LET'S INTEGRATE! WORKING WITH THE MEDICAL TEAM TO ENHANCE INTEGRATED CARE:

Being a Behavioral Scientist

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OUTLINE

- History and rational of the Behavioral Scientist within family medicine residencies
- Current guidelines for psychosocial/behavioral medicine
- Example curriculum
- Application

POLL

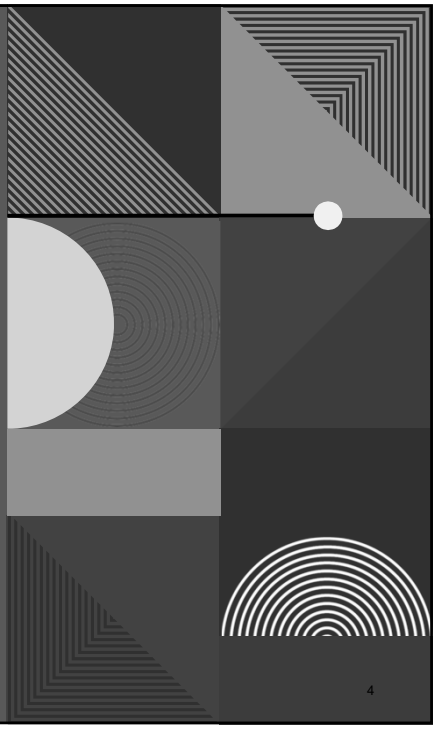
HOW MANY OF YOU ARE CONSIDERING:

- ✓ Being a Behavioral Scientist?
- ✓ Working in a medical setting?
- ✓ Supervising others?
- ✓ Working as part of ateam?
- ✓ Ever seeing a medical provider????

As a patient, think of an encounter you had with medical provider that was:

- Good
- Not sogood

What made itthat way?



MEDICAL RESIDENCY

- Required of MD's & DO's post degree
- 3yrs (FM) to 7yrs (Neurosurgery)
- Supervised (Preceptors)
- Can go on to specialize afterwards (e.g. OB, sports med)

What and who are behavioral scientists???

HISTORY OF THE BEHAVIORAL SCIENTIST

Baird et al.,2017

Early years (1966-1986)

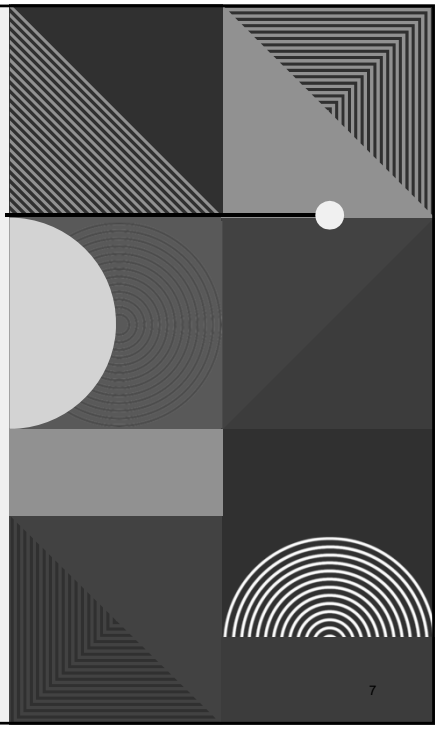
- Family Medicine –"The sine qua non of family practice is the knowledge and skill which allow the family physician to confront relatively large numbers of unselected patients with unselected conditions and to carry on therapeutic relationships with patients over time."
- Family medicine trying to figure itself out
- BS roles mostly filled by psychiatrist
- Tension in goals of the BS
  - Diagnosis/treatment skills VS interpersonal/interviewing skills

HISTORY OF THE BEHAVIORAL SCIENTIST

Early years (1966-1986, con)

- 90% had a Behavioral Scientist
  - Shift in who was doing it
- In 1986, STFM proposed CCs:

Sociocultural issues
Normal development/developmental crises
Dr/pt relationship
Family systems/life cycles
Biopsychosocial assessments
Biopsychosocial management
Personal/professional relationships



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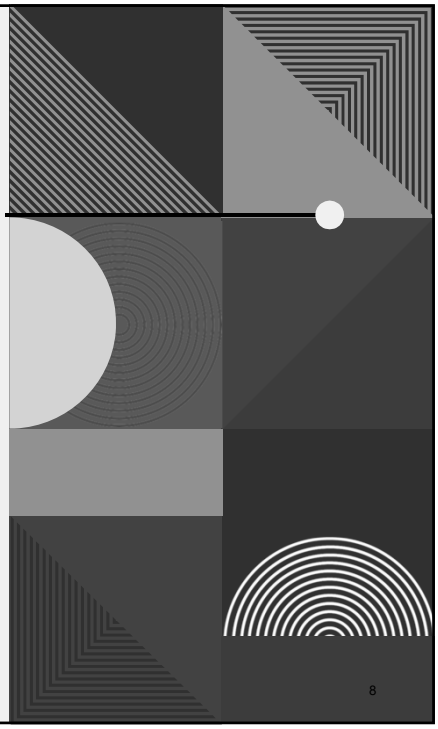
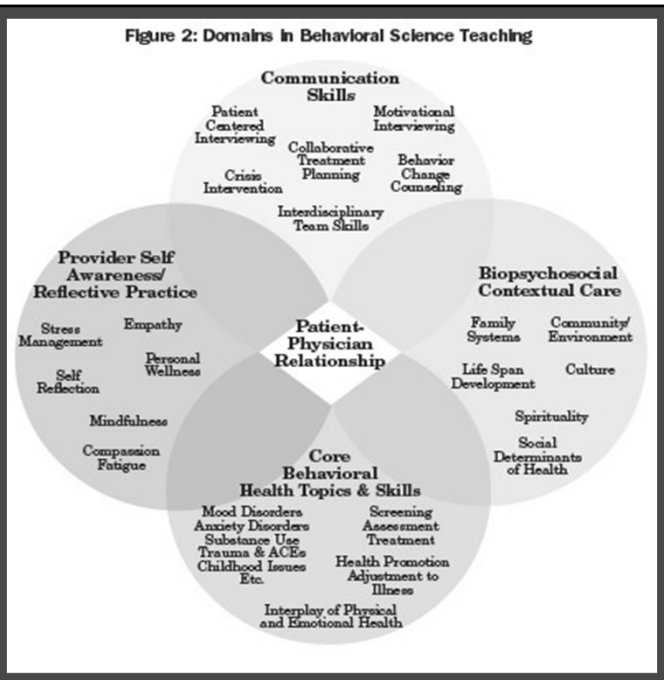




MIDDLE YEARS (1987-2001)

- Common ground curriculums
- Beginning to see integrated behavioral health components
- Focus on cultural competencies
- Contextualism influence

HISTORY OF THE BEHAVIORAL SCIENTIST

Recent Years (2002-2016)

- A move towards integration
  - Significant increase in BS also doing IBH
  - Residents responding
    - 97% of residents said they would be more inclined to accept and/or apply for a job w/ IBH
- More workforce development
  - STFM BFEF
  - Imbedding BS truly within FM

ACGME

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

- Set requirements for graduate medical education
  - APA for MDs/DOs
  - Ex. Procedures, number of patients seen, etc.

