due to lack of knowing what to do or how to help complex patients as they see non-adherence and little improvement realizing the training they received in medical school did not cover this (Linzer et al., 2002). What they are referring to is not the medical knowledge, but the additional skills of interacting with and understanding these patients in ways that could affect change. The intervention in this study will address new ways to do this for PCPs aiming at 1) teaching PCPs the spirit of motivational interviewing (MI) and basic MI skills 2) educating PCPs on complex patients and stress illness; diagnosis and treatment as many of these patients experience childhood stressors (trauma) or current stressors resulting in emotional, physical and/ or behavioral issues (Anda & Felitti, 1998). The participants in this study are patients, PCPs, and BHCs of a large integrated primary care practice. This study involves a two-part training comprised of 4 forty-five minute didactic, interactive and experiential group trainings along with optional individual BHC-PCP shadows involving real-time training. All components of training will be designed to be achievable within the fast pace of primary care. The goal of the study is to lower physician daily stress levels (DSLs) and improve treatment outcomes for complex patients with an intervention delivered by the behavioral health consultant (BHC) to the PCPs within the practice. With this intervention, the frustration associated with the treatment of these patients evolves into a collaborative relationship, employing joint decision-making processes, increasing patient adherence and improving treatment outcomes thereby reducing the PCP's stress affiliated with visits and improving daily stress levels (Rollick et. al, 2008). The study is currently in progress.


*Presenter(s):*

- *Cindi Stone, DBH, Director of Behavioral Health, Community Care Physicians, Glenmont, NY*
- *Lesley Manson, PsyD, Associate Chair of Integrated Initiatives, Arizona State University, Phoenix, AZ*
- *Kristine Campagna, DO, Board of Directors, Community Care Physicians, Latham, NY*
- *Holly Cleney, MD, Board of Directors CDPHP, Managing Physician Community Care Physicians, Clifton Park, NY*
- *Elizabeth Locke, MD, Managing Physician, Community Care Physicians, Clifton Park, NY*


Date: Thursday, 10/8/2020

Time: 11:00 AM - Noon

Session Type: Live streaming

Content Level: All Audience


Keywords:

- Burnout
- Complex Patient Care
- Interprofessional education


Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify challenges for PCPs in treating complex patients and how this leads to increased provider stress and burnout.
- Describe how the use of motivational interviewing skills assists in the treatment f complex patients
- Identify the factors that contribute to and constitute stress illness in patients who have experienced childhood or current stressors to aid in the diagnosis and treatment of these patients with complex issues.

# Podcasts

## Podcast 01: A Feasibility and Acceptability Study of a Patient-Initiated Approach to Increasing Communication about Weight in Primary Care

The frequency of communication about weight between patients and providers in primary care is low despite the tremendous potential to improve health by preventing or treating obesity. Brief interventions with patients to address communication barriers and promote patient-initiated weight discussions may be a key strategy to increasing the frequency with which weight is addressed in primary care. This study tested the feasibility and acceptability of a waiting room-based pamphlet that targeted patient barriers to weight communication in primary care and promoted patient-initiated discussions. Adult participants (N = 60) with overweight or obesity were recruited from a primary care office in Philadelphia. Study flow was tracked and compared to pre-set benchmarks to assess feasibility. Mixed methods were utilized to measure acceptability with patients, physicians, and front desk staff. This study met 3 of 4 feasibility benchmarks. It is likely that without the logistical paperwork required of a research study the feasibility would be even greater. Quantitative and qualitative results demonstrated high participant and physician acceptability. Participants reported appreciating the pamphlet's tools for how to start a potentially uncomfortable conversation about weight. Physicians reported wanting all patients with obesity to receive the pamphlet and provided feedback about which sections of the pamphlet they found promising. Physicians also reported that time constraints in the appointment limited application of the pamphlet's topics, despite the usefulness of the pamphlet. Front desk staff had concerns about additional paperwork in the waiting room, but generally found the idea of a pamphlet acceptable. In conclusion, the intervention pamphlet was feasible to deliver in a primary care waiting room and was acceptable to participants, physicians and staff. A brief patient-focused intervention in the waiting room may be a promising format to address patients' complex needs in obesity management.

*Presenter(s):*

- *Jocelyn Remmert, PhD, Postdoctoral Fellow, Corporal Michael J. Crescenz Philadelphia VA Medical Center, Philadelphia, PA*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Implementation science
- Patient-centered care/Patient perspectives

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Explain the feasibility of a brief intervention promoting patient-initiated weight discussions in a primary care waiting room.
- Describe the acceptability of the intervention from the patient, physician, and front desk staff perspectives.
- Identify translatable aspects of this intervention format for future projects.

## Podcast 02: In Pursuit of the Quadruple Aim: Evaluating the Role of a Health Resilience Specialists in an Integrated Behavioral Healthcare Setting

Background: Health systems are in constant pursuit of the quadruple aim, which embraces patient-centered, high quality, low cost healthcare: patient-centered, high quality, low cost healthcare, and fulfilled staff. This is particularly challenging, yet critical, in a population of patients with serious and persistent mental illness (SPMI). Cascadia Behavioral Healthcare partnered with CareOregon (Medicaid payer) to embed a Health Resilience Specialist (HRS) into an integrated health center with the objective of improvements in the quadruple aim. HRSs engage in extensive outreach, and are particularly skilled in working with complex patients with co-occurring physical and mental health concerns. Only one study has evaluated the use of a HRS to improve care, reduce emergency department (ED) visits, and decrease costs. Embedding a HRS in a behavioral healthcare setting has not been

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Chronic Care Model of Integrated Care
- Primary Care Behavioral Health Model
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

evaluated. We will evaluate the process of embedding a HRS into an outpatient integrated behavioral health center, to determine its effectiveness for the highest risk patients. Methods: Cascadia serves individuals with mental health and addictions. Many clients have SPMI and co-occurring physical health and addictions concerns. Cascadia is piloting the use of a HRS in an outpatient health center, selected based on staff culture and readiness for change, and high rates of emergency care utilization among clients. Clients who engage with the HRS will complete baseline and follow-up assessments. Outcomes will assess the quadruple aim: satisfaction with and quality of care; ED visits and hospitalizations; healthcare costs; and physical and mental health. Analyses will include a pre- post-intervention comparison, as well as changes over time. Results: In the past 12 months, 332 adults in the health center visited the ED at least once, and on average, clients had 9 ED visits in the past year. Of this sub-population, 13% visited the ED 5 or more times. Clients with a SPMI represent 58% of those using the ED at high rates. Cascadia will engage in population health management to target HRS services to clients identified as higher risk for using the ED, and outcomes in this cohort will be evaluated. Conclusions and Implications: This research will provide evidence to support the effectiveness of embedding a HRS in an integrated behavioral health setting. Results will highlight whether this role can contribute to realization of the quadruple aim and benefit Cascadia and similar organizations.

*Presenter(s):*

- *Allison Brenner, PhD., MPH, Population Health Research Director, Cascadia Behavioral Healthcare, Portland, OR*
- *Renee Boak, MPH, Senior Director of Population Health Research and Innovation, Cascadia Behavioral Healthcare, Portland, OR*
- *Molly Dressler, LCSW, Health Resilience Specialist, CareOregon, Portland, OR*
- *Aspen Sartoris, Counselor III, Cascadia Behavioral Healthcare, Portland, OR*

- Understand how population health management can be applied to identifying a population on which to focus targeted outreach or services
- Apply rigorous analytic methods to evaluate the effectiveness of new services that are piloted in a specific population of patients in a health center setting
- Determine how a HRS can be utilized to improve specific outcomes related to the quadruple aim, and whether the effects of engaging with a HRS are differential based on individual-level patient characteristics

## Podcast 03: Clinical Health Coaching in Primary Care

Motivating and assisting people to change their health behavior is a major challenge in primary care settings. It has been suggested 50% of patients leave office visits without understanding what advice their physician gave, and fewer still how to effectively implement recommended health behavior changes. In this respect, greater knowledge and action concerning health behavior change within primary care is essential to improve health outcomes. Clinical health coaching is an Evidence-Based approach that facilitates healthy, sustainable behavior change and is a valuable tool for primary care. The primary function of clinical health coach is to assist patients to gain knowledge, skills, and confidence to self-manage their health conditions. Clinical health coaching techniques enable efficient use of consultation time by focusing on what patients can actively do to improve their health. Coaches promote patients' responsibility for their own health management. Consultations can be face-to-face, telephone- or video-based or within a group setting. Clinical health coaching included individual and group coaching visits as well as coaching for specific clinical pathways (cancer, diabetes, etc). The addition of a clinical health coach to the primary care team allows for more comprehensive primary care in partnership with the patient consistent with agreed upon goals of care. The presentation will provide context for how the clinical health coaching program was developed at the University of Delaware based, in part, on perceived need in the primary care community. Case examples of what clinical health coaching looks like in applied health settings, academic training and professional development of clinical health coaches, and a discussion of how clinical health coaching could be further

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: Novice

Keywords:

- Chronic Care Model of Integrated Care
- Primary Care Behavioral Health Model
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the role of clinical health coaching within the primary care team
- Understand how clinical health coaching may be integrated within the primary care team
- Understand the academic preparation and requirements necessary for a clinical health coach

integrated within existing Integrated Care models.

*Presenter(s):*

- *Michael Peterson, EdD, Professor and Chair, Department of Behavioral Health and Nutrition, University of Delaware, Newark, DE*
- *Tara Leonard, MS, Clinical Instructor, Department of Behavioral Health and Nutrition, University of Delaware, Newark, DE*
- *Michael Mackenzie, PhD, Assistant Professor, Department of Behavioral Health and Nutrition, University of Delaware, Newark, DE*
- *Douglas Tynan, PhD, ABPP, Mental Health Educator, American Diabetes Association, Arlington, VA*

## Podcast 04: Entering the IBH World - Now I Can See

The Primary Care Behavioral Health (PCBH) Model illustrates the importance of including behavioral health providers within primary care settings with the goal of using a team-based approach to care to address biopsychosocial concerns that arise during visits (Reiter, J., Dobmeyer, A., & Hunter, C., 2018). Often when behavioral health providers are added to the team, medical providers are not part of the initial conversation on how this integration may change a variety of components of medical visits. Collaborative and team-based care is not a simple solution that is automatic once a behavioral health clinician (BHC) is added to the team. Both medical providers and BHCs have different language that is used during patient contact and requires continuous communication between providers in order to build trust with families and reliance on each other to meet the families' needs. BHCs in integrated setting typically are expected to be the leader in teaching medical providers on how to build collaboration through warm hand-offs, co-visits, etc., although BHCs can also learn invaluable information when present for medical visits. Medical providers and BHCs will discuss and review their different viewpoints on specific cases that they have experienced within their clinics and how collaborative, integrated care has improved patient care. Ideas on how to continue to grow collaboration in a money driven landscape will be discussed.

*Presenter(s):*

- *Maribeth Wicoff, PhD, Psychologist, The Children's Hospital of Philadelphia, Philadelphia, PA*
- *Kelly Hanlon, PsyD, Psychologist, University of Rochester, Rochester, NY*
- *Kathryn Mancini, PhD, Psychologist, MetroHealth Medical Center, Cleveland, OH*
- *Kate Depippo, NP, Nurse Practitioner, University of Rochester, Rochester, NY*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Patient-centered care/Patient perspectives
- Primary Care Behavioral Health Model
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify and apply practices used by 3 health systems to build collaborations between providers
- Describe how collaborative, integrated care has improved patient health care.
- Discuss current methods and ideas for improving integration of behavioral health clinicians in primary care

## Podcast 05: "What is She Doing Here?" Why Providers Are Ambivalent about Working with Family Caregivers and How to Change That

Several recent research studies show that healthcare professionals have greater appreciation for family caregivers but are still reluctant to fully embrace them as partners in care. The cordial distance they maintain can make many family caregivers feel marginalized. In this workshop, a primary care provider, a behavioral health provider specializing in family caregiving, and a family caregiver of a patient with complex health needs will discuss ways that the collaborative healthcare team can engage, support and empower family caregivers as valued and integral team members with specific duties as observers and implementers of care plans.

