Session # C6a

Teaching family-centered care to family medicine residents: evaluation of a longitudinal family skills curriculum

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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Bibliography / Reference

1. Zubatsky, M., Harris, S.M., Mendenhall, T.J. (2017). Training experiences of family medicine residents on behavioral health rotations. *Family Medicine,* 49(8), 635-639.
2. Schiefer, R., Devlaeminck, A.V., Hofkamp, H., Levy, S., Sanchez, D., & Muench, J. (2017). A family systems curriculum: back to the future? *Family Medicine*, 49(7), 558-562.
3. Fogarty, C. T., & Mauksch, L. B. (2017). 'Imagine a clinical world without family systems thinking.'. *Families, Systems, & Health*, *35*(4), 395-398. doi:10.1037/fsh0000321
4. Stratton, J. S., Buck, K., & Heru, A. M. (2017). Best practice for family-centered health care: A three-step model. In R. E. Feinstein, J. V. Connelly, & M. S. Feinstein (Eds.), Integrating behavioral health and primary care. (pp. 514–526). New York, NY: Oxford University Press.
5. Korin, E.C., Odom, A.J., Newman, N.K., Fletcher, J., Lechuga, C., & McKee, M.D. (2014). Teaching family in family medicine residency programs: results of a national survey. *Family Medicine*, 46(3), 209-214.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Identify the hallmarks of family-centered care
- List different methods of assessing family-centered beliefs, attitudes, and clinical skills
- Discuss the importance of multifaceted residency curriculum evaluation

Introduction to family-centered care

https://www.flickr.com/photos/11164709@N06/6880493318/sizes/c/

Introduction: Teaching family-centered care (FCC)

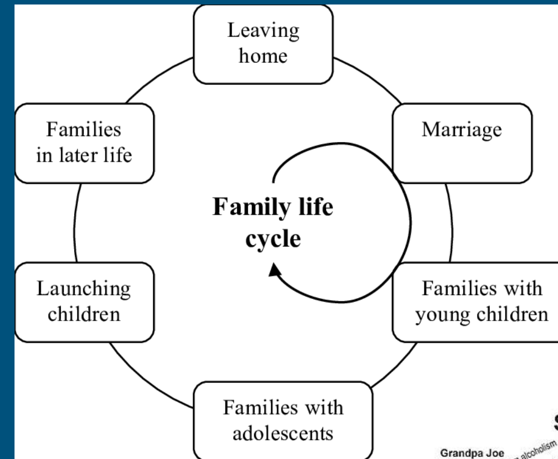
- A 2011 national online survey asked family medicine program directors, behavioral science faculty, and chief residents (n = 489, response rate 36%) about FCC in residency training (Korin *et al.* 2014)
    - Most respondents (90%) believed integrating FCC concepts/skills were important or very important
    - A minority (~24%) felt this teaching was seen as very important in their programs

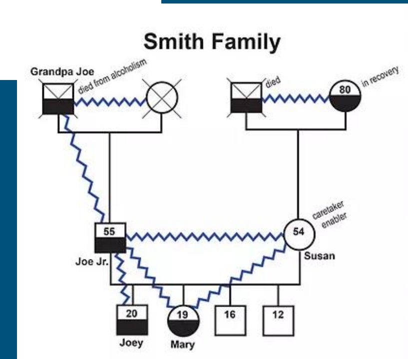
Introduction: Teaching FCC, continued

- The OHSU family medicine program developed and implemented a longitudinal family systems curriculum (2013-2015) (Schiefer *et al*. 2017)
    - Self-assessments showed significant improvements in confidence, knowledge, and skills
- In 2016, family medicine residents were again surveyed about their experiences on behavioral health rotations (n = 84, 89% were R2s or R3s) (Zubatsky *et al*. 2017)
    - Residents desired more contact with behavioral health colleagues
    - 62% reported little/no exposure working with couples or families