ACGME

REQUIREMENTS FOR PSYCHOSOCIAL MEDICINE:

- Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health.
  - Understand family dynamics & impact of ACEs
  - Address behavioral health and inequities in health and health care.
  - Diagnose, manage, and integrate care for common mental illness and behavioral issues in patients of all ages
  - Apply the biopsychosocial model of health & appropriately acknowledging racial categories as social constructs as opposed to biologically distinct determinants of health

(ACGME, 2023)

ACGME MILESTONES

A milestone is *a significant point in development… competency-based developmental outcomes… that can be (progressively) demonstrated*

Milestone's development also gave rise to Clinical Competency Committees (CCC's)
Different residency to residency

- Patient care
- Medical Knowledge
- Systems-Based Practice
- Practice-Based Learning and Improvement
- Professionalism
- Interpersonal and Communication

(ACGME, 2019)

ACGME MILESTONES

Interpersonal and Communication Skills 1: Patient- and Family-Centered Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Uses language and nonverbal behavior to demonstrate respect, establish rapport while communicating one's own role within the health care system	Establishes a therapeutic relationship in straightforward encounters using active listening and clear language	Establishes a therapeutic relationship in challenging patient encounters	Maintains therapeutic relationships, with attention to patient/family concerns and context, regardless of complexity	Mentors others in situational awareness and critical self-reflection to consistently develop positive therapeutic relationships
Recognizes easily identified barriers to effective communication (e.g., language, disability)	Identifies complex barriers to effective communication (e.g., health literacy, cultural)	When prompted, reflects on personal biases while attempting to minimize communication barriers	Independently recognizes personal biases while attempting to proactively minimize communication barriers	Leads or develops initiatives to identify and address bias
Identifies the need to individualize communication strategies	Organizes and initiates communication, sets the agenda, clarifies expectations, and verifies understanding	Sensitively and compassionately delivers medical information, managing patient/family values, goals, preferences, uncertainty, and conflict	Independently uses shared decision making to align patient/family values, goals, and preferences with treatment options to make a personalized care plan	Role models shared decision making in patient/family communication including those with a high degree of uncertainty/conflict
Comments:				

ACGME MILESTONES

Medical Knowledge 1: Demonstrates Medical Knowledge of Sufficient Breadth and Depth to Practice Family Medicine				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes the pathophysiology and treatments of patients with common conditions Describes how behaviors impact patient health	Applies knowledge of pathophysiology with intellectual curiosity for treatment of patients with common conditions Identifies behavioral strategies to improve health	Demonstrates knowledge of complex pathophysiology and the comprehensive management of patients across the lifespan Engages in learning behavioral strategies to address patient care needs	Integrates clinical experience and comprehensive knowledge in the management of patients across the lifespan Demonstrates comprehensive knowledge of behavioral strategies and resources to address patient's needs	Expands the knowledge base of family medicine through dissemination of original research
Comments:				

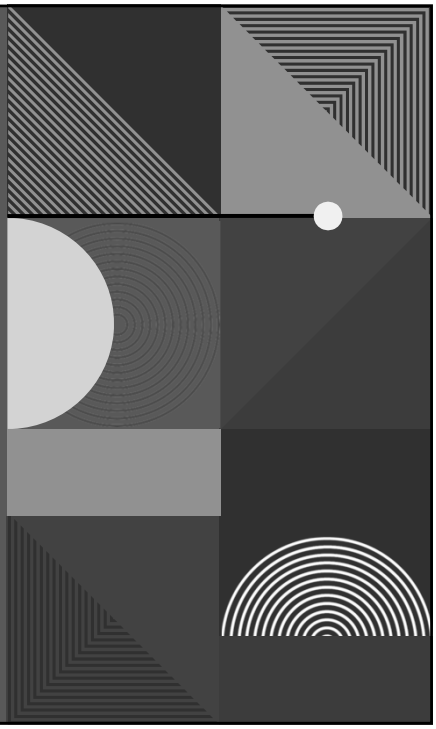
ACGME MILESTONES

Patient Care 3: Health Promotion and Wellness				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies screening and prevention guidelines by various organizations	Reconciles competing prevention guidelines to develop a plan for an individual patient, and considers how these guidelines apply to the patient population	Identifies barriers and alternatives to preventive health tests, with the goal of shared decision making	Incorporates screening and prevention guidelines in patient care outside of designated wellness visits	Participates in guideline development or implementation across a system of care or community
Identifies opportunities to maintain and promote wellness in patients	Recommends management plans to maintain and promote health	Implements plans to maintain and promote health, including addressing barriers	Implements comprehensive plans to maintain and promote health, incorporating pertinent psychosocial factors and other determinants of health	Partners with the community to promote health
Comments:				

STFM'S CORE PRINCIPLES OF BEHAVIORAL MEDICINE

- Use biopsychosocial approach
- Promote patient self-efficacy and behavior change
- Integrate behavioral health
  - Mental health and substance use
  - Physical symptoms
- Address sociocultural factors
- Understand impact of systems, contexts
- Apply developmental and life-cycle perspective
- Provider self-awareness, empathy, and well-being

(Schirmer, J. M., Taylor, D., & Zylstra, R., 2008).



SUMMARIZING THE BEHAVIORAL SCIENTIST ROLE

Train medical providers to offer whole person, biopsychosocial, equitable, care that is respectful of, and responsive to, individual patient preferences, needs and values.

- **Behavioral/mental health diagnoses and interventions**
- **Patient Centered-Care**
- **Antiracism and Health Equity**
- **Working on integrated teams**
- **Wellness/Resiliency**

HOW IT IS TYPICALLY DONE…

One Behavioral Scientist,variety of disciplines

Maybe sees patients, often in traditional model

Works with residents on a RANGE of things

One month rotation in a three-year residency

CENTRAL WASHINGTON FAMILY MEDICINE RESIDENCY

- 10-10-10 FM residency program
  - Locations in Ellensburg and Yakima, WA
- Teaching Health Center
- Residents receive a variety of experiences ranging from outpatient, OB, inpatient and… psychosocial medicine

HOW CWFM DOES IT

- All core BHCs have a roll, plus postdocs and interns
- Integrated into 3 Rotations x3yrs: AFM, Geriatrics, Am Peds
- Infuse patient-centered, biopsychosocial, antiracist, equitable care across all elements of training:
  - Role plays: contextual interview, anti-racism, equity
  - Residents shadowing BHCs: contextual interview
  - BS shadows residents: Patient Centered Communication
  - One-on-ones
  - Didactics for all residents throughout the year
  - Readings
- Behavioral Scientist at Clinical Competency Committee meetings

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Working on integrated teams
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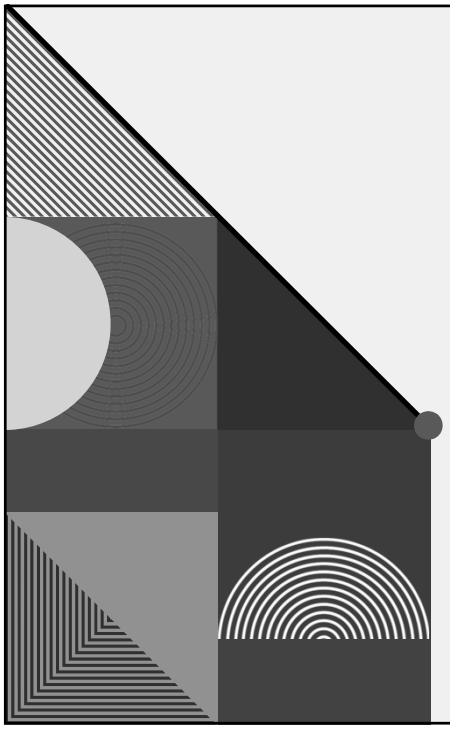
Patient Centered-Care
Antiracism and Health Equity



