2023-24 Scholarly Activity and QI Work

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Class of 2024

MISSOULA

Sienna Foxton DO

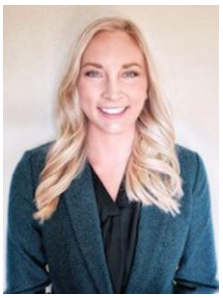
Rebecca Sharar MD

Kara Francis MD

Cecilia Weeks MD

Alec Kerins MD

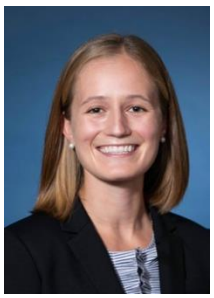
KALISPELL



Sarah Davis DO

Travis Kinane DO

Emilie McIntyre MD



Jennifer Selland MD

Bryce Roberts DO

Class of 2024 Scholarly Activity Work

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Sarah Davis, DO, MHS

CONFERENCE PRESENTATIONS

***Project Title**:* Montana Society of Medical Assistants Conference: *Providing Excellent Care to Individuals with Intellectual and Developmental Disabilities*

Details of the project: I presented at the Montana Society of MA's conference on care for individuals with intellectual and developmental disabilities. My goals for the presentation were to discuss ways MA's as clinic staff can help better the experience of health care visits for patients with IDD, to demonstrate specific ways to apply these concepts and other considerations during patient encounters.

Reflections: I believe it was a successful presentation and was able to accomplish my goals of making the material applicable to MA's and clinic staff for education about working with this population in their specific roles.

~Date project completed: March 11th, 2023

***Project Title**:* MAFP Winter Conference: *Providing Excellent Care to Individuals with Intellectual and Developmental Disabilities*

Details of the project: I gave a presentation at the Winter Montana Academy of Family Physicians Conference in Whitefish, MT. My goals for the presentation were to discuss ways we as providers and clinic staff can better the experience of health care visits for patients with IDD, to demonstrate specific ways to apply these concepts and other considerations during patient encounters and to introduce common topics and medical issues needing to be addressed for this population.

Reflections: The presentation was well received, I appreciated the positive feedback for presenting on a topic that is often not found in typical medical school and residency curriculum.

~Date project completed: January 24th, 2024

***Project Title**: Discovering the Overlap in Global Health and Rural Medicine: One Family Medicine Resident's Volunteer Experience in Tanzania*

Details of the project: I gave a poster presentation at the Rural Track Training Collaborative Conference on the parallels between global health in developing countries and rural medicine. The presentation focused on the model used by the Foundation for African Medicine and Education where I volunteered.

Reflections: The barriers to healthcare that rural communities face are similar in many ways to those of developing countries, and rural areas across the globe. We can stand to learn from one another's experiences to better our practice. Though each rural community is unique, there are a lot of similarities amongst the disparities they face, even in other countries, and we could all stand to learn from one another's experiences.

~Date project completed: April 10-12th, 2024

TEACHING/PRESENTATIONS

Presentation title: Early Intervention for Children Aged 0-2 with or at High Risk for Cerebral Palsy

Brief summary of presentation: Journal Club presentation on this systematic review. The conclusions and practice changing recommendations were that when a child meets criteria of high risk for CP, intervention with therapies should start as soon as possible. Early diagnosis, and support implementation is key in this critical development period.

Date presented: 4/7/2022

Presentation title: Newborn Care Theme Day- Breastfeeding

Brief summary of presentation: As part of a Newborn Care Theme presentation day, I presented cases of common breastfeeding challenges that may present to a primary care office.

Date presented: 6/28/2022

Presentation title: Shoulder Imaging

Brief summary of presentation: This was a didactics presentation where I provided a systematic approach to evaluating shoulder radiographs and a case-based review of common shoulder concerns that may require imaging along with their common imaging findings.

Date presented: 8/24/22

Presentation title: Inpatient Peds Theme Day: Bronchiolitis

Brief summary of presentation: This was a didactic presentation where I discussed bronchiolitis using a case based discussion con common presentation, work up and management.

Date presented: 12/21/22

Presentation title: Gender Affirming Hormone Therapy: An Updated Review with an Eye on the Future

Brief summary of presentation: Journal Club presentation on this systematic review. With increasing numbers of transgender patients seeking hormone replacement therapy the body of available research has been expanding, this article provided an updated review of treatment recommendations for clinical practice.

Date presented: 4/6/2023

Presentation title: Interpretation of Pediatric Chest Radiographs

Brief summary of presentation: This was a didactics presentation where I provided a systematic approach to evaluating pediatric chest radiographs and a case-based review of common pediatric concerns that may require imaging along with their common imaging findings.

Date presented: 9/27/2023

Presentation title: Long term complications of Diabetes Mellitus

Brief summary of presentation: This was a presentation I gave during a morning provider meeting while volunteering in Tanzania at an organization called Foundation for African Medicine and Education. Volunteers are asked to present at least once on relevant topics. During my time in Tanzania, we saw many patients suffering from complications of diabetes and this is what inspired this presentation. While the pathology faced is the same no matter the population or location, the resources available to treat the complications were limited, and presentation was tailored to the resources they do have available.

Date presented: 1/9/2024

Presentation title: Emergency contraception with levonorgestrel plus piroxicam

Brief summary of presentation: Journal club presentation on this RTC. The outcome and practice changing recommendation is that co-administering levonorgestrel with piroxicam improved efficacy, and so if the patient's choice for EC is levonorgestrel, we should consider adding piroxicam when possible.

Date presented: 2/1/2024

Presentation title: Didactics Theme Day: NRP Skills

Brief summary of presentation: To Be completed

Date presented: 5/22/2024

Presentation title: Peer Review for GVHC: Cervical Cancer Screening

Brief summary of presentation: To Be Completed

Date presented: 5/29/2024

Presentation title: OMT: Newborn and Pediatric Techniques

Brief summary of presentation: To Be Completed

Date presented: 6/5/2024

OTHER

Project Title*: Medical Volunteer trip to FAME in Tanzania*

Details of the project: I had the opportunity to volunteer in Karatu, Tanzania at a medical facility called FAME (Foundation for African Medicine and Education). I worked alongside local Tanzanian doctors. We saw patients together in the outpatient clinic, ED, inpatient setting and on the Women's and Children's ward. The goal of FAME is to have the American volunteer doctors work alongside the staff physicians and to learn from one another as they treat patients together.

~Date project completed: Jan 1-14th, 2024

Project Title*: Special Olympics MedFest*

Details of the project: Volunteer as healthcare provider for the Missoula Special Olympics Medfest providing physicals and health education to SO Athletes.

~Date project completed: Missoula March 2023

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Sienna Foxton, DO

Friday Morning Medical Conference

Treatment of Opioid Use Disorder in the Fentanyl Era

February 2024

The goal of this presentation was to increase awareness about rising fentanyl use in Montana as well as provide some options for initiating treatment for fentanyl use disorder with Suboxone. Overall the talk went well and there were a lot of questions at the end showing that people were engaged. A professor at UM also asked if she could show the recording of the presentation to her undergraduate class afterwards.

Quality Improvement Projects:

QI project 2022: Savoring Outdoor Time to Increase Overall Wellbeing

For this project I used at least one savoring activity for each outdoor activity I participated in during the study period. I found that savoring the outdoor activity helped improve my overall wellbeing.

QI project 2023: Developing a Telemedicine Program to offer PREP to Patients in Rural Montana

This project was part of a grant which provided money to develop a telemedicine program to increase access to pre-exposure prophylaxis for patient in rural Montana. My part of the project was to develop a pilot program to identify pitfalls and areas for improvement. The project encountered several challenges including logistics of offering telemedicine to new patients, keeping patient information confidential, developing a system for accurate lab monitoring, and navigating the limitations of our current EMR and scheduling process.

QI project 2024: Improving Healthcare for Native Americans through Education of Healthcare Providers

This project involved creating a survey to determine aspects of Native American health that residents and faculty would want to learn more about. Then I worked with Drew Babcock to create a didactic session regarding Native American Health Care Delivery and Native American Health Innovations. After the session participants completed a survey to give feedback on the presentation. Overall the feedback was positive. See my QI write-up for more information.

Journal Club Presentations:

Journal Club 2021: *Red Flags for Low Back Pain*

Journal Club 2022: *Secondary Prevention of CVD with Mediterranean Diet*

Journal Club 2023: *Colonoscopy Recommendations and Life Expectancy*

Didactics Presentations:

The Strong Heart Study: Considerations for CVD risk in Native American Populations *April 2022*

Management of Early Pregnancy Loss *October 2022*

Staphylococcal Scalded Skin Syndrome *November 2022*

Urology Jeopardy *May 2023*

Review of Abdominal CT Interpretation *March 2023*

Cases studies in pediatric infectious disease *June 2023*

Diagnosing Acute MI in the Setting of LBBB *January 2024*

Native American Health Care Delivery *February 2024*

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Kara Francis, MD

CONFERENCE PRESENTATIONS

***Project Title**:* Healthcare in a Time of Increasing Homelessness: And what we can do about it

Details of the project: With this presentation, my goal was to recognize that homelessness is a growing crisis both nationwide and locally, to provide easily implemented practice adaptations to better serve people who are facing homelessness, and to challenge all of us to work to change collective attitudes toward people who are unhoused.

Outcome: The presentation was overall well received and compiling the information was very helpful for my own learning and development.

Reflections: I have continued to reflect on my biases toward people who are unhoused and find myself trying to make small changes in how I provide medical care. I would like to continue to develop better strategies within the clinical setting but also try to have more conversations and interactions with people facing homelessness outside of medicine.

~Date project completed: 3/25/2024

TEACHING/PRESENTATIONS

Presentation title: Neonatal and Pediatric Heart Murmurs

Brief summary of presentation: An overview of pediatric cardiac auscultation, identifying common murmurs, and indications for echo or further interventions.

Date presented: 3/10/2022

Presentation title: Evidence- Informed Milestones of Developmental Surveillance Tools

Brief summary of presentation: A journal club presentation around the new CDC guidelines for developmental surveillance.

Date presented: 5/5/2022

Presentation title: Language and Literacy

Brief summary of presentation: A case based discussion of Reach out and Read and promotion of early literacy in the clinical setting.

Date presented: 9/7/2022

Presentation title: Heart Blocks

Brief summary of presentation: A rapid review of heart blocks, their clinical presentations, and their ECG findings.

Date presented: 11/23/2022

Presentation title: Low FODMAP Diet in the Treatment of IBS

Brief summary of presentation: A journal club presentation around a systematic review and meta-analysis investigating the efficacy of low FODMAP diets for IBS.

Date presented: 3/9/2023

Presentation title: A Predictive Model for the Diagnosis of Kawasaki Disease

Brief summary of presentation: Evidence based tools for evaluation of the patient with possible Kawasaki disease. Presented to pediatric hospitalists

Date presented: 3/10/2023

Presentation title: Managing Rare Complications of Medical and Surgical Abortions

Brief summary of presentation: A RHEDI presentation of the most common, albeit overall very rare, complications of abortions.

Date presented: 4/2023

Presentation title: Hemolytic Uremic Syndrome

Brief summary of presentation: A review of the current literature on typical vs atypical HUS and long term outcomes of HUS cases.

Date presented: 9/21/2023

Presentation title: A Smattering of Hemoglobinopathies

Brief summary of presentation: An interactive review of hemoglobinopathy types, their clinical presentations, and diagnosis.

Date presented: 12/13/2023

Presentation title: Clinical Significance of Pre-Diabetes in Older Adults

Brief summary of presentation: A journal club of a cohort study from the English Longitudinal Study on Aging around the long term outcomes of geriatric patients with prediabetes.

Date presented: 12/14/2023

Presentation title: Unlocking the Chest: Chest imaging modalities

Brief summary of presentation: A case-based review of the correct imaging modality for thoracic imaging

Date presented: 4/24/2024

Presentation title: Simulation day: urgent and emergent situations at Blue Mountain Clinic

Brief summary of presentation: Led simulated cases of possible complications of surgical abortion procedures and their management. Participants included residents, faculty, and clinic staff.

Date presented: 5/8/2024

QUALITY IMPROVEMENT PROJECTS:

Project title: Reducing Stress through Meal Planning

Details of the project: In this personal quality improvement project, I attempted to decrease self-rated stress at dinnertime by preparing a meal on my day off with sufficient leftovers for the rest of the week, “meal prepping.”

Outcomes and Lessons Learned: To measure the effect of my meal prepping, I used a subjective stress rating scale to examine my average pre- and post-dinner stress levels on days where I had a pre-prepared meals and those where I did not. I found it difficult to take the time to implement meal prepping and therefore ended my trial period with less data than intended. Based on this limited data, meal prepping does not significantly impact my dinnertime level of stress. However, I did discover that having a ready-to-eat, home cooked meal resulted in significantly more enjoyment of my food, greater satiety, and healthier content. Thus, although difficult to execute, I do feel that meal prepping has the potential to increase my overall sense of wellbeing. In the future, I would like to strive to plan more meals and use this as a time to prepare food with my partner and find more joy in cooking and eating.

Date completed: 5/2021

Project title: Increasing discussion of contraception among refugees

Details of the project: Through discussions with our clinic's refugee care team, I discovered that many of our refugee patients were receiving inequitable reproductive health care. Stefano Zamora, RN, the refugee program coordinator at Partnership, reported that he often encountered patients who admitted that, while they did not desire pregnancy in the near future, they never discussed this with their care provider. This represented a missed opportunity to further reproductive autonomy and health equity.. To address this, I aimed to increase documented discussions of contraception for all new refugee patients of child bearing age and with a uterus. To attempt this, I worked with our refugee coordinators to incorporate questions around family planning into their intake process and added a field to the visit templates to help remind providers to include the discussion in their new patient visits with refugees.

Outcomes and Lessons Learned: To gather data, I conducted a chart review, examining pre- and post-intervention measurement of the percentage of refugee establish care visits in which there was a documented discussion of contraception. I included only patients of child bearing age and with a uterus. I found that, in the pre-intervention period, only 28 % of refugee patients of reproductive age, with a uterus, had a documented discussion of family planning in their initial visit. Unfortunately, due to low volumes or refugee patients, my study period only captured 2 new refugee visits that met inclusion criteria. Therefore, I was unable to interpret my results as statistically significant. However, in the course of doing this project, I discovered several resources that provide helpful information on contraception in numerous languages. Since this project, I have been able to share these resources with our refugee care team and other providers. I am hopeful that with incorporation of these resources and with more time, my intervention will have an impact on reproductive health care

Date completed: 5/2022

Project title: Improving hospital discharge communication

Details of the project: My goal of this project was to increase communication from inpatient providers to clinic care teams in order to improve patient safety and continuity of care. To do so, I took advantage of the fact that we, as residents, operate in both the inpatient and outpatient settings and as a clinic we have RN panel managers who help coordinate patient care. I designed a new workflow, requesting that senior residents send useful discharge information to a patient's panel manager. Additionally, I designed a template in the clinic's EMR, eClinicalWorks, to prompt inclusion of useful information, the content of which was determined by input from the panel managers.

Outcomes and Lessons Learned: I evaluated the effect of the new discharge workflow through pre- and post-intervention surveys completed by the panel managers. With the introduction of the discharge templates and new discharge workflow the perceived frequency of communication from the resident inpatient team was unchanged to slightly increased, and the perceived utility of said communication improved by 50%. Thus, the intervention was not as impactful as I hoped. This further confirmed to me that while we can modify processes, patient care is best done through a unified electronic medical record. Ideally, our clinic and local hospital will eventually be on the same EMR or at the very least have more communication capabilities between systems.

Date completed: 5/2024

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Alec Kerins, MD

CONFERENCE PRESENTATIONS

Project Title: Beyond the Pill Box: Using Integrative Medicine

Details of the project: Presentation for Friday Morning Medical Conference

Reflections: Presentation went well. Was nice to spend time learning and reviewing integrative medicine techniques

Date of presentation completed: April 12, 2024

Project Title: Hocus Pocus: Integrating Point of Care Ultrasound into Family Medicine Residency

Details of the project: Presentation at MAFP winter conference highlighting my work during R2 year to create and implement an ultrasound elective within our family medicine residency

Reflections: Presentation was well received.