Introduction: URMC DFM “P2” curriculum

- 20 week psychosocial medicine and practice management curriculum
  - Family practicum: 3 hour weekly curriculum focused on family skills





https://www.researchgate.net/figure/Family-life-cycle-stages_fig1_299601645

Introduction

- Research shows that FM residents desire family-centered training
- There is a lack of research demonstrating the effectiveness of existing curricula aside from self-reported comfort, knowledge, or skills
- Our study seeks to address this gap by using 2 methods to evaluate learning:
  - Direct observation
  - Q-sort

Introduction

Miller's Pyramid

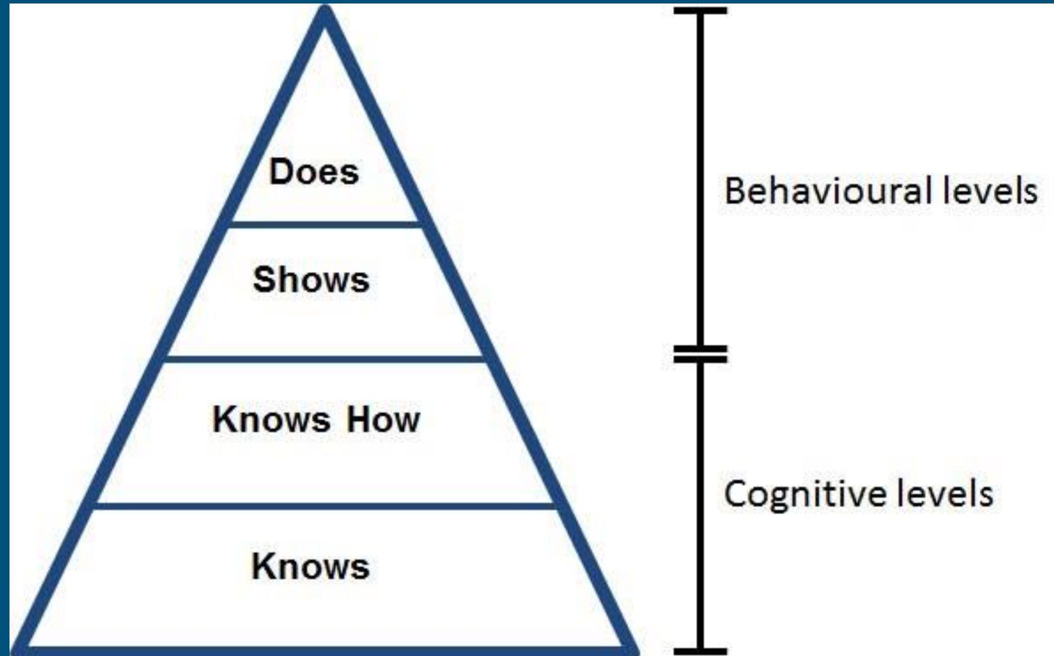


Image: https://www.researchgate.net/figure/Millers-Pyramid_fig1_285593745

Methods: Family-centered observation form (FCOF)

- Based on the patient-centered observation form (PCOF) which is in use in multiple residency programs to systematically evaluate communication skills
- Evaluates clinicians based on both patient- and family-centered skills
- Residents were evaluated in 1-2 select adult chronic care visits pre- and post-practicum

Family-Centered Observation Form (FCOF)

Side B: Family NOT present
(or 1 family member present if patient is unable to communicate)

This form structures feedback and enhances self-awareness of family-oriented interviewing skills. ☑ Check only what you see or hear. Avoid giving benefit of the doubt. Circle checkboxes ○ indicate skills critical for competence and proficiency. Cross out any non-applicable items.