PATIENT-CENTERED CARE

Institute of Medicine (2001):

> "Care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[4]

PATIENT-CENTERED CARE

Improved **adherence** to treatment plans

Higher **satisfaction** for patients and health-care providers

Better overall **health**

(Barbosa et al, 2015)

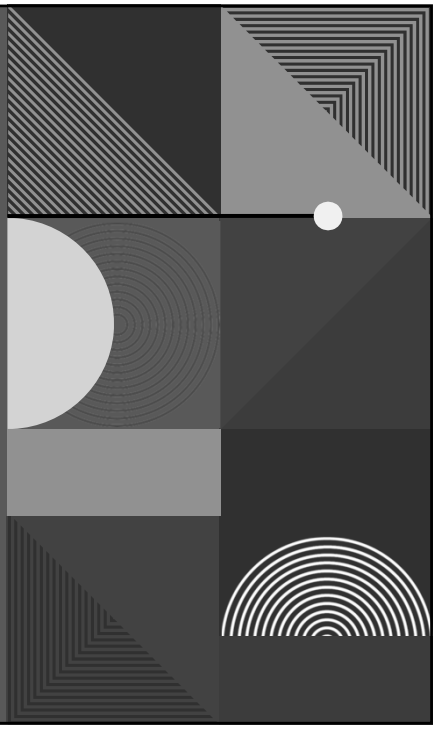
PATIENT-CENTERED COMMUNICATION (PCC)

Communication that promotes shared understanding and shared decision making

Poor communication:

- Misunderstanding of information
- Post-care complications
- Medical errors and readmissions

(Epstein & Street, 2007; Lee & Lin, 2010; Mahler et al, 2012; Mazor et al., 2012)



PATIENT-CENTERED COMMUNICATION (PCC)

Physicians

Good:

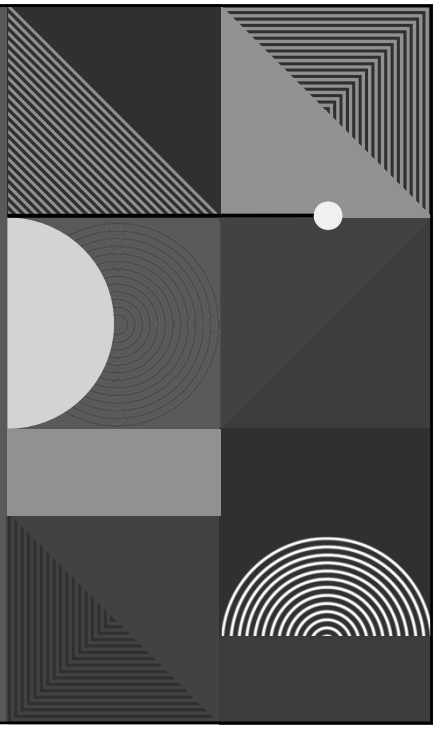
- Discussing clinical decisions with patients

Not so good:

- Determining the patients' preferences
- Assessing if patient understands information
- Discussing pros and cons or alternative methods of health care.

And most of us aren't good at recognizing personal and systemic biases

Braddock et al, 1997; Saha, Beach, & Cooper, 2008; Stewart, 1995)



PATIENT-CENTERED COMMUNICATION (PCC)

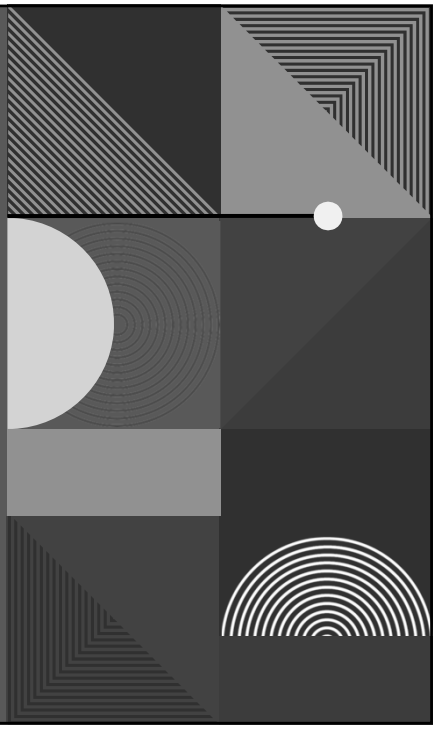
Improved understanding of medical regimens

Increased patient involvement

Increased adherence to self-care

Improved health care utilization

(Brown, 1999; Beck, Daughtridge & Sloane, 2002; Golin, DiMatteo & Gelberg, 1996)



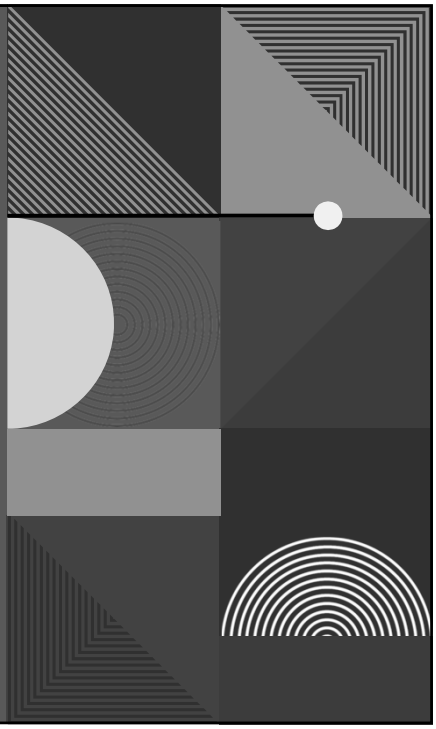
PCC SKILL DOMAINS

Eliciting and understanding patient perspectives

Understanding the patient's unique psychosocial and cultural contexts

Reaching a shared understanding of patient concerns and shared decision regarding treatments that are concordant with patient values

(Epstein & Street, 2007)



STFM GUIDELINES FOR CULTURAL SENSITIVITY, COMPETENCE & HUMILITY

Knowledge

Health Disparities

Social Determinants of Health

Skills

Patient-centered communication

Biopsychosocial assessment and intervention

Attitudes

Awareness, acceptance, and appreciation for the ways in which cultural factors impact health and willingness to incorporate these factors into treatment decisions.

