Methods for Developing and Modifying Behavioral Medicine Curriculum to Prepare Residents for Interdisciplinary/Integrated Care

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Disclosures

- None
- To the best of our knowledge, no traumatic materials will be discussed during this presentation

Goals and Objectives

1. Articulate a rationale to leadership for updating or modifying their behavioral medicine curriculum.

2. Equipped with evidence-based frameworks that they can use for developing and modifying curricula that align with ACGME milestones and competency across multiple domains.

3. Identify modern educational strategies for preparing residents as effective leaders and providers in an interdisciplinary/ integrated care practice.

Intended Audience

- Family medicine faculty (medical doctors, psychologists, etc.) or those interested in medical education.
- Those interested in creating, adopting, or modifying existing behavioral medicine curriculum.

Rationale

- Health care reform necessitates change in training to be more integrated and interdisciplinary.

Institute *for* Healthcare Improvement

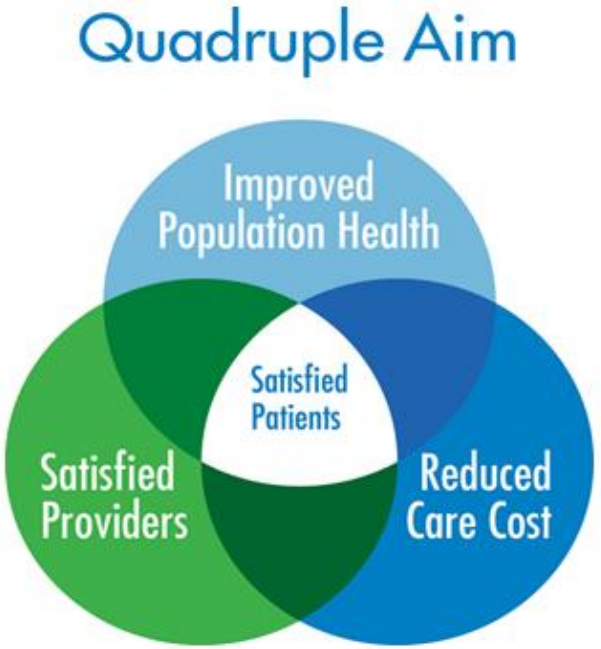


Image 1: Cooper Health Care (2018).

Rationale

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)

[The Review Committee must further specify]

Common Program Requirements (Residency)

ACGME

Rationale

INSTITUTE OF MEDICINE

IOM Report: Improving Medical Education—Enhancing the Behavioral and Social Science Content of Medical School Curricula

Institute of Medicine

Roughly half of all deaths in the United States are linked to behavioral and social factors. The leading causes of preventable death and disease in the United States are smoking, sedentary lifestyle, along with poor dietary habits, and alcohol consumption. In addition to adverse health effects of harmful behaviors, psychological and social factors have also been shown to influence chronic disease risk and recovery. Psychological factors, such as personality, developmental history, spiritual beliefs, expectations, fears, hopes, and portion of the population aged 65 and over is expected to grow by 57 percent by 2030, and with Americans now having an average life expectancy of 77 years, physicians need the knowledge and skills to care for this aging population. To this end, they must understand the interplay of social and behavioral factors (e.g., diet, exercise, and familial and social support) and the role these factors play in delaying or preventing the onset of disease and slowing its progression. A second demographic change is the rising percentage of minorities in the overall U.S.