Establishing Rapport with Patient (PT) in a Family Context

- ☐ Introduced self to patient if new
- ☐ Acknowledged patient by name
- ☐ Introduced other care providers in room
- ☐ Made appropriate eye contact
- ☐ Briefly discussed non-medical topic or used humor
- ○ Inquired about FMs' involvement in PT's healthcare

Novice	Competent	Proficient
☐	☐	☐
0-5 total Including 0 critical ○ skills	4-5 total Including 1 critical ○ skill	6 total Including 1 critical ○ skill

Comments:

Family-Centered Agenda Setting

- ☐ Noted previous agenda items from:
  - (1) previous medical visits, or
  - (2) the Electronic Health Record (EHR), or
  - (3) other care team members (e.g. MA or nurse)
- ☐ Solicited PT input on agenda (*"Something else?"*)
- ○ Solicited patient's view of FMs' goals for the visit*
- ☐ Stated provider's own goals for the visit
- ☐ Confirmed or prioritized agenda with patient

Novice	Competent	Proficient
☐	☐	☐
0-4 total Including 0 critical ○ skills	3 total Including 1 critical ○ skill	4-5 total Including 1 critical ○ skill

Comments:

**When appropriate, have a patient share his/her family member(s)' concerns (e.g. "What does your family want you to address with me today?")*

Family-Centered Interviewing – SKILLS

- ☐ Used jargon-free language (or explained terms)
- ☐ Asked open-ended questions
- ☐ Reflected content to emphasize or clarify
- ☐ Explained physical exam and findings
- ☐ Summarized key points and patterns
- ☐ Redirected conversation topic as needed
- ○ Conveyed curiosity about FMs' perspectives
- ○ Verbally acknowledged differing PT/FM perspectives
- ○ Verbally acknowledged shared PT/FM perspectives

Novice	Competent	Proficient
☐	☐	☐
0-6 total Including 0 critical ○ skills	4-7 total Including 1 critical ○ skill	6-9 total Including 2-3 critical ○ skill

Comments:

Family-Centered Interviewing – PROCESS

- ☐ Was "present" (e.g. curious, attentive, not rushed)
- ☐ Was sensitive to matters of culture and diversity
- ☐ Maintained appropriate eye contact
- ○ Maintained neutrality / avoided taking sides
- ○ Was empathetic (verbally or non-) toward patient
- ○ Expressed empathy toward FM(s)' potential emotions

Novice	Competent	Proficient
☐	☐	☐
0-4 total Including 0-1 critical ○ skills	4-5 total Including 2 critical ○ skills	6 total Including 3 critical ○ skills

Comments:

Family-Centered Interviewing – CONTENT

*Check whether the provider asked about the following family-centered topics using direct Ⓓ and/or relational Ⓡ questioning***

- ⒹⓇ Family history of patient's health condition(s)
- ⒹⓇ Family problems associated with PT's condition(s)
- ⒹⓇ Family beliefs or emotions about PT's condition(s)
- ⒹⓇ How family communicates about PT's condition(s)
- ⒹⓇ How the family adds support for PT's condition(s)
- ⒹⓇ How the family adds stress to PT's condition(s)
- ⒹⓇ Family patterns & dynamics (roles/rules/behaviors)
- ⒹⓇ Differing opinions in answers to any of these topics

Novice	Competent	Proficient
☐	☐	☐
Less than 2 Ⓡ questions asked	3-5 total Including 2+ Ⓡ questions	6-16 total Including 3+ Ⓡ questions

Comments:

***Direct questioning is asking the patient directly (e.g. "How does your husband help you with your [problem]?"). Relational or circular questioning is having the patient consider answers from a family member's perspective (e.g. "How would your husband say he helps you with your [problem]?")*