→ Health Equity and Antiracism

(Like, Steiner & Rubel, 2018)

KNOWLEDGE

Social Determinants of Health:

"The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities…Social determinants of health are shaped by the distribution of money, power, and resources"

Physical environment

Social environment

Access to health services

(CSDH, 2008)

KNOWLEDGE

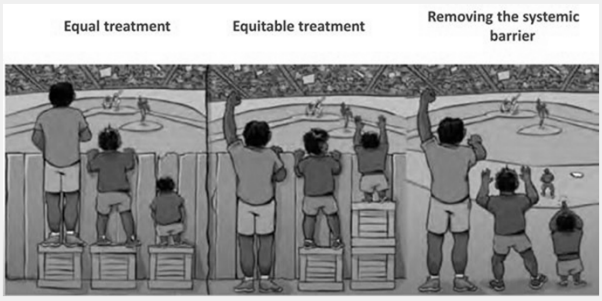
Health Disparities

What

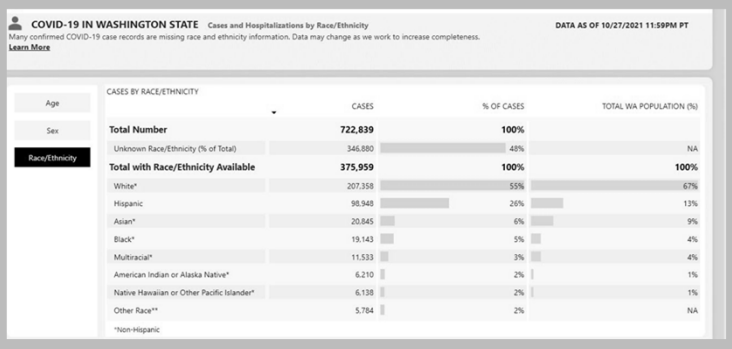
Differences in health outcomes that are linked to social, economic, and/or financial inequality.

Who

People who have systematically experienced greater obstacles to health often due to discrimination or exclusion.



(Jeffrey T. Berger & Dana Ribeiro Miller, 2021)



COVID-19 IN WASHINGTON STATE Cases and Hospitalizations by Race/Ethnicity

DATA AS OF 10/27/2021 11:59PM PT

Many confirmed COVID-19 case records are missing race and ethnicity information. Data may change as we work to increase completeness.

Learn More

Age | Sex | Race/Ethnicity

CASES BY RACE/ETHNICITY

	CASES	% OF CASES	TOTAL WA POPULATION (%)
Total Number	**722,839**	**100%**	
Unknown Race/Ethnicity (% of Total)	346,880	48%	NA
Total with Race/Ethnicity Available	**375,959**	**100%**	**100%**
White*	207,358	55%	67%
Hispanic	98,948	26%	13%
Asian*	20,845	6%	9%
Black*	19,143	5%	4%
Multiracial*	11,533	3%	4%
American Indian or Alaska Native*	6,210	2%	1%
Native Hawaiian or Other Pacific Islander*	6,138	2%	1%
Other Race**	5,784	2%	NA

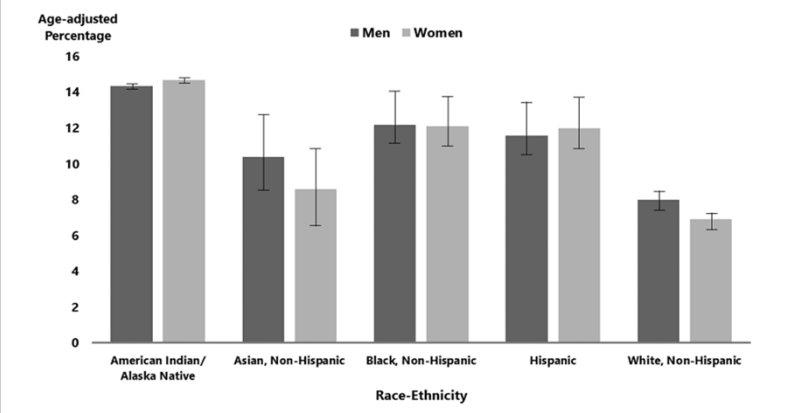
*Non-Hispanic

doh.wa.gov

Rate ratios compared to White, Non-Hispanic Persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	2.8x higher	1.1x higher	2.6x higher	2.8x higher
Hospitalization[2]	5.3x higher	1.3x higher	4.7x higher	4.6x higher
Death[3]	1.4x higher	No Increase	2.1x higher	1.1x higher

cdc.gov

Age-adjusted estimated prevalence of diagnosed diabetes by race/ethnicity group and sex for adults aged 18 years or older, United States, 2018-2019



CDC: 2018–2019 National Health Interview Survey; 2019 Indian Health Service National Data Warehouse (for American Indian/Alaska Native group only).

Patient Centered-Communication: Communication that promotes shared understanding and shared decision making

Cultural Competence	Ability to engage knowledgeably w/people of other cultures.
Cultural Humility	Life-long process of personal reflection and growth around culture in order to increase awareness.
Anti-racism	Actively opposing racism by advocating for changed in political, economic, and social life.

(Castillo et al, 2020; Jeffrey T. Berger & Dana Ribeiro Miller, 2021)

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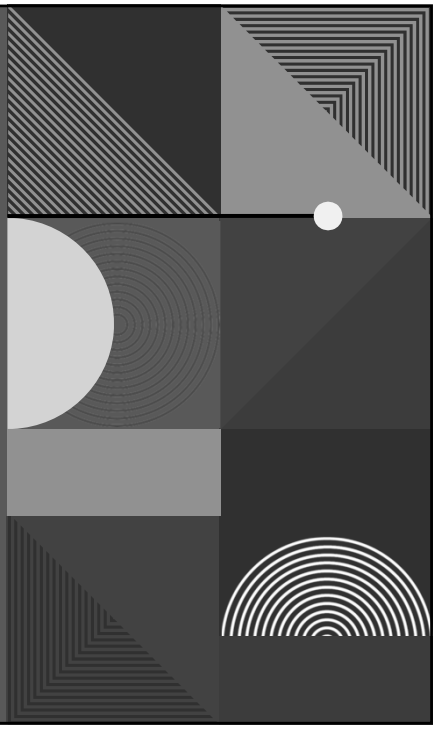
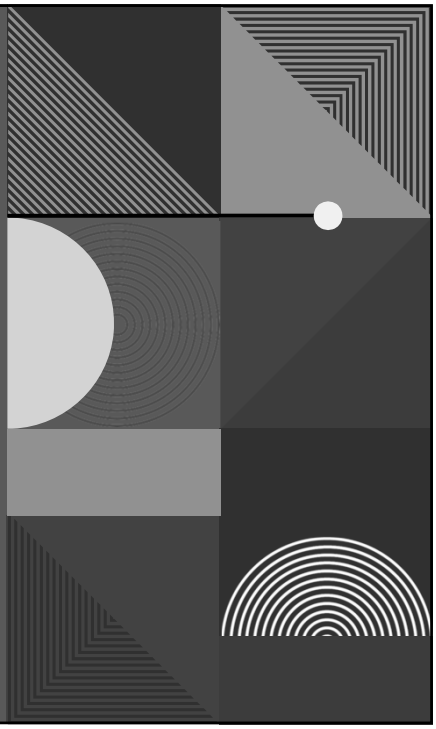


GETTING YOUR FEET WET…

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

Jot down your reactions…

What does this provider do well, what could she do better?