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Complex Patient Care
- Family centered care/Family perspectives
- Team-based care

*Presenter(s):*

- *Barry Jacobs, PsyD, Principal, Health Management Associates, Philadelphia, PA*
- *Kimberly McGuinness, CRNP, Nurse Practitioner, Inspira Health Network, Vineland, NJ*

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Review findings from four recent research studies on physician-family caregiver interactions
- Identify time-efficient and reimbursable means for integrated team members to collaborate with the family caregivers of complex patients
- Define 5 means by which integrated team members can engage, support and empower family caregivers to conduct specific healthcare duties

## Podcast 06: Bringing Mental Health to the Ngäbe in Bocas del Toro, Panama through Floating Doctors

Floating Doctors is a non-government organization (NGO) located in Bocas del Toro, Panama since 2011. They provide mobile medical clinics to 24 NgÃ¤be communities on a quarterly rotating basis. Support for these clinics comes from Panama's Ministry of Health, partnerships with various local businesses, financial and in-kind donations, and 85% from medical and non-medical volunteer programs. In response to volunteer physicians recognizing and expressing concerns about the mental health of their patients - both in presentation and as interference to best medical outcomes - Floating Doctors formed a collaboration with Dr. Kristina Brown, Professor and Chair of the Couple and Family Therapy Department at Adler University, in 2017. Working with Founder and CEO of Floating Doctors, Dr. Ben LaBrot, they developed initial plans to incorporate the provision of mental health into the programs offered through Floating Doctors. After many conversations and preliminary learnings about the organization and the region, Drs. LaBrot and Brown initiated a doctoral couple and family therapy internship in 2019. The internship included a research project to assess mental health literacy and needs. Concurrently, they also developed a pilot implementation of the inclusion of mental health consultations over a two-week period in summer 2019. Dr. Brown brought seven students to Panama to volunteer in the mobile medical clinics. This presentation will include a narrative of the creation of Floating Doctors, rationale for the collaboration with Couple and Family Therapy, and a description of both the research project and the piloted mental health consultations. The presenters will introduce participants to the indigenous NgÃ¤be peoples and share their experiences and learnings highlighting the mutual strengths of collaboration. Future directions and plans for the permanent inclusion of a mental health program as part of Floating Doctors will be reviewed.

*Presenter(s):*

- *Kristina Brown, PhD, LMFT, Professor and Chair of the Couple and Family Therapy Department, Adler University, Chicago, IL*
- *Ben LaBrot, MD, Founder, CEO, Floating Doctors, Bocas del Toro, Panama*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: Intermediate

Keywords:

- Collaborative Care Model of Integrated Care
- Cultural Humility
- Interprofessional teams

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand about the unique medical and mental health needs in the local NgÃ¤be communities served by Floating Doctors that also reflect relatively common predicaments for similar populations around the world
- Identify complimentary mental health interventions to typical medical presentations seen in the mobile medical clinics
- Experience the learnings and challenges faced by the collaboration between Floating Doctors and Couple and Family Therapy

## Podcast 07: We Will Survive: How Integrated Primary Care and Value-based Initiatives are Sustained Within a Fee-for-Service System Utilizing Strategic Planning

The University of Utah Health's Integrated Team-based Care Delivery spans nine Community Clinics across 4,000 square miles in Northern Utah. Within these Primary Care Practices are embedded population health teams comprised of Clinical Pharmacy, Nursing Care Management, and Integrated Behavioral Health. This presentation seeks to share our integration story, and also demonstrate the use of strategic planning for sustainability and quality improvement. We have worked together towards a prescriptive balance of value and outcome-based programs (PCMH, population health, health risk-management, SDoH), while executing various revenue-generating initiatives to sustain our programs (Collaborative Care, Chronic Care Management, SBIRT, brief therapy). We plan to demonstrate and describe how this shapes day-to-day clinical delivery for each care team member. The managers and administrator will explain how the programs and initiatives have been developed and refined for integrated care delivery, all while reporting through multiple divisions and stakeholders, sometimes with competing interests. We plan to address the specific barriers our integrated teams have navigated through, including stigma, culture, and funding. We'll discuss how we've utilized the Academic Medical Center to empower our teams with resources, creating a continuous flow of evidence-based practice and empirical research directly tied to our clinical settings. We will demonstrate how utilization of CQI processes and lean thinking in behavioral health integration have built our strategic planning frameworks, creating a firm foundation for optimal patient experience, quality, and sustainability. We will provide the audience members with CQI templates they will practice with in session, and also discuss the application of these processes for their own programs and teams.

*Presenter(s):*

- *Teresa Lopez, LCSW, Program Manager, University of Utah Health Behavioral Health Integration Program, Salt Lake City, UT*
- *Crystal Armstrong, MD, Primary Care Physician, Behavioral Health Integration Liaison, University of Utah, Salt Lake City, UT*
- *Daryl Huggard, MBA, FACHE, Administrative Director, University of Utah Community Physician's Group, Salt Lake City, UT*
- *Tiffany Noss, RN, Program Manager, University of Utah Health Ambulatory Care Management Program, Salt Lake City, UT*
- *Benjamin Berrett, PharmD, Program Manager, University of Utah Health Ambulatory Clinical Pharmacy Program, Salt Lake City, UT*
- *Annie Mervis, MSW, University of Utah, Salt Lake City, UT*
- *Dr. Rachel Weir, University of Utah, Salt Lake City, UT*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Primary Care Behavioral Health Model
- Sustainability
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Implement successful elements of team-based care including administrative support & collaboration, relationship building, care conferences, risk-registry management.
- Discuss and learn about sustainability through an evidence-based, collaborative lens; utilizing all members of the care team to execute PCBH, Chronic Care management, PCMH, fee-for service psychotherapy & HBAI.
- Gain tools to implement the CQI process for Behavioral Health Integration across multiple sites using strategic planning templates and PDSA spreadsheets. Evidence for staff engagement through Press Ganey to support the process will be shared.

## Podcast 08: The Challenges and Successes of Shifting to Full Integration to Meet the Needs of our Patients with Complex Care Needs in an Under Served Community

Minority women in the United States are at higher risk of adverse birth outcomes and have lower utilization of prenatal care. Hispanic/Latina women are less likely to initiate prenatal care in the first trimester or to receive adequate prenatal care. Immigrant and migrant women, and undocumented women in particular, face additional challenges that include reduced access to health facilities and behavioral health care, lack of health insurance, socioeconomic stressors and language barriers to communicating with primary care providers. To support providers in addressing

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: Intermediate

Keywords:

- Prevention
- Primary Care Behavioral Health Model

this need, our organization began co-locating behavioral health therapists. After testing this approach for several years, we found that access was still limited and most patients could not come back for therapy. To better meet the needs of our population, we made the shift to full integration in which the BHC provides same day access and functions as part of the medical team. One example of BHC involvement is their collaboration in Centering Pregnancy which is an innovative model of group prenatal care and childbirth education. It consists of organizing healthcare delivery, identifying risk factors and addressing needs, providing health education, and peer support. Centering is conceptually grounded in self-efficacy theory, the idea of empowering women by actively involving them in their care will lead to better health outcomes. Numerous published studies show that Centering moms have healthier babies and that Centering nearly eliminates racial disparities in preterm birth. This presentation will provide interactive, round table discussion on shifting from co-location to full integration at a Federally Qualified Health Center to customize care to the needs of a high-risk pregnancy population. We will review practical strategies for how BHCs become part of the medical team and expanded to a whole array of prevention and intervention supports. The importance of education and training will be stressed and modeled through practical examples and implementation tips. Participants will be provided a worksheet to better customize services to the needs of their populations with high risk.

*Presenter(s):*

- *Yesenia Rios, LPC-S, NCC, CCI, Director of Behavioral Health Services, El Centro de Corazon, Houston, Texas*
- *Wendy Bradley, LPC-MHSP, CAADC, CPHQ Director of Behavioral Health Integration, TMF Health Quality Institute, Austin, TX*

- Underserved populations (e.g. LGBTQ)
- High Risk Pregnancy

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Describe how shifting to full integration allowed BHCs to provide preventative services, meet the unique needs of the population and be incorporated into the medical teams.
- Identify key elements for integrating BHCs into preventative services and Centering Pregnancy Groups to support high risk pregnancies.
- Using population based strategies identified, develop one action item that can be applied to your own sub population.

## Podcast 09: Making the Business Case for Sustainability: Clinical and Economic Outcomes from Jefferson Plaza Family Health Home

This presentation describes the Jefferson Plaza Family Health Home model which offers preventative physical and behavioral healthcare to the entire family in one location. An evaluation of clinical, operational, and economic components are presented. The outcomes explored in this presentation are instrumental in describing the impact this type of care delivery has on the population it serves. The challenges and future directions of this clinic seek to contribute to the growing body of knowledge around health home implementation, design, and sustainability. The wholistic approach of health homes may offer an opportunity to transform the healthcare system and advance the public health impact of the primary care setting. Presenters will discuss virtual/telehealth options that integrated practices may wish to employ for optimizing integration.

*Presenter(s):*

- *Jeanette Waxmonsky, PhD, VP Integrated Care, New Directions & University of Colorado Dept. of Family Medicine, Denver, CO*
- *Shannon Tyson-Poletti, MD, Assistant Medical Director, Jefferson Center, Wheat Ridge, CO*
- *Tatiane Santos, MPH, PhD, Post-Doctoral Fellow, Leonard Davis Institute of Health Economics at University of Pennsylvania, Philadelphia, PA*
- *Megan Swenson, LPC, LAC, Director Integrated Care, New Directions, Overland Park, KS*
- *MaryAnn Shiltz, PNP, Westside Medical Director, STRIDE Community Health Center, Lakewood, CO*
- *Meghan Pataky, DSW, LCSW, Manager of Integrated Care, Jefferson Center, Wheat Ridge, CO*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: Intermediate

Keywords:

- Cost Effectiveness/Financial sustainability
- Multi-generational care
- Primary Care Behavioral Health Model

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Describe an integrated care model for families.
- Define clinical outcomes for an integrated care model for families
- Identify economic data for evaluating sustainability for an integrated care family health home model. 4. Describe considerations for telebehavioral health services to optimize integration.

## Podcast 10: "I've got a team behind me here"□: Integrated Behavioral Health in Primary Care from the Patient's Point of View

Integrated behavioral health in primary care settings (IBHPC) is associated with numerous benefits, including cost savings, decreased provider stress, and improved health outcomes. Research on patient experiences has focused on satisfaction, which raises questions about the impact of IBHPC from the patients' perspective. Six people who have received IBHPC (partnership between the physician and behavioral health clinician in the medical clinic), but not traditional therapy were interviewed and transcribed for qualitative analysis. Results revealed the prevalence of Adverse Childhood Experiences (ACEs) for this patient population and how tenets of IBHPC embrace trauma-informed care. Based on this qualitative research project, team-based primary care using a trauma-informed lens is the best approach to maximize wellness with complex patients. The audience will learn concrete ways to recognize red flags that indicate the possibility of ACEs, to identify and treat risk factors, and incorporate available resources into whole-person care.

*Presenter(s):*

- *Aimee Burke Valeras, PhD, LICSW, NH Dartmouth Family Medicine Residency at Concord Hospital, Concord, NH*
- *Erin Cobb, PhD, MFT*
- *Amanda Pereira, MD*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Complex Patient Care
- Patient-centered care/Patient perspectives
- Trauma-informed care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- To understand, based on the patient perspective, how to respond to adults with ACEs using a trauma-informed approach in an integrated primary care setting.
- To identify how the team can function around working with adults with ACEs
- To identify ACEs as a hazardous, quantifiable exposure which has a substantial and direct impact on health outcomes.