Date project completed: January 23, 2023

TEACHING/PRESENTATIONS

Presentation title: The Ubiquitous PPI

Brief summary of presentation: Presentation highlighting most recent evidence regarding the prevalence of PPI prescribing and possible adverse events, including gastric cancer

Journal Club Paper: Gut 2022;71(1):16-24; Am J Gastroenterol 2022;117(1):27-56.

Date presented: April 7, 2022

Presentation title: Pediatric Resuscitation Virtual Simulation

Brief summary of presentation: Hands on-small group PALS simulations done via virtual setting given COVID restrictions

Date presented: January 12, 2022

Presentation title: Evaluation and Treatment of Children and Adolescents with Obesity

Brief summary of presentation: Presentation highlighting recent updates from the American Academy of Pediatrics. Presented both during FMRWM journal club and during a PHC provider meeting.

Date presented: February 23, 2023; April 18, 2023

Presentation title: Radiology Review: CXR and Ultrasound of Chest and Abdomen

Brief summary of presentation: Small group based practice of common xray and ultrasound findings, focused primarily on chest and abdomen

Date presented: September 14, 2022

PresentationTitle*:* Management of Acute Appendicitis, A Pediatric Case Study

Brief summary of presentation: Presentation during Pediatric Grand rounds highlighting a case of pediatric appendicitis managed during my time on inpatient pediatrics.

Date presented: January 5, 2023

Presentation Title*:* Primer on Ocular Ultrasound

Brief summary of presentation: Reviewed techniques for using point of care ultrasound to identify and diagnosis common ocular complaints

Date presented: March 14, 2023

Presentation Title: Musculoskeletal Review for the Primary Care Physician

Brief summary of presentation: Reviewed common MSK complaints, physical exam findings, and treatment

Date presented: June 7, 2023

Presentation title: Ultrasound Course Instructor during Introduction to Family Medicine

Brief summary of presentation: Lead multiple hands-on learning sessions for incoming interns on basics of using point of care ultrasound to help aid in evaluation and diagnosis

Date presented: July 18, 2023

Presentation title: PALS Case Review

Brief summary of presentation: Lead small groups through various cases requiring use of knowledge and skills from the Pediatric Advanced Life Support curriculum

Date presented: August 9, 2023

Presentation Title: FMRWM Ultrasound Course Instructor

Brief summary of presentation: Helped teach various sections of the course including gallbladder, aorta, and pulmonary ultrasound.

Date presented: August 17, 18, 2023

Presentation title: Cardiovascular Safety of Testosterone Supplementation

Brief summary of presentation: Reviewed recent placebo controlled trial evaluating whether transdermal testosterone-replacement therapy leads to increased incidence of major adverse cardiac events in middle-aged and older men with hypogonadism and either preexisting or a high risk of cardiovascular disease

Paper Reviewed: Lincoff AM, Bhasin S, Flevaris P, et al, for the TRAVERSE Study Investigators. Cardiovascular safety of testosterone-replacement therapy. N Engl J Med 2023;389(2):107-117.

Date presented: November 16, 2023

Presentation title: Non-ST Elevation Myocardial Infarctions

Brief summary of presentation: Reviewed presentation and common ECG findings with NSTEMIs in an interactive, case-based session

Date presented: February 23, 2024

QUALITY IMPROVEMENT

Project Title*: The Pursuit of Happiness: Using Exercise to Improve Mood*

Details of the project: Measuring happiness through residency and correlating it with amount of time spent exercising

Outcome: Project completed successfully. Results showed exercise produced twice as many days in the pleasant quadrants as compared to days without exercise (18 vs 9). Lack of exercise was associated with feelings of depression, sadness, tiredness.

Reflections: "I had a strong suspicion going into this project that exercise would be associated with improved mood. This project served as a bit of an accountability tool, though one of the reasons it was held to such a short time frame is due to the time needed to exercise at least 3 days/week. I would love to be exercising every day, but with the demands of residency and personal/family life, it just isn't feasible. Though exercise was correlated to improved mood, I wonder what other (less time consuming) interventions might be useful given the setting."

Date project completed: May, 2022

Project Title*:* Increasing Opportunities to Learn and Practice Point of Care Ultrasound

Details of the project: The residency did not have an established ultrasound elective and I created this course as a way for myself and othe residents to have more dedicated time to learn/practice point of care ultrasound skills.

Outcome: Successfully created an elective from which a more robust course can be built upon. The course was used by other residents during the 2022-2023 academic year

Reflections: This was a bit of a selfish project in that I wanted to create a dedicated time to practice POCUS skills with real patients and this was successfully done. It was very self-directed and it would have been nice to have a more experienced physician scanning intermittently with me to provide real-time coaching on scanning technique. It would also be helpful to review images/video with someone more knowledgeable than myself to learn the nuances/intricacies of interpreting ultrasound studies.

Date project completed: *May, 2023*

Project Title*:* Limiting the Overlap: Improving Clinic Efficiency by Limiting Overlap of Work done by MA and Provider

Details of the project: This project was an attempt to increase clinical efficiency by decreasing the amount of overlap done by the MA and provider during a patient visit. This was done by streamlining the intake process to include more questioning around chief complaint.

Outcome: Project ultimately did not work out as it proved to be too cumbersome for the medical assistant to get adequate information in the time needed to keep our clinic day moving along. Visits were taking too long and thus the project was stopped as a result.

Reflections: The problem this project attempted to fix is a huge contributor to physician burnout however I think this intervention will only work with a certain medical assistant. It requires someone to be efficient at their intake and this proved to be difficult during the time I studied this intervention.

Date project completed: May, 2024

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Travis Kinane, DO

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TEACHING/PRESENTATIONS

Presentation title: *A randomized, placebo-controlled trial of ibuprofen, metaxalone, tizanidine, or baclofen for acute low back pain*

Brief summary of presentation: *There is minimal benefit to adding a muscle relaxer to relive a patients pain 3 -14 days post new onset acute back pain.*

Date presented: *2/10/2022*

Presentation title: *Benefits and harms of interventions with surgery compared to interventions without surgery for musculoskeletal conditions*

Brief summary of presentation: *Systematic review with analysis of common msk injuries and their outcomes with and without surgery*

Date presented: *12/8/2022*

Presentation title: *MSK Theme Day*

Brief summary of presentation: *Hands on learning physical exam for back, shoulder, knee and hip. Also provided sensitivity and specificity for each special test.*

Date presented: *6/7/2023*

Presentation title: *Fascial Distortion Model OMT Lecture*

Brief summary of presentation: *Presented the FDM from at an FDM conference that I attended several months prior. Focused on trigger bands and herniated trigger points. Hands on lab*

Date presented: *3/29/2023*

Presentation title: *ENT Sports Medicine Didactic Lecture*

Brief summary of presentation: *Common ENT sport injuries in relation to the ear*

Date presented: *11/15/2023*

Presentation title: *Preparticipation Physical Evaluation (PPE) for Athletes in Primary Care*

Brief summary of presentation: *Why PPE are performed, physical exam findings, what not to miss and practice cases of PPEs.*

Date presented: *1/12/24 at Western Montana AHEC*

Presentation title: *The risks of sexual transmission of HIV in individuals with low level HIV Viraemia*

Brief summary of presentation: *Encourage medication adherence with HIV antivirals as patients with low level viremia have almost no incidence of transmission.*

Date presented: *2/29/2024 Journal Article Presentation*

Presentation title: *Myocarditis and Pericarditis*

Brief summary of presentation: *Physical exam findings and ECG findings for myocarditis and pericarditis*

Date presented: 6/5/24. *FMRWM didactics*

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Emilie McIntyre, MD

CONFERENCE PRESENTATIONS

***Project Title**:* Syphilis: Recent trends and considerations for perinatal care

Details of the project: Logan Health OB Grand Rounds lecture given on the history, recent drastic rise in rates, testing, treatment, and specific management considerations of syphilis infection in pregnancy.

Outcome: well received by attendees.

Reflections: Difficult to summarize such a complicated topic within the time allotted.

~Date project completed: 3/2024

TEACHING/PRESENTATIONS

Presentation title: Syphilis in Pregnancy

Brief summary of presentation: FMRWM Didactics presentation on the recent drastic rise in rates, screening, and specific management considerations of syphilis infection in pregnancy.

Date presented: 5/2024

Presentation title: Syphilis Basics

Brief summary of presentation: GVHC Provider Peer Review meeting presentation given on the history, recent drastic rise in rates, testing, and treatment of syphilis infection.

Date presented: 5/2024

Presentation title: Outpatient head imaging: modality and ordering

Brief summary of presentation: FMRWM Didactics presentation on indications for, modalities of, and specifics regarding head and neck imaging in outpatient primary care.

Date presented: 12/2023

Presentation title: Effect of Colonoscopy Screening on Risks of Colorectal Cancer and Related Death

Brief summary of presentation: FMRWM Journal Club presentation on a large European trial on the effects of invitation for screening colonoscopy.

Date presented: 10/2023

Presentation title: (withheld)

Brief summary of presentation: FMRWM RHEDI Didactics presentation.

Date presented: 9/2023

Presentation title: Physical therapy referral from primary care for acute back pain with sciatica

Brief summary of presentation: FMRWM Journal Club presentation comparing outcomes on acute back pain with sciatica when comparing immediate referral to PT with usual care.

Date presented: 5/2023

Presentation title: Where do I go with my RHEDI training after residency?

Brief summary of presentation: FMRWM RHEDI Didactics presentation on navigating the spectrum of options for continuing abortion practice after residency.

Date presented: 3/2023

Presentation title: Intervention Prevention on Labor & Delivery

Brief summary of presentation: FMRWM Didactics presentation on the normal physiology birth and strategies for avoiding the outcomes associated with obstetric interventions.

Date presented: 3/2023

Presentation title: QT prolongation

Brief summary of presentation: FMRWM Didactics presentation on detection, causes, and management of QT prolongation.

Date presented: 1/2023

Presentation title: Wilderness navigation

Brief summary of presentation: Led FMRWM wilderness retreat attendees through a hands-on activity on how to use a map and compass to navigate in the backcountry.

Date presented: 9/2022

Presentation title: Aspirin for the prevention of preterm delivery in nulliparous women

Brief summary of presentation: FMRWM Journal Club presentation on the data regarding use of low-dose aspirin for primary prevention of preterm birth.

Date presented: 3/2022

Presentation title: Common pregnancy symptoms and management

Brief summary of presentation: FMRWM Didactics presentation on management of common symptoms during pregnancy.

Date presented: 2/2022

OTHER

***Project Title**:* Implementation of a postpartum visit template to standardize postpartum care

Details of the project: R3 quality improvement project. In order to improve resident learning about and to improve the quality of postpartum care, I created a postpartum visit note template for our clinic EMR.

Outcome: There was a significant increase in OB provider confidence in items needing to be addressed at postpartum visits, regarding both standard and patient-specific care.

Reflections: The template has provided an opportunity for OB providers to streamline documentation of standard postpartum care topics. It would likely benefit from a companion template for the Labor & Delivery discharge summary that further addresses patient-specific items requiring follow up in the postpartum period to ensure that communication about patient care needs is seamless between the inpatient and outpatient EMR's.

~Date project completed: 5/2024

***Project Title**:* Implementation of a prenatal checklist to standardize obstetric care

Details of the project: R2 quality improvement project. In an effort to streamline L&D admission, as well as to communicate a patient's prenatal history to providers other than the PCP who may take care of a patient during pregnancy, I created a prenatal checklist for our clinic EMR that is updated throughout pregnancy.

Outcome: There was a dramatic increase in the proportion of Kalispell residents reporting that they were able to get up to speed about a patient at prenatal visits, especially when seeing other residents' patients, and upon admission to L&D.

Reflections: This streamlining of the EMR for prenatal care was a celebrated change among residents, faculty, and clinic staff. Since its implementation as a manual text list within the chart, it has now become formalized within the built structure of the EMR.

~Date project completed: 5/2023

***Project Title**:* Preparing For Birth

Details of the project: R1 quality improvement project. Childbirth is widely regarded as one of the most difficult and painful human experiences. To maximize a sense of preparedness for my own birth, I engaged in regular birth-related self-care activities (such as exercise, reading about birth, yoga, meditation, working with a doula, etc.) throughout my third trimester. I tracked my subjective sense of preparedness for birth.

Outcome: Seemingly successful. I felt prepared when my labor began, and I was able to avoid epidural analgesia during my own birth.

Reflections: It appeared from my subjective ratings that the amount of time I spent preparing for birth correlated with preparedness, rather than any one activity in particular.

~Date project completed: 5/2022

FMRWM SCHOLARLY WORK **RESIDENT**

Name: M Bryce Roberts, DO

Creation of the Introduction to OMT Elective Rotation – for my scholarly activity, I created an elective rotation which can be utilized by both DO and MD residents alike to boost osteopathic learning and practice. The rotation itself consists of a mixture of both online and hands-on learning which will provide a good introduction for MDs who have never had any osteopathic training while at the same time provide opportunities to learn new skills/techniques for DO residents as well. The rotation summary will serve as a framework for creating the rotation specifics according to each resident's specific goals. If a resident wants to see multiple OMT styles/techniques, then that is also possible with this rotation. There are also lots of opportunities to build upon this rotation in the future as well (i.e. add curriculum, increase the number of community preceptors, expand the learning locations, etc…).

FMRWM ROTATION SUMMARY

Updated: 3/14/24

Rotation name: Introduction to OMT

Responsible core faculty member: Robert Stenger

Community faculty:

Dr. Terrence O'Malia, Libby Clinic – (406) 293-8711
Dr. Daniel McCarthy, Curry Health Center – (406) 243-2122
Dr. Madeline Mussman, Bitterroot Health –> Contact Nathan Kunz (nathankunz@bitterroothealth.org) or Jennifer Chavez (jenniferchavez@bitterroothealth.org) for scheduling.
Dr. Kevin Kropp and Dr. Sarah Davis, Logan Health
***

Year of training: PGY 1, 2, or 3

Number of blocks: 1 (2 weeks)

Rotation locations:

Partnership Health Center (PHC) – 401 Railroad St. W, Missoula
Greater Valley Health Center (GVHC) – 1035 1st Ave W, Kalispell
Libby Clinic – 211 E 2nd St, Libby
Curry Health Center – 634 Eddy Ave, Missoula
Bitterroot Health – 1200 Westwood Dr, Hamilton
Logan Health – 1280 Burns Way, Kalispell

Nature of the experiences:

Online Learning:

Residents will learn the fundamentals of osteopathic medicine and the philosophy behind its use. They will utilize both online and written resources to learn proper evaluation/diagnosis of somatic dysfunctions and both basic and advanced techniques for correcting these dysfunctions. Residents will be required to demonstrate a basic understanding of these written and online materials through completion of online quizzes (passing score >80%). Additionally, they will have multiple opportunities to demonstrate all that they have learned in a practical clinic setting.

ACOFPOMTeaching Required Online Chapters and Quizzes -- Patient must review the chapter and pass the associated quiz with a score >80%. Please send core faculty member your score reports after completion.

- Chapter 2
- Chapter 4
- Chapter 5 (PowerPoint and Videos)
- Chapter 6
- Chapter 7
- Five additional chapters of interest

Hands on Training:

Residents will participate in the diagnostic evaluation and treatment of patients who suffer from somatic dysfunctions under the supervision of a trained attending who will provide real time feedback/education. By engaging with patients in the clinic setting, residents will have the opportunity to put into practice all they have learned regarding osteopathic principles and practices. At the end of the rotation, a formal practical evaluation will be completed which will test the resident's ability to properly diagnose and treat the most common somatic dysfunctions.

Focused goals and objectives:

1. Learn the history of osteopathy and the basics of osteopathic principles and practices
2. Understand that patients often have osteopathic complaints that we can treat quickly and easily
3. Obtain a thorough yet targeted osteopathic history
4. Demonstrate an understanding of appropriate osteopathic referrals
5. Gain a basic understanding of diagnostic/treatment principles and develop a system in which to use these principles clinically
6. Properly diagnose and treat patients with the most common somatic dysfunctions utilizing a variety of treatment modalities including but not limited to soft tissue, muscle energy, FDM, BLT, FPR, counterstrain, HVLA, LVMA, MFR, etc…
7. Understand indications and contraindications to certain osteopathic treatments and/or medical conditions
8. Develop the ability to educate patients regarding their somatic dysfunctions
9. Create plans to prevent/delay recurrence of symptoms following an osteopathic treatment
10. Locate and use evidence-based resources for additional educational opportunities and osteopathic practice
11. Identify a community of osteopathic providers to whom residents can turn for mentorship/education as we improve osteopathic care

Additional Information for Residents

What to Log: OMT encounters

Evaluations Sent To: PHC, GVHC, Libby Clinic, Curry Health Center, Bitterroot Health

Pertinent AAFP Article: https://www.aafp.org/pubs/afp/issues/2019/0215/p214.html.