FAMILY-CENTERED INTERVIEWING – CONTENT

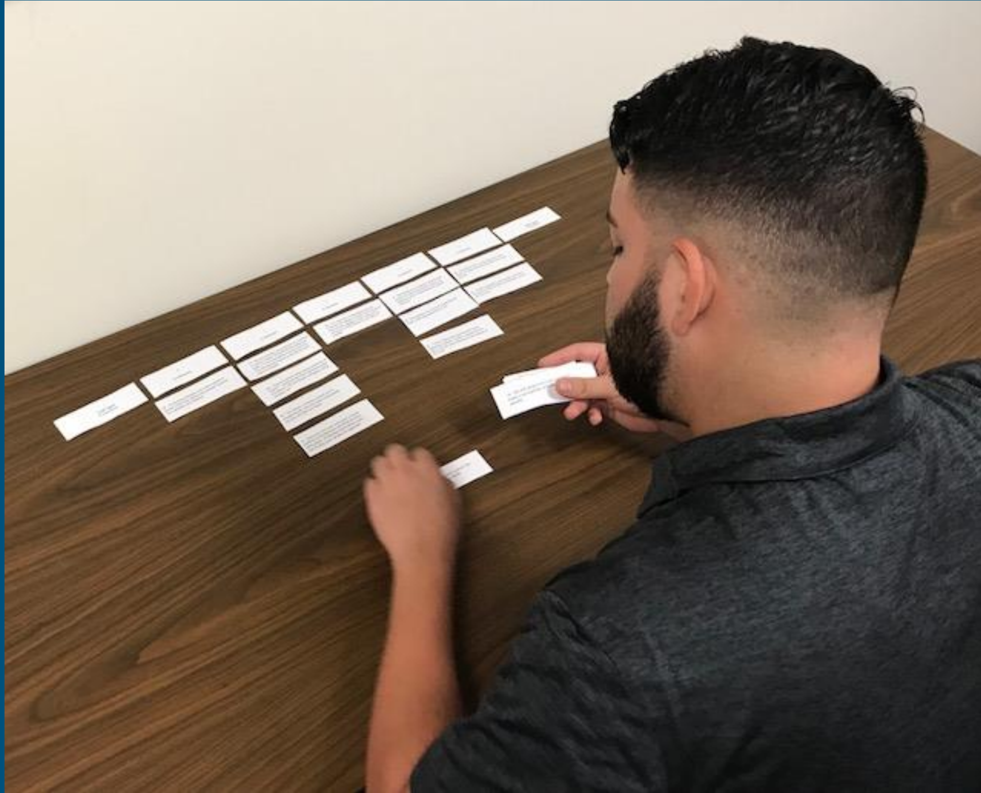
Please check if provider asked the patient and/or family member(s) about the following family-centered topics:

- ○ Family history of patient's health condition(s)
- ○ Family problems associated with PT's condition(s)
- ○ Family emotions / beliefs about PT's condition(s)
- ○ How family communicates about PT's condition(s)
- ○ How the family adds support for PT's condition(s)
- ○ How the family adds stress to PT's condition(s)
- ○ Family patterns & dynamics (roles/rules/behaviors)
- ○ Differing health opinions between PT/FM(s)

Novice	Competent	Proficient
☐	☐	☐
0-1 topics discussed	2-3 topics discussed	4-8 topics discussed

Comments:

Methods: Q-Sort



Q-methodology, an under-utilized approach (Stephenson, 1953), offers a useful way to capture distinct viewpoints on a particular topic and then quantify respondents' affiliation with those viewpoints.

Methods: Family in Medicine Q-Sort

Least Agree 1	2	3	4	5	6	Most Agree 7
1	31	24	41	3	25	34
36	38	2	17	16	4	6
7	23	28	8	26	9	29
37	15	14	5	18	13	21
30	32	22	11	27	10	35
19	39	12	40	33	42	20

How well do the rankings of these 42 statements reflect your daily clinical practice?

1 2 3 4 5 6 7 (8) 9 10

poorly so-so very well

- Consists of 42 items, spanning topics such as physicians' scope of practice, continuity of care, training priorities, etc.
- Items are sorted along a continuum from "least agree" (category 1) to "most agree" (category 7), with 6 items per category.
- Calibration of the q-sort deck utilized a convenience sample of mid- and late-career family physicians, internists, pediatricians, and educators (N=17).

Q-Sort: Family-centered viewpoint

FC - High

Item #17: Interacting with the patient and at least one other family member improves the effectiveness of care.

FC - Low

Item #36: Assuming a therapist role with a patient or family could raise ethical and practical concerns for a primary care clinician.

Q-Sort: FC “Idealist” vs. FC “Pragmatist” viewpoints

Idealist - High

Item #29: A central aim of family-oriented care is to prevent the separation of psychosocial caring from biomedical treatment.

