Teaching Behavioral Sciences to Family Practice Residents: The "Shared Care" Approach

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Conflict of Interest
Jon Davine

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Educational Presentation, Advisory Board Member

AGENDA

- Description of Behavioural Sciences Program at McMaster University
- Description of program at University of Manitoba
- Using video in clinical supervision

Overview

- Introduction
- Description of Behavioural Sciences Program
  (DFM, McMaster University)
- Goals of Program
- Teaching Methods
- Evaluation
- Conclusions

Introduction

- 70% of antidepressants and 90% of anxiolytics are prescribed by Family MD's

Introduction

- 15 – 50% of all patients in family medicine have significant psychological dysfunction
- 21% receive care from mental health specialists
- 54% receive care from primary care only
- “De Facto Mental Health System”

Introduction

- 1,000 people

- 250 → 230 → 140 → 17 → 6

Psychologic Morbidity Based on GHQ	Go to FD	Identified by FD	Involved with MH specialist	in patient psych treatment

Description of Program

- Hybrid model at McMaster (FP SW Psychiatrist triad)
- No Block Rotation
- ½ day behavioral sciences x 2 years
- 3 ‘units’ in Hamilton (40-50 residents per year)
- 3 ‘satellite units’ (20 residents)
- PGY1’s and PGY2’s are separated

Description of Program

- Teaching techniques

- Small group format
- Case presentations – video, oral
- Process issues – communication, interpersonal skills
- Content issues – diagnostics, treatments, life cycle, problem based

Description of Program

- Other Teaching Techniques

- Topic centred
- 20-30 topics / 2 years
- Arise out of cases presented, flexible
- Some didactic presentations
- Large group sessions – resident driven, invited speakers

Description of Program

- Other Teaching Techniques

- Case presentations
- Role playing
- Visits to community centres (detox, shelters)
- Representatives from community present to the unit (SISO, CAS)

Description of Program

- Other Teaching Techniques

- Tutor shows his/her own tape
- Viewed by the group
- Tutor as model
- Process and content issues explored

Description of Program

- Who?

- Psychiatrist, Family Doctor, Social Worker
- Hybrid Model
- Multi-disciplinary Model
- Different viewpoints

Description of Program

- Where?

- Family Practice Clinic

Description of Program

- Central coordinator, site coordinators (MFP, SFHC, community, KW, Niagara, Brampton)

- Four times per year
- All tutors attend from all units
- Evaluate program. Discuss what has worked and what has not worked.
- Share ideas/resources.
- Team building/faculty development.

Description of Program

Psychotherapy Modalities

1. Supportive
2. CBT (change therapy)
3. Solution Focused therapy
4. Motivational interviewing

Description of Program

- Curriculum Requirements

- BS is a clinical rotation!
- Attendance Guidelines
- Participation Guidelines
- Evaluation Guidelines

Goals of Program

- Enhance collaborative, interprofessional skills.
- Enhance communication, interpersonal skills.
- Promote FP as primary delivery of mental health care, psych as consultant.

Goals of Program

- Increase detection, diagnostic and treatment skills
- Psychopharmacology
- Psychotherapeutics

Other Teaching Methods

- Large Group Sessions
- 4x/year
- PGY1's and PGY2's are separated
- Topics such as counseling, ethical issues, etc.
- Residents organize some of these sessions themselves

Other Teaching Methods

New update – PeTR

Enrichment month for PGY2's

- CBT
- Motivational Interviewing

Evaluation

- Round table self and group every 6 months
- Individual evaluation every 6 months
- Formal written evaluations of residents and tutors

Evaluation

- Individual evaluation every 6 months
- Involves resident, bs tutor, and family medicine supervisor
- 50% attendance.
- 2 +2 rule, every 6 months
- Must pass “BS” to write the exam. Treated as ‘seriously’ as any other rotation

New Evaluation Forms and Process

- Resident evaluations
  - Four Principles of Family Medicine
  - Reflects objectives of the BS program
  - Formative and Summative
  - Summative based on expectations for level of training
  - Honours longitudinal program
  - Supervisor- larger role
  - Tutor responsible for evaluating tutorial
  - Educational Planning-resident, tutor, supervisor

New Evaluation Forms and Process

- Tutor Evaluation
  - Timely and accurate
  - Formative and summative
  - Incorporates feedback from all residents
  - Honour longitudinal relationship of tutor/resident
  - All tutors evaluated using same form

Funding

- McMaster FHT
- Sessional funding for psychiatrists
- Funding for counselors

Conclusions

- DFM Accreditation Report, April 2009

- Behavioural Sciences "…particularly noteworthy strength of the residency program….unique and effectively meets the needs of the residents."