## Podcast 11: Introducing OWEP-ITI: An Interdisciplinary Training Program for Helping Youth and Families Impacted by Opioids

The Interdisciplinary Training Initiative for Children, Adolescents & Families Impacted by Opioid Use Disorder (ITI) is a HRSA-funded project that offers workforce development training and preparation of behavioral health students at Drexel University and University of Akron to help combat opioid use disorders (OUDs) and other substance use disorders (SUDs) among adolescents and their families. This is critical in our communities, as the CDC reported in 2017 that Ohio and Pennsylvania were two of the top five states with the highest rates of fatal drug overdoses in the nation. The training program includes online educational modules, and mixed-reality simulation in evidence-based, trauma-informed,:culturally competent practices for the prevention, treatment and recovery support services for at-risk youth and their families. Multiple disciplines were represented in the training components, including behavioral health, medicine, nursing, and pharmacy. The proposed presentation aims to describe preliminary program evaluation for educational modules component and their impact on the trainee's a) knowledge in OUD and SUD as assessed through pre- and post-test quizzes, b) perceptions of substance use as measured by the Substance Abuse Attitude Survey, and c) their understanding of

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Interprofessional education
- Opioid management
- Workforce development

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the need for workforce development in the area of substance use.
- Identify core components of a substance use training modules and how they impact knowledge building

team-based care as measured by the Team Skills Scale. Data from 25 Masters-level trainees and10 supervisors were included. Analysis includes univariate statistics to contextualize the sample, bivariate analysis to examine the linkages between variables, and paired samples t-tests to examine if there is a change between pre- and post-test. Implications from the findings will be discussed within the context interprofessional collaboration, multicultural competence, addiction knowledge, and trauma-informed care.:

*Presenter(s):*

- *Rikki Patton, PhD, Associate Professor, University of Akron, Akron, OH*
- *Jessica Chou, PhD, Assistant Professor, Drexel University, Philadelphia, PA*
- *Heather Katafiasz, PhD, Assistant Professor, University of Akron, Akron, OH*
- *Asif Zaarur, Graduate Assistant, Drexel University, Philadelphia, PA*
- *Yue Dand, PhD, Assistant Professor of Instruction, University of Akron, Akron, OH*
- *Christian Jordal, PhD, Associate Clinical Professor, Drexel University, Philadelphia, PA*

in the areas of substance use knowledge, perceptions, and team-based care.
- Describe how interdisciplinary educational modules advance substance use training.

## Podcast 12: Buprenorphine Treatment in Integrated PCBH model

In response to the opioid epidemic, Community Health Center, Inc. (CHC) created a program to meet the medical and behavioral health needs of individuals with Substance Use Disorder (SUD) diagnoses in CT. Understanding how to provide Medication Assisted Treatment (MAT) in coordination with group therapy has helped patients eliminate their dependence on illicit opioid use and develop skills and support systems on their road to sustained recovery. Attendees will learn how a MAT program can be designed and implemented in integrated primary care settings, including how to facilitate coordinated care across mental health and medical staff, and troubleshoot a variety of patient and program challenges that may arise.

*Presenter(s):*

- *Dariush Fathi, PsyD, Director of Behavioral Healh, Community Health Center (CHC), Danbury, CT*
- *Constantino Rago, LPCA candidate, BH Intern, Community Health Center (CHC), Danbury, CT*

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Opioid management
- Primary Care Behavioral Health Model
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe 3 key benefits of a Medication-Assisted Treatment (MAT) program using Buprenorphine for individuals with opioid use disorders
- Identify the roles of Behavioral Health Clinicians, Medical providers, and Recovery Care Coordinators in providing effective treatment to populations struggling with substance use
- Apply lessons-learnt from the CHC model of integrated care to their own healthcare clinics

## Podcast 13: Specialty Care IBH: Elevating the Special in Specialty Care

Integrated Behavioral Health (IBH) is a well-supported approach to care. Traditionally, this approach has focused on primary care clinics. The CentraCare System, based in Central Minnesota, has also found value in integrating behavioral health (BH) providers in the specialty care setting. As primary care is asked to take on ever increasing responsibility for complex patients, Specialty IBH can provide an opportunity for in the moment care during specialty care appointments, rather than deferring an additional concern to the next primary care visit. Adapting a primary care BH model, Specialty IBH providers utilize medically specific knowledge and

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: Intermediate

Keywords:

- Innovations
- Interprofessional teams

experience to address BH issues within their respective departments, offering patients compassionate and effective interventions and resources. The IBH program at CentraCare currently includes 7 primary care sites, 4 sites served by Tele IBH, and 2 Specialty IBH Sites: Outpatient Physiatry & Rehabilitation (P&R) Department and Heart & Vascular Center (HVC). IBH providers in specialty departments support clinic culture allowing the systems of care to better understand the relationship between psychological symptoms, physical health concerns, and the role this plays to help or hinder medical treatment. Within P&R, the IBH provider offers opportunities for education, psychological support, and resources and referrals. Specific programs include brain injury therapy and support groups, as well as regular professional development opportunities for allied professionals. At the HVC, the IBH provider is available in clinic, in the acute hospital setting, and in cardiac rehab to assist patients with behavioral health symptoms, to support normative adjustment, and to facilitate health behavior change. Specific programs include education workshops as a part of the Intensive Cardiac Rehab Program and Shared Medical Appointments addressing hypertension. Both specialty IBH providers also coordinate with their colleagues in primary care to facilitate patients' transitions between specialty and primary care. This adaptation of IBH has been well received by both patients and staff, utilized fully by the departments, and has garnered system wide support as IBH expands across CentraCare.

*Presenter(s):*

- *Toni Mahowald, PsyD, LP Integrated Behavioral Health Provider, CentraCare, St. Cloud, MN*
- *Christine Gilyard, MA, LMFT, CBIS Integrated Behavioral Health Provider, CentraCare, St. Cloud, MN*

- Special populations (e.g. disability)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Define Specialty IBH and their role within the health care clinic
- Describe the benefits of Specialty IBH to patients within Specialty clinics
- Detail the benefits of Specialty IBH psychotherapists to medical providers within Specialty clinics

## Podcast 14: Demographic, Mental Health, and Treatment-Related Correlates of Anxiety Treatment Preferences among Veteran Primary Care Patients

Background: Anxiety symptoms are common among primary care patients. Research has demonstrated the efficacy of behavioral interventions for anxiety when delivered in primary care settings; however, anxiety continues to be under-treated in primary care. One way to improve utilization of anxiety interventions in primary care is to consider patient preferences for treatment. Assessing patient treatment preferences is an important first step when providing treatment from a patient-centered care framework, which may be associated with greater treatment utilization, retention, and adherence. The current study aims to identify correlates of patient preferences for anxiety treatment in integrated primary care. Method: Participants were 144 Veterans who endorsed current anxiety symptoms in the past two weeks and were seen in primary care within the last year. Participants completed self-report measures of demographics, mental health symptoms, treatment-related characteristics (e.g., readiness to change) and indicated their preference for five attributes of anxiety treatment (method, type, location, frequency, duration) via mailed survey. Chi-squared and multinomial logistic regression analyses were conducted to examine relationships between each variable and preference for treatment attribute on a bivariate level. Next, any variable that was associated with an outcome on a bivariate level was entered into a multinomial logistic regression model to identify multivariate correlates of each preferred treatment attribute. Results: Level of education, perceived need for help, and attitudes toward therapy were correlated with preferred treatment method. Anxiety severity and a depression diagnosis were correlated with preferred treatment type. Perceived need for help was correlated with preferred treatment

Date: Asynchronous Content

Time: Available throughout conference

Session Type: Podcast

Content Level: All Audience

Keywords:

- Evidence-based interventions
- Mood (e.g., depression, anxiety)
- Patient-centered care/Patient perspectives

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify patient preferences for a variety of anxiety treatment attributes
- Identify demographic, mental health, and treatment specific correlates of anxiety treatment preferences
- Discuss the benefits of the incorporating data on patient preferences into clinical practice

location. No significant correlates emerged for preferred frequency or duration of treatment. Conclusions: Assessing patients' symptom profiles, perceived need for help, and attitudes toward therapy may help inform treatment recommendations. Results have implications for both behavioral health providers in primary care and primary care providers, as greater knowledge of patient preferences may lead to improvement in utilization of interventions for anxiety in primary care.

*Presenter(s):*

- *Katherine Buckheit, MS, Psychology Intern, VA Center for Integrated Healthcare, Syracuse, NY*
- *Robyn Shepardson, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare, Syracuse, NY*

# Posters

## Poster 01: The Impact of the Patient-Provider Relationship on LGBTQ Health Outcomes

The patient-provider relationship is an essential component of providing good health outcomes (i.e., medication compliance and management of chronic conditions). Looking at both the patient and the provider is crucial to understanding what variables emerge as differences that make a difference in their relationship, but little dyadic research is done looking at the relationship between the patient and provider, and less still looking at the LGBTQ patients and their providers. The Four World View provides a lens informing the four worlds of healthcare: clinical, operational, financial, and training/educational. Each of the four worlds has a responsibility in improving LGBTQ patients' lower health outcomes and utilization of healthcare services. Recommendations will be given to help each of the four worlds improve health outcomes for LGBTQ patients through patient-provider relationship.


***Presenter(s):***

- *Corin Davis, MS, PhD Student, East Carolina University, Greenville, NC*
- *Angela Lamson, PhD LMFT, Associate Dean for Research and Professor, East Carolina University, Greenville, NC*


**Session Type:** Poster

**Content Level**: All Audience

**Keywords**:

- Cultural Humility
- Evidence-based interventions
- Interprofessional education
- Outcomes
- Patient-centered care/Patient perspectives
- Skills building/Technical training
- Special populations (e.g. disability)
- Underserved populations (e.g. LGBTQ

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- describe the Four World View in relation to the LGBTQ patient-provider relationship.
- identify the three components of the patient-provider relationship that lead to improved health outcomes.
- identify three LGBTQ population health outcomes where improved patient-provider relationships can improve health outcomes.

## Poster 02: Understanding the Relational Implications of Treating Complex Patients in Integrated Primary Care Settings

Primary care continues to be on the front lines of care in treating more socially and behaviorally complex patients. However, the ways in which the patient-physician relationship are shaped as a result of this increasing complexity in primary care are not clearly understood. In order to provide quality care that effectively addresses social and behavioral health needs and leads to positive patient outcomes, greater attention needs to be paid to the influence this care has on the patient-provider relationship. This presentation will outline a burgeoning conceptual model developed to understand the implications of treating behavioral health conditions in primary care on the patient-physician relationship. The model addresses issues of trust and collaboration in the context of the working alliance (Bordin,1979) as well as frames patient-physician interactions through the lens of the therapeutic relationship in psychotherapy (Balint, 2000). The presentation will also highlight the importance of interprofessional collaboration with social workers in helping to facilitate improved provider relationships with complex patients and as well as mitigating provider burnout.


***Presenter(s):***

- *Lauren Dennelly, LCSW, Behavioral Health Specialist at Lehigh Valley Health Network and Doctoral Candidate; Bryn Mawr Graduate School of Social Work and Social Research, Bryn Mawr, PA*
- *Sara Bressi, PhD, LSW, Associate Professor of Social Work; Bryn Mawr Graduate School of Social Work and Social Research, Bryn Mawr, PA*


**Session Type:** Poster

**Content Level**: Not applicable (being considered as poster only)

**Keywords**:

- Burnout
- Collaborative Care Model of Integrated Care
- Complex Patient Care
- Interprofessional education
- Interprofessional teams
- Primary Care Behavioral Health Model
- Team-based care

**Objectives:** *At the conclusion of this presentation, participants will be able to...*

- Define the concept of the therapeutic relationship in psychotherapy as applied to the primary care relationship.
- Identify elements of trust and collaboration as related to the primary care working alliance and the importance of maintaining these

elements in relationships with complex patients.
- Discuss the implications of treating increasing numbers of patients with complex social and behavioral health needs on the therapeutic relationship in primary care and physician burnout and identify potential solutions to mitigating provider burnout in th

## Poster 03: Interdisciplinary Training Academy for Substance/Opioid Use Disorder: A Prevention and Healthcare Model

Opioid misuse is a nationwide public health crisis. In response to the high incidence of opioid-related drug overdoses in Arizona, the Center for Applied Behavioral Health Policy (CABHP) has initiated an innovative training model to prepare emerging behavioral health practitioners to tackle the opioid epidemic. The Interdisciplinary Training Academy (ITA), developed by students, for students, will broadly prepare emerging professionals to address the complex treatment needs of opioid misuse and other substance use. Through funding from the Health Resources and Services Administration (HRSA), CABHP is directing the three-year student-led interdisciplinary project that will enhance competencies around evidence-supported prevention and treatment practices. Currently in its initial year, psychiatric doctoral nursing students with direct supervision and support from the CABHP team are developing the framework and curriculum for the second year. During the second year, a 30-week training rotation will be carried out by Arizona State University (ASU) School of Social Work, Master's in Social Work (MSW) Interns. During the second year the MSW interns will participate in direct field work through a series of rotating experiential training sites related to prevention, treatment, and policy, providing students with exposure to, and appreciation for, diverse systems that influence patient outcomes. Additionally, they will receive specialized training seminars facilitated by ASU faculty and CABHP staff. The training model is a unique and innovative means to train emerging professionals across all systems that touch the opioid epidemic. This poster will describe the framework, curriculum, and its implications for interprofessional graduate education of behavioral health providers, including those working in primary care.