Idealist - Low

Item #26: Most family assessment methods are too time consuming or complex to be practical in primary care.

Q-Sort: FC “Idealist” vs. FC “Pragmatist” viewpoints

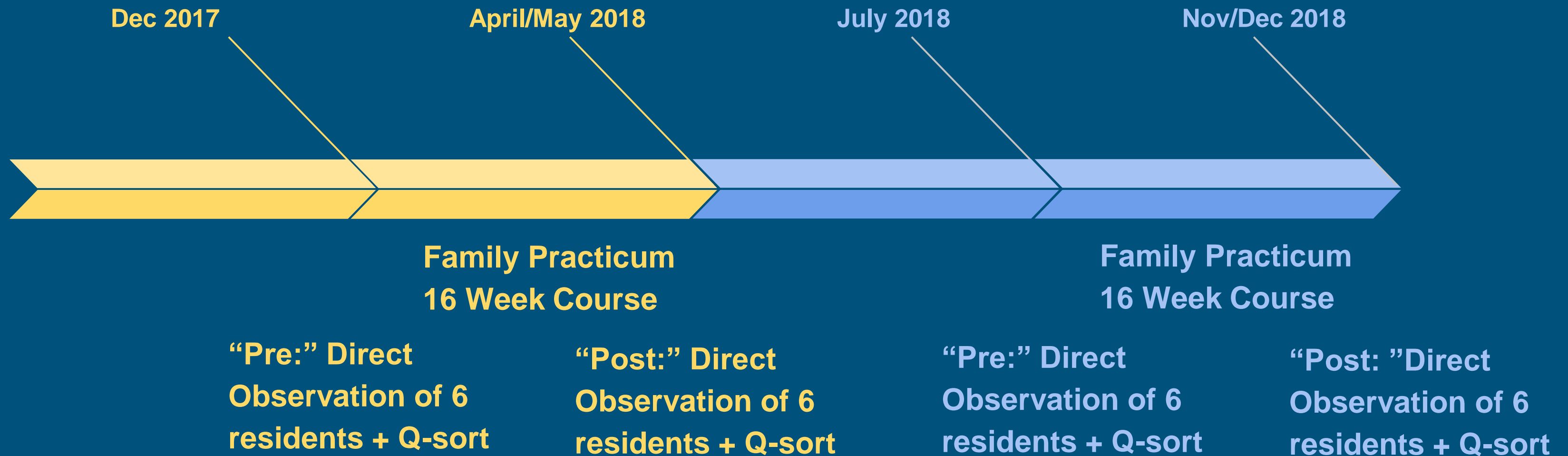
Pragmatist - High

Item #42: Ideal primary care involves recognizing the family as the appropriate unit of care.

Pragmatist - Low

Item #35: To best address the psychosocial factors impacting a patient’s health, a patient must be able to see the same clinician for the duration of their care.

Methods: Study design



Demographics

Residents

- 12 residents (8 female, 4 male), 6 per cohort
  - Cohort 1: Pre- and post-data available
  - Cohort 2: Pre-data available
- Cohort 1: 10 “pre” observations; 7 “post” observations
- Cohort 2: 9 “pre” observations

Patients

- 14 female, 11 male, 1 MTF (ages 28-74)
- 10 patients new to resident
- 4 patient visits with family present

Results: FCOF

- More family centered content was noted in post-practicum visits in cohort one compared to pre-, though it did not necessarily address the process-focused questions on the FCOF
    - In 1/8 pre-practicum encounters w/ out family present, patients were asked how family provided support for the patient's condition vs 3/7 post-encounters

- Post-practicum family-focused questions included:
    - "Does your wife help you?" (with checking blood pressure)
    - "How are you doing with everything in your family?" (re: depression and recent death)
    - "Have you talked to your family about it?" (re: recent health problems)
    - "Who's living with you? Who's your support? Good relationship with your sons?"