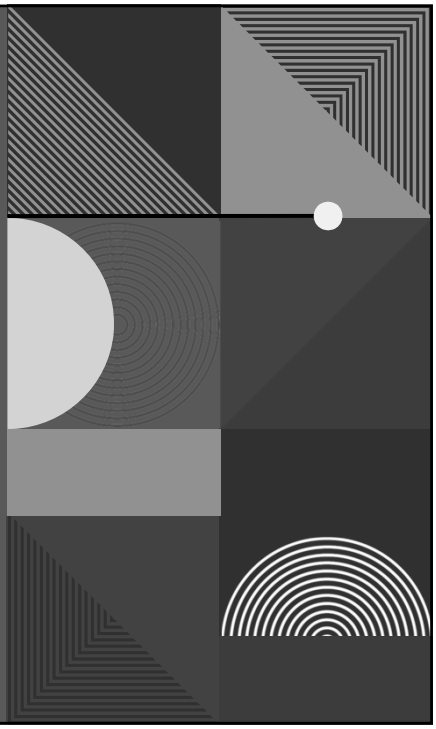
PCC SKILLS ASSESSMENT

Resident is observed for multiple clinics by BHC(s) throughout their residency

Complete Patient-Centered Observation Form

Each BHC who observed resident submits an evaluation re: if milestones were observed and provides summary of skills

- Seen by resident and their advisor
- Reviewed during Clinical Competency Committee meetings

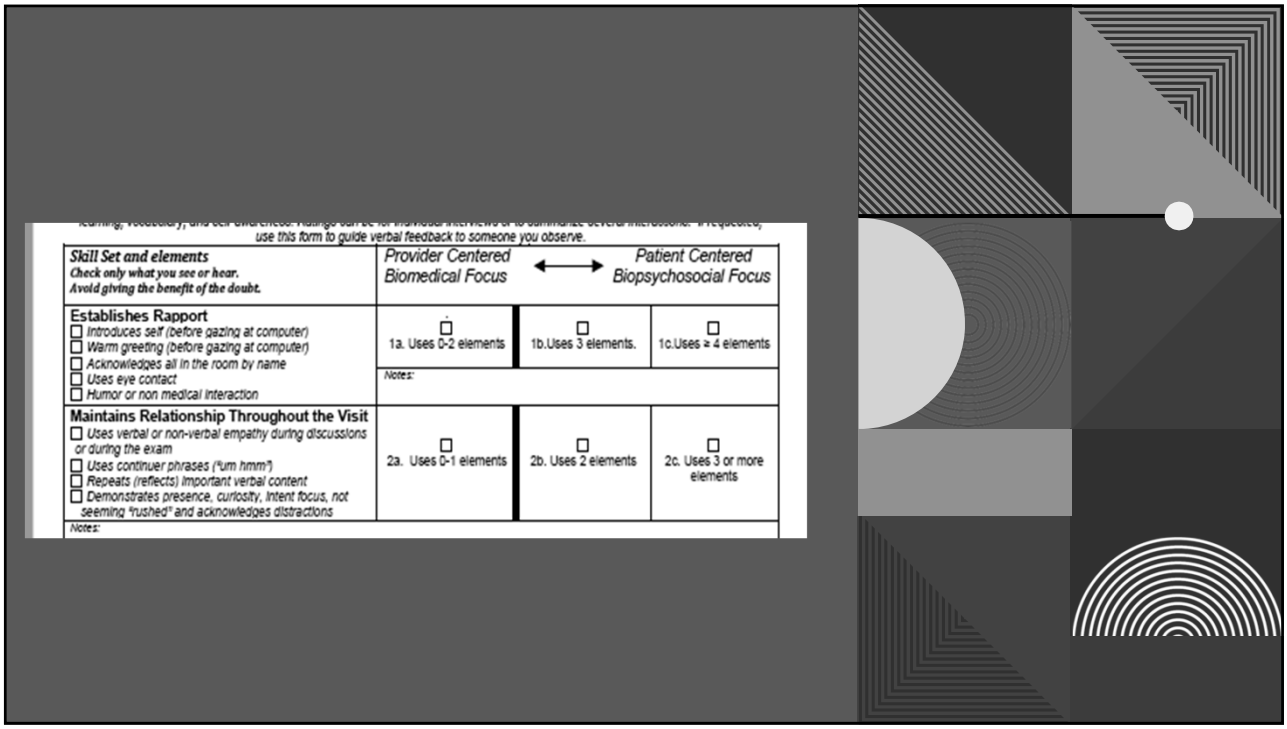


Patient Centered Observation Form - Clinician version

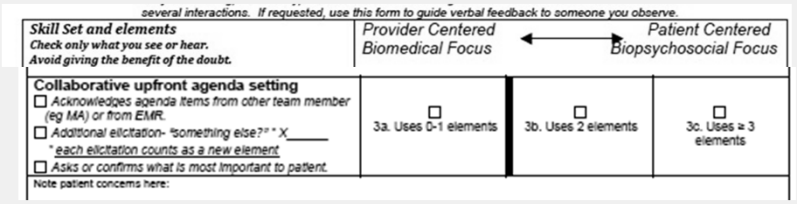
Trainee name_____ Observer_____ Observ#____ Date_____

Directions; Track behaviors in the left-side column. Mark one box per row. Competent skill use is in either of the two right side columns. Only rate what you see; avoid giving benefit of the doubt. Use notes to record questions, patient cues, and reflections for subsequent discussion and learning. This form is designed to help structure feedback, build vocabulary, and enhance self-awareness. . There is an inverse relationship between patient complexity and demonstration of competence until sufficient training is acquired. No single observation should characterize competency; as the number of observations increases so does the accuracy of competency assessment.

Skill Set and Elements ***Check only what you see or hear. Avoid giving the benefit of the doubt.***	*Provider Centered Biomedical Focus* ← → *Patient Centered Biopsychosocial Focus*		
Establishes Rapport ☐ Introduces self (before gazing at computer) ☐ Warm greeting (before gazing at computer) ☐ Acknowledges all in the room by name ☐ Uses eye contact ☐ Humor or non-medical interaction	☐ 1a. Uses 0-2 elements	☐ 1b. Uses 3 elements	☐ 1c. Uses ≥ 4 elements
Notes: ***FM ACGME Milestones 2.0 ICS 1.1 - 1.4***			
Maintains Relationship Throughout the Visit ☐ Uses verbal or non-verbal empathy during discussions or during the exam ☐ Uses continuer phrases ("*um hmm*") ☐ Repeats (reflects) important verbal content ☐ Demonstrates presence, curiosity, intent focus, not seeming "rushed" and acknowledges distractions	☐ 2a. Uses 0-1 elements	☐ 2b. Uses 2 elements	☐ 2c. Uses ≥ 3 elements
Notes: ***ICS 1.1-4; PROF 1.2-4***			
Collaborative Agenda Setting ☐ Acknowledges agenda items from other team member (e.g., MA) or from EMR. ☐ Additional elicitation- "*something else?*" X_____ Each elicitation counts as a new element ☐ Asks or confirms what is most important to patient.	☐ 3a. Uses 0-1 elements	☐ 3b. Uses 2 elements	☐ 3c. Uses ≥ 3 elements
Note patient concerns here: ***ICS 1.2; PC 2.4***			
Maintains Efficiency Using Transparent (out loud) Thinking and Respectful Interruption: ☐ Talks about visit time use / visit organization ☐ Negotiates priorities (includes provider agenda items) ☐ Talks about problem solving strategies ☐ Respectful interruption/redirection using ***EEE***: Excuse yourself, Empathize/validate issue being interrupted, Explain the reason for interruption (e.g., Topic Tracking)	☐ 4a. Uses 0 elements	☐ 4b. Uses 1 element	☐ 4c. Uses ≥ 2 elements
Notes: ***ICS 1.2-4; Prof 2.1-3; PC 2.4***			
Gathering Information ☐ Uses open-ended question X_____ ☐ Uses reflecting statement X_____ ☐ Uses summary/clarifying statement X_____ Count each time the skill is used as one element.	☐ 5a. Uses 0-2 elements	☐ 5b. Uses 3 elements	☐ 5c. Uses ≥ 4 elements
Notes: ***ICS 1.2; MK 2.1***			
Exploring Patient or Family Perspective on Health ☐ Acknowledges patient verbal or non-verbal cues. ☐ Explores patient beliefs (explanatory model) or feelings ☐ Explores contextual influences: family, cultural, spiritual. Number of patient verbal / non-verbal cues_____	☐ 6a. Uses 0 elements	☐ 6b. Uses 1 element	☐ 6c. Uses ≥ 2 elements
Notes: ***ICS 1.3-4; PC 1.3-4; PC 2.2, 2.4; PBLI 1.***			