*Presenter(s):*

- *Colleen Clemency Cordes, PhD, Clinical Professor, Assistant Dean NTE Faculty, Arizona State University, Phoenix, AZ*
- *Nidia Hernandez, Graduate Research Assistant, Center for Applied Behavioral Health Policy, Arizona State University, Phoenix, AZ*
- *Natasha Mendoza, PhD, MSW, Director, Center for Applied Behavioral Health Policy, Arizona State University, Phoenix, AZ*
- *Adrienne Lindsay, DBH, Associate Director, Center for Applied Behavioral Health Policy, Arizona State University, Phoenix, AZ*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Interprofessional education
- Opioid management
- Training Models

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Describe a model of interprofessional education related to opioid misuse
- Describe the need to provide both didactic and experiential learning across diverse models of multidisciplinary care and systems to support patients with opioid misuse
- Articulate an approach to interprofessional faculty and student engagement in curricula development

## Poster 04: Addressing Smoking Cessation with Integrated Behavioral Tele-Health

We plan to demonstrate that integrated behavioral care through tele-health can support patient smoking cessation efforts. Implementing a bidirectional care model can reinforce and augment the care received from the medical health care provider. Smoking is a primary cause of morbidity and mortality. It negatively impacts outcomes for chronic disease patients resulting in significantly increased healthcare costs (Centers for Disease Control, 2019). Smoking cessation is a multifactorial process that includes addressing the underlying addiction through pharmacological measures along with promoting and supporting behavior change through motivational interviewing, cognitive behavioral strategies, and dialectical behavioral strategies. By working in tandem, integrated behavioral health providers and primary care providers can increase patient satisfaction, smoking cessation success rates, and a decrease in provider burnout. In rural communities, access to behavioral health care is sparse (Jolly, 2019). In this model, integrated behavioral health care is provided via technology to allow more access to patients. The tele-health is done by using a wall mounted screen in a designated tele-health room as well as by utilizing rolling iPad carts which can be taken directly into a patient's room.

*Presenter(s):*

- *Summer Coleman, MSW, LGSW, Associate Psychotherapist, Integrated Behavioral Health, Tele-Health, CentraCare, Sartell, MN*
- *Wendy Miller, APRN, CNP, NCTTP, Family Nurse Practitioner, CentraCare Health - Paynesville, Paynesville, MN*
- *Kelsey Lynch, MSW, LGSW, CentraCare, Sartell, MN*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Primary Care Behavioral Health Model
- Substance abuse management (e.g., alcohol, tobacco, illicit drugs)
- Technology (e.g. health informatics)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- identify how team based care provides supports to primary care providers addressing smoking cessation.
- recognize the impact of using an interdisciplinary approach to addressing smoking cessation on patient satisfaction.
- discuss how technology can provide access to behavioral health services in a rural setting.

## Poster 10: How An Innovative Program in Kentucky is Addressing the Opioid Crisis Through Refining the Delivery of Integrated Primary Care

Kentucky has one of the highest rates of opioid prescription and addiction. High levels of opioid-based coping patterns co-exist with high levels of health disparity and lack of access to healthcare in disenfranchised populations with a high rate of co-morbid trauma. Patients present in primary care with a complex interplay of medical, dental, and mental health problems that create treatment obstacles, increase provider burnout, and lead to poor outcomes. Assessing and addressing all concerns simultaneously from a multi-disciplinary approach is critical. Differential diagnosis between clinical pain and opioid- seeking behaviors is challenging and not mutually exclusive. This is complicated by neurologically-based pain sensitivity, which increases with long-term opioid use as well as with trauma-related psychopathology. Refinement of integrated team approaches mitigates many of these concerns. Reduction of stressors and increased adjunctive supports allow patients to focus on acquisition of more adaptive coping skills while experiencing a reduction in emotional distress. Additionally, peripheral supportive services reduce the shame and guilt cycle that contributes to relapse. Shared responsibility across a healthcare team with complementary competencies reduces patient burden on individual providers and increases problem solvability, thereby reducing provider burnout while improving health outcomes. Eliciting community support and inter-organizational collaboration is key. A multi-disciplinary team that strategically coalesces can help patients and providers effectively navigate a network of peripheral services which often includes intersecting with law and government entities. A model of addressing the opioid crisis within integrated primary care resulting from a HRSA-funded behavioral health training program is highlighted, in which psychologists, physicians, dentists, nurse practitioners, physician's assistants, nurses, and social workers collaborate in underserved communities with elevated

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Opioid management|Primary Care Behavioral Health Model|Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the complex and intersecting issues associated with opioid use among dual diagnosis patients in disenfranchised communities with barriers to accessing care that also have comorbid trauma.
- Describe how these challenges uniquely present in primary care and how they can uniquely be met by an integrated approach.
- Discuss the numerous benefits of adopting an integrated approach to assessing and addressing opioid use in primary care for both patients and providers.

risks.

*Presenter(s):*

- *Sarah Shelton, PsyD, MPH, MSCP, Founder & CEO, Shelton Forensic Solutions, Louisville, KY*

## Poster 20: Exploring Pre-Implementation Perceptions of Integrated Care in a College Setting

Integrated behavioral health (IBH) services on college campuses may provide students with comprehensive treatments that meet both their physical and psychological needs. However, the existence of integrated services on college campuses appears to be rare, as is research related to implementation. The purpose of this study was to examine provider perceptions of integrated care prior to integration occurring at a midwestern college campus. Seventeen providers (9 medical and 7 mental health) completed the Patient-Centered Medical Home – Attitudes, Interest, and Knowledge Scale (PCMH-AIKS; Cassano & DiTomasso, 2017) to assess pre-implementation attitudes, interests, and knowledge related to integrated behavioral health (IBH). These providers also completed a semi-structured interview to discuss perceptions of the model and concerns related to the upcoming transition. On average, providers showed favorable attitudes towards IBH (M = 5.17, SD = 0.56) and moderate to high interest in IBH (M = 4.87, SD =0.85). Regarding knowledge of IBH, providers on average showed an 87% correct response rate indicating a good understanding of integrated healthcare practices. These results suggest that prior to the integration, healthcare providers were not resistant towards the IBH model and held favorable views of the IBH. Future analysis will compare medical and psychological healthcare providers pre-implementation perceptions of integrated healthcare. Future analysis will also examine the qualitative interview data within context of the survey data.

*Presenter(s):*

- *Melissa Miller, Wichita State University, Wichita, KS*
- *Jonathan Larson, MS, Wichita State University, Wichita, KS*
- *Rachel Petts, PhD, Assistant Professor, Wichita State University, Wichita, KS*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Implementation science
- Interprofessional teams
- School-based

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Describe attitudes, interests, and knowledge of healthcare professionals related to upcoming integration on a college campus
- Explain implications of integrated healthcare on college campuses
- Describe potential barriers and/or obstacles faced by healthcare providers related to integrated care

## Poster 21: Barriers and Facilitators to Integrated Behavioral Health Model Adoption: A Mixed Method Study Among Community Health Care Providers at a FQHC

While integrated behavioral health services are emerging as a promising model of health care, research regarding implementation outcomes, and specifically adoption of the model, are lacking (Hunter et al., 2018). This study aimed to identify barriers and facilitators to adoption of integration among behavioral health and medical providers at an urban community health clinic using a mixed methods design (i.e., survey, interview, and ecological momentary assessment; EMA). Fourteen health care providers (medical, behavioral, and dental) completed the Barriers and Facilitators Assessment instrument (Harmsen, et al., 2005), with some items reworded to address integrated care. Six providers also completed a brief, semi-structured interview related to barriers and facilitators at the site. Lastly, a small sample of providers agreed to complete bi-weekly "probes" (i.e., EMA) that assessed same-day report of integration (e.g., # of warm hand-offs) as well as factors that facilitated or impeded delivery of the model. Responses on the Barriers and Facilitators Assessment instrument indicated that most providers felt that integrated care fits into their ways of working at their practice, is flexible enough to take their patient's preferences into account and it is not difficult to implement with older (60+) and younger (under 18) patients. However, half of the sample either agreed or fully agreed that they wished they had known more about integrated care before they

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Implementation science
- Primary Care Behavioral Health Model
- Sustainability

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Identify barriers and facilitators to the PCBH model adoption.
- Describe the importance of evaluating provider experience of the PCBH model in a FQHC.
- Describe the importance of mixed methodology on the evaluation of the PCBH model.

were asked to implement it. Further, almost a third (28.6 %) of participants agreed that parts of integrated care are not helpful and that it is difficult to implement integrated care to patients with a different cultural background. Interviews and brief probes will be analyzed via a qualitative thematic analysis (Braune & Clarke, 2006) and reviewed within context of the survey data. It should be noted that these results are reflective of the opinions of medical providers working exclusively within an urban, community FQHC and may not be representative of other settings. This research and use of unique methodology will add to the primary care integrated behavioral health literature by providing more data on model implementation, facilitators, and barriers to adoption from medical, behavioral health, and dental provider perspectives.

*Presenter(s):*

- *Sarah McGill, BA, Clinical Psychology Doctoral Student, Wichita State University, Wichita, KS*
- *Rachel Petts, PhD, Assistant Professor, Wichita State University, Wichita, KS*
- *Monet Tang, Wichita State University, Wichita, KS*

## Poster 22: Developing an Integrated Behavioral Health and Child Advocacy Center Partnership: Benefits of a Multidisciplinary Team When a Child Discloses Abuse

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Family centered care/Family perspectives
- Patient-centered care/Patient perspectives
- Pediatrics

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Identify key benefits of offering immediate mental health services in a CAC setting.
- Describe how IBH can be integrated within a CAC.
- Identify the importance of supporting non-offending caregivers as part of the healing process for the patient.

The Central MN Child Advocacy Center (CAC) provides a multi-disciplinary team (MDT) approach that gives children and their families a single, child-friendly, coordinated response after the disclosure of sexual or physical abuse. According to a national survey of Child Advocacy Center directors (Huey & Medford, 2015), the majority of cases were referred for behavioral health services. However, only about 30% of CACs provide behavioral health services in-house, and 65% of directors felt there was not adequate access to behavioral health services. The Central MN CAC recently partnered with Integrated Behavioral Health (IBH) to provide mental health services immediately following a forensic interview to the patient and their non-offending loved ones. In 2019, the Central MN CAC served 324 children. Since IBH began partnering with the Central MN CAC in August 2019, 56 patients elected to participate in IBH services right at the CAC. The purpose of this poster is to evaluate the need of mental health services within CACs and how our IBH program offers a unique model to provide immediate behavioral health care to those who are seen at the Central MN CAC. Our IBH/CAC partnership has been able to offer behavioral health screenings, immediate access to psychotherapy, and more significant collaboration with all members of the MDT. The goal of our partnership with the Central MN CAC is to provide high quality, holistic care to those who enter the CAC and help foster healing from the trauma children and their non-offending loved ones have experienced.

*Presenter(s):*

- *Monica Guggenberger, MS, LMFT, Integrated Behavioral Health psychotherapist, CentraCare, Saint Cloud, MN*
- *Barbara Skodje-Mack, MS, LMFT, Integrated Behavioral Health psychotherapist, CentraCare, Saint Cloud, MN*

## Poster 23: Implementation of Developmental Screening by Childcare Providers

Early identification of young children at developmental risk is important for linkage to needed services. Yet, despite guidelines for developmental screening, many pediatricians do not systematically use screening tools. Because many young children spend time in childcare settings, conducting screening in these settings may improve rates of early identification. 356 childcare providers who attended brief developmental screening training were surveyed about practices and perceptions related to implementation of screening in the childcare setting. Most respondents strongly agreed that developmental screening should be conducted in childcare centers, that it is important for staff to discuss developmental concerns with parents and to link children with concerns to resources, and that their center director supported used of the screening tool. Several attitudes both about developmental screening and about organizational support had a positive and significant relationship with current use and intended future use of developmental screening tools. Findings suggest that even brief staff training may positively impact screening attitudes and practices, although follow-up technical assistance may result in fuller, more effective implementation.