Resources:

Osteopathic Learning Resources: https://acofpomteaching.com/. ***(FMRWM has an account)***

Osteopathic CME Opportunities:

https://www.aafp.org/cme/all/procedural/osteopathic-manipulative-medicine.html.

https://www.academyofosteopathy.org/cme.

https://osteopathicmedicine.msu.edu/info/continuing-education.

https://www.une.edu/com/cme/omm-series.

Introduction to OMT Elective Rotation - Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
*Online Learning	OMT Clinic	PHC/GVHC Clinic	OMT Clinic	OMT Clinic
PHC/GVHC Clinic	OMT Clinic	Didactics	OMT Clinic	OMT Clinic

*ACOFP OMTeaching Chapter PowerPoints and Quizzes – residents must review the following chapters and pass the associated quizzes with scores >80% prior to completion of the rotation. Quizzes can be submitted to the rotational core faculty member either in paper form or electronically per resident preference.

- Chapter 2
- Chapter 4
- Chapter 5 (PowerPoint + Videos)
- Chapter 6
- Chapter 7
- Five additional chapters/quizzes that the resident chooses

TEACHING/PRESENTATIONS

Presentation title: Single dose of ondansetron for vomiting in children and adolescents with acute gastroenteritis: an updated systematic review and meta-analysis

Brief summary of presentation: I presented a journal club on the benefits of a single dose of Zofran for pediatric patients with acute gastroenteritis. The study showed that a single dose of Zofran reduced vomiting within 8h after administration, lowered the chances of oral rehydration therapy failures, lowered IV rehydration needs in the emergency department, and decreased hospitalization rates at 8h in pediatric patients with suspected gastroenteritis. However, there was no difference in terms of return visits to the emergency department, hospitalizations at 48h, and number of diarrheal episodes.

Date presented: 01/13/22

Presentation title: Pediatric Asthma

Brief summary of presentation: I presented a didactics lecture on pediatric asthma during the Asthma Theme Day.

Date presented: 02/09/22

Presentation title: Neonatal Jaundice

Brief summary of presentation: I presented on Neonatal Jaundice to the NICU team at the Logan Health hospital.

Date presented: 07/21/22

Presentation title: Smoking cessation for improving mental health (a Systematic Review)

Brief summary of presentation: I presented a journal club on whether or not smoking cessation worsens mood/anxiety in those who struggle with mental health concerns. According to the systematic review, there was no significant worsening of mood/anxiety and many of the participants actually reported improvement in their mental health conditions.

Date presented: 09/22/22

Presentation title: Ophthalmologic Infections and Red Eye

Brief summary of presentation: I gave a presentation in didactics on ophthalmologic infections and red eyes.

Date presented: 03/22/23

Presentation title: Introduction to OMM/OMT

Brief summary of presentation: Together with Dr. Kinane, we gave a presentation to the incoming R1s during their orientation about osteopathy and the risks/benefits of OMT.

Date presented: 06/26/23

Presentation title: High- Versus Low-Dose Exercise Therapy for Knee Osteoarthritis

Brief summary of presentation: I presented a journal club on a randomized controlled multicenter trial regarding the benefits of high vs low dose exercise therapy for knee osteoarthritis which demonstrated no significant long-term difference between the two groups.

Date presented: 09/14/23

Presentation title: Moving a Patient

Brief summary of presentation: I presented on appropriate patient transport in a wilderness setting at the FMRWM wilderness weekend from 9/14-9/17.

Date presented: 09/16/23

Presentation title: Laceration Repair with Suture

Brief summary of presentation: I presented a didactics lecture on laceration repair for the Emergent/Urgent Care Theme Day

Date presented: 01/10/24

Presentation title: Peer Review: Anxiety

Brief summary of presentation: I presented on GAD diagnosis/treatment and appropriate use of benzodiazepines as part of a GVHC peer review.

Date presented: 02/13/24

Presentation title: ER review of chest CT

Brief summary of presentation: I presented a brief didactics lecture on radiologic review of a chest CT

Date presented: 03/13/24

OTHER

***Project Title**:* FDM Course December 9-10, 2023

As part of my scholarly requirements for 3rd year, I helped coordinate and lead a CME course which spanned 2 days. During this course, I helped with presentations, coordinated the schedule for all 15-16 participants coming from various locations in the US, and helped with hands-on training. The material for the course revolved around the treatment of upper and lower extremities (primarily shoulder, knee, and ankle). This was a 2-day course in which we learned about the principles of the Fascial Distortion Model and then applied them to treatment of the extremities. The course was well organized by the FDMA and there was good participation by all who were able to attend. The most challenging part of this event was the remote coordination from Kalispell for an event based out of Missoula, but in the end it all worked out. I very much appreciated all the assistance of those who helped. Thank you!

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Jen Selland, MD

CONFERENCE PRESENTATIONS

Project Title: Climate Change and Health

Details of the project: Climate change has always been a topic I deeply care about, and after moving to Montana from Massachusetts I was confronted with climate disasters such as wildfires and extreme particle pollution in ways that I had never experienced before. There are so many ways that climate change impacts health outcomes and climate health is a quickly evolving field of medicine. Thus, I choose to center my Friday Medical Conference around climate change and health, hoping to educate viewers on how intimately linked the two are and also provide strategies for moving forward.

Outcome: The presentation was overall well received and creating the presentation strengthened my own confidence in being able to talk about these difficult topics with others.

Reflections: There is so much more to learn about climate change and health, it is an enormous topic. I became motivated to educate and presented a follow-up to the nurses at St. Pat's hospital during their Earth Month as I talk about below. I want to continue to speak on climate change and health, even when I move back to the East because it is by no means a problem that is isolated to the West or any part of the world, it is everywhere.

Date project completed: November 17th, 2023

Project Title: Eco-Friendly Healthcare

Details of the project: This was an educational presentation I was asked to present as part of the St. Patrick's Hospital Hospitalist Nursing Education Series for Earth Month. I was honored to be asked to present on this topic after one of the Earth Month organizers watched my Friday Medical Conference presentation. I adapted my original presentation to be more applicable to hospital medicine and nursing care.

Outcome: I am still waiting on the feedback from this presentation because it was recorded and open for nurses to view for the entire month of May. However, based on the audience in person, it was well-received.

Reflections: I am really glad that hospitals such as St. Pat's are taking a stance on climate change and health and actively seeking out opportunities to increase education for all employees. I was flattered to be seen as an expert on this topic even though I feel like I still have so much to learn myself.

Date project completed: April 24th, 2024

TEACHING/PRESENTATIONS

Presentation title: Antidepressants: Is two greater than one?

Brief summary of presentation: A journal club presentation about a systematic review and meta-analysis looking at the effect of combining antidepressants vs antidepressant monotherapy for treatment of patients with acute depression.

Date presented: June 16th, 2022

Presentation title: CT vs Invasive Coronary Angiography in Stable Chest Pain

Brief summary of presentation: A journal club presentation about the

Date presented: December 21st, 2022

Presentation title: Trans-Affirming Reproductive Health

Brief summary of presentation: A RHEDI presentation on contraception, abortion, and fertility specific to care of transgender, non-binary, and gender diverse patients

Date presented: January 25th, 2023

Presentation title: Shoulder Radiology Self-Study

Brief summary of presentation: Compiled resources for self-study on shoulder radiology including X-ray, MRI, and overall shoulder anatomy. Presented a brief overview for how to navigate these resources and then the rest was independent study because I was recovering from COVID.

Date presented: April 5th, 2023

Presentation title: Respiratory Emergency Jeopardy

Brief summary of presentation: Created and then led residents through a jeopardy game with facts relating to respiratory emergencies as a part of the Emergency/Urgent Care theme day.

Date presented: April 12th, 2023

Presentation title: Electrolyte Abnormalities on EKG

Brief summary of presentation: A didactic presentation on common electrolyte abnormalities seen on EKG including hypo/hyperkalemia and hypo/hypercalcemia.

Date presented: August 23rd, 2023

Presentation title: ACLS Mini-Cases

Brief summary of presentation: Led two ACLS mini-simulations with resident groups focused on early identification of cardiac emergency situations and treatment algorithms.

Date presented: December 3rd, 2023

Presentation title: Esketamine Nasal Spray versus Quetiapine for Treatment-Resistant Depression

Brief summary of presentation: A journal club presentation on the results of the ESCAPE-TRD trial completed October 2023 for the use of esketamine for treatment-resistant depression.

Date presented: December 20th, 2023

Presentation title: RHEDI Simulation Day at Blue Mountain Clinic

Brief summary of presentation: Led simulated cases of possible complications of surgical abortion procedures and their management. Participants included residents, faculty, and clinic staff.

Date presented: 5/8/2024

QUALITY IMPROVEMENT PROJECTS:

Project Title*:* Note Completion and Effect on Mood

Details of the project: Primary care physicians are frequently effected by burn-out due to high-stress working environments, limited time for patient care, and subsequently even less time for administrative duties. I sought to analyze how whether or not completing my notes after a clinic day had a positive effect on my mood for the next day, to try to build resiliency strategies to combat burnout.

Outcome: Overall, my average mood was greater when I had completed my notes prior to leaving clinic compared to when I finished them at home or on subsequent days.

Reflections: Even though I am not perfect with note completion prior to leaving clinic, I feel like I have come a long way since intern year when I did this project and I have strategies and routines in place to help with my efficiency now that I feel like will benefit my mental health long term.

Date project completed: May 2022

Project Title*:* Trans-Affirming and Gender Diverse Medical Care at PHC – Updated Provider Resources

Details of the project: Access to trans-affirming medical care, including trans-affirming surgery, remains limited in rural areas due to structural and institutional barriers. As the need for trans-affirming care in the Missoula community has been increasing, so has the need from PHC providers to provide hormone therapy (HT) for trans-affirming care. I wanted to support PHC providers in that endeavour by creating a resource, but first I needed to figure out what the most helpful type of resource would be.

Outcome: Successfully identified areas of hormone therapy that providers wanted extra support in, while also assessing provider confidence for prescribing and monitoring hormone therapy and having risk/benefit discussions with patients at baseline, without any new resource creation.

Reflections: I used the data I collected to guide my QI project in 2024.

Date project completed: June 2023

Project Title*:* Trans-Affirming and Gender Diverse Medical Care at PHC – Change in Provider Confidence after Resource Creation

Details of the project: I created a resource for masculinizing and feminizing hormone therapy for PHC providers by consolidating information from validated resources that already exist. I then assessed for changes in provider confidence in providing this care through a follow-up survey.

Outcome: Success! There was an increase in provider confidence with access to the resource for both prescribing and monitoring trans-affirming HT as well as with counselling patients on the risks and benefits of trans-affirming HT. Overall I had really positive feedback about the resource I created and helpful feedback suggestions on how to improve it in the future.

Reflections: An important concern that was noted in the feedback was who would update the resource when I leave PHC. I think this is a valid problem, and a difficulty in trying to create a concise resource. Since guidelines and best practices can change and update in an evolving field of medicine, the benefit of viewing a resource through a larger institution such as USCF or Rainbow Health directly is that they have the bandwidth to make sure they are staying up to date.

Date project completed: June 2024

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Rebecca Sharar, MD, MPH

CONFERENCE PRESENTATIONS

***Project Title**:* Things we do for no reason: evidence against common clinical practices

Details of the project: Each FMRWM PGY-3 is required to give a presentation at Missoula's "Friday Medical Conference." I reviewed multiple clinical pearls from the Journal of Hospital Medicine's "Things we do for no reason" series. Each pearl represents a common low value practice that is generally unsupported by evidence.

Outcome: A good review of common but unsupported clinical practices resulting in a smooth presentation. I am hopeful I will read the journal series regularly to constantly challenge my clinical practice in the future.

Reflections: (thoughts going forward, are there things to build on here, what did you learn- barriers etc).

Date project completed: October 26, 2023

TEACHING/PRESENTATIONS

Presentation title: Pharmacologic Management of ACS

Brief summary of presentation: Didactics presentation on the acute and long-term pharmacologic management of ACS in different clinical contexts.

Date presented: May 1, 2024

Presentation title: Integrating abortion practice into primary care

Brief summary of presentation: RHEDI presentation and discussion highlighting key considerations and resources available to support the integration of abortion practice into primary care.

Date presented: March 26, 2024

Presentation title: Wolff Parkinson White

Brief summary of presentation: Didactics presentation on Wolff Parkinson White, associated arrhythmias, and management.

Date presented: March 27, 2024

Presentation title: Managing Rare Complications of Medical and Surgical Abortions

Brief summary of presentation: Kara Francis and I collaborated on creating a review of potential complications of medical and surgical abortions. Few complications are associated with these procedures and they are low frequency events, so residents often aren't exposed to complications clinically.

Date presented: 2023 RHEDI night

Presentation title: Hypertension Management to Reduce Cardiovascular Events.

Brief summary of presentation: FMRWM Journal Club Presentation comparing hydrochlorothiazide and chlorthalidone for hypertension management.

Date presented: October 26, 2023

Presentation title: Urinary Catheters

Brief summary of presentation: Didactics presentation reviewing different types of urinary catheters and their indications.

Date presented: May 3, 2023

Presentation title: Tachycardias: wide, wild things

Brief summary of presentation: Didactics presentation reviewing common wide complex tachycardias and their management.

Date presented: March 22, 2023

Presentation title: Infant Fever & Neonatal Meningitis Potpourri

Brief summary of presentation: Presentation to paediatrics hospitalist group at Community Medical Center reviewing new neonatal fever guidelines.

Date presented: December 8, 2022

Presentation title: Tympanostomy Tubes or Medical Management for Recurrent Acute Otitis Media

Brief summary of presentation: FMRWM Journal Club Presentation comparing T tubes versus medical management alone of recurrent acute otitis media.

Date presented: September 22, 2022

Presentation title: Newborn care

Brief summary of presentation: Interactive, case-based didactics presentation on common newborn care questions.

Date presented: June 8, 2022

Presentation title: Pre-diabetes: to metformin or not to metformin

Brief summary of presentation: FMRWM Journal Club Presentation reviewing the data around pharmacological treatment of prediabetes with metformin on multiple outcomes.

Date presented: December 30, 2021

OTHER

Project Title*:* Helping Residents Inform Rural Training Site Selection

Details of the project: Evaluating the resident-driven online database I created as my QI project the year before, to help inform residents when they're making rural training site selection.

Outcome: Evaluation showed that residents found the survey helpful.

Reflections: I think the database could be helpful for future generations of residents but would require some upkeep and ideally some formatting to make the document more user friendly.

Date project completed: June 2024

***Project Title**:* Helping Residents Inform Rural Training Site Selection

Details of the project: Driven by my own frustrations and dissatisfaction with selecting rural training sites I wanted to make a live document/database of resident experiences at each of our different rural training sites, with the hope of this being available to future residents so that they can feel more informed when selecting rural training sites.

Outcome: Got at least one response for each training site, but the hurdle will be continuing to disseminate the survey to keep the database updated.

Reflections: As my next QI projected my aim was to evaluate whether or not residents thought this was a helpful tool.

Date project completed: June 2023

***Project Title**:* Running after from the afternoon energy slump

Details of the project: As a personal QI project intern year I sought to explore if regular runs would boost my overall energy levels.

Outcome: More workouts correlated with more energy, but was not statistically significant.

Reflections: I struggled to collect data from myself daily. I realized that's a lot to ask for myself if I'm not super invested in the data. There were lots of confounders when analyzing the data and how energetic I am is multifactorial.

Date project completed: June 2022

FMRWM SCHOLARLY WORK **RESIDENT**

Name: Cecilia Weeks, MD

CONFERENCE PRESENTATIONS

Project Title: Trauma Informed Care: Improving Providers' Knowledge

Details of the project: Presentation at Big Mountain Medical Conference

Reflections: Enjoyed presenting at a conference!