Conclusions

2007-2008 End of year questionnaire SFHC PGY2

Overall Evaluation	Very Useful			Neutral			Not useful at all
	6	2	1	2			

Conclusions

2007-2008 End of year questionnaire SFHC PGY1

Overall Evaluation	Very Useful			Neutral			Not useful at all
	7		2	1			

NORTHERN CONNECTIONS MEDICAL CLINIC/PSYCHIATRY COLLABORATIVE TEACHING PROJECT

Shared Mental Health Care in Collaboration with

The NCMC Family Medicine Training Centre

Winnipeg, Manitoba

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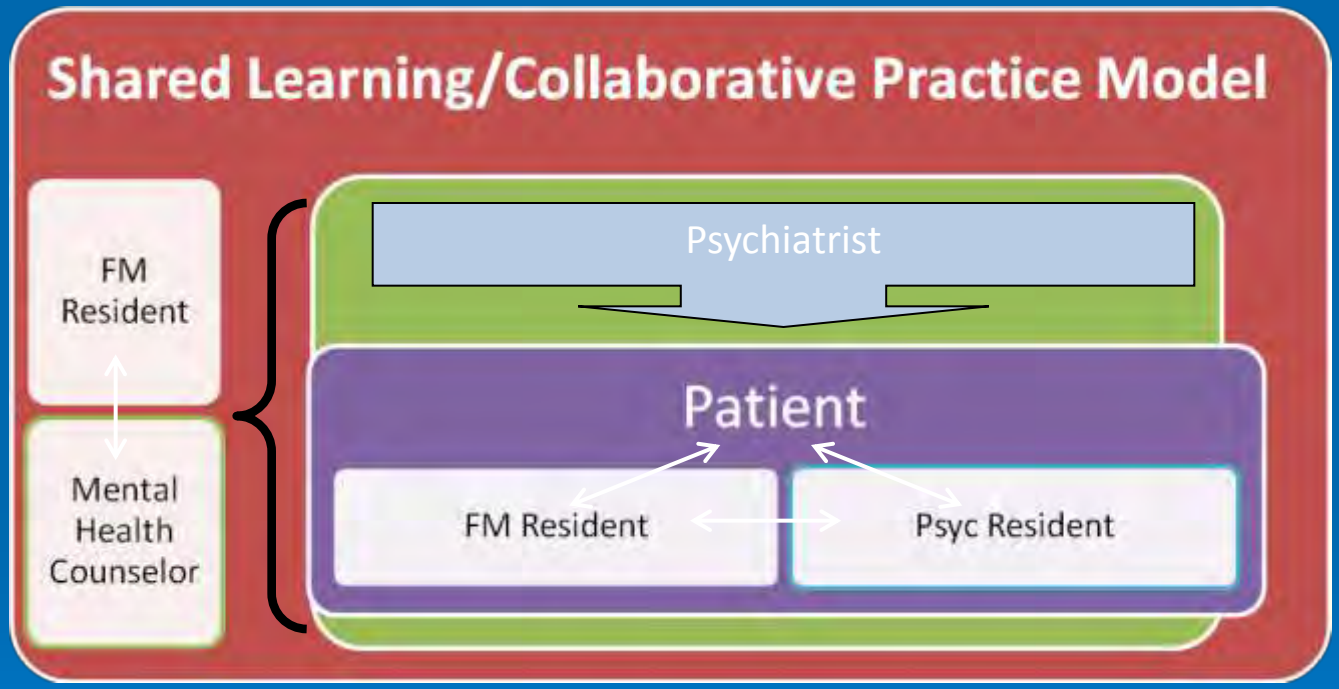
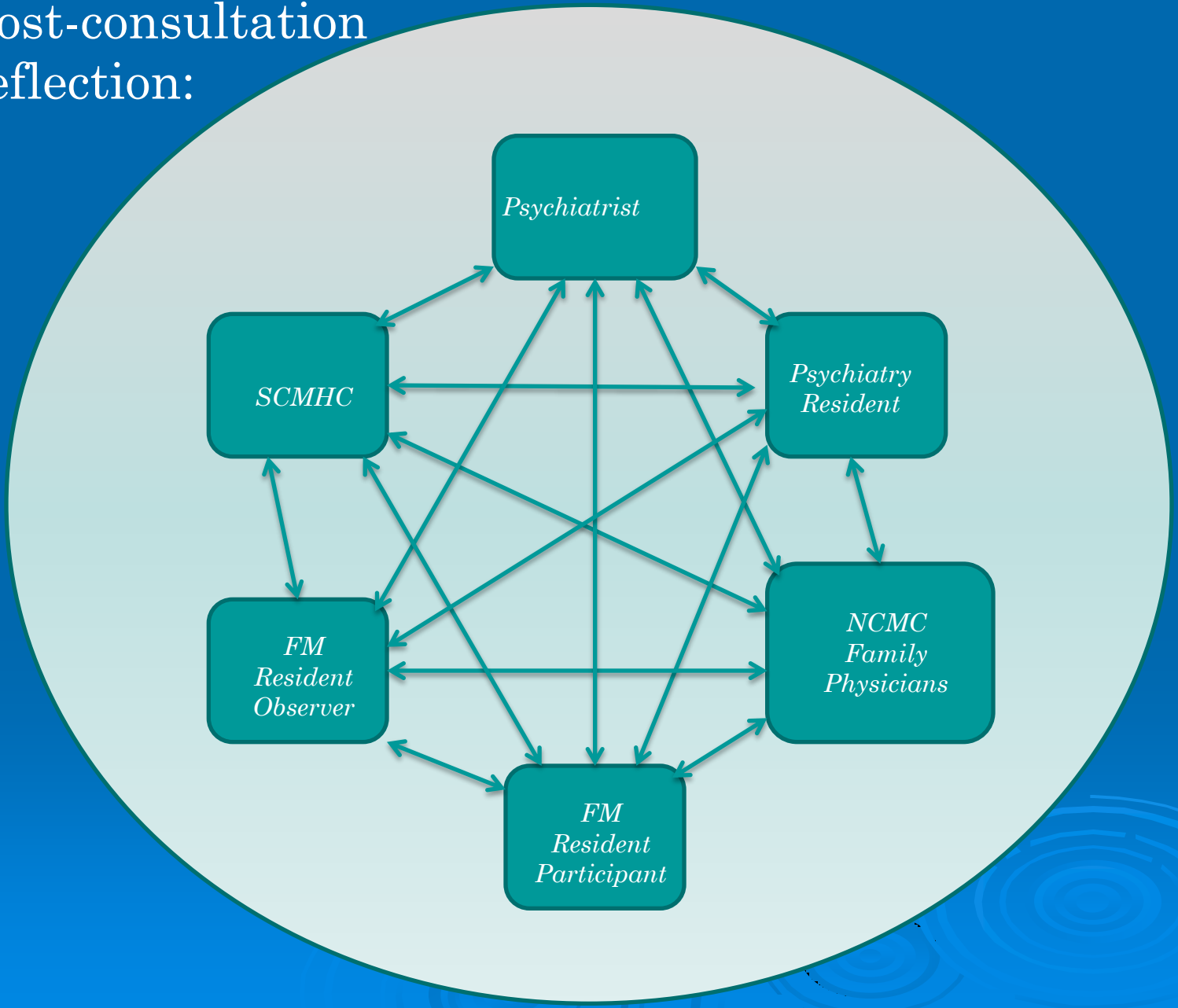
NCMC/PSYCHIATRY TEACHING MODEL

- Participants:
  - FM Residents
  - PGY-4 Psychiatric Resident(s)
  - Psychiatrist
  - Shared Care Mental Health Counsellor
  - Patient(s)
  - NCMC Family Physicians
  - [Psychologist - potentially]

Consultation Mode:



Post-consultation reflection:



DIDACTIC TEACHING: Collaborative & Reflective

- Facts
- Stories and/or Case Review
- Discussion/Questions
- Management

INTERVIEWING: Collaborative & Reflective

- Family Resident starts
- PGY-4 wraps up
- Psychiatrist completes
- Reflective Session Begins
  - Invite the patient to sit in as audience
  - Discussion and Reflections of Strengths & Strategies amongst the interviewees and the counsellor (who joins from behind the mirror).
  - Conclusions and Plan of Action
  - Feed back from Patient who then leaves
- Review of interview content/technique and unique aspects of the particular presentation.
- Review with the Family Physician