National Academy of Sciences
doi: 10.1197/j.aem.2005.07.009

Rationale

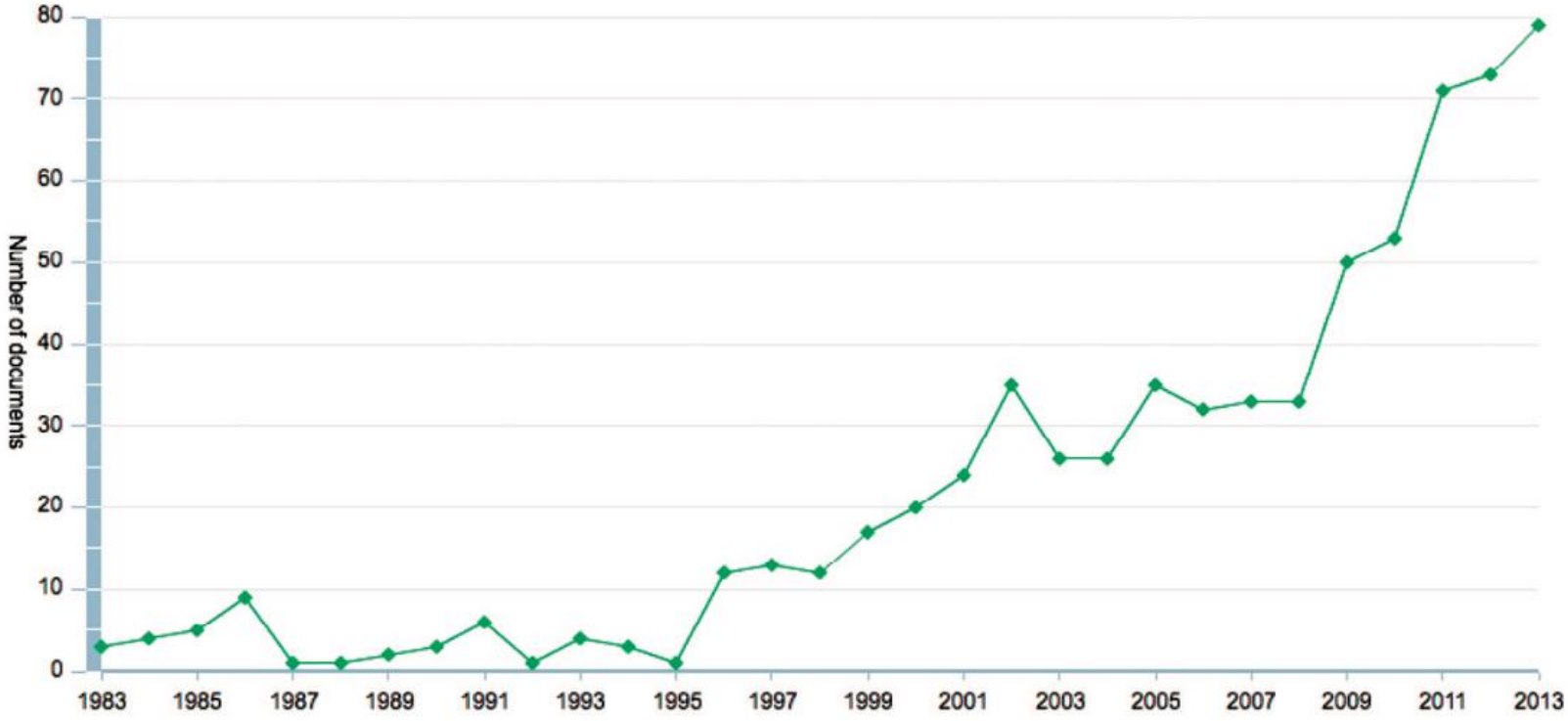


Figure 1. "Integrated curriculum" in the literature, 1983–2013. Published uses of "integrated curriculum", 1983–2013, in the Scopus database, Health Sciences and Life Sciences subject areas (Scopus 2014). A significant increase in the publications utilizing the term "integrated curriculum" can be seen, particularly within the last two decades.

Adapted From:
Kotter 8-Step Model For Leading Change

Rationale

Rationale

- Multiple approaches exist (Kern/Thomas, Kotter, etc.)
- Variety of health care problems faced by current educators
  - Need to update outdated BM curricula
  - Changes is faculty
  - Residencies without prior formal BM curricula
  - Increased focus on interdisciplinary care

Overview

- Develop a behavioral medicine curriculum, following Thomas et. al. (2016) six-step model, which is ACGME compliant for a Family Medicine Residency Program
  - Problem Identification and General Needs Assessment
  - Targeted Needs Assessment
  - Goals and Objectives
  - Educational Strategies
  - Implementation
  - Evaluation and Feedback

Problem Identification & General Needs Assessment

- Health Care Problem
- Current Approach
- Ideal Approach

Health Care Problem

- Single accreditation system (ACGME)
- Residency was an AOA-Accredited program
- Residency reported wanting assistance with resident/patient communication, addressing wellness/burnout, and assisting with ACGME
- Need to prepare residents for increased focus on interdisciplinary treatment

Current Approach

- Behavioral Medicine
  - No formal behavioral medicine curriculum
- Psychiatry Rotation
  - Residents previously rounded with the psychiatrists on their inpatient unit, no formal curriculum

Ideal Approach

- ACGME Compliant
- Able to be managed by one provider
- Consists of both longitudinal and focused approaches
- Longitudinal
  - Year-long, with all learners (residents)
- Focused
  - Block-long, with one resident at a time

Targeted Needs Assessment

- Learners
- Learning Environment

Learners

- PGY-I's, II's, and III's at the residency program
  - AOA-accredited residency
  - No history of a behavioral medicine faculty member

Learning Environment

- Based on multiple meetings with CMO, CEO, residency director, psychiatrists, and current residents, a number of needs were identified by resident year.