Date completed: 1/27/23

Project Title*: Friday Medical Morning Conference*

Details of the project: Trauma-Informed Care: An Overview for Health Care Providers

Reflections: Helpful to have reusable presentations

Date project completed: 9/29/23

TEACHING/PRESENTATIONS

Presentation title: Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record, Anna P. Goddu et al. (2018), Journal of General Internal Medicine

Brief summary of presentation: Journal club

Date presented: 4/21/22

Presentation title: CT Head Imaging

Brief summary of presentation: Rad review didactics

Date presented: 3/3/23

Presentation title: Trauma-informed Pelvic Exam

Brief summary of presentation: RHEDI didactics

Date presented: 3/3/23

Presentation title: Opioid analgesia for acute low back pain and neck pain (the OPAL trial): RCT, Caitlin Jones et al. (2023), Lancet

Brief summary of presentation: Journal club

Date presented: 8/3/23

Presentation title: RHEDI + DEI: Pregnancy Counseling

Brief summary of presentation: Didactic presentation, RHEDI and REACH

Date presented: 4/14/24

Presentation title: Mindfulness-Oriented Recovery Enhancement vs Supportive Group Therapy for Co-occurring Opioid Misuse and Chronic Pain in Primary Care

Garland et al. (2022), JAMA

Brief summary of presentation: Journal club

Date presented: 4/4/24

Class of 2024 QI Work

QI PROJECT

Author: Sarah Davis, DO, MHS

Project Title: Improving Greater Valley Health Center's System for Recording and Accessing Patient's Health Care Maintenance

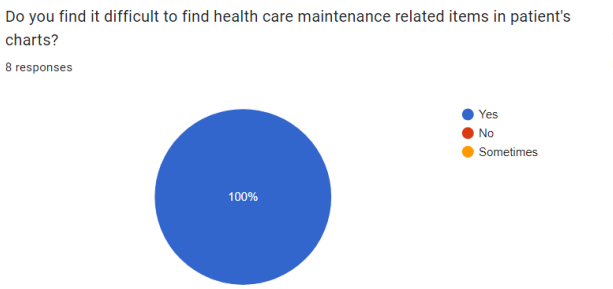
Problem: Providers and staff at Greater Valley Health Center often spend excessive time pre-visit planning, looking for information regarding patients' health screenings and health care maintenance. Our EMR, eClinical Works, does not have a streamlined process for recording this data or for easily accessing it later. As providers are preparing for an upcoming patient's visit, we have to look for the information in several different places including scanned documents, labs or imaging, previous notes or even log into another EMR. We then document this in our current note, however then often we are searching for this information all over again, repeating all of this work prior to a subsequent visit later as there is not one standardized place to reference back to to avoid redundant work. Staff members are also doing their own pre-visit planning, but providers are typically repeating this work on their own, because not all staff members have a standardized way of doing this either and providers prefer to do this for themselves as well. Lastly, when providers are covering their colleagues' patients, it is also very difficult for them to find this information if necessary and they too have to locate health care maintenance information. Not having a single place to look for this information and a standardized way for recording it creates an excessive amount of redundant and unnecessary work for both clinic staff and providers.

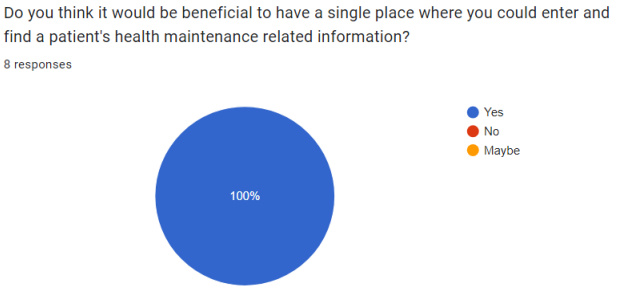
Aim of the project: In order to increase efficiency for providers and staff, the goal of this project was to create an easily accessed checklist in patient's charts with routine/recommended health care maintenance items and screenings that any provider or staff member looking for this information could quickly access or update.

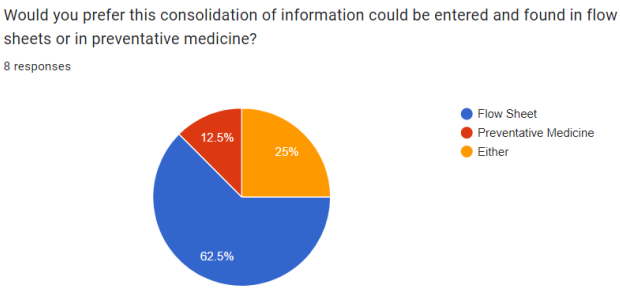
Key Measures for Improvement: The initial goal for key measures of improvement were improved provider and staff satisfaction with a standardized system for gathering and recording health care maintenance information, as well as amount of time saved for pre-visit planning. A longer term goal for the project would be improved patient outcomes with higher rates of obtained health screenings as it would then be easier to tell who was due for particular health screenings, if one of the barriers to obtaining these is that it was not easily recognized when patient's were due.

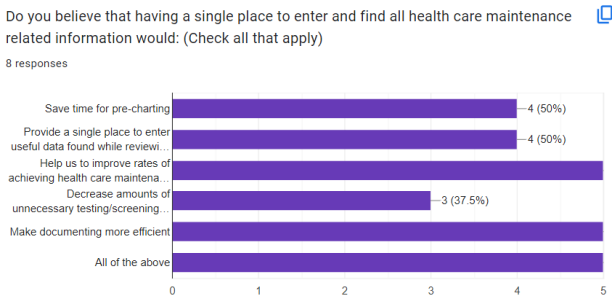
Process of gathering information: This project was initially discussed with clinic administrators to determine if they agreed this was a concern that required addressing, and they confirmed that this had been something they have been hoping to improve for some time now. After knowing this, a six question survey was then sent to providers of GVHC to determine if they too found this to be an issue in their own practice, and how and why they would prefer to see it improved.

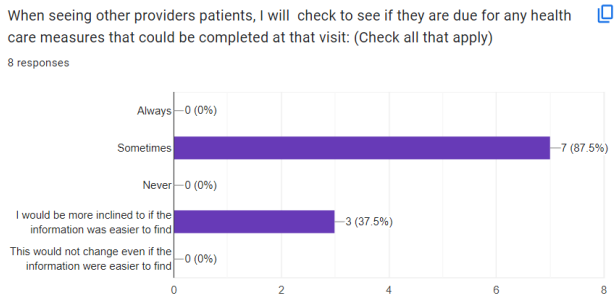
Analysis and interpretation: The survey results are reflected below. The results demonstrated that all providers who responded found it difficult to find health care maintenance information for patients and that they would find it beneficial to have a single place to enter and to find this information, with the benefits including saving time on pre-charting, improving rates of achieving health care maintenance measure goals, decreasing amount of redundant or unnecessary screening because the patient was not actually due, and making documenting more efficient. The majority also preferred that Flowsheets be the place in eCW that was used to create this standardized system. Several also said they would be more likely to check these measures for other provider's patients if they were seeing them if they had an easier way to find the information of what patients are due for.

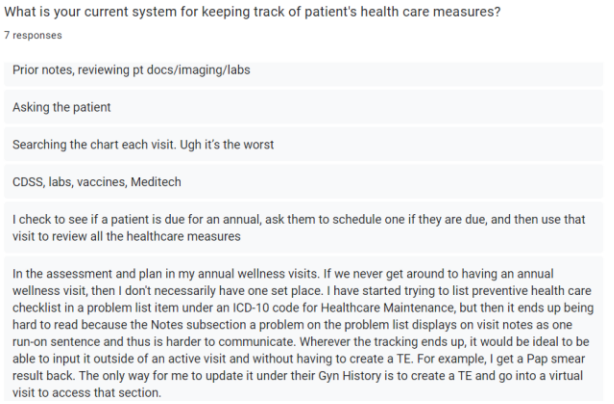












Strategies for change: Using the responses from providers in the survey, I worked with our clinic administrators, IT department and EMR specialists to determine the best way to accomplish these goals. Providers had specified that they would prefer this to be created using the Flowsheets section of eCW, and so this is where I started, however it became clear throughout the process that the Flowsheets section does not currently have the capabilities to do much of what we were hoping to accomplish. I was able to determine 3 other proposed ways we may be able to try and improve our process and started to build these options. I even began to use each of them for my own patients trying to determine which I felt was most efficient and best for accomplishing our goals, however due to time constraints, I was unable to then have the other providers in the clinic also start to use these 3 proposed methods to gain their perspective as well.

The three possible methods for accomplishing the goal of streamlining the recording and accessing of patient's health care maintenance are:

1. Health Care Maintenance Assessment (ICD 10 code) Template
    a. The method that I have been using most frequently is by using a template that I made in eCW that documents recommended Health Care Maintenance and recommended screenings. I then take the time to fill this out in detail for the patient by gathering this information as I typically would, however this can then be pulled forward to a future note (or in a virtual visit in a TE) by clicking on the carrot adjacent to

"Assessment" in a new note and finding the note where I previously documented this information under a "Health Care Maintenance" ICD 10 code.

Plan:

Treatment:
Health care maintenance

Clinical Notes:
Health Care Maintenance
Cancer Screenings:

Breast Cancer Screening:
USPSTF [B]- Age 50-74, mammogram every other year
ACOG [A] and USPSTF [C]- Age 40-75, mammogram every 1-2 yrs
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

Lung Cancer Screening:
USPSTF [B]: Age 50-80 with 20 pack yr hx AND currently smoke OR have quit in last 15 years
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

Colon Cancer Screening:
USPSTF: Age 45-49 [B], Age 50-75 [A] (If strong FH, 10 years younger than family member's age of Dx)
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

Cervical Cancer Screening:
USPSTF [A] and ACOG [A]- Age 21-65 (21-30 every 3 years cytology alone, 30-65 co-testing)
ACS- Age 25-65
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

Prostate Cancer Screening:
USPSTF [C]- Men aged 55-69 may choose to undergo PSA
ACS- If men choose to be screened, interval should be every 2 years
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

Skin Cancer Screening
USPSTF [I], ACS, no guidelines
- Last completed full body skin exam: [Date]
- Findings:
- Recommended follow up: [Method and date]

Other:
Screen for AAA
USPSTF [B]: Age 65-75, if they EVER smoked
- Last completed: [Date]
- Result:

Screen for hyperlipidemia:
USPSTF [A]: Men 35+, women 45+, Men and Women starting at age 20 if increased risk
Interval recommendations are not clear, every 3-5 years
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

Screen for pre-diabetes/diabetes
USPSTF [B]: Age 35-70, asymptomatic who are overweight or obese
Screen every 3 years
- Last completed: [Method and date]
- Result:
- Recommended follow up: [Method and date]

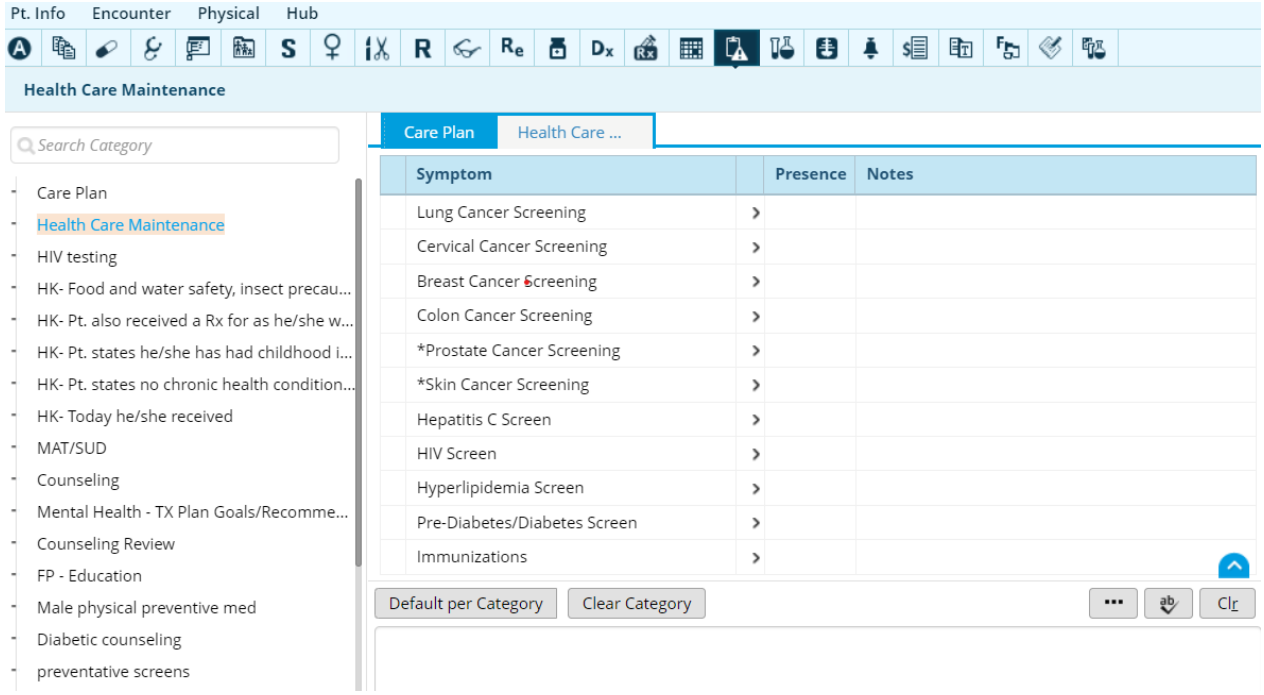
Screen for Hepatitis C:
USPSTF [B] Everyone aged 18-79, one time screening unless risk factors
- Last completed: [Date]
- Result:

Screen for HIV:
USPSTF [A]- Everyone aged 15-65, one time screening unless risk factors
- Last completed: [Date]
- Result:

Immunizations (if age <65)
- COVID: 2 or 3 dose primary series and booster (s)
- Influenza (IIV4 or RIV4): Once annually
- TDap: Every 10 years
- Shingles: 2 doses at age 50 and above (unless immunocompromised then >18)
- PCV **(If additional risk factors)**
One dose PCV 15 followed by PPSV23
OR one dose PCV20
- HPV: Shared decision making up to age 45 if never received

Immunizations (if age >65)
- COVID: 2 or 3 dose primary series and booster (s)
- Influenza High Dose: Once annually
- TDap: Every 10 years (+/- one dose per wound management)
- Shingles: 2 doses
- PCV

2. Preventative Measures
    a. Under the preventative health measures section (near the bottom of a note), I created an Adult Health Care Maintenance category that has pre-filled options to select and can also be carried forward to future notes



3. Checklist in the Medical History
    a. The last method may be the simplest and most efficient, however some may feel it crowds the patient's note especially if they are only being seen for an acute visit, but this entails simply keeping a running checklist in the patient's medical history section that can be easily updated and accessed.

All methods seem to have their respective pros and cons. Some are more difficult to access outside of documentation and update if you are for example reviewing some incoming documents and want to access and update this information outside of a note, however others make documentation much more efficient.

Next Proposed Steps: Seeing as I was unable to fully complete this project in the time allotted, I will be taking these proposed methods for possible standardized systems again to the clinic administrators, IT department and providers. The goal now is to possibly have incoming residents also interested in this project to continue the work in the upcoming year, or another GVHC provider at the clinic as this has been an ongoing long-standing goal for GVHC.
I have also created note templates and patient education templates in eCW for health care maintenance measures with attached orders than be used in the future of this ongoing project.

Lessons learned:

- I have learned through this process that quality improvement projects, especially at a larger systems level, can certainly take more time to accomplish than expected and that you may not always accomplish your initial goal in the time desired, but that they can continue to be ongoing and evolving.
- This work also highlighted for me how individualized and unique quality improvement projects are to their unique organization. This one in particular is very specific to the eCW EMR used at our clinic alone, and may not be applicable to many other settings. However, there were also certainly many lessons that can be applied more broadly and used in future practice settings.
- Lastly, I learned that you may find more than one solution to the issue you are trying to solve, in which case you can explore these options with the assistance of your colleagues to determine which is best suited to your practice.