*Presenter(s):*

- *Anindita Chaudhuri, MA, Doctoral Student, Rutgers University, New Brunswick, NJ*
- *Susan Forman, PhD, Professor, Rutgers University, New Brunswick, NJ*
- *Amy Norton, MA, Developmental Specialist, Children's Specialized Hospital, Mountainside, NJ*
- *Jill Harris, PhD, Director of Autism Research, Children's Specialized Hospital, Mountainside, NJ*
- *Jeffrey Shahidullah, PhD, Assistant Professor of Psychiatry, University of Texas at Austin, Austin, TX*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Across the Lifespan
- Multi-sector partnerships
- School-based

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Identify the need to developmental screening to occur early in the lifespan in order for children to be linked with appropriate evaluation and support services
- Describe potential implementation barriers and facilitates identified by childcare providers when attempting to screen children for developmental concerns
- Recognize how novel approaches to screening, such as within the daycare setting, can potentially increase early recognition of developmental concerns

## Poster 24: Correlation Between Reduced Inpatient Hospital Stays and Provision of Wellness Recovery Team Integrated Care

Review of available data indicates that individuals who are receiving Wellness Recovery Team Integrated Care are less likely to have either physical or psychiatric inpatient events than individuals who are not. This is despite the fact that individuals receiving that level of care are required to have a chronic medical issue in order to be eligible, which would make them more likely to have inpatient events. This type of data further reinforces the value and importance of an integrated care approach.

Merakey's Wellness Recovery Team combines Behavioral Health and Nurse Navigators to provide integrated clinical care to individuals who suffer from both behavioral and physical health conditions. Poster presentation will include both a description of the program as well as a comparative/correlative outcomes data component. A comparison of both physical and behavioral health inpatient hospitalization rates between individuals receiving this program and not receiving this program yield a correlated 25% lower rate of physical health hospitalizations (not including hospitalizations for events like car accidents or muggings) and a 56% lower rate of psychiatric hospitalizations. The former was a comparison between two similar case management program populations in neighboring suburban counties, one of which had access to a Wellness Recovery Team program and one of which did not. The latter was a comparison between individuals in a case management program within the same county, some of whom received Wellness Recovery Team services and some who did not. Data was compiled using hospitalization incidents among these populations of 100-200 with near-identical demographics (low-income adults with behavioral health conditions, some of whom had physical health

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Chronic Care Model of Integrated Care
- Innovations
- Outcomes

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Demonstrate knowledge of what integrated care entails.
- Identify specific examples of effective integrated care.
- Understand the dual-system impact of integrated care.

conditions and some of whom did not).

*Presenter(s):*

- *Margaret Mueller, MA, Associate Executive Director, Merakey Montgomery County, Colmar, PA*
- *Kimberly Caton, Merakey Montgomery County, Colmar, PA*

## Poster 25: Team approach to good control: Interdisciplinary hypertension management in primary care

The presentation will describe the workflow process and feasibility measurements of interdisciplinary team-based approach to a rural population with chronic hypertension which will add to the existing knowledge of clinical and behavioral management to increase patient's confidence in better self-management of their hypertension.

*Presenter(s):*

- *Flora Ma, MS, Psychology Intern, Providence Medical Group*
- *Jeri Turgesen , PsyD, ABPP, MSCP, Board Certified Clinical Health Psychologist, Providence Medical Group - Newberg*
- *Jeremy Swindle, MD, Clinic Manager Family Medicine*
- *Kristin Tallman, PharmD, Clinical Pharmacist*
- *Ericka M Koellermeier, RN, Clinical Nurse*

Session Type: Poster

Content Level: Intermediate

Keywords:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Collaborative Care Model of Integrated Care
- Evidence-based interventions
- Interprofessional teams

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the workflow of the Interdisciplinary-based Hypertension Clinic Program in Primary Care and identify the role of each discipline.
- Define measurable goals of program acceptability and satisfaction
- Provide program evaluation materials and patient informational handouts to increase patient's self-management of hypertension.

## Poster 26: Integrated Direct Care Team Efforts toward Improving Diabetes Group Medical Visit Patient Outcomes

Diabetes is a complex condition that is challenging to manage given the interplay of biological, psychological, and environmental factors. The CDC (2020) found that more than 1 in 10 Americans experience diabetes, and 1 in 3 meet criteria for prediabetes. Given the prevalence and complexity of the disease, group medical visits (GMVs), facilitated by interdisciplinary primary care teams emphasizing clinical care, health education, and peer support, have been effective for patient self-management and improving efficiency of service delivery. Moreover, there is research to suggest that the structure of GMVs can shift the power imbalance inherent in patient-provider relationships, particularly among marginalized groups, to disrupt healthcare inequities through patient empowerment. This study explored the effects of an integrated direct care team's (IDCT) efforts toward improving patient outcomes of diabetes GMVs at a family medicine residency training clinic. The IDCT includes physicians, psychologists, RN case managers, patient health navigators, social work, and pharmacy. The majority of patients served by the safety-net clinic are enrolled in Medicaid, Medicare, or are uninsured, and face complex medical presentations and psychosocial barriers. Targeted improvements to the existing GMV curriculum and protocol were implemented by the IDCT to address common patient barriers. Improvements included a revised recruitment protocol, consolidation of the curriculum from 8 visits down to 6, and offering an afternoon

Session Type: Poster

Content Level: All Audience

Keywords:

- Chronic Care Model of Integrated Care
- Interprofessional teams
- Self-care/Self-management

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the benefits of a group medical visit in the context of diabetes management
- Identify the value of integrated direct care team member involvement in recruitment, design, and implementation of the group medical visits
- Understand the improvements in patient outcomes associated with group medical visits coordinated and

time slot. Preliminary data from a between-groups design with 54 participants, 63% women, ages 20 to 81 years old, demonstrated statistically and clinically significant improvements in GMV attendance and attrition after implementation of the targeted improvements. Data collection (i.e., post-intervention patient weights and A1Cs) is ongoing, and ANOVAs to determine effectiveness of the GMV intervention are pending, with results to be discussed.

delivered by an integrated direct care team

*Presenter(s):*

- *Sarah Sanders, PhD, Postdoctoral Psychology Fellow, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Erin Iwamoto, PsyD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Virginia Parret, PhD, Behavioral Scientist, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*
- *Full Name*
- *Sarah Dewane, PhD, ABPP, Director of Behavioral Health, Alaska Family Medicine Residency/Providence Family Medicine Center, Anchorage, AK*

## Poster 30: Utilizing PDCA Cycles to Enhance Integrated LGBTQ-Affirming and Inclusive Care in a FQHC

Context: Project HOME is a Federally Qualified Health Center (FQHC). Project HOME Healthcare Services (PHHS) expanded affirming, inclusive, and integrated care for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) individuals across all sites with the implementation of the LGBTQ Health Champion program in Fall 2019 to task a voluntary team with ensuring an equitable and affirming environment for LGBTQ staff, patients and their families. The Joint Commission's 2011 LGBTQ Care Field Guide states that interdisciplinary champions are critical to promote inclusivity and affirming care. Sexual orientation (SO) and gender identity (GI) are social determinants of health. Stigma and minority stress are risk factors for adverse health outcomes for LGBTQ individuals (Hatzenbuehler, et al, 2016). Members of sexual minority groups are more likely to encounter barriers to care than straight individuals and tend to have less access to care (Dahlhamer, et al, 2016; Hatzenbuehler, et al, 2016; Diamant et al, 2000). LGBTQ individuals, especially LGBTQ people of color, experience chronic health issues, mental health issues, suicide, and homelessness at higher rates than heterosexual and cisgender individuals. The intersection of complex needs of people who inhabit two or more marginalized identities, such as transgender youth who are also people of color, highlights the need for integrated, affirming, and inclusive care to combat the convergence of minority stress with bio-psycho-social-spiritual issues (Moe, et al, 2018; Hatzenbuehler, et al, 2016). Motivation: PHHS LGBTQ Health Champions conducted brown-bag lunches to raise awareness across all PHHS departments about LGBTQ care needs. Through this, we learned that the National Academy of Medicine, the Joint Commission, and the Centers for Medicaid and Medicare Office of Minority Health's Equity Plan report that the collection of standardized, comprehensive patient data, including SOGI, is a required first-step to plan for quality improvements, improve population health, and address LGBTQ health disparities (Kruse, et al, 2018; Maragh-Bass, et al, 2018; CMS, 2015). Methods and Data: PHHS LGBTQ Health Champions are focused on improving SOGI data collection at the primary and largest PHHS site, the Stephen Klein Wellness Center (SKWC), using Plan-Do-Check-Act (PDCA) cycles. P: We examined data based on service location, stratified by age, in March 2020. 61.2% of the SKWC's active patient census has missing SO data, while 82.5% has missing GI data. D: Examine and expand data collection workflows at SKWC to capture more complete SOGI data C: We predict that the percentage of documented SOGI data at SKWC will increase by at least 10% in the next 6 months. A: Analyze the success or failure of the expanded SOGI data collection processes from a variety of perspectives to implement change,

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Quality improvement programs
- Social determinants of health (SDoH)
- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Learn the importance of SOGI data collection to improve population health over time.
- Understand how to utilize PDCA cycles to engage in improved data collection and quality improvement.
- Advocate for the implementation of LGBTQ Health Champion programs to enhance integrated LGBTQ-affirming and inclusive care.

monitor effects, and adjust as needed to increase SOGI data capture within PHHS.

*Presenter(s):*

- *Genevieve Gellert (she/her), LCSW, Behavioral Health Consultant and LGBTQ Health Champion, Project HOME, Philadelphia, PA*
- *Nyasha George (she/her), MD, Primary Care Physician and LGBTQ Health Champion, Project HOME, Philadelphia, PA*

## Poster 31: Primary Care Behavioral Health Partnerships Advancing & Transforming Health Sciences (PCBH PATHS): Provider Wellness Initiative

The PCBH PATHS initiative is a workforce development pipeline to train the next generation of healthcare professionals to address gaps in skills, and design and deliver (IBH) in the Rio Grande Valley (RGV), Texas – a medically underserved area (MUA). UTRGV has a strategic priority to "Promote a culture of health and well-being for UTRGV and surrounding communities that employs a holistic approach to wellness, health, medical education, training, and research," as well as key initiatives for integrating, coordinating, and leveraging programs and resources to support activities that enhance health and wellness and increase healthcare delivery to underserved communities. Our initiative, aligned with UTRGV strategic priorities and key initiatives, will integrate basic (model specific strategy and operational elements), midlevel (role identity and profession specific behavioral competencies specific to each health profession), and advanced (behavioral medicine clinical skills) applications of the evidencebased PCBH model of delivery. In support of the national and HRSA priorities, the PCBH PATHS initiative will have a curricular priority for training providers in Opioid Use Disorder (OUD)/ Substance Use Disorders (SUD), increasing the number of graduates with Medication Assisted Treatment (MAT)-Waiver training, and advancing psychological skills to self-monitor and manage clinician well-being. Based on evidence from Adverse Childhood Experiences (ACEs) and its link to behavioral, physical, and addictive disorders, trauma-informed care (TIC) will serve as the foundation for MAT, OUD/SUD training. By year 2024, PCBH PATHS will help sustain wellness committees and practices as part of PCBH PATHS implementation. Additionally, a measurement feedback system (MFS) will assess improvements in trainees' wellness through self-monitoring and Rapid Cycle Quality Improvement (RCQI) initiatives by program committees and clinic committees.

*Presenter(s):*

- *Salvador Arellano III, BSA, Research Associate, UTRGV School of Medicine, Edinburg TX*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Burnout
- Primary Care Behavioral Health Model
- Quality improvement programs
- Research and evaluation (e.g. data analysis methods)
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the negative impacts on healthcare quality and safety, patient satisfaction, and public health that are associated with physician burnout and poor wellness.
- Understand the need for the development of a measurement feedback system (MFS) to assess the wellness of residents as they complete their graduate medical education.
- Discuss the benefits of a Wellness Initiative for medical residents, faculty, a university, and the community.