PCC SKILLS: AGENDASETTING



1. Acknowledge: "I see you're here to discuss diabetes..."
2. Elicit: "Is there something else?"
   This is done until patient say's "No."
3. Prioritize: "We will have time to address two of those concerns, which is most important to you?"

Complete first before discussing details of concerns for:

Efficiency/time management

Patient-centered!

PCC SKILLS: AGENDASETTING

…getting into the nittygritty

"What brings you intoday?"

- Might be different from reason on appointment or what they've told theMA
- Assess if patient awareness of theirhealthcare needs
- ….might be the 3rd time patient has had to relay this info

"You're here for…."

- Demonstrates PCP preparation
- Demonstrates communication
- More efficient
- Agenda setting process will assess if patient has other concerns

PCC SKILLS: AGENDASETTING

…getting into the nittygritty

Patient-Centered

- Identify patient's needs/goals forvisit
  - **80%** of patients' expectations are not met during PC visits
  - PCP's often assume:
    - First thing the patient mentions in most important
  - Patients will spontaneously report allconcerns
- When done well, more concerns get addressed in same amount of time

Example scripts from Mauksch,2001

(Epstein, Mauksch, Carroll, & Jaen, 2008: Irish, 1995; Kravitz, 1996; Mauksch, Dugdale, Dodson & Epstein, 2008).

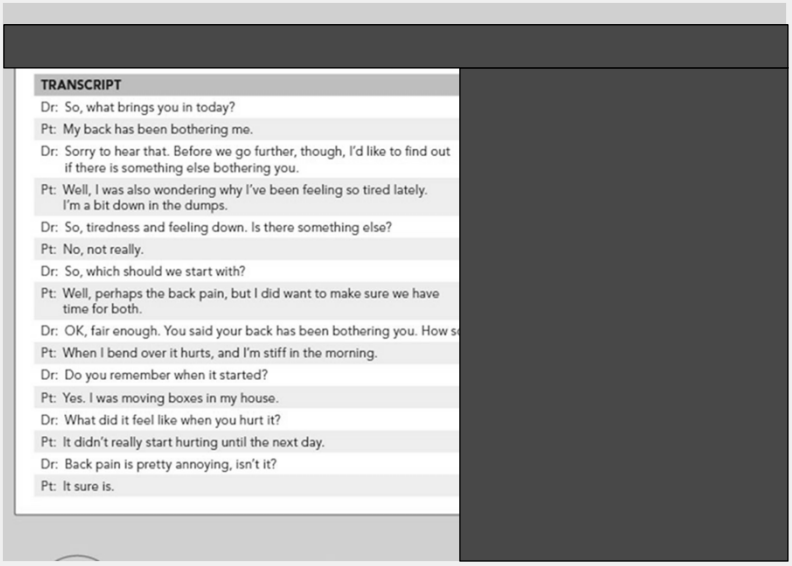
PCC SKILLS: AGENDASETTING

TRANSCRIPT
Dr: So, what brings you in today?
Pt: My back has been bothering me.
Dr: What kind of work do you do?
Pt: Um, well, I was an administrative assistant as of the beginning of January, but I got laid off, so –
Dr: So, recently laid off.
Pt: Yes.
Dr: OK. OK. And when was your last physical exam, like pelvic exam, breast exam and all that?

PCC SKILLS: AGENDASETTING

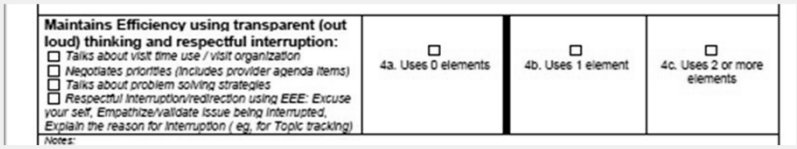
TRANSCRIPT
Dr: So, what brings you in today?
Pt: My back has been bothering me.
Dr: How so?
Pt: When I bend over, it hurts, and I'm stiff in the morning.
Dr: Do you remember when it started?
Pt: Yes. I was moving boxes in my house.
Dr: What did it feel like when your hurt it?
Pt: It didn't really start hurting until the next day.
Dr: Back pain is pretty annoying, isn't it?
Pt: It sure is.

PCC SKILLS: AGENDASETTING



TRANSCRIPT
Dr: So, what brings you in today?
Pt: My back has been bothering me.
Dr: Sorry to hear that. Before we go further, though, I'd like to find out if there is something else bothering you.
Pt: Well, I was also wondering why I've been feeling so tired lately. I'm a bit down in the dumps.
Dr: So, tiredness and feeling down. Is there something else?
Pt: No, not really.
Dr: So, which should we start with?
Pt: Well, perhaps the back pain, but I did want to make sure we have time for both.
Dr: OK, fair enough. You said your back has been bothering you. How s
Pt: When I bend over it hurts, and I'm stiff in the morning.
Dr: Do you remember when it started?
Pt: Yes. I was moving boxes in my house.
Dr: What did it feel like when you hurt it?
Pt: It didn't really start hurting until the next day.
Dr: Back pain is pretty annoying, isn't it?
Pt: It sure is.

PCC SKILLS: MAINTAIN FOCUS/EFFICIENCY



Maintains Efficiency using transparent (out loud) thinking and respectful interruption: ☐ *Talks about visit time use / visit organization* ☐ *Negotiates priorities (Includes provider agenda items)* ☐ *Talks about problem solving strategies* ☐ *Respectful Interruption/redirection using EEE: Excuse your self, Empathize/validate issue being interrupted, Explain the reason for interruption (eg, for Topic tracking)*	☐ 4a. Uses 0 elements	☐ 4b. Uses 1 element	☐ 4c. Uses 2 or more elements
Notes:			

The polite interruption

Not all interruptions are intrusive, competitive, or power-claiming[26]

The three E's

Excuse: "I'm sorry to interrupt…"

Empathize: "….your back pain sounds distressing."