QI PROJECT
Author: Sienna Foxton, DO
Project Title: Improving Healthcare for Native Americans through Education of Healthcare Providers

Problem: Native American health outcomes are well below those for other ethnic groups in the USA. Of note, the Montana Department of Public Health and Human Services reported that between 2017 and 2021 "the median age of death was 60 among American Indian men and 64 among American Indian women. That is 15 years younger than white men and 17 years younger than white women in Montana." This disparity is due to a variety of factors including historical trauma, higher prevalence of chronic disease such as heart disease and kidney disease, substance use, and lack of trust in the healthcare system. Improving health outcomes for Native Americans is a long process, but one way we can help is to increase education about factors that affect Native American health for healthcare providers. If healthcare providers are more aware of factors that affect Native American health they will be more likely to address them, leading to better health outcomes.

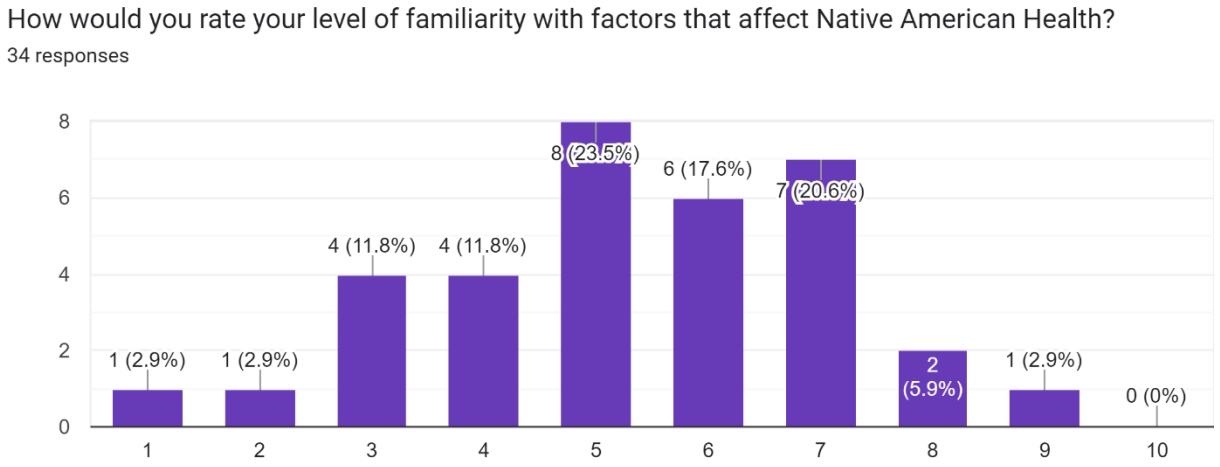
Aim of the project: Increase familiarity with factors that affect Native American Health in order to improve healthcare for Native Americans.

Key Measures for Improvement: Rating of familiarity with factors that affect the health of Native Americans before and after workshop.

Methods: First, a baseline survey was sent out to gather information from residents and faculty regarding which topics related to Native American health would be the most useful to cover. Based on this information, a workshop related to two of the topics chosen by poll respondents, Native American healthcare delivery and Native American health innovations, was developed. After the workshop, a post-workshop survey was distributed to gather feedback on the workshop.

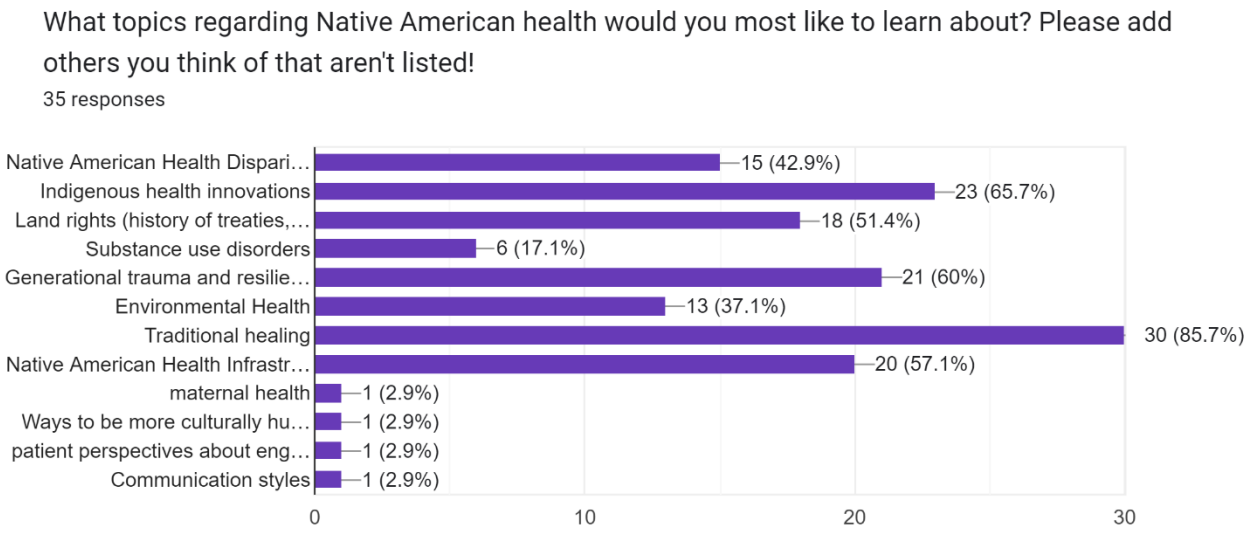
Results:
Baseline survey results:
A total of 35 participants responded to the baseline survey. The participants were asked to rate their level of familiarity with factors that affect Native American health on a scale from 1 to 10, with 1 being not all familiar and 10 being very familiar. Of the 35 participants in the survey, only 8.8% of participants rated their level of familiarity as an 8 or higher and no participant rated their familiarity a 10 (see figure 1). The average rating was 5.14.

Figure 1: Rate your level familiarity with factors that affect Native American health with 1 being not at all familiar and 10 being very familiar.



Results of the baseline survey showed the four topics that respondents most wanted to learn about included traditional healing, Native American health infrastructure, generational trauma and resilience, and indigenous health innovations (see figure 2).

Figure 2:

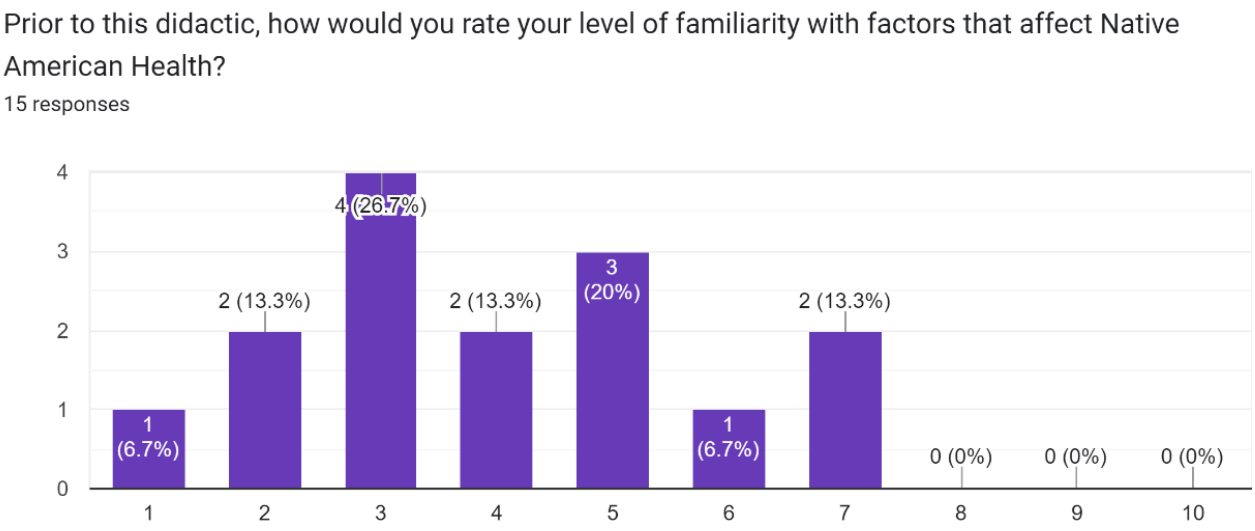


Baseline survey participants were also asked how they thought learning about factors that affect Native American health might impact their work. Answers included providing more culturally competent/humble care, increasing ability to advocate for patients, and putting Native American patients more at ease.

Post workshop survey:
Prior to the workshop, participants were again polled regarding their familiarity with factors that affect Native American health. This was done on order to more directly compare familiarity before and after the workshop between people that attended. Not all participants in the baseline survey were present for the workshop.

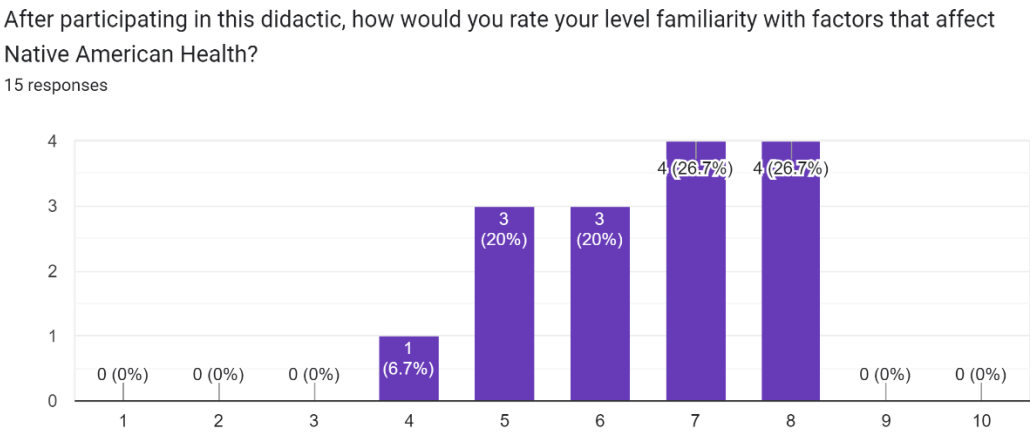
In this survey, 15 participants responded. All participants rated their initial familiarity as a 7 or less with an average score of 4 (see figure 3).

Figure 3: 1 being not at all familiar, 10 being very familiar



After the workshop, participants' familiarity ratings increased with an average score of 6.5 (figure 4). The difference between familiarity before and after the workshop is significantly different ($p < 0.0001$).

Figure 4: 1 being not at all familiar, 10 being very familiar



Qualitative Feedback:
Respondents were also asked to share what they liked most about this didactic. Responses included hearing from someone connected to a tribe, interactive and open discussion, comprehensive review of a complex topic, among other responses.

Additionally, respondents were asked how this didactic could have been improved. Responses included further reading or resources on how to learn more, more instructions with group work, and including more specific information for Montana AI population.

Discussion/Conclusion: Baseline survey results showed an average of 5.14 rating on familiarity with factors that affect Native American health, indicating a need for increased education on this topic. Survey of participants who attended the workshop had an average score of 4, even lower than baseline data.

After the workshop, there was a significant increase in the ratings of familiarity of factors that affect Native American health, indicating that the workshop was effective in increasing knowledge on this topic.

Qualitative feedback was also positive and indicated that participants enjoyed the workshop and felt it was worthwhile.

There is still a lot of work that must be done in order to increase health outcomes from Native American health, but this project showed that increasing education for health providers on this topic is one small way to make a change.

Next steps: Continuing education is needed in order to build on this work. Other topics identified that would be useful to cover included traditional healing, generational trauma and resilience, land rights, and environmental health, among others. Future didactics or workshops could focus on these topics. Additionally, continuing to work on other issues that affect the health of Native Americans including addressing generational trauma, substance use, and chronic disease management is also needed.

QI PROJECT
Author: Kara Francis, MD
Project Title: Improving Hospital Discharge Communication

Problem: Hospital discharges are a dangerous and challenging time for patients, their caregivers, and their medical providers. Patient care was carefully managed while they were admitted, medications adjusted, and they often have accumulated several new diagnoses. On discharge, they receive little or no communication about their medication changes, need for ongoing management of conditions, or follow up needs. Their primary care provider eventually receives a discharge summary of their care but this is often delayed several days and they may not see the patient for weeks.

At Partnership Health Center (PHC), we are fortunate to have panel managers who help coordinate the discharge process and try to ensure patients' ongoing needs are met. We, as residents and faculty, are in a unique position of working in both the inpatient and clinic settings. As such, we can better understand and help coordinate the discharge communication with panel managers to improve continuity of care. Despite this, I often see patients in clinic who were discharged by our resident run, 'silver team', but have not had intervening communication from Partnership and are missing critical medications, labs, or other care needs. Additionally, in conversations with panel managers, they often receive no communication about a patient's discharge aside from a summary that may be received days after discharge and is often too lengthy, making it difficult to pull out key information. This results in easily preventable gaps in care.

Aim of the project: Increase perceived frequency of communication from resident team discharges to panel managers by 50%, and perceived usefulness of said communication by 75% between December 2023 and April 2024. To accomplish this, I will create a template in the clinic's EMR, eClinicalWorks, to prompt inclusion of useful discharge information, as identified by the panel managers, and educate senior residents on use of this template.

Key Measures for Improvement: The frequency and usefulness of discharge communication was gathered through pre- and post-intervention surveys completed by the panel managers. The survey questions and possible responses are shown below.

Pre- intervention Survey:

- How often do you think you get a TE about a patient discharging from St Pat's after being on Silver Team (the resident service there): *Most of the time; sometimes; rarely; never*
- How helpful do you find the information you get from a discharge TE?: *Very helpful; somewhat helpful; not helpful; I never get a discharge communication*
- What information would you find most helpful in a discharge TE? Keep in mind, we want to keep it brief but useful:

Post intervention Survey:

- How often do you think you get a TE about a patient discharging from St Pat's after being on Silver Team (the resident service there): *Most of the time; sometimes; rarely; never*
- How helpful do you find the information you get from a discharge TE?: *Very helpful; somewhat helpful; not helpful; I never get a discharge communication*
- Have you noticed any increase in communication from silver team the last several months?: *Yes; No*
- Do you think discharge TEs should be continued or are they just another thing filling your box?: *Please continue; I could do without them*

Process of gathering information: The pre-intervention survey, shown above, was sent to all RN panel managers at Partnership in early December 2023, responses are shown below. The responses to the survey were used to design a telephone encounter template in eCW prompting information from the discharging team. The template included the following fields: recommended timing of clinic follow up; who the patient should see in follow up (PCP or other provider is okay if PCP unavailable); any specialty referrals placed on discharge; Any labs needed prior to their appointment; any new medications and to what pharmacy they were sent; any chronic medications that were stopped (please update in their clinic chart).

I requested that all senior residents use the new template when a patient was discharging from the resident team. Instructions for use of the template were emailed to all seniors and copies of these instructions were placed in the resident workspace.

To evaluate the efficacy of the new discharge workflow, 4 months after the initial survey and template roll out, the post-intervention survey was sent to all panel managers.

Analysis and interpretation: The pre- and post-survey responses are shown below in *Figure 1* and *Figure 2* respectively. As displayed, The perceived frequency of communication from silver team discharges remained unchanged during the study period, with 80% of respondents responding that they sometimes get communication and 20% stating they rarely do in both the pre- and post-surveys. Interestingly, on the post-survey, 100% of respondents responded, “yes,” when asked whether they felt communication had increased during the study period. This discrepancy may be due to changes in staff during the period, and resultant different frames of reference, and lack of quantitative response options to the survey.

The introduction of the template appeared to have more of an impact on the perceived utility of the discharge communications. In the pre-survey only 40% of respondents found the discharge communication they did receive helpful. This number increased to 80% in the post-survey. This improvement is likely due to the use of panel manager input in the design of the template.