Goals and Objectives

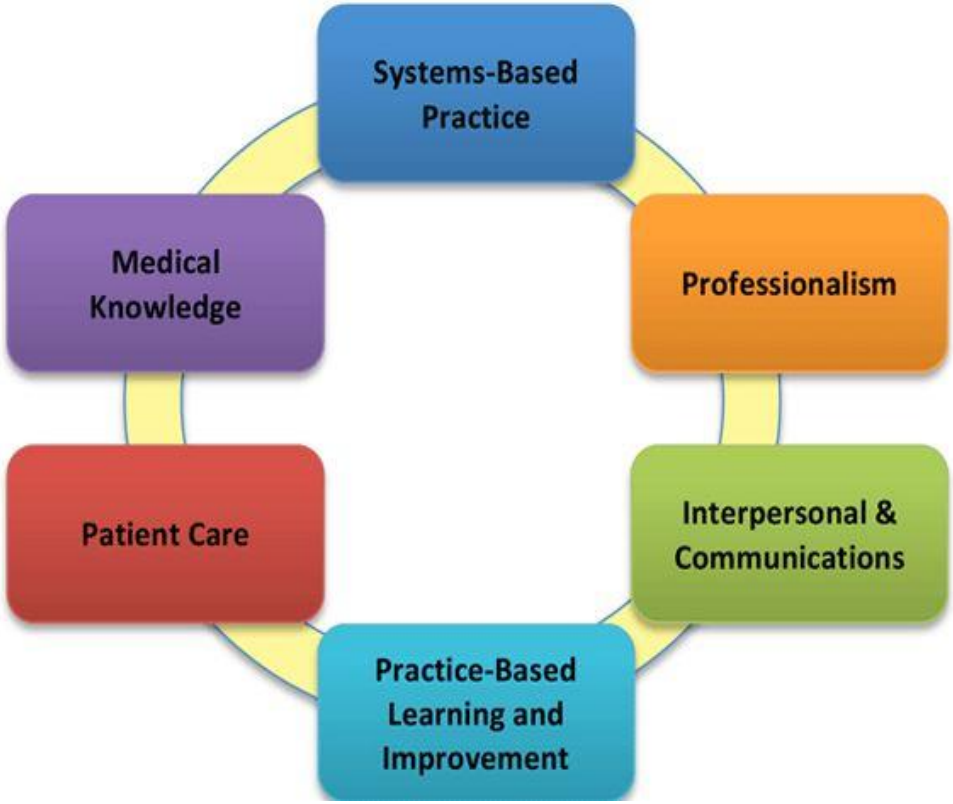
- Broad Goals
- Specific Measurable Objectives

Broad Goals

- Increase resident behavioral medicine/psychiatry knowledge-base and clinical skills
- Improve resident communication skills
- Improve resident professionalism skills
- Assist with becoming ACGME-accredited

Specific Measurable Objectives

- Track residents progress: Milestones, core-competencies
- Individual tracking using the Patient Centered Observation Form
- Participate in resident 360-evaluations
- Tests on BoardVitals psych related FM questions



Educational Strategies

- Content
- Method

Content

- Based on needs assessment
- Using an online portal
- Developed year-specific lectures, readings, clinical experiences, goals/objectives

Content

PGY-I	PGY-II	PGY-III
Risk (SI/HI/Abuse)	Substance Use	Antipsychotics
Clinical Interviewing	Opiate Use Disorder	Gender Identity & Development
Antidepressants/ Anxiolytics	Chronic Pain & Treatment	Sexual Orientation
Mood, Anxiety, & Thought D/O	Neurocognitive D/O & Delirium	Somatic & Personality D/O

Method

- Focused
  - Two half-days Consultation-Liaison (Hospital)
  - One half-day Behavioral Precepting (Clinic)
  - One half-day Lecture/Reading
  - One half-day of focused lectures/readings by year
  - Incorporating online portal

Method

- Longitudinal:
  - Biopsychosocial Lectures provided throughout the academic year
  - Psychiatry/Psychology Lectures during core block of AHD
  - Incorporating online portal
  - Wellness

Implementation

- Obtaining Political Support
- Securing Resources
- Addressing Barriers
- Introducing the Curriculum
- Administering the Curriculum

Evaluation and Feedback

- Individual Learner
- Program

Modifying an Existing Curriculum

- 2016-2017
  - Rationale
  - Methodology
  - Curriculum Framework
- 2017-2018
  - Implementation Results
  - Resident feedback
  - Reflections

Rationale & Opportunity for Change

- Outdated
- Evolution of health care
- Change in BH services

Methodology

Review literature and current training materials PGY 1-3 packets and determine relevance to