## Poster 32: Enhancing Provider Skills and Preventing Burnout: Facilitation and Training in Trauma-Informed Pediatrics

Implementation of Trauma-Informed Care (TIC) in a Pediatric or Family Practice setting is an emerging field of study. A "Gold Standard" has yet to be established, as this is an emerging practice. There is a growing base of evidence and a need to explore research to establish best practice. The project explores emerging practices and highlights the need to customize the approach to match the resource of the practice and the needs of the patient population. This poster provides highlights of this project including our TIC guide, assessment of practices, choosing a population, screening schedules, selecting a tool(s) tool for screening, QI methods for implementation and reflective self-care practices for systems and individuals to address the secondary trauma that can be associated with this work.

*Presenter(s):*

Session Type: Poster

Content Level: All Audience

Keywords:

- Adolescents
- Burnout
- Care Management
- Complex Patient Care
- Implementation science
- Interpersonal violence
- Interprofessional teams
- Multi-sector partnerships
- Pediatrics
- Prevention
- Quality improvement programs
- Self-care/Self-management

- *Felicity Bernard, LCMHC, Project Director, Institute of Health Policy and Practice, Concord, NH*

- Team-based care
- Technical assistance/practice facilitation for integrated care

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Identify methods of selecting a screening schedule and population
- Identify which screening tool(s) to use
- Increase provider skills in identifying treating and partnering with external community resources to address adverse childhood experiences in their practice setting Utilizing QI methods

## Poster 33: Taking a Team Based Approach to Treating Sleep Disorders

Sleep complaints/disorders account for more than 5 million office visits per year in primary care. There are several important risk factors for sleep disorders including age, sex, current life circumstances, intrinsic and genetic factors, and a variety of other health conditions including cardiac, pulmonary, metabolic diseases, chronic pain, conditions encouraging hyperarousal, cancer, neurological conditions, mental health problems, and other sleep disorders. Additionally, it's important to recognize that many of the medication treatments provided for the commonly co-occurring conditions, such as antidepressants, beta blockers, prednisone, and OTC medications, will unfortunately have sleep disturbance as a potential side effect, which is why research suggests the importance of addressing co-occurring conditions. Early identification of problematic sleep, frequent education of patients, and utilization of a team based intervention approach may help both providers and patients decrease frustration with persistent sleep disturbance symptoms, improve intervention compliance and confidence, encourage support, address co-occurring conditions and/symptoms, and leave the patient with skills that can be used for potential subsequent episodes of sleep disturbance. Members of care teams may include, but are not limited to, primary care providers, sleep medicine providers, behavioral health providers, pharmacists, and nurses. Team based interventions may include referrals for sleep studies, mask desensitization for patients with sleep apnea, referral to a CBTi trained provider, or use of CBTi adapted for primary care. Having on hand a variety of educational material that is population specific may also help with patient education and intervention reinforcement. This presentation will discuss the development and implementation of a performance improvement project within the CentraCare Health System in Central Minnesota.

*Presenter(s):*

- *Stephanie Baas PsyD, LP, Integrated Behavioral Health Provider, CentraCare, St. Cloud, MN*
- *Toni Mahowald, PsyD, LP Integrated Behavioral Health Provider, CentraCare, St. Cloud, MN*

Session Type: Poster

Content Level: Intermediate

Keywords:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Interprofessional teams
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Participants will be able to identify criterion for diagnosis of insomnia and circadian rhythm sleep wake disorders.
- Participants will be able to list and discuss common co-occurring medical conditions with sleep disorders and populations at higher risk for sleep disorders
- Participants will be able to describe their immediate available resources for education and team-based care of sleep disorders

## Poster 34: Young Adults Living with Sickle Cell Disease: Contextual Insights and Recommendations for Treatment

Sickle cell disease is a genetic condition involving pain syndromes, infections, organ damage, and other disease complications. Prior to the 1950's, the survival of individuals with sickle cell disease (SCD) to age 20 was 50%. However, today, 50% of individuals with SCD live past age 50. Although the mortality rate among those living with SCD has significantly decreased, the disease experience is still predominantly characterized by debilitating pain, especially among young adults. Support for children living with SCD is well integrated into healthcare systems. However, as these children transition into young adults, the resources needed to successfully guide this transition are often limited. Knowing how to effectively transition from pediatric care into adult care, managing SCD as a chronic illness as an adult, navigating relationships, family planning, advanced education and moving into the workforce are all areas guidance needed during this developmental phase of life. This poster will provide a review of the literature through the biobehavioral family therapy model. This model offers perspectives on the interplay between the biological, psychological, and social levels of individuals living with SCD. The goal of this presentation is to provide an understanding on the specific challenges individuals and families living with SCD face, as well as offer recommendations on how to effectively work with young adult patients living with sickle cell disease.

*Presenter(s):*

- *Brittany Huelett, MS, AMFT, PhD Student, Loma Linda University, Loma Linda, CA*
- *Zephon Lister, PhD, Director of Systems, Families and Couples PhD Program, Loma Linda University, Loma Linda, CA*
- *CarmeneomiAngela Reyes, MS, AMFT, PhD Student, Loma Lina Univeristy, Loma Linda, CA*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Care Management
- Complex Patient Care
- Patient-centered care/Patient perspectives

Objectives: *At the conclusion of this presentation, participants will be able to…*

- At the conclusion of this presentation, participants will be able to identify the challenges faced by young adults transitioning to adult care.
- At the conclusion of this presentation, participants will be able to identify the interplay between the biological, psychological, and social levels of individuals living with SCD.
- At the conclusion of this presentation, participants will be able to identify recommendations on how to effectively work with young adult patients living with sickle cell disease.

## Poster 35: Philadelphia Freedom from High Blood Pressure: An Integrated MultiDisciplinary Approach to Support Hypertension Control (DASH-C) in Primary Care

Philadelphia Freedom from High Blood Pressure: An Integrated MultiDisciplinary Approach to Support Hypertension Control (DASH-C) in Primary Care Rationale: Philadelphia has the highest prevalence of hypertension (33%) out of the six largest US cities. Population: This program is conducted in three CPC track 2 Primary Care practices of Jefferson Health in Philadelphia. Of patients 18-85 years of age with hypertension, 59% have controlled blood pressure (BP below 140/90). A sample chart review of 250 patients with hypertension shows that 58% have BMI over 30 and 39% have a mental health diagnosis indicating a complex patient population. Study design: Quasi-experimental, pre-post evaluation of an interdisciplinary quality improvement program on hypertension control using an integrated, patient-centered, team-based approach. Data Collection: EHR reports to collect: baseline data, social determinants, medication adherence (ARMS scale and refill data), self-management knowledge and skills, PHQ9, and stress. Procedures: Patient enrollment began 3/1/20 with a goal of 750 patients enrolled over 4 years. Based on an intake scoring tool, a patient-centered intervention will be designed with health coaching, home blood pressure monitoring, and referrals (behavioral health, pharmacy, nutrition, social work, care coordination, community organizations). Each professional assesses and manages patient specific factors with in-person or telephonic encounters until goals are achieved. Patients will be followed for at least 6 months or until two BP readings are below 140/90. All patients receive health coaching sessions and biweekly outreach and support. Results: The primary outcome of this program is the percent of patients with controlled BP below 140/90 after 4 years. Other outcomes: number of referrals, medication adherence, and patient related outcomes and satisfaction. Data will be analyzed using descriptive

Session Type: Poster

Content Level: All Audience

Keywords:

- Collaborative Care Model of Integrated Care
- Complex Patient Care
- Patient-centered care/Patient perspectives

Objectives: *At the conclusion of this presentation, participants will be able to…*

- List important elements in the implementation of a team-based approach to support uncontrolled hypertension.
- Identify unique skill set of each member in an interdisciplinary team, and how these skills complement each other.
- Identify patient-centered strategies to support patients with uncontrolled hypertension.

statistics and t-test for significance level. Results after 7 months of the program will be presented. Conclusions: Outcomes of a multidisciplinary integrated program within Primary Care on supporting hypertension control will be analyzed and presented.

*Presenter(s):*

- *Emmy Stup, MPH, Director of Practice Transformation and Value Based Programs, Thomas Jefferson University, Philadelphia, PA*
- *Tanya Dougherty, PharmD, BCPS, Population Health Pharmacist, Jefferson Health, Philadelphia, PA*
- *Maya Yancy-Hunte, CCMA, Practice Transformation Coordinator, Thomas Jefferson University, Philadelphia, PA*
- *Rachelle Rene, PhD, BCB, HSMI, Director of Primary Care Integrated Behavioral Health, Thomas Jefferson University, Philadelphia, PA*
- *Lawrence Ward, MD, Executive Vice Chairman & Vice-Chair, Clinical Practice & Quality, Thomas Jefferson University, Philadelphia, PA*
- *Emily Scopelliti, PharmD, BCPS, Associate Professor of Pharmacy Practice at Thomas Jefferson University, Philadelphia, PA*
- *Bracken Babula, MD, Clinical Assistant Professor, Thomas Jefferson University, Philadelphia, PA*

## Poster 36: Improving Sleep Quality in Behavioral Health Patients Through Evidence-Based Screening and Treatment

Background/Rationale: This quality improvement project aimed to improve the quality of care for behavioral health patients experiencing sleep disturbances through implementation of the most recent American Academy of Sleep Medicine Practice Guidelines, which recommend routine screening of patients for sleep problems followed by sleep hygiene education and/or cognitive-behavioral therapy (CBT) as first-line treatments. The evaluation question was: What is the effect of implementation these guidelines on the quality of sleep and sleep pattern problems as measured by the Pittsburgh Sleep Quality Index over a period of eight weeks? Description of sample: During an eight-week evaluation window at a rural behavioral health clinic, patients who indicated problems with sleep were given the Pittsburgh Sleep Quality Index (PSQI). Of the 35 patients screening positive for sleep problems who were evaluated in this project, 15 (42.9%) identified as male and 20 (57.1%) identified as female. The average age was 39.3 (SD = 13.4) years old with a range of 19 to 71. The most common reasons for not sleeping were racing thoughts (n = 6, 17.2%), stress (n = 5, 14.3%) and pain (n = 4, 11.4%). Study design: The design included a pretest-posttest assessment of sleep quality (PSQI) for all those indicating problems with sleep, with no control group. Procedures and measures: All participants screening positive for sleep problems received completed sleep hygiene handouts and education. Most participants (66%) completed eight weekly sessions of CBT targeting insomnia, and the remainder did not. The tool for screening and outcome evaluation was the PSQI, a well-established reliable (Cronbach's alpa = .83) and valid instrument often used in clinical and non-clinical settings for the screening of sleep dysfunction. Lower scores on the PSQI indicate better sleep quality. Key results and conclusions: The Wilcoxon sign-rank test was run on the pre- and posttest PSQI scores for all participants, and there was a statistically significant difference between the global pretest median PSQI score (26.60) and posttest median (19.50), Z = -2.328, p = 0.020. This indicates significantly improvements in the quality of sleep for the patients evaluated in this quality improvement project. Although there are many uncontrolled threats to internal validity, this QI study demonstrated the feasibility and acceptability of screening for sleep problems in behavioral health patients, and excellent outcomes for patients receiving sleep hygiene education and/or CBT for insomnia as an alternative to a pharmacological

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Behavioral Medicine Topics (e.g., insomnia, medication adherence)
- Evidence-based interventions
- Outcomes

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Analyze the significant effects of poor sleep quality on health and behavioral health functioning, particularly among those with behavioral health disorders.
- Explain the reasons why sleep disturbances are often inadequately assessed and treated in integrated healthcare settings.
- Describe the significant outcomes of a quality improvement process implementing evidence-based screening and treatment of sleep problems in a behavioral health setting.

sleep aid.