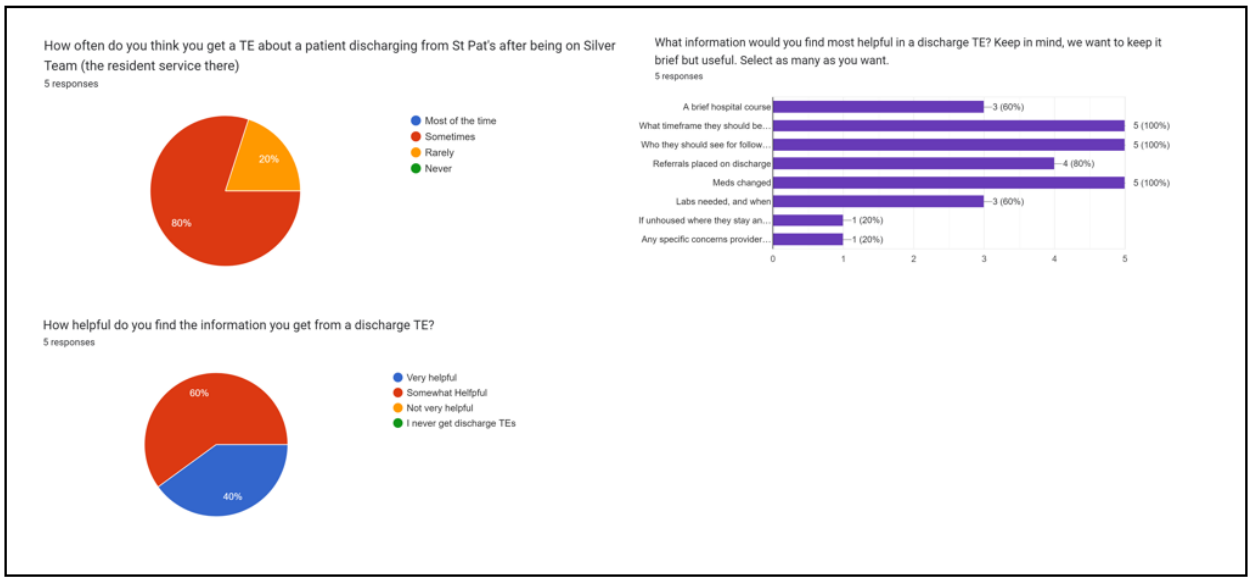


Figure 1: RN panel managers' responses to the pre-survey

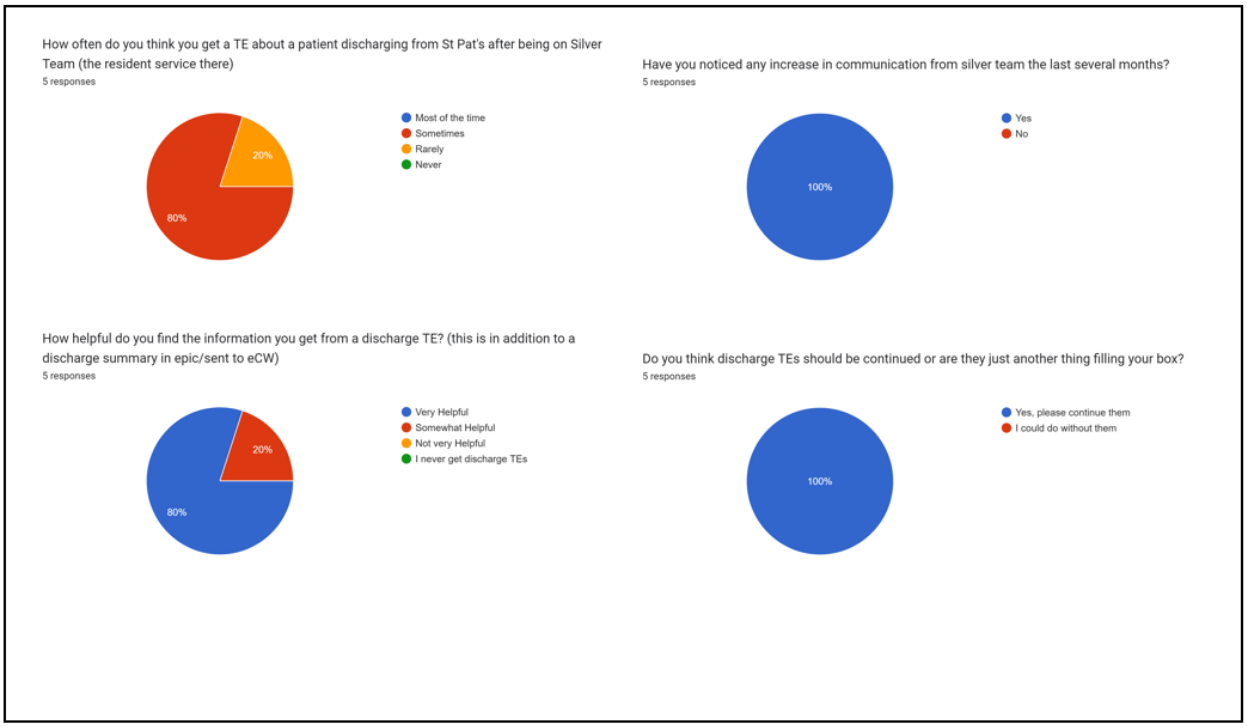


Figure 2: RN panel managers' responses to the post-survey

Effect of change: With the introduction of the discharge templates and new discharge workflow the perceived frequency of communication from silver team was unchanged to slightly increased, and the perceived utility of said communication improved by 50%.

Opportunities for future change: The lack of improvement in the frequency of silver discharge communication is likely due to several factors. First, while many of the Partnership patients admitted to St Patrick's Hospital are assigned to the resident team, many are assigned to other teams or admitted to the other local hospital. The attendings on these services do not have access to the clinic EMR and thus no discharge communication occurs in these settings. The panel managers are often unable to differentiate what patients were cared for by residents over other teams and therefore likely had difficulty quantifying the frequency of appropriate discharge communications. Second, even on the resident service, sending a communication from the inpatient team requires several, cumbersome steps. This includes getting on a separate lap-top, logging into eCW (which requires several steps), and assembling the discharge information. In the course of a busy day, this is often difficult to accomplish.

The most impactful intervention to improve discharge communication and continuity of care would be a single EMR between the hospital and clinic settings. In the absence of this option, it would be very helpful to provide inpatient providers with a more seamless way of contacting clinic providers and panel managers. However, given overall positive feedback from the panel managers, at present, I recommend continuing to use the current template.

QI PROJECT
Author: Alec Kerins, MD
Project Title: Limiting the Overlap: Improving Clinic Efficiency by Limiting Overlap of Work done by MA and Provider

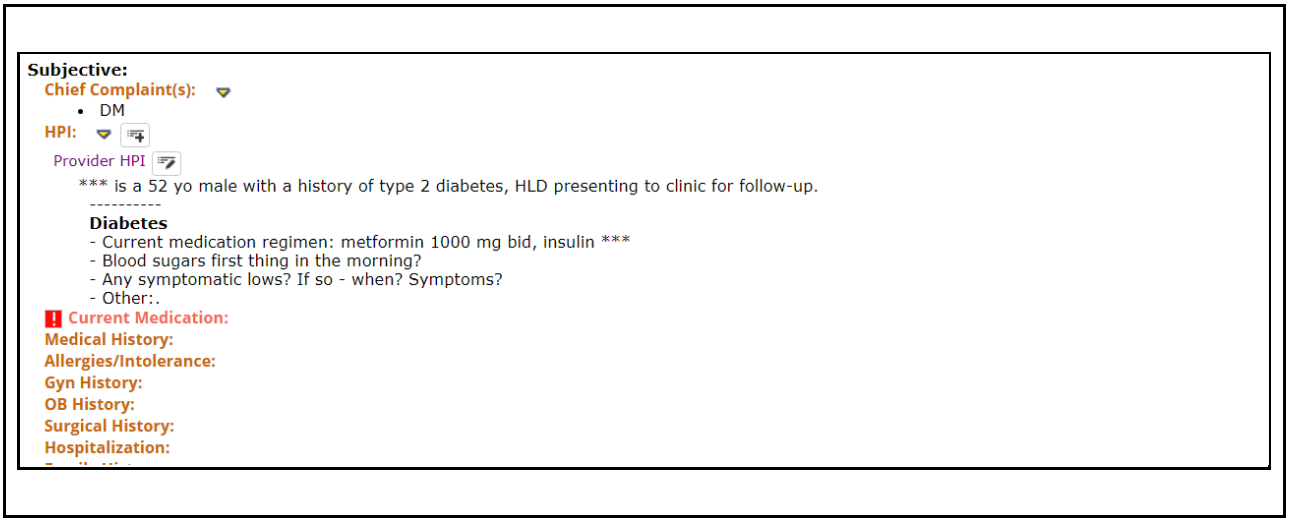
PROBLEM: Patients often come into clinic with a multitude of issues they'd like addressed in the visit. The visit starts by the medical assistant getting vitals and doing a basic intake to include reason for visit, medications, and updates on medical history among others. Given the multitude of problems the patient wants to discuss and the MA intake process visits often becom quite lengthy. Interestingly, the Medical Assistant often asks the patient similar questions to the physician, but they're not documenting the conversation in a structured way. The aim of this project was to improve efficiency in the clinic by streamlining the patient intake process to include documentation of more specifics of the symptoms in order to eliminate redundancy and just aren't documented or conveyed in a meaningful way and end up getting duplicated. the aim of this project was to fix this so visits were more timely, and both physician and patient satisfaction was not sacrificed.

AIM STATEMENT: Does implementing a pseudo-flipped model of patient intake with a structured intake process and decreased patient-to-physician contact times lead to increased clinic efficiency (as measured by number of notes completed by the end of the clinic day) and MA and provider satisfaction?

KEY MEASUREMENTS FOR IMPROVEMENT:

- Total visit time as calculated from check-in to check-out
- Number of notes done during clinic - a large part of physician satisfaction is getting work done during the clinic day. This includes visit notes, of course
- Physician Satisfaction - measured at the end of each clinic visit
- Medical Assistant Satisfaction - measured using same scale as physician satisfaction at the end of the clinic visit

PROCESS OF GATHERING INFORMATION: Each patient's chart was prepared prior to the allotted clinic time with a script for the MA to use to guide conversation. This script was then reviewed during the pre-visit planning time immediately prior to clinic starting (Image 1).



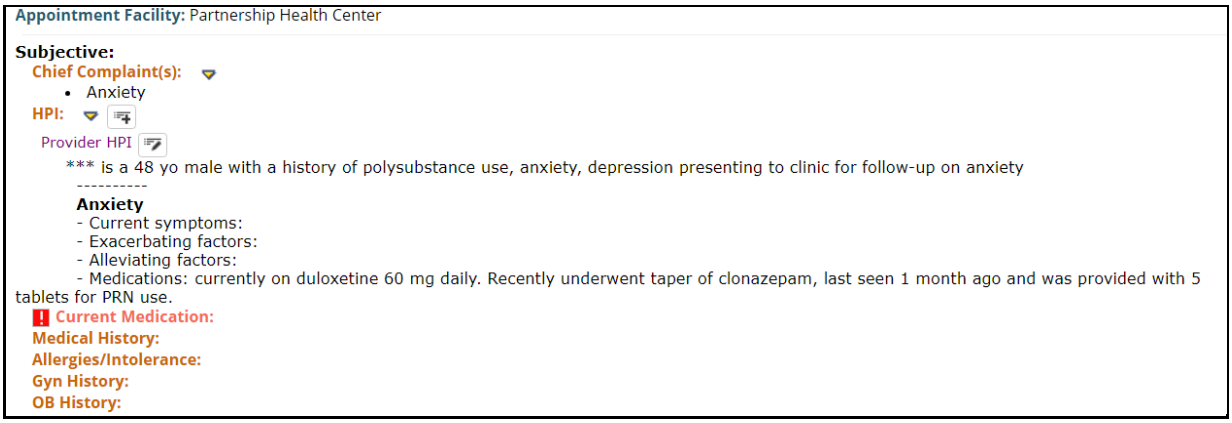


Image 1: Examples of scripted intake within the HPI of patient notes.

Data was gathered using total visit times and number of notes finished before the end of the dedicated clinic time as indicated within the electronic medical record. Surveys were also given to both the provider and MA following clinic visits in order to assess overall satisfaction. The satisfaction survey was a simple 1-5 scale satisfaction survey based on overall satisfaction with the visit with particular attention to visit efficiency.

ANALYSIS AND INTERPRETATION: Overall, the the collection of data was cut short due to the increased time it took to see patients with the new intake process. It became too burdensome for both MA and provider. The average visit time with the modified intake was 70.4 minutes, whereas the average visit time without the new intake was 50.3 minutes (Image 1, Table1).. MA satisfaction with and without the new intake was 4.1 vs 4.3, whereas physician satisfaction was 2.75 vs 3.3 respectively (Image 2, Table 1). Tracking of note completion was not done due to lack of feasibility of the quality improvement intervention in general.

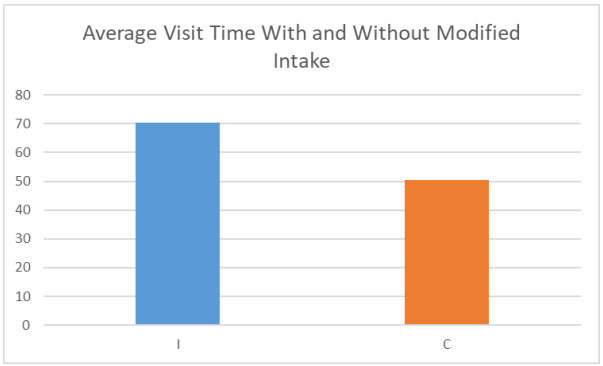


Image 2: Average visit time with and without the modified intake.

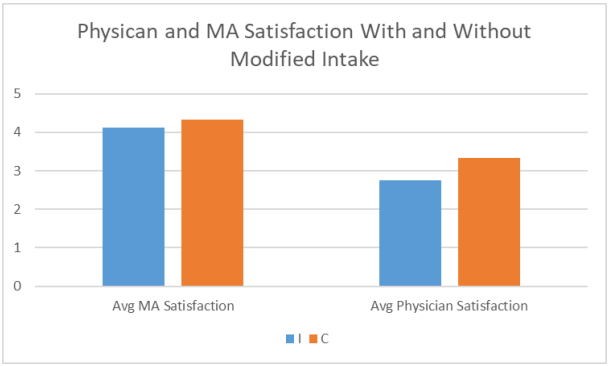


Image 3: Average MA and physician satisfaction with and without the modified intake

Control or Intervention	Number of Visits	Avg Visit Time	Avg MA Satisfaction	Avg Physician Satisfaction
I	8	70.375	4.125	2.75
C	9	50.33333333	4.333333333	3.333333333

Table 1: Data showing number of visits, visit time, MA and Physician satisfaction with the new intake (Intervention, "I") versus the traditional intake (Control, "C").

EFFECTS OF CHANGE: The change had a negative effect on time of visit and therefore clinic efficiency. The increase in time it took to complete clinic visits put us behind on future visits that day and thus lead to an significant drop in visit satisfaction of the physician. MA satisfaction remained largely unchanged, however, did show a small drop in satisfaction with the new intake.

LESSONS LEARNED:

1. Clinic efficiency is very multifaceted and dependent on both intrinsic characteristics of the provider as well as external factors.
2. MA skillset/efficiency is important when designing an intervention that relies so heavily on them

QI PROJECT

Author: Travis Kinane, DO

Title: Enhancing Resident Training in Acute Musculoskeletal Care Through Community Event Participation

Problem: In 2022, The Society of Teachers of Family Medicine (STFM) estimated that up to 40% of family medicine physician visits were for chronic or acute musculoskeletal concerns. While it is difficult to access acute injuries in residency training, it will be a large part of many of our practices.

FMRWM is surrounded by beautiful mountains and trails, which provide some of the best trail running and races in the U.S. Historically, there has been little involvement from residents in covering races and other athletic events. This is an untapped opportunity that we could capitalize on in our residency training.

Aim: Residents come in with different levels of comfort and experience to assess and treat MSK injuries. The current resident classes feel unprepared in covering races because of a lack of education and experience. The goal of this QI project was to identify a way for family medicine residents to have more opportunities to evaluate and treat these conditions.

Key measures for improvement: The first goal was to identify areas in the community that would allow residents to participate as team/event physicians at events. These events included the Run Wild Missoula Races, the Missoula Marathon, the University of Montana Hockey and Women's Basketball, and the Missoula Motor Cross World Championships.

There has been minimal resident participation in event coverage. To address this knowledge gap, this project provides respondents with documentation on common race injuries, treatments required equipment, and local contacts to increase the likelihood they will participate in local events and ultimately increase their level of comfort in treating acute MSK injuries.

Process of gathering information: Residents were asked if they had participated in event coverage during their residency training. A document summarizing the mass participation event management guidelines for team physicians, equipment checklist, and local considerations was provided. They were then asked if they felt more comfortable participating in event coverage after reviewing the provided materials. Respondents were also asked if residents believed they were getting adequate MSK training during residency.