Explain: "I want to make sure we finish addressing your asthma, and then if we have time we can address your back pain today or schedule another visit."

Patient who is repetitive, disorganized and/or tangential

Forgive me. You are sharing a lot and I can see you are really bothered about … your headache, fatigue, allergy, stomach pain … and this is frustrating and scary for you. I would like to switch gears and ask several specific questions, then do an exam to make sure we develop a plan that works best for you.

(Irish & Hall, 1995)

PCC SKILLS: GATHERING INFORMATION

Gathering Information			
☐ Uses open-ended question X ☐ Uses reflecting statement X ☐ Uses summary/clarifying statement X Count each time the skill is used as one element	☐ 5a. Uses 0-1 elements	☐ 5b. Uses 2 elements	☐ 5c. Uses 3 or more elements

Notes:

Basic Counseling Skills

- Non-directive, non-judgmental
  - Tell me about…How is the anxiety impacting your life?
- Reflections/summaries: Demonstrates listening and understanding of what patient is saying, or opportunity to be corrected

PCC SKILLS: ASSESSING PT/FAMILY PERSPECTIVE

Exploring Patient or Family Perspective on Health ☐ Acknowledges patient verbal or non-verbal cues. ☐ Explores patient beliefs (explanatory model) or feelings ☐ Explores contextual influences: family, cultural, spiritual. Number of patient verbal / non-verbal cues_____	☐ 6a. Uses 0 elements	☐ 6b. Uses 1 element	☐ 6c. Uses ≥ 2 elements
Notes: ***ICS 1.2-4; PC 1.2-4; PC 2.2, 2.4; PBLI 1.***			

Verbal and non-verbal cues

Individual and cultural beliefs

- What are your/family/cultural beliefs about:
  - What is wrong?
  - What might be causing this issue?
  - What might make it better?
  - *Experiences with the medical system*

Contextual influences

- Work –Love –Play –Health Behaviors

	Biomedical Focus		Focus
Electronic Medical Record Use ☐ *By 10 seconds, describes reason for each screen gaze* ☐ Shares/points at screen during at least 2 visit phases (agenda setting, history, Rx / Lab review, typing AVS) ☐ Maintains eye contact / shares screen ≥ $^2/_3$ of the visit ☐ Asks patient to confirm or contribute to documentation	☐ 7a. Uses 0 or 1 elements.	☐ 7b. Uses 2 elements	☐ 7c. Uses ≥ 3 elements
	Notes: ***ICS 3.1-3.4 PROF 2.3-4; SBP 3.2***		

Balancing charting/using EHR w/maintaining rapport

Including patient in the process

Efficiency

PCC SKILLS: PHYSICAL EXAM

Physical Exam ☐ *Prepares patient before physical exam actions and describes exam findings during the exam* *("I am going to ___" then "your lungs sound healthy")*	☐ 8a. 0-1 exam elements (eg., lungs)	☐ 8b. 2 exam elements (eg, heart, lung)	☐ 8c. > 2 exam elements (eg, heart, lung, ears)
Notes:			

Prepare

- Reduces anxiety/discomfort
- Trauma-informed

Describe

- Includes patient in their health/body
- Reduces anxiety that's caused by lack of information

PCC SKILLS: SHARING INFO

Sharing Information / Patient Education ☐ Tailors to patient health literacy needs; avoids jargon ☐ Summaries cover biomedical concerns ☐ *Summaries cover psychosocial concerns.* ☐ Invites Q/A	☐ 9a. Uses 0-1 elements	☐ 9b. Uses 2 elements	☐ 9c. Uses ≥ 3 elements
Notes: ***ICS 1.3; PC 2.3 PC 4.3 MK1.1-4***			

PCC SKILLS: BEHAVIOR CHANGE

Behavior Change / Self-Management **Clinician Asks:** ☐ *If patient wants to set a behavior change goal* ☐ *Patient to brainstorm activities to reach goal* ☐ *Patient to pick specific activity* ☐ *Patient to name activity frequency and time of day* ☐ *How will patient track effort and progress?* **Clinician offers:** ☐ *Guidance about personal, environmental or relational behavior change strategies* ☐ *Affirmations of past or current efforts*	☐ 10a. Uses 0-2 elements or lectures patient	☐ 10b. Uses 3 elements	☐ 10c. Uses ≥ 4 elements
Notes: ***ICS 1.4 PC 2.3-4; PC3.1-4; MK1.2-4;***			

Medical culture has historically been prescriptive

E.g. Smoking is bad, you should stop

Engaging Patient in goal-setting → Behavior change

PCC SKILLS: SHARED DECISION-MAKING

Co-Creating a Plan / Shared Decision-Making
- ☐ Describes options to address patient concerns
- ☐ Discusses pros, cons and uncertainties of options
- ☐ Asks for patient preferences
- ☐ Identifies and resolves decisional differences, if any
- ☐ Scales confidence/feasibility to follow plan (1- 10)
- ☐ Assesses patient barriers to follow plan
- ☐ Adjusts plan to address barriers
- ☐ Proposes follow-up plan

*Notes: **ICS 1.3-5; PC1.2-4; PC2.2-4; PC3.2-; SBP 3.3; PBLI 1.3-***

Closure
- ☐ Asks for questions about today's topics.
- ☐ Co-creates an After Visit Summary
- ☐ Uses Teachback. = Asks the patient to explain his/her understanding of the plan
- ☐ Combines Teachback and AVS creation while sharing the screen or notepad. (Counts for 3 elements)

*Notes: **ICS 1.1-2; ICS 3.1, 3.3-4; SBP 3.2***

- **Assesses patient's understanding** of the treatment plan
  - Asks for questions
  - Uses teach-back
  - Provides written plan

Describes options and **facilitates patient decision** regarding treatment
- Pros/Cons
- Discusses uncertainties and preferences
- Assesses confidence and barriers

PRACTICING PCC ASSESSMENT

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

Take notes on form

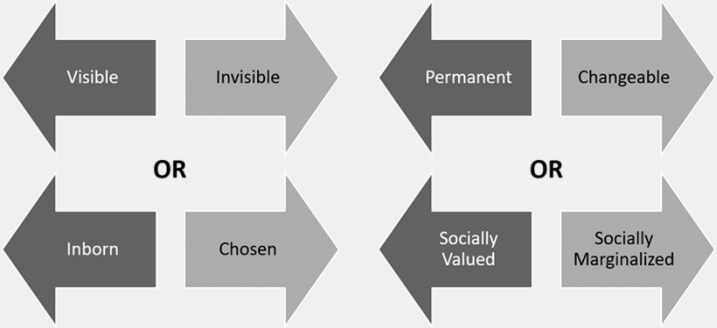
GIVING EFFECTIVE FEEDBACK

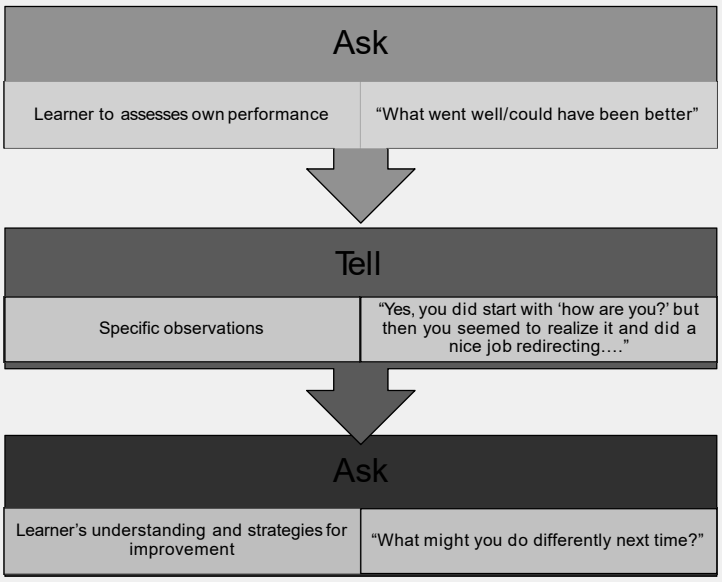
- Considers learner's stage of professional developmental
- Specific
- Timely
- Engages the learner
- Checks bias

BIASES AND POWER DIFFERENTIAL

Biases can lead to being over or under criticizing.