*Presenter(s):*

- *Paul Thomlinson, PhD, Psychologist, Executive Director, Research, Compass Health Network, Springfield, MO*
- *Cynthia Hollis-Keene, DNP, Psychiatric Nurse Practitioner, Emo-Logic Clinic, Branson, MO*

## Poster 37: Depression Outcomes in Primary Care

Depression is one of the leading causes of disability across the globe and it is associated with several adverse outcomes such as potential to self-harm, comorbid medical conditions such as diabetes, stroke, and heart disease among others. The purpose of the current study is to examine the effectiveness of primary care behavioral health treatment on levels of depressive symptoms in patients diagnosed with a depressive disorder at a large community clinic within Geisinger Health system using. Ninety-one patients completed Patient Health Questionnaire-9 (PHQ-9) screening tool before and after treatment. The age of this sample ranged between 21-79 years with an average age of 41 years. Results of this data analysis showed that 87% of the patients participating in this integrated behavioral health treatment experienced improvement in their depressive symptoms. Sixty five percent out of 87% of these patients reported at least 5+ points decrease in their PHQ-9 scores at the end of the treatment. The average number of visits for this patient population is 3.40 with a booster session scheduled for 3 months after the completion of the treatment. Overall, the patients that were referred for the treatment of depressive symptoms by their primary care physician reported improvement in their symptoms. Further data analysis will be conducted to identify gender differences for depression outcomes and will be included for final presentation.

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Complex Patient Care
- Primary Care Behavioral Health Model

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Learn about the complex needs of primary care patient population
- Learn about the Depression outcomes in a primary care community clinic with the integration of behavioral health
- Learn about the fidelity to Primary Care Behavioral Health model of treatment

*Presenter(s):*

- *Shahida Fareed, PsyD, Geisinger Health System, Danville, PA*

## Poster 40: Prevalence of Social Vulnerability in a Health Clinic: Works-in-Progress

Screening for social determinants of health (SDH) can promote collaboration between clinical and allied health services and the community by identifying unmet health-related social needs, barriers to health, and assisting individuals to access appropriate services. The Concord Hospital Family Health Center (CHFHC) is a selected site for a Medicaid payment transformation project that aims to achieve better outcomes at a lower cost. This project entailed screening for social determinants of health (SDH) in individuals covered by Medicaid and analyzing SDH data to identify patterns between biopsychosocial needs and healthcare utilization. The data collection took place at a family medicine residency-based community health center in a mixed urban-rural city in New Hampshire, which serves primarily under-insured individuals; 36% of whom have Medicaid. All adult English-speaking patients of CHFHC with NH Medicaid coverage who came to a clinic appointment were screened. Analysis looked at correlations between stressors, such as safety, education, transportation, housing, substance use, and depression screening, as well as healthcare utilization. Thus far (n=190), results identify positive correlation between stressors (including safety, education, transportation, housing and substance use) and anhedonia (52%) and depression (57%, r=0.64). This project is continuing in the data entry and analysis phase to continue to examine this correlation. A better understanding of the stressors of our Medicaid population, and their relationship to mental health outcomes can lead to an integrated behavioral health approach that would more adequately address these patterns and decrease

Session Type: Poster

Content Level: All Audience

Keywords:

- Mood (e.g., depression, anxiety)
- Social determinants of health (SDoH)
- Underserved populations (e.g. LGBTQ)

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Identify the stressors of our Medicaid population leading to anhedonia/depression.
- Identify correlations between the stressors and mental health outcomes.
- Adequately address specific stressors and decrease barriers to care in our Medicaid population.

barriers to care.

*Presenter(s):*

- *Xinuo Gao, MD, Resident Physician, NH Dartmouth Family Medicine Residency at Concord Hospital, Concord, NH*
- *Aimee Valeras, PhD, LICSW, NH Dartmouth Family Medicine Residency at Concord hospital, Concord, NH*
- *Samantha Gulotta, MFT doctoral intern, Concord Hospital, Concord, NH*

## Poster 41: An Interprofessional Mock Code-Care Transition-Parkinson's Disease (PD) Patient- Missed, Omitted and Delayed Medication Simulation Case Study

An Interprofessional Mock Code Care Transition-Parkinson's Disease (PD) Patient Missed/Omitted/Delayed (MOD) Medication Simulation Case Study. This innovative and diverse simulation addressed a critical need to increase the competency among four healthcare professions to function during a mock code. While doing so, students gained requisite knowledge about Parkinson's Disease, advanced directives, and roles and functions of this healthcare team. This interprofessional education initiative aimed to have students learn about, from, and with each other to enable effective communication and collaboration, and comfortability with unknown team members, which may ultimately lead to improved health outcomes (IPEC). An Interprofessional Mock Code Care Transition-Parkinson's Disease (PD) Patient Missed/Omitted/Delayed (MOD) Medication Simulation Case Study. This innovative research study directly addresses a priority area to increase the competency of healthcare professionals on the care of people living with Parkinson's Disease. This research has the potential to increase the interprofessional health care team's knowledge regarding the unique needs of all individuals living with PD during a care transition in the acute care setting as it relates to their missed, omitted, and delayed (MOD) medications. The purpose of this study was to increase competency, educate and increase comfortability, communication, and collaboration among the following disciplines: Baccalaureate Degree Senior Nursing Students (n=76), Master's and Doctoral Junior and Senior Nurse Anesthesia Students (n=24), Doctor of Osteopathic Medicine Fourth Year Students (n= 24), and Doctoral of Psychology Fourth Year Students (n=21). The required case-study simulation was of a patient's care transition and ultimate code, with a family member present. Following the simulation, a process debriefing session was conducted by the PsyD students for the rest of the student healthcare team. The session concluded with an educational debriefing by nursing staff, with supplemental commentary provided by physician and psychology collaborating faculty. The aims of this simulation were: 1) Determine baseline understanding prior to the simulation of the four different groups of students regarding their comfort level and competency of working together during a mock code (valid-reliable pre-test), 2) Quantify the change in knowledge and perceived importance of competency and collaboration, following the mock code simulation and debriefing (valid-reliable post-test), 3) Determine the percent change in self-perceived competency, collaboration, communication, and comfortability following the mock code simulation and debriefing among the four professions (valid-reliable post-test). Combining the pre- and post- test data for all student types, statistically significant improvements were found for the following questions (each with p-value<0.001): • When is it acceptable to hold medications for a patient with Parkinson's disease (PD)? (correct: Never) • Which of the following medications is only administered orally? (correct: Levodopa/Carbidopa (Sinemet)) • Which of the following equipment is required to prepare for an elective intubation? (correct: Providing a respiratory/intubation box at the bedside) The final two items asked

Session Type: Poster

Content Level: All Audience

Keywords:

- Innovations
- Interprofessional education
- Interprofessional teams

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Determine baseline understanding prior to the simulation of the four different groups of students regarding their comfort level and competency of working together during a mock code
- Quantify the change in knowledge and perceived importance of competency and collaboration, following the mock code simulation and debriefing
- Determine the percent change in self-perceived competency, collaboration, communication, and comfortability following the mock code simulation and debriefing among the four professions

students to evaluate their comfortability working with an interprofessional team and their competency working with an interprofessional team on a scale from 0 to 5, with 0/1 corresponding to minimal or no comfortability/competency and 2-5 corresponding to moderate to extreme comfortability. Among all students who reported minimal to no comfortability/competency before the mock code, 93.3% and 92.9%, respectively, reported at least moderate comfortability/competency in the post-test. Average raw scores increased most substantially for undergraduate students, from 2.32 and 2.04, respectively, to 3.47 and 3.33, respectively. This simulation educated interprofessional healthcare members across four professions as to the importance of collaborative communication during a mock code. While also promoting and improving interprofessional collaboration and comfortability among interprofessional team members during a mock code. This simulation aligns with the goals of the Interprofessional Collaborative Practice.

*Presenter(s):*

- *Diane Ellis, Villanova University, Villanova, PA*

## Poster 42: The Association between Mental Health Diagnoses and Influenza Vaccine Receipt among Older Primary Care Patients

Evidence suggests mental health diagnoses are associated with an increased likelihood of not having an influenza vaccine. However, little is known about this association in older adult primary care patients, a population vulnerable to flu-related sickness, hospitalization, and death. The purpose of this study was to determine the association between flu vaccine receipt in patients 65 to 80 years old and a depression and/or anxiety in a primary care setting. This study used a cross-sectional analysis of a retrospective cohort of EHR data from 4,102 patients who had a primary care appointment between July 2008 and June 2016. Conference attendees will learn the results of this study, including that adjusted analyses supported that any mental health diagnosis were associated with greater odds of vaccination in the total sample (aOR=1.47) and in a subset with physical comorbidities (aOR=1.77). No evidence for a relationship between mental health diagnosis and vaccination was found in the subset without physical comorbidities. The results highlight the prevalence of mental health concerns in primary care settings and the complex interplay between mental health, social determinants of health, and health behaviors. Results also provide further evidence for the comorbid relationship of mental and physical health which supports the role of behavioral health providers in primary care settings. This poster will directly address the conference theme social determinants of health by describing how racial and socioeconomic factors, as well as mental health factors, impact primary care patient's health behaviors. The target audience for this poster will include integrated behavioral health, medical providers, or those in public health interested in learning about the interconnectedness of mental health, social determinants of health, and health behaviors. While study methodology may be more pertinent to those with an intermediate or advance content knowledge, the results summary will be applicable to all audience members.

*Presenter(s):*

- *Tyler Lawrence, PhD, Behavioral Health Faculty, Sea Mar Marysville Family Medicine Residency, Marysville, WA.*
- *Max Zubatsky, PhD, Associate Professor, Saint Louis University, Department of Family and Community Medicine, St. Louis, MO*
- *Dixie Meyer, PhD, Associate Professor, Saint Louis University, Department of Family and Community Medicine, St. Louis, MO*

Session Type: Poster

Content Level: All Audience

Keywords:

- Electronic Medical Record
- Mood (e.g., depression, anxiety)
- Population and public health

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Describe the relationship between mental health diagnoses and influenza vaccine receipt among older adults.
- Discuss the relationship social determinants health and health behaviors.
- Identify how results from an original study further support the integration of behavioral health providers into primary care settings.

## Poster 43: Same Team, Different Diagnosis?: Physician and Behavioral Health Provider Diagnostic Agreement in a General Hospital Setting

Session Type: Poster

Content Level: All Audience

Keywords:

- Complex Patient Care, Hospital Setting
- Interprofessional teams
- Hospital setting

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe the importance of integrating behavioral health providers into general hospital settings.
- Identify the psychosocial conditions that appear to be underdiagnosed in a general hospital setting.
- List the methods for improving the accuracy of diagnosing psychosocial conditions.

The integration of behavioral health providers (BHPs) in general hospital settings is potentially advantageous because hospitalized patients can have complex care needs and have high rates of psychosocial problems. Physicians are often the gatekeepers for identifying patients with psychosocial problems and referring them to a BHP. However, to our knowledge, there has been no literature on mental health diagnostic discrepancies between referring physicians and BHPs. Assessing for discrepancies between hospital physician and BHPs diagnosis may be beneficial for two main reasons. First, low diagnostic agreement would suggest behavioral health services are often used inappropriately. Second, it would highlight a potential need for systematic screening or training on psychosocial health screening in hospitals to identify patients with mental psychosocial problems. Attendees will learn about the results of study assessing for diagnostic agreement between initial physician diagnosis and BHPs' diagnosis for 60 inpatient physician referrals. The sample consisted of an equal number of male and female patients. The majority of patients were white (73%), followed by African American (25%), and American Indian (1.7%). The mean sample age was 55.5 (SD=13.9) years old. Diagnostic agreement was assessed using the kappa statistic with a coefficient ≥0.7 being considered substantial agreement. Kappa statistics indicated good agreement between initial physician diagnoses and BHP diagnoses for substance abuse (.79), anxiety disorders (.82), adjustment disorders (.88), relational conflict (.88), and "other" (.74). There was lower agreement for depressive disorders (.55). While diagnostic agreement for many conditions was better than anticipated, there was lower diagnostic agreement for depression. This suggests systematic depression screening or training medical providers to identify depression in hospitalized patients may increase diagnostic accuracy and improve appropriateness of referral rates. Hospitalized patients frequently have very complex biopsychosocial-spiritual needs. Thus, the focus of this presentation is directly in line with the conference theme. Presentation content will be applicable to a wide audience; especially providers, physicians, and administrators whose roles include work in a hospital setting.