- ACGME milestones
- Population served
- BH services

Curriculum Consultation

- Develop semi-structured interview
- Consultation (N = 7)
- Conduct an informal thematic analysis

Curriculum Consultation Themes

Faculty Role

- Broadly respected for expertise that the Beh Sci faculty provides
- Provided independence and significant support to develop/modify curriculum
- Significant reinforcement for providing feedback during CCC
  - ❿ Use of PCOF
  - ❿ New Innovations or other evaluation system

Curriculum Consultation Themes

Structure

- Block vs Longitudinal – Mix, but if block then there is a longitudinal overlay
- Time – varies from working with residents every year, to heavy in one or two years, some offer elective

Direct time

- Didactic: 8-12 hrs of lecture time/yr
- Direct observation: >4, 0.5 d/yr
- Behavioral precepting: 0.5-1.5d/wk

Curriculum Consultation Themes

Training Materials

- Mild reading loads, dedicated time, and directed readings with write-up or discussion (if you don't tell them, they won't do it)
- Mild-Mod presence of video/webinar training

Others providing training

- Providers: BHC, SW, Care Coordination, Pain management, Addiction Specialist
- Faculty: Pediatric Psychiatry, Geropsychiatry, C/L & Inpatient Psychiatry, PharmD.

Curriculum Consult Recommendations

- Seek resident feedback and input regularly and when considering and implementing curriculum modifications
- Utilize other specialties and available resources (FMDRL)
- Hot training topics:
  - Public health concerns (pain, polypharmacy),
  - Professionalism & interpersonal skills,
  - Integrated Primary Care / PCBH / PCMH
  - Diverse populations, cultural sensitivity

PGY 1 Framework

Common MH problems

- Identify
- Learn screening protocol
- Develop diagnosis
- Identify appropriate medication or referral

BH services

- Warm Handoff
- Available Services
- Integrated treatment plan
- Complete referral

CDSM

- Assess history
- Learn stages of change
- Describe brief MI & behavioral interventions

CDSM = Chronic Disease Self-Management

Interpersonal skills

- Gain self-awareness
- Identification of unique patient characteristics
- Learn basic patient centered interviewing skills

PGY 2 Framework

MH/BH Problems

- Case directed lit review, guidelines
- Complete an appropriate warm handoff
- Prescribing psychotropic medications

CDSM

- Determine stage of change
- Employ basic MI and CBT interventions
- Create individualized SMART goals

Interpersonal skills

- Adjust interpersonal style appropriately
- Effective use of agenda setting and BATHE/NURS skills
- Learn goal setting and visit summary skills
- Cultural competence & sensitivity

PGY 3 Framework

MH/BH management

- Coordinate with BHPs and/or refer to CMHs
- Employ basic MI and CBT interventions
- Appropriate psychotropic med mgmt
- Develop integrated treatment plans with BHP
- Risk Management

Interpersonal skills

- Align and partner with difficult patients
- Appropriate history gathering
- Cultural competency & sensitivity
- Effective patient - centered interviewing skills

Implementation 2017-2018

- Residents informed us that the new curriculum was the most extensive and thorough of any of their rotations.
  - Some rotations do not have any assigned curriculum beyond shadowing experiences
- Residents were surprised at the volume of material.
- Our previous curriculum had grown so outdated that residents did not typically complete the readings, resulting in transition to new expectations of completing the updated curriculum.

Implementation 2017-2018

- What's Worked:
  - Webinar-based learning
    - Matching generational learning style to curriculum
  - Using ACGME Milestones as a guide in identifying the underlying foundational learning components

Implementation 2017-2018

- What's Worked:
  - Linking the specific curriculum items to the underlying foundational components
  - Focus on practical aspects of Beh Sci related to primary care medicine, for example:
    - Differential diagnoses of common psychopathology seen in primary care (i.e., insomnia secondary to ruminating worry vs. mania)
    - Effective communication with resistant patients

Implementation 2017-2018

- What Hasn't Worked:
  - Curriculum requirements for weekly timeline to complete readings during rotation
    - Residents prefer self-directed timeline to accommodate PTO / their personal schedule
  - Literature review requirement
    - While we (Beh Sci) feel this to be an important learning goal / task, residents have been avoidant to completing a lit review with exception of PGY-III Sept-Dec rotation residents (time coincides with their senior project)

Implementation 2017-2018

- Ideas for Ongoing Improvements:
  - Review and identify some items to make "reference" rather than "required"
  - Look for ways to add more Board Prep into curriculum.
    - Current curriculum covers psychopharm via webinar
    - ACGME milestones align much closer to traditional Beh Sci curriculum than Board Prep, yet residents have inherent motivation to focus on Board Prep items.

Reflection & Discussion