Effects how feedback is delivered and received



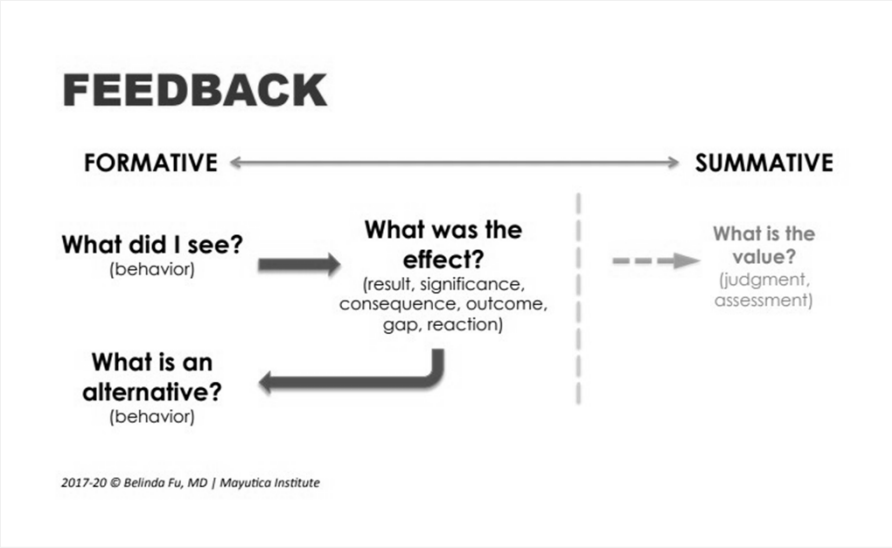


GIVING FEEDBACK

A new kind of sandwich

Let's Practice!

BELINDA FU, MD MODEL



SUMMARIZING THE BEHAVIORAL SCIENTIST ROLE

Train medical providers to offer whole person, biopsychosocial, equitable, care that is respectful of, and responsive to, individual patient preferences, needs and values.

- **Behavioral/mental health diagnoses and interventions**
- **Patient Centered-Care**
- **Antiracism and Health Equity**
- **Working on integrated teams**
- **Wellness/Resiliency**

OTHER TEACHABLE MOMENTS

After warm hand-off/Curbside consults

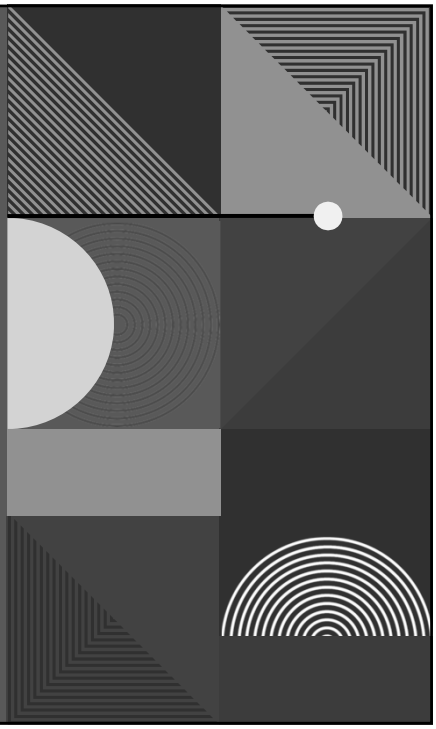
Recommendations in chart

Informal conversations

OTHER TEACHABLE MOMENTS

Scenario: You respond to a hand-off request for a 45yo Latinx male who complains of racing heart and tightness in his chest. PCP has ruled-out physiological causes of these symptoms and believes it's anxiety. You meet with patient. Going through time, trigger, trajectory of these symptoms you find out they started right after he was almost hit by a car. When directly asked, he denies feeling anxious. You explain the physiology of the stress response and teach him deep breathing to help with the racing heart and tightness in his chest.

PCP recommendations: Pt's sx's are likely the result of almost being hit by a car two week ago. He does not identify with having anxiety but was responsive to focusing on the physiology of stress and practicing deep breathing to alleviate his sx's. We want to cont' to focus on the physical sx's rather than labeling it anxiety.

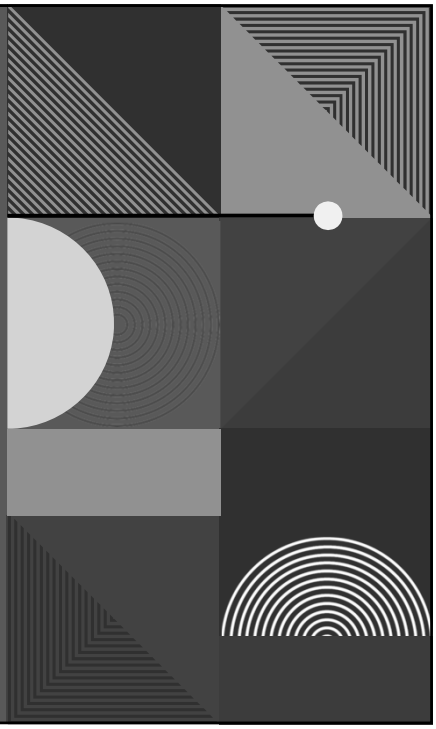


OTHER TEACHING MOMENTS

Scenario: You're standing in the team area. Resident comes out of an exam room clearly frustrated. She has just seen a patient that you have worked with. The resident says to you, "Why is she so mean to me? She's impossible to work with, as soon as I say I'm not going to increase her pain medication she stops listening to me."

Your response:

"I hear you, visits with her can be challenging. She's in a lot of pain and doesn't feel like people understand that. Sometimes all we can do is listen and let her know we hear her pain."



TEACHABLE MOMENTS

Modeling patient-centered care

- Responding to biases, insensitivities, microaggressions, overt discrimination etc…..

Scenario: You're shadowing a resident to evaluate their PCC skills. You're listening in as the resident is describing a patient who he thinks might have sleep apnea. The preceptor is sharing that sometimes getting a patient to sleep on her/his side is enough to address the issue. The preceptor says, "Here's what you do, you tell the patient to have his wife sew a pocket on the back of his t-shirt and to put a tennis ball in that pocket so that every time he tries to roll onto his back at night the ball stops him."

NO MATTER WHERE YOU GO…

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