Results: Family In Medicine Q-Sort

Residents	*Family-Centered - Pre*	***Family-Centered - Post***
Res. #1	.44**	**.55*** **
Res. #2	.33*	**.09**
Res. #3	.27†	**.49** **
Res. #4	.52***	**.42** **
Res. #5	.57***	**.71*** **
Res. #6	.49**	**.59*** **
Res. #7	.23	---
Res. #8	.40**	---
Res. #9	.48**	---
Res. #10	.76***	---
Res. #11	.64***	---
Res. #12	.58***	---

† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$ (2-tailed)

Results: Family In Medicine Q-Sort

Residents	*FCC Idealist Pre*	***FCC Idealist Post***	*FCC Pragmatist Pre*	***FCC Pragmatist Post***
Res. #1	.24	**.37***	.45**	**.36***
Res. #2	.22	**.10**	.38*	**-.02**
Res. #3	-.02	**.29†**	.48**	**.35***
Res. #4	.27†	**.27†**	.53***	**.36***
Res. #5	.39*	**.60*****	.37*	**.39****
Res. #6	.41**	**.52*****	.20	**.21**
Res. #7	.33*	---	.09	---
Res. #8	.24	---	.23	---
Res. #9	.47**	---	.22	---
Res. #10	.62***	---	.49**	---
Res. #11	.53***	---	.46**	---
Res. #12	.49**	---	.35*	---

† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$ (2-tailed)

Discussion

Challenges:

- Small "n" for both residents and patients
- Maximum of 2 observations per resident pre- or post → limited opportunities to demonstrate skills
- In order to standardize, avoided encounters that may have allowed for more FOC, including peds and OB
- Potential for bias as only 1 FCOF reviewer + unintended effect on behavior given presence of an observer

Discussion

- UR FM residents demonstrated strong family-centered views and attitudes at baseline and these improved following their involvement in practicum
- Family-centered skills were less frequently observed, even after the longitudinal curriculum, though they may have been imperfectly captured. This study also suggests that more time and experience may be needed to hone these skills.

Discussion

Future directions:

- Continued conversations with other users of the FCOF and possible modifications of the form as appropriate
- Potential addition of this form or specific FCOF components to residency requirements

Thanks!

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Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

Residents	*Family-Centered - Pre*	***Family-Centered - Post***	*Patient-Centered - Pre*	***Patient-Centered - Post***
Res. #1	.44**	**.55*** **	.25	**.27†**
Res. #2	.33*	**.09**	.23	**.19**
Res. #3	.27†	**.49** **	.19	**.01**
Res. #4	.52***	**.42** **	.29†	**.32***
Res. #5	.57***	**.71*** **	.42**	**.17**
Res. #6	.49**	**.59*** **	.19	**-.04**
Res. #7	.23	---	.08	---
Res. #8	.40**	---	.21	---
Res. #9	.48**	---	.12	---
Res. #10	.76***	---	.24	---
Res. #11	.64***	---	.01	---
Res. #12	.58***	---	.08	---

† p < .10 * p < .05 ** p < .01 *** p < .001 (2-tailed)

Residents	*Idealist - Pre*	***Idealist - Post***	*Pragmatist - Pre*	***Pragmatist - Post***	*Skeptic - Pre*	***Skeptic - Post***
Res. #1	.24	**.37***	.45**	**.36***	.10	**.14**
Res. #2	.22	**.10**	.38*	**-.02**	.13	**.01**
Res. #3	-.02	**.29†**	.48**	**.35***	.02	**-.14**
Res. #4	.27†	**.27†**	.53***	**.36***	.04	**.16**
Res. #5	.39*	**.60*****	.37*	**.39****	-.06	**.04**
Res. #6	.41**	**.52*****	.20	**.21**	.10	**.14**
Res. #7	.33*	---	.09	---	-.16	---
Res. #8	.24	---	.23	---	.02	---
Res. #9	.47**	---	.22	---	.01	---
Res. #10	.62***	---	.49**	---	.01	---
Res. #11	.53***	---	.46**	---	.07	---
Res. #12	.49**	---	.35*	---	-.06	---

† $p < .10$ * $p < .05$ ** $p < .01$ *** $p < .001$ (2-tailed)