A Patient's Perspective

- Found the collaborative – reflective experience most helpful:
  - "I'm not fed bullshit."
  - Thought has been taken in working out options
  - If one thing doesn't work then we'll try another
  - Not just given what comes to mind
  - Compassion

STUDY DESIGN

Philosophy of Providing Mental Health Care

Philosophy of Collaborative Practice

Competencies in Mental Health Care:

1.Identification
2.Interviewing Skills
3.Management
4.Medications
5.Collaboration

Recognition (Knowledge)

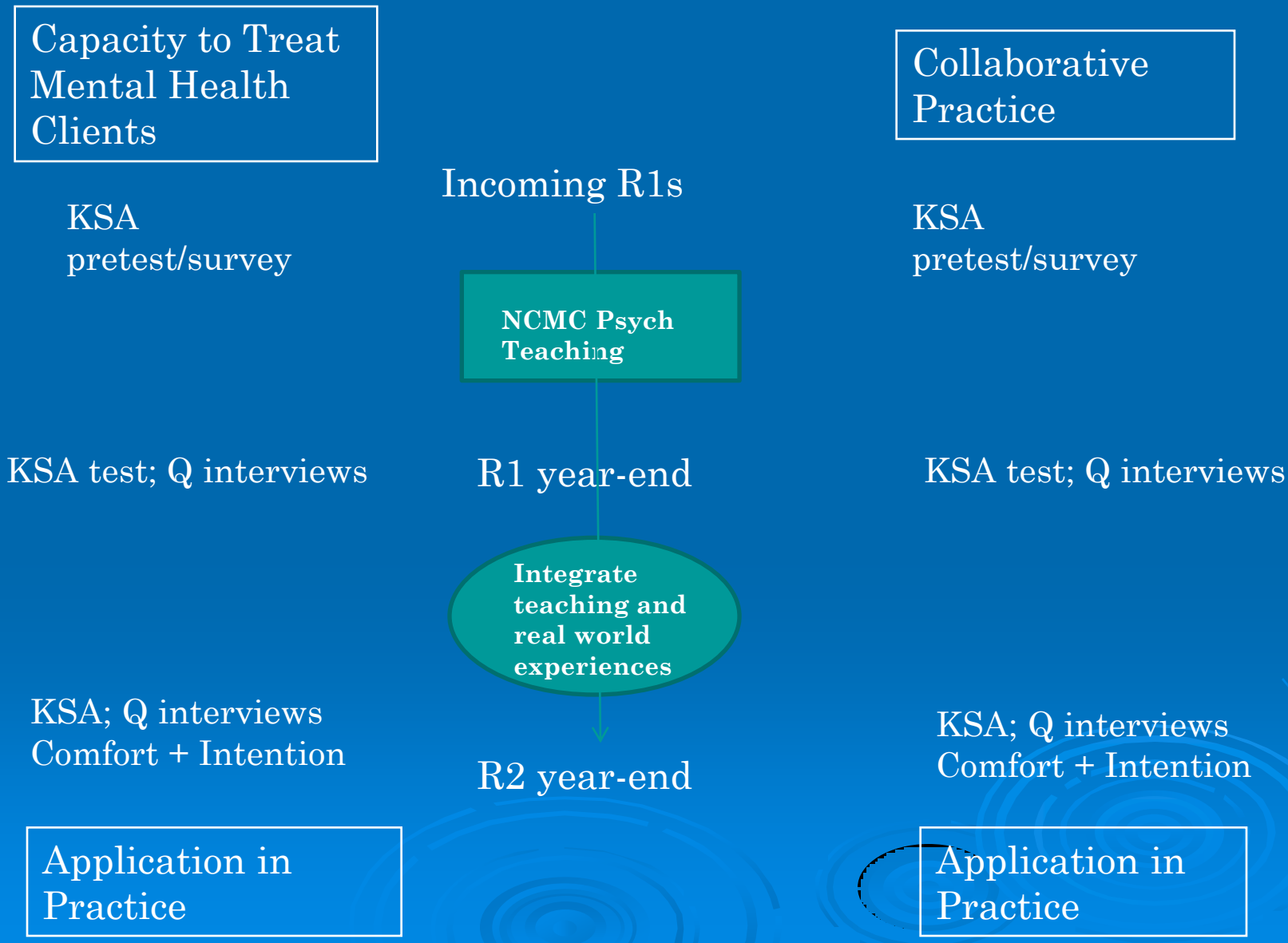
Acceptance (Attitudes)