Analysis and interpretation: A survey was sent to the 27 residents of the FMRWM program, via Google Forms, and 18 were completed. Residents were asked if they had ever participated as a team physician in a mass event, local race, or sporting event.

67% of the residents reported no participation in any sporting events. There was a follow-up question asking to what extent residents feel prepared to cover an event, with 1 being strongly disagree and 5 being strongly agree. Only one resident responded with a score greater than 3. The average score was 2.11.

Residents were then provided a document on mass event coverage and smaller local event coverage details. They were then asked to rescore if they felt more comfortable covering event. In general, the document improved residents' comfort, with an average score of 3.38.

Lastly, the residents were asked if they felt we received sufficient acute MSK training at FMRWM, with 89% saying no.

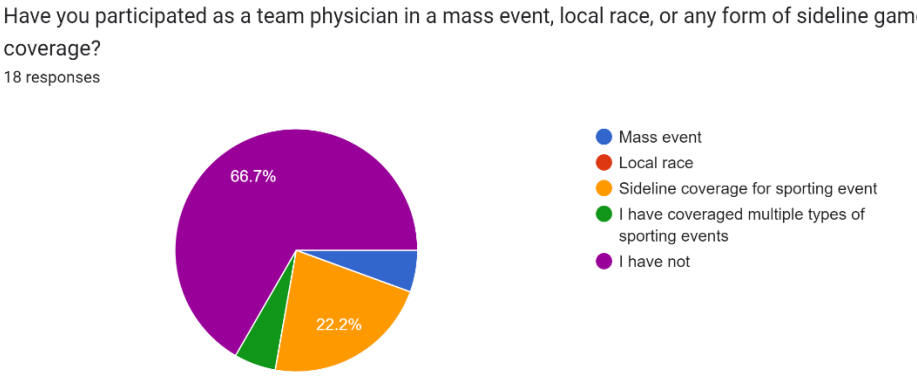
Strategies for change: Evaluating and treating acute MSK injuries requires a different set of skills than treating chronic pain. Exposure to acute injuries on the field, at a sporting event or race will help residents in their clinic reasoning and in their future practice. Suggested changes:

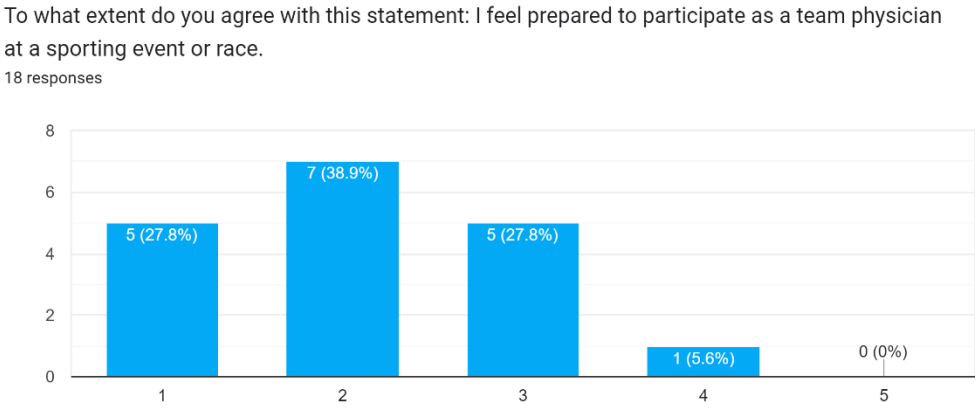
1. Build event coverage built into the resident schedule prior to their sports medicine rotation in their third year.
2. Encourage faculty to participate in events to allow easier resident access. (Physicians present at events would bring future acute injuries to the PHC clinic).
3. Consider adding a sports medicine track to the residency.

Effects of change: Better clinic reasoning and feeling more comfortable with acute MSK injuries, which will comprise up to 40% of concerns for patients in the future practice of residents.

Lessons learned: There are many opportunities in the Missoula community that would provide high-yield learning. With just a simple email or outreach to event/race directors, athletic trainers, or athletic directors, many would welcome the opportunity to partner with their programs to provide the best care for their athletes and an environment for our learning.

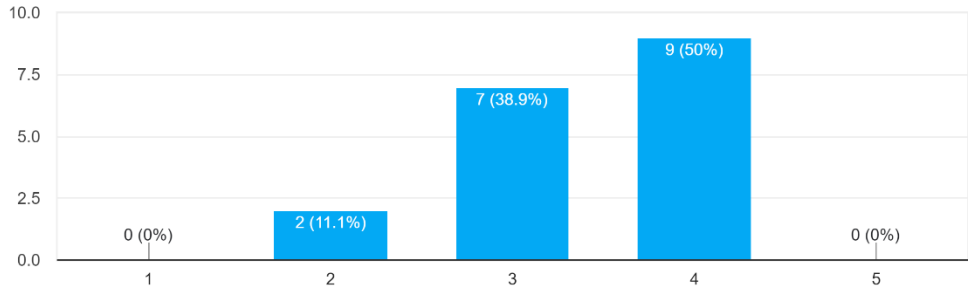
Data Appendix:





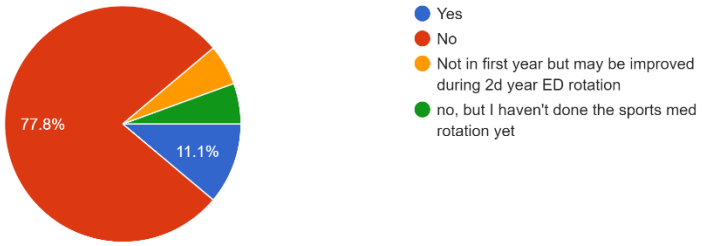
After reviewing the above information, to what extent do you agree with this statement: I feel prepared to participate as a team physician at a sporting event or race.

18 responses



Do you feel we receive sufficient acute MSK training in residency?

18 responses



QI PROJECT
Author: Emilie McIntyre, MD
Project Title: Implementation of a postpartum visit template to standardize postpartum care

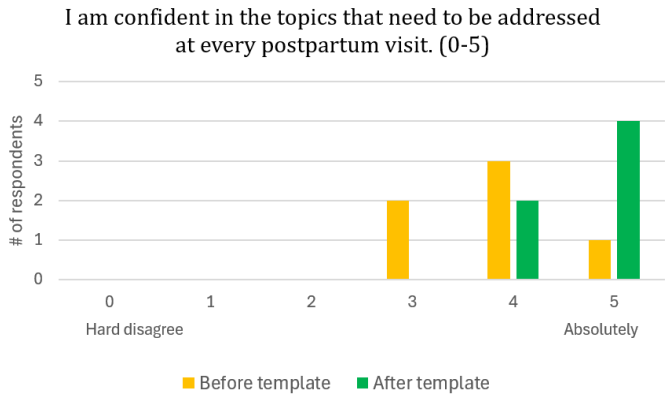
Problems: Currently, postpartum care conducted at 2-week and 6-week follow up visits at our clinic is not standardized. Different OB providers focus on and document different aspects of care in different places and in different ways, and we often see other residents' patients postpartum for the first time. I plan to create a postpartum visit template for clinic OB providers to use for documentation. My goal is for this template to prompt OB providers to address a standard list of postpartum issues, to identify what patient-specific items require follow up in the postpartum period, and to standardize postpartum workflow and documention to ensure that nothing clinically relevant is missed at postpartum visits.

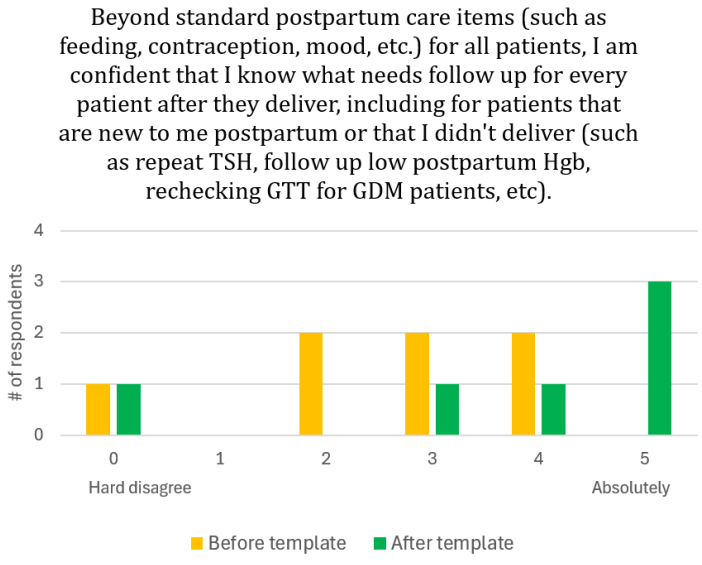
Aim / key measures for improvement: Via implementation of a standardized postpartum visit note template, my goals are:

- to have every OB provider in our clinic reporting high confidence (rating 4 or 5 on a scale of 0 to 5) in what needs to be addressed at all postpartum visits for all patients.
- to have every OB provider in our clinic reporting high confidence (rating 4 or 5 on a scale of 0 to 5) in knowing what specific items require follow up at postpartum visits, even if they are seeing a patient in the postpartum period for the first time.

Process of gathering information: Kalispell residents and OB attending were surveyed prior to and after implementation of a postpartum visit template. Brief surveys primarily focused on providers' confidence in items needing to be addressed at postpartum visits.

Analysis and interpretation:





- For standard postpartum items to address at every visit, the share of OB providers reporting high confidence (rating 4 or 5 on a scale of 0 to 5) in what needs to be addressed at all postpartum visits for all patients increased from 67% to 100% after implementation of a standardized postpartum visit note template.
- For patient-specific items requiring follow up in the postpartum period, the share of OB providers reporting high confidence (rating 4 or 5 on a scale of 0 to 5) in what needs to be addressed at postpartum visits increased from 29% to 67% after implementation of a standardized postpartum visit note template.

Strategies for change: A standardized postpartum note template was developed and shared with all clinic OB providers. The relevant, fully editable, templated sections of the note as they appear in the EMR are shown below:

Subjective: Verify Histories

Chief Complaint(s):

- Postpartum2

HPI:

Postpartum

.

[] is a []-year-old G[]P[] here for [2][6]-week postpartum follow-up visit. She delivered at []w[]d via [] following []. Delivery was [un]complicated by []. Pregnancy was complicated by []. Notably, previous pregnancies complicated by [].

.

- Maternal well-being:
- Baby: boy/girl "[]" doing well
- Feeding:
- Breast concerns:
- Lochia:
- Menses: not yet resumed
- Abdominal / pelvic / perineal pain concerns:
- Elimination: urinating and BM without issue, denies incontinence
- Sleep:
- Sexual activity: not yet resumed
- Contraception:
- PNV: taking
- Mood / mental health concerns: [], EPDS = [] today

[- Other:]

Objective:

Vitals:

Past Results:

Examination:

General Examination

General Appearance: NAD, well nourished, well appearing.
Psych good eye contact, normal speech, affect appropriate, normal judgment, normal thought content, pleasant, cooperative.
Skin: warm, dry, no rashes noted on areas of exposed skin.
HEENT: normocephalic, sclerae white, EOMI.
Heart: regular rate and rhythm, normal S1S2, no murmurs, rubs, or gallops.
Lungs: normal work of breathing, clear to auscultation bilaterally without wheezes, rales, rhonchi.
Abdomen fundus below the umbilicus.
Extremities: no edema in BLE.
Neurologic Exam: alert and grossly oriented x4, non-focal, MAEE, no facial droop noted, CN II-XII grossly intact.
Female Genitourinary: deferred.

Assessment:

Assessment:

- Encounter for routine postpartum follow-up - Z39.2

Plan:

Treatment:

Encounter for routine postpartum follow-up

Clinical Notes:
Pt is a G[] now P[] who is [] weeks postpartum from [] at []w[]d. L&D discharge summary reviewed and obstetric history updated above.
-- Postpartum: meeting postpartum milestones so far, continue routine postpartum care. [Provided pt with postpartum packet.]
-- Continue daily PNV
-- Feeding:
-- Contraception:
-- Labs: Rh [pos][neg, received Rhogam prior to discharge] / Rubella [immune][non-immune, received MMR prior to discharge][non-immune, declined MMR prior to discharge] / GTT [] / Pap [due, repeating today][UTD, last was *** in MM/YYYY]
-- Immunizations: UTD on Tdap, flu

Next Appointment:

4 Weeks (Reason: 6-week PP visit)

Billing Information:

Visit Code:

- 99213 Office Visit, Est Pt., Level 3.

Effects of change: With implementation of the postpartum visit template, every clinic OB provider in our program is reporting a high level of confidence in knowledge about what to cover at all postpartum visits. Additionally, the share of OB providers reporting a high level of confidence in patient-specific items requiring follow up in the postpartum period has more than doubled. In addition to the template created above, a postpartum visit order set was created to streamline any labs, contraception, physical therapy referrals, or patient education that may be necessary. This project did not measure the effects of that order set, but could be explored further in the future.

Lessons learned: Because the template is inherently standardized, it is not surprising that its implementation appeared to lead to greater improvements in OB provider confidence in standard postpartum care than in confidence with patient-specific care items. Feedback from residents thus far recommends creation of a companion template for the Labor & Delivery discharge summary which would mirror the postpartum visit template and could be used to highlight any items requiring follow up at postpartum visits. This would allow clinic providers to quickly get up to speed on follow up needs at postpartum visits, especially for patients that they did not deliver or are new to them at the postpartum visit. Ultimately the broad goal of the template is to reinforce resident learning about postpartum care and to ensure that nothing is missed for our patients. The rate of identifying missed postpartum care items was beyond the scope of this project, though it is my hope that using this template will reduce the likelihood of that occurring. I hope that this postpartum template spurs further standardization of visit workflow with support staff such that the relevant L&D documentation for our patients, including the L&D H&P, delivery note, and discharge summary, is downloaded to the patient's chart as part of the standard pre-visit planning process.

QI PROJECT
Author: M. Bryce Roberts, DO
Project Title: Improving Prenatal Education for Spanish Speaking Patients

PROBLEM: Given the increase in Spanish speaking prenatal patients in the Flathead Valley over the past year, it became apparent that there is a mismatch between patient education needs and Spanish language resources. A lack of prenatal education can often lead to missed prenatal screenings, lapses in laboratory testing and subsequent diagnoses, unnecessary L&D evaluations, and even fetal demise or maternal morbidity/mortality.

AIM: To increase the confidence of prenatal providers in providing Spanish language resources and to increase the amount of written prenatal education that is provided to patients by at least 25%

TIMELINE: September 2023 to December 2023

METHODS: A provider survey with the following questions was distributed in September 2023.

1. What percentage of your Spanish speaking prenatal patients receive written education that they can read/understand?
2. How confident are you currently in providing prenatal education to Spanish speaking prenatal patients?
3. Would you utilize Spanish language prenatal educational resources if available?

After responses were collected, Spanish language prenatal education resources were collected/created and subsequently distributed to providers for administration to their Spanish speaking prenatal patients. A secondary survey was then administered in December 2023 with the following questions:

1. Now that there are Spanish prenatal packets available, what percentage of your Spanish speaking prenatal patients receive (or will receive) written education that they can read/understand?
2. Now that there are Spanish prenatal packets, how confident are you in providing prenatal education to Spanish speaking prenatal patients?
3. Do you plan to utilize written Spanish language prenatal educational resources with future patients?

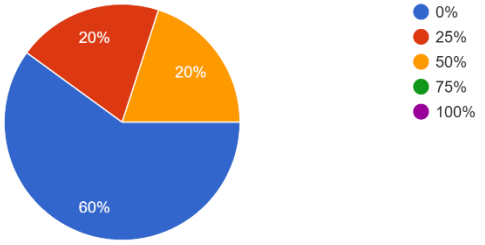
KEY MEASURES FOR IMPROVEMENT: Provider confidence in providing prenatal education and percentage of Spanish speaking patients who received written prenatal educational resources in their primary language.

PROCESS OF GATHERING INFORMATION: Data was collected regarding provider confidence and the percentage of Spanish speaking patients receiving prenatal education was collected from the initial survey. Spanish language prenatal educational resources were then collected and created including education for each of the three trimesters, the immediate postpartum period, and for breastfeeding. These resources were then distributed to the prenatal providers at Greater Valley Health Center (GVHC) to be utilized for their Spanish speaking patients. Following a 3-month implementation period, follow up data was then collected via a secondary survey as above.