*Presenter(s):*

- *Tyler Lawrence, PhD, Behavioral Health Faculty, Sea Mar Marysville Family Medicine Residency, Marysville, Washington*
- *Jennifer Caspari, PhD, Director of Behavioral Medicine, General Internal Medicine, University of Nebraska Medical Center, Omaha, Nebraska*
- *Elizabeth Lyden, MS, Associate Director, Center for Collaboration on Research, Design and Analysis, University of Nebraska Medical Center, Omaha, Nebraska*

## Poster 44: Assessing Mental Health Needs in Indigenous NgÃ¤be Communities in Bocas del Toro, Panama

Session Type: Poster

Content Level: All Audience

Keywords:

- Cultural Humility
- Ethics
- Family centered care/Family perspectives
- Interpersonal violence
- Population and public health
- Quality improvement programs

Objectives: *At the conclusion of this presentation, participants will be able to...*

Western Panama is home to the NgÃ¤be-Bugle, the largest group of Indigenous Panamanians making up 6.7% (del Rosario, 2011) of the total population of Panama. Several social, legal, and political challenges have placed Panama in a complex economic and social climate. Amongst those challenges is mental health concerns, particularly violence amongst men, suicide, and excessive drug and alcohol use. This qualitative study explored the needs, knowledge, and beliefs about mental health as defined in Western culture amongst the NgÃ¤be of Western Panama. Participants were recruited from 9 NgÃ¤be communities where Floating Doctors holds clinics by word of mouth and snowball sampling. With the assistance of a native Spanish-speaking translator, interviews took place in semi-private areas throughout the communities. Consent forms were translated using a certified translation service.

Interviews were recorded, transcribed, and double-checked for translation discrepancies. Data was then coded by 5 students, and themes were determined by the researcher. This research revealed the impact of structural violence in Indigenous communities that may contribute to an increase in exposure and usage of drugs and alcohol and dependence on violence to maintain various structures of social power.

- Identify mental health concerns of NgÃ¤be people in 9 communities.
- Describe perceptions of mental health in 9 NgÃ¤be communities.
- List potential resources that may further positive health and life satisfaction amongst NgÃ¤be people.

*Presenter(s):*

- *Megan Chapman, Adler University, Chicago, IL*

## Poster 45: Utilization of the EMR to Improve Family and Support Person Engagement in Health Care

This phenomenological study was designed to research the experience of engaging family/support persons (i.e., proxy) using the electronic medical record (EMR). The target population was patients with complex care needs (i.e., patients who benefit from interdisciplinary treatment), their identified family member/support person with proxy access, and their primary care provider (PCP). No known studies have examined EMR use for this purpose. This qualitative investigation was guided theoretically by the BPS-S (Engel, 1977, 1980; Wright et al., 1996) and patient-and family-engagement (Carmen et al., 2013) frameworks. Participants were selected using a purposive sampling strategy (Birks & Mills, 2015) from a primary care clinic in a southeastern state. Participants included adult patients with at least one chronic condition, a participating PC provider, and an identified proxy. Patient participants (n=12), ranged in age from 26 to 68 (M=51.6, SD=10.5), were both male (n=6) and female (n=6), and identified as White (n=5), Black (n=5), Native American (n=1), Latino/a/x (n=1). Support persons (n=7) ranged in age from 25 to 65 (M=48.1, SD=11.4), were all female, and identified as White (n=4), Black (n=2), and Native American (n=1). PCP participants (n=2) were both 41 years of age, with one male and one female, and identified as White (n=2). The phenomenological study utilized focus groups and individual interviews to explore participants' interactions with and lived experiences of using the EMR (Creswell, 2013). Qualitative data were collected pre-, mid-, and post-proxy EMR access from all participants. Thematic analysis was completed using Colaizzi's (1978) seven-step phenomenological analysis method. The study yielded themes covering the benefits and challenges of utilizing the EMR proxy feature to engage families/support persons. Results will help to improve the onboarding of proxies and identify the best method for optimal workflow and systemic/relational EMR usage.

*Presenter(s):*

- *Melissa Welch, MA, doctoral student, Medical Family Therapy Doctoral Program, East Carolina University, Greenville, NC*
- *Emily Tucker, MS, doctoral student, Medical Family Therapy Doctoral Program, East Carolina University, Greenville, NC*
- *Jennifer Hodgson, PhD, Nancy W. Darden Distinguished Professor & Director, Medical Family Therapy Doctoral Program, East Carolina University, Greenville, NC*
- *Thompson Forbes, PhD, RN, Assistant Professor, College of Nursing, East Carolina University, Greenville, NC*
- *Joe Pye, MD, Vice President of Medical Affairs, Regional and Associate Chief Medical Officer at Vidant Health*

Session Type: Poster

Content Level: Not applicable (being considered as poster only)

Keywords:

- Complex Patient Care
- Electronic Medical Record
- Family centered care/Family perspectives

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Identify outcomes of a phenomenological study on the benefits and challenges of engaging families/support persons through EMR utilization.
- Develop strategies for patient and family/support system engagement using EMR technology with secure access features.
- Promote the use of EMR proxy access in their settings to advocate for family/support person engagement.

## Poster 50: MHTTC: Munroe-Meyer Institute's Training in Integrated Care

To improve access to care and build the workforce of behavioral health professionals, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) have funded programs to train behavioral health (BH) students and practitioners to partner with primary care medical practices. This approach involves the creation of integrated "medical homes" where patients' physical and mental health needs can be addressed in a single site. The integration of behavioral health has been shown to produce improved access to care, higher levels of patient satisfaction, increased cost effectiveness and reductions in stigma that have traditionally been associated with seeking BH care. The Mid-America Mental Health Technology Transfer Center partners with state mental health authorities, universities, and provider organizations in Iowa, Kansas, Missouri, and Nebraska to train behavioral health providers in integrated care, thus increasing access to BH services for patients and families with behavioral concerns. Technical assistance is available and addresses the unique needs and strengths of each medical practice and its surrounding communities. On-site consultation can also be provided for program implementation and sustainability of integrated care practice. Training and program implementation services can be attained through face to face sessions, distance learning, and/or online sessions to improve the knowledge base and competencies of the behavioral health workforce. Ultimately, the mission of the MHTTC is to increase access to care and develop the behavioral health workforce.

*Presenter(s):*

- *Rachel Valleley, Munroe-Meyer Institute, Omaha, NE*

Session Type: Poster

Content Level: All Audience

Keywords:

- Pediatrics
- Primary Care Behavioral Health Model
- Technical assistance/practice facilitation for integrated care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Describe goals of Mid-America MHTTC
- Increase knowledge of training programs and content available for education in integrated pediatric primary ca
- Describe options for integrating behavioral health provision into pediatric and family medicine practices

## Poster 51: Studying Abroad with Couple and Family Therapy Students as a Medical Family Therapy Learning Experience: Floating Doctor in Bocas del Toro, Panama

Consistent with Adler University's mission of educating socially responsible practitioners, developing opportunities for community engagement, and infusing social justice across the students' training, this program embraced global learning through the development of a study abroad immersion course. In the summer of 2019, seven students and one faculty studied abroad volunteering for Floating Doctors located in Bocas del Toro, Panama. Floating Doctors is a non-government organization (NGO) located in Panama since 2011 that provides single and multi-day mobile medical clinics to 24 Ngäbe communities on a quarterly rotating basis. CFT students interested in medical family therapy as well as a global experience as part of their training joined together to volunteer for two weeks. Study abroad has been confirmed as a valuable experience at every level of higher education including in behavioral health training programs; this immersion course was no different providing both hard lessons and expanded opportunities for exploration of self-of-the-therapist specifically through a socially responsible and just lens of practice. Our learning extended beyond the clinics including each of our abilities to navigate internal and external stressors. We engaged as volunteers but also shared our perspectives through a therapeutic lens in presenting clinical rounds each week and as feedback for the ongoing inclusion of mental health as a Medical Family Therapy program in Floating Doctors.

*Presenter(s):*

- *Kristina Brown, PhD, LMFT, Professor and Chair of the Couple and Family Therapy Department, Adler University, Chicago, IL*

Session Type: Poster

Content Level: Intermediate

Keywords:

- Administration
- Early Career Professionals
- Interprofessional education
- Population and public health
- Skills building/Technical training
- Team-based care

Objectives: *At the conclusion of this presentation, participants will be able to...*

- Understand the range of strengths to challenges inherent with a study abroad opportunity in a behavioral health training program
- Embrace requirements, e.g. preparation including budget and syllabus, and considerations to develop their own study abroad experience including with Floating Doctors
- Confirm important tasks and assignments to incorporate in study abroad to uphold best learning experiences both social justice /

socially responsible practice and clinical skills

## Poster 52: Using BDSM to Manage Endometriosis Pain: A Clinical Case Report

Endometriosis is a chronic gynecological condition that indiscriminately effects approximately 176 million women across the world. Three major symptoms – dysmenorrhea (painful menses), dyspareunia (painful intercourse), and infertility – are the most commonly seen both at diagnosis and throughout management of the disease. Pain due to endometriosis impacts a woman on a daily basis and management of this pain is as varied as the woman diagnosed. Research has been done on the utilization of alternative treatments ranging from yoga to spinal cord stimulation. This presentation will present a clinical case report about a woman engaging in BDSM (Bondage and discipline, Dominance and submission, Sadism, and Masochism) to manage her endometriosis pain. A history of the patient's diagnosis, interventions, and treatment will be presented as well as how the patient came to utilize BDSM in response to debilitating endometriosis pain. The patient's decision-making process as well as descriptions of actual engagement in BDSM and how it connects to manage the pain for the patient will be presented. A common myth about BDSM is that it is about the desire to experience or inflict pain. In this case, we have discovered that it is the actual control and power over the pain as well as the displacement of pain that mitigates the experience of endometriosis pain for this patient. Considered an "invisible illness," many women with endometriosis express their feelings of loss in their quality of life across multiple facets as well as being betrayed by their own bodies. By expanding a clinician's repertoire with additional methods of pain management for women with endometriosis and other pelvic pain experiences broadens the opportunity for improved quality of life for the woman and the couple.

*Presenter(s):*

- *Kristina Brown, PhD, LMFT, Professor and Chair of the Couple and Family Therapy Department, Adler University, Chicago, IL*
- *Leisel Iverson, MS, ATC, Doctoral Student in Clinical Psychology at Adler University, Chicago, IL*

Session Type: Poster

Content Level: Novice

Keywords:

- Complex Patient Care
- Self-care/Self-management
- Pain Management

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Understand introductory information about both endometriosis and BDSM.
- Explain the intersections between the experience of pain in endometriosis and BDSM as an alternative method of pain management for pelvic pain.
- Expand their abilities to help women and couples who struggle with pain management.

## Poster 53: Barriers and Facilitators to Integrating Behavioral Health in Primary Care Settings.

Few social work and mental health counseling researchers have utilized photovoice methodology in studies exploring barriers and facilitators to integrating behavioral health in primary care settings. The use of photovoice, an innovative participatory action research methodology, gives individuals the opportunity to explore and define for themselves, through photography and narration, the everyday reality of their lives and their perceptions about the world. Limited research exists in the literature that explores barriers and facilitators to integrating behavioral health in primary care settings. This paper helps to address this gap in the literature by exploring the perceived barriers and facilitators to integrating behavioral health in primary care settings through the lens of photovoice. Findings revealed that barriers to integrating behavioral health in primary care settings were associated with lack of financial resources, lack of basic needs, limited physical space for meetings, lack of transportation, lack of cultural competence, stigma, lack of education, and lack of collaboration. Facilitators to integrating behavioral health in primary care settings were associated with a collaborative inter-professional team, community resources, partnerships, physical space for meetings, and other resources. Practice implications

Date: ,

Time:

Session Type: Poster

Content Level: All Audience

Keywords:

- Primary Care Behavioral Health Model
- Research and evaluation (e.g. data analysis methods)
- Community-Based Participatory Action Research

Objectives: *At the conclusion of this presentation, participants will be able to…*

- Participants will understand barriers to facilitating behavioral health in primary care settings.

are made for behavioral health providers in primary care settings.

*Presenter(s):*

- *Dana Harley, PhD, Associate Professor, University of Cincinnati, Cincinnati, OH*
- *Shauna Acquavita, PhD, Associate Professor, University of Cincinnati, Cincinnati, OH*
- *Michael Brubaker, PhD, Associate Professor, University of Cincinnati, Cincinnati, OH*
- *Amanda LaGuardia PhD, Assistant Professor, University of Cincinnati, Cincinnati, OH*

- Participants will gain awareness of facilitators to integrating behavioral health in primary care settings.
- Participants will gain insight into community-based participatory action research methods.