Application in Practice (Behaviour & Skills)

Core Competencies in Collaborative Care:

1.Role Clarity
2.Communicator
3.Collaborative Leadership
4.Team functioning
5.Pt/Family Centered Care
6.Conflict Resolution

STUDY DESIGN



Competencies	**Exposure: Introduction**	**Immersion: Development**	**Mastery: CPD**
Interpersonal & Communication Skills	Knowledge	Skills Behaviour	
Person-Centred & Family Focused Care	Knowledge Attitudes	Skills Behaviour	
Collaborative Practice Decision Making	Knowledge Attitudes	Skills Behaviour	
Collaborative Practice Roles & Responsibilities	Knowledge Attitudes	Skills Behaviour	
Collaborative Practice Team Functioning	Knowledge Attitudes	Skills Behaviour	
Collaborative Practice Continuous Quality Improvement (CQI)	Knowledge Attitudes	Skills Behaviour	

TOOLS:

- Already have:
  - Family Medicine-Psychiatry Questionnaire
- Need to develop:
  - Knowledge test re: Six Core Competencies in Collaborative Practice
    - (have permission to use Dr Grymonpré's MCQ test)
  - Assessment of Competencies in Mental Health Care
  - Stigma Awareness
  - Post-graduation survey
  - ?? Any other suggestions

NEXT STEPS...

- Review ‘pilot survey’ info
- REB proposal
- Review Evaluation options
- Shared Care Evaluation Survey Review

Using Video in Clinical Supervision

- Help learners become comfortable
- Tape all their encounters
- Tape regularly
- Get consent on tape

Using Video in Clinical Supervision

- Give constructive feedback in a supportive manner
- “McMaster Sandwich”
- Resident to resident feedback important

Using Video in Clinical Supervision

- Presenter gives a preamble
- States learning objectives
- They can decide which specific parts of the tape are important to watch
- Can re-edit if possible
- Presenter keeps remote control
- Any person in the group can stop tape
- Encourage frequent stops

Using Video in Clinical Supervision

- Ask the resident who is presenting for their reflections and ideas
- Then ask other residents
- Then facilitators may speak up

Using Video in Clinical Supervision

- Can ask about attitudes
  - What were you feeling, thinking?
  - What is another way of saying that?
- Can look for non-verbal cues
  - Using silence
  - Making “empathic statements”

Using Video in Clinical Supervision

- Can help develop efficient information gathering skills
- Use of open and closed questions
- Can help develop exact questioning for making psychiatric diagnoses
- Can use the case to get into treatment issues, content issues

Using Video in Clinical Supervision

- Modeling can be helpful
- Facilitators may show their own tapes
- Residents can then critique facilitators
- Showing a tape that did not go well is highly useful for teaching

Using Video in Clinical Supervision

- Try to review the tape as soon as possible from the time of taping
- Residents can then remember more of the issues that were involved in this presentation

Using Video in Clinical Supervision

- Prioritize tapes at the beginning of a session
- Clinical questions take priority
- Let the group decide which tapes may be most appropriate
- Choice also made on viewing particular residents

Using Video in Clinical Supervision

- Log is kept with resident presentations
- Try to ensure that each resident shows the required number of tapes

Using Video in Clinical Supervision

- Non-judgmental supportive critique
- Develop a trusting relationship in which learners feel comfortable with vulnerability
- Be respectful and straightforward

Using Video in Clinical Supervision

- Be specific in feedback, e.g., here is how one could ask these specific questions versus “good interview”

Using Video in Clinical Supervision

- Avoid overloading the learner with feedback
- Get the presenter's reaction to feedback they have received

Using Video in Clinical Supervision

- Advantage of this system: Residents can learn from other people's cases
- An example of this is teaching CBT where we watch one resident with an ongoing case

Using Video in Clinical Supervision

- Use case as platform to explore treatment, epidemiology, personal responses (transference and countertransference) communication

Reference

Westberg J, Hilliard J. Teaching Creatively with Video: Fostering Reflection, Communication and Other Clinical Skills. Springer Publishing Company, New York, 1994.

USING VIDEO IN CLINICAL SUPERVISION

- Lights, camera, action……

emails

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