ANALYSIS AND INTERPRETATION: According to responses from the initial survey, every GVHC provider indicated that there was a lack of written educational materials provided to their Spanish speaking prenatal patients. 3 providers indicated that 0% of their patients left with written educational materials in the Spanish language. 1 provider indicated that 25% of their patients left with written materials and 1 provider indicated 50% of their patients left with written materials. Mixed results regarding provider confidence were also noted with 80% indicating feeling “somewhat confident” in providing prenatal education to Spanish speaking patients while 20% indicated feeling “not at all confident.” Additionally, every GVHC provider indicated that they would utilize Spanish language prenatal educational resources if these were available (4 responded “Yes” and 1 responded “Heck Yes” which was a new category added by that provider).

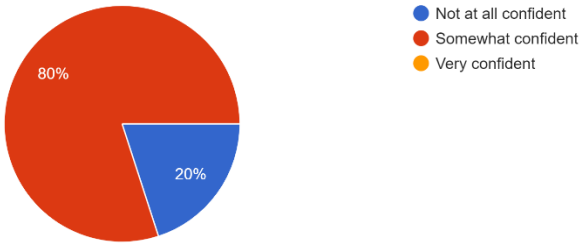
What percentage of your Spanish speaking prenatal patients receive written education that they can read/understand?

5 responses



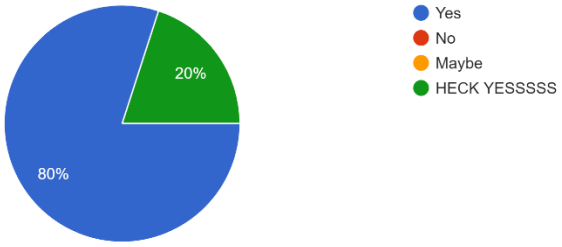
How confident are you currently in providing prenatal education to Spanish speaking prenatal patients?

5 responses



Would you utilize Spanish language prenatal education resources if available?

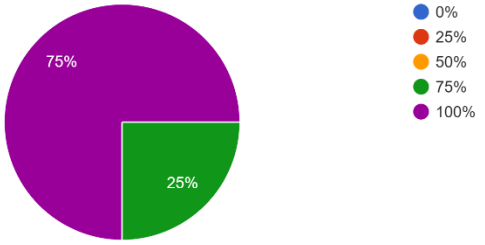
5 responses



Following the creation of Spanish language prenatal educational resources and a 3-month implementation period there was an obvious improvement in provider confidence and the actual administration of prenatal educational materials. 75% of providers indicated that they would use the prepared resources for 100% of their patients and only 1 provider indicated that they would use them for less (i.e. 75% of their patient population). Provider confidence also increased to now 50% feeling “very confident” and 50% feeling “somewhat confident in their ability to provide prenatal education to Spanish speaking patients. Lastly, 100% of providers indicated that they planned on utilizing the written materials for future patients.

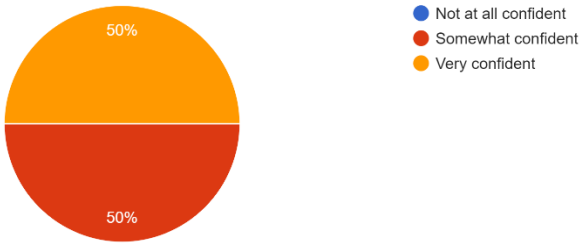
Now that there are Spanish prenatal packets available, what percentage of your Spanish speaking prenatal patients will receive written education that they can read/understand?

4 responses



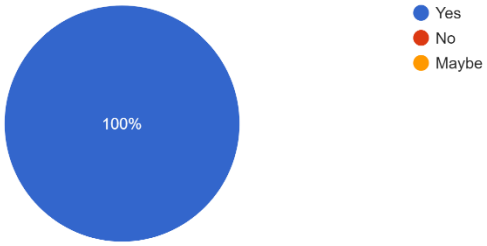
Now that there are Spanish prenatal packets, how confident are you in providing prenatal education to Spanish speaking patients?

4 responses



Do you plan to utilize written Spanish language prenatal educational resources with future patients?

4 responses



Based on these results, it's obvious that having readily available resources in other languages improves the confidence of providers in administering appropriate education and in the actual administration of said education to patients whose primary language is different than that of the provider. Ideally, this improvement in both provider confidence and the actual administration of educational resources will result in increased patient screening tests, increased laboratory testing and subsequent diagnoses, fewer unnecessary hospital evaluations, and decreased morbidity/mortality. Unfortunately, these downstream measures were not evaluated as a part of this study but could be pursued as a secondary follow up study.

BARRIERS TO SUCCESS: It was difficult to obtain/create Spanish language prenatal educational materials; however, once I was able to compile sufficient resources, it was rather easy to distribute these materials to GVHC prenatal providers for immediate use. There was also considerable difficulty in distributing these resources to Spanish speaking prenatal patients secondary to missed appointments (often due to lack of transportation or language-barrier miscommunication) and lack of provider knowledge regarding the existence of Spanish language education; however, these barriers were

minimized by GVHC care coordinators reaching out to patients prior to their appointments and by making sure that Spanish language prenatal education packets were readily available when patients did present to clinic. It is also important to note that one GVHC provider was lost to follow up which most certainly affected the results of the study.

EFFECTS OF CHANGE: As a result of this project, GVHC provider confidence increased regarding administration of prenatal educational materials and an increased distribution percentage of written prenatal education for our Spanish speaking prenatal patients was also achieved.

LESSONS LEARNED: Patient education is an important piece of what primary care providers do every single day, and I would argue that it is especially important for patients with language barriers. Providers are much more confident and likely to provide written educational materials to Spanish speaking patients when these resources are readily available. It's also important to remember that these lessons can and should be applied to patients of other languages as well.

QI PROJECT

Author: Jennifer Selland, MD

Project Title: Trans-Affirming and Gender Diverse Medical Care at PHC – Change in Provider Confidence after Resource Creation

PROBLEM: Trans-affirming and gender diverse medical care is a growing area of medicine, and primary care providers are frequently asked to support patients in either gender transitioning or non-binary affirmation by prescribing hormone therapy (HT). Multiple recent studies have shown that access to trans-affirming care is associated with a decrease in mental health disparities among trans and non-binary people and positive psychological effects[1,2]. It is challenging to find a concise, user-friendly guideline in a quick search to support providers in this practice. Last year I found multiple resources with variation in recommendations. I then surveyed providers at Partnership Health Center about what would be the most helpful to have in their practice when starting patients on, and monitoring, hormone therapy. This year, I expanded off of my 2023 QI project by creating a resource that can help providers more easily manage HT and help patients make informed decisions about their care. This resource was intended for hormone therapy in patients over the age of 18.

AIM: By Spring of 2024 I will compile an easy to access and utilize resource that will aid PHC providers in the provision of hormone therapy to transgender and non-binary patients. Following sharing this resource I will survey PHC providers for feedback and re-assess provider confidence in prescribing, monitoring, and discussing the risks/benefits of both masculinizing and feminizing hormone therapy.

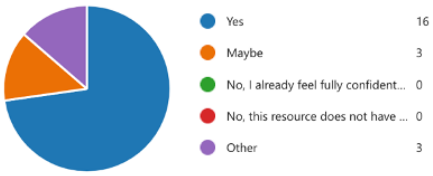
KEY MEASURES FOR IMPROVEMENT: Change in provider confidence with prescribing FtM and MtF hormone therapy with access to created resource, change in provider confidence of discussion of risks and benefits of hormone therapy with access to created resource

PROCESS OF GATHERING INFORMATION: For my QI project in 2023, a survey was sent out to FMRWM faculty and residents, as well as PHC providers, asking for input on what sorts of resources would empower providers to feel comfortable and confident in providing full-spectrum trans-affirming and gender diverse care. For my QI project this year, based on responses to the initial survey, I created a resource "2024 Provider Reference for Masculinizing and Feminizing Hormone Therapy". I sent out this resource to FMRWM faculty and residents, as well as PHC providers, and asked them to complete a follow-up survey regarding the information in the resource. There were 22 total respondents to this survey and responses were anonymous. It was a 5-question survey and took approximately 4 minutes for respondents to complete.

On my 2023 survey I had asked which areas relating to trans-affirming and gender diverse medical care would providers benefit most from having a resource for and the top 3 answers were – spironolactone dosing and when to start, testosterone dosing and monitoring, and estradiol dosing and monitoring. I used these top 3 categories to guide the majority of information included in my resource, as well as including information on the risks and benefits of hormone therapy, and some resources for counseling patients in clinic.

For gathering information for the resource, I consolidated information from multiple reputable reference sources including UCSF, Fenway Health, Rainbow Health, Cedar River Clinic, and more, which can all be found in the reference section.

ANALYSIS AND INTERPRETATION:



Survey Responses about Provider confidence:

- **With access to the resource, would providers feel more confident prescribing and monitoring hormone therapy for trans-affirming and gender diverse care?**
    - o 16/22 (72.7%) respondents answered yes

- **With access to the resource how confident do you feel about prescribing and monitoring trans-affirming HT?**
    - *Assessed a scale from 1-10 (with 1 being no confidence at all, and 10 being full confidence/no questions or concerns at all)*
    - **Average answer was a 7.76 out of 10 (22 respondents)**

- **With access to the resource how confident do you feel about counseling patients about the risks and benefits of trans-affirming HT?**
    - *Assessed on a scale from 1-10 (with 1 being no confidence at all, and 10 being full confidence/no questions or concerns at all)*
    - **Average answer was a 7.66 out of 10 (22 respondents)**

Based on these results, providers feel more confident in both prescribing and monitoring trans-affirming HT and counseling patients about the risks and benefits of trans-affirming HT with access to the resource I created. I asked the same questions regarding confidence on a scale from 1-10 between both years. With access to the resource, the average answer for confidence about prescribing and monitoring trans-affirming HT was 7.76/10 (compared to 6.83/10 without access to the resource in 2023) and the average answer for confidence about counseling patients about the risks and benefits of trans-affirming HT was 7.66/10 (compared to 5/10 without access to the resource in 2023).

EFFECTS OF CHANGE: In addition to the increased provider confidence as discussed above – overall, I had positive feedback on my resource. Multiple people commented that it was concise, simplified, clear, and organized. Sections that had feedback on being particularly helpful included the links for patient counseling and the information on when in a patient's dosing cycle to monitor hormone levels.

Follow-up would be needed to see how much the resource is actually utilized after I am not at PHC. Some concerns regarding accessing the resources that providers brought up included – where would the best place for the resource to "live" within PHC and who would be updating the resource after I have graduated. Other respondents also noted that although they had positive things to say about the resource, they are already confidently using other resources and felt like this was repetitive to information they already had. UCSF and Rainbow Health were the two outside resources that providers said they are already using the most, both of which I referenced for the creation of my own resource.

LESSONS LEARNED: Trans-affirming and gender diverse medical care is an evolving field of medicine. Although I looked at multiple references from institutions that are known as leaders in transgender medicine to create my resource, there was still variation in recommended dosing regimens, target values of hormone levels, and frequency of lab monitoring. In real-life practice, this care is more nuanced and individualized than my resource may make it out to seem. I also have

personally learned a lot just from listening to my LGBTQIA+ patients talk about their experiences on hormone therapy. All that to say – I don't think there is one gold standard way to provide this type of care. The most important thing we can do as providers, in addition to making sure our patients are safe and we are not causing harm with hormone therapy, is to listen to our patients and be an ally to the LGBTQIA+ community.

Additionally, there were a minority of respondents to my survey who do not feel comfortable providing this care for patients and described feeling pressure to prescribe trans-affirming hormone therapy despite personal struggles with it. While initially I struggled with this feedback because it does not align with my own values, I want to remain open to having conversations with providers that feel that way so that I can understand more about where they are coming from and try to educate them on why I think this care is so important from my perspective. However, at the end of the day every provider will not have the same values and every provider will not provide hormone therapy. I hope to be seen as a provider who really does believe in the benefits of hormone therapy and who would be happy to accept referrals or patient transfers from other providers that do not feel the same way.

If you are reading this and do not already have access to my resource, feel free to email me at jlselland@gmail.com.

References:

1. Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Netw Open. 2022;5(2):e220978. doi:10.1001/jamanetworkopen.2022.0978
2. Nguyen, H.B., Chavez, A.M., Lipner, E. et al. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. Curr Psychiatry Rep 20, 110 (2018). https://doi.org/10.1007/s11920-018-0973-0
3. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. UCSF Transgender Care. https://transcare.ucsf.edu/guidelines
4. *Feminizing Hormone Therapy and Masculinizing Hormone Therapy*. Trans Primary Care. https://bmc1.utm.utoronto.ca/~kelly/transprimarycare/gp-mascht.html
5. *The Medical Care of Transgender People*. Fenway Health. https://www.lgbtqiahealtheducation.org/wp-content/uploads/COM-2245-The-Medical-Care-of-Transgender-Persons-v31816.pdf
6. *Practical Guidelines for Transgender Hormone Treatment*. Boston University. https://www.bumc.bu.edu/endo/clinics/transgender-medicine/guidelines/
7. *Gender Dysphoria/Gender Incongruence Guideline Resources. Endocrine* Society. https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence
8. *Hormone Therapy Guidelines*. Sherbourne Health | Rainbow Health Ontario. https://www.rainbowhealthontario.ca/TransHealthGuide/index.html
9. *Clinical Care Toolkit*. Cedar River Clinics. https://cedarriverclinics.org/transtoolkit/clinicalcare/

QI PROJECT
Author: Rebecca Sharar MD, MPH
Project Title: Helping Residents Inform Rural Training Site Selection

Problem: Residents are asked to rank rural sites before the upcoming academic year, but are given very limited information to help inform these rankings. This is particularly challenging for incoming interns who do not have anecdotal information about the sites. Different residents have different priorities for their rural training, and different sites offer different opportunities and experiences.

Aim of the project: The aim of the project was to increase how informed residents feel when choosing a rural training site by introducing a database of resident-collected information on the experience at each of our rural sites.

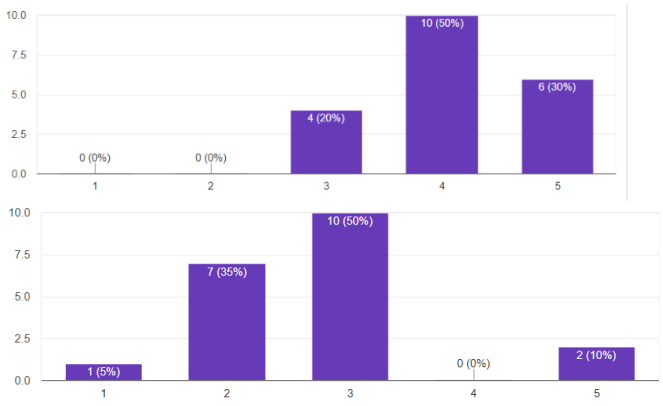
Key Measures for Improvement: The key measure is resident self assessment of how informed they feel when choosing a rural training site. This measure will be assessed prior to introducing the database summarizing prior resident experiences, and again after review of the database.

Process of gathering information: During the 2022-2023 year I created a live document containing resident-driven data about their experiences at all of our rural sites. Residents who completed rural rotations provided information on the following components of their rural experience at each site: housing details, scope of practice, procedural information, hours worked weekly, call expectations, quality of instruction, and degree of autonomy, in addition to any additional free text information. These categories were partially derived from a faculty-led survey that identified resident priorities in rural rotations.

This year I disseminated a pre/post survey to residents, evaluating how informed they feel in selecting a rural site prior to reviewing this database, and again after reviewing the database. Both surveys asked the same question: to what extent do you feel informed when selecting your rural training site (ranked on a scale of 1 to 5, with 1 being “completely uninformed” and 5 being “completely informed”)? Additional space was provided for additional comments. Twenty residents completed both surveys.

Analysis and interpretation:

Figure 1: Resident self assessment of how informed they feel when choosing a rural site, both before (left graph) and after (right graph) reviewing the online database of resident experiences at each training site.



On the pre survey, the mean self report of feeling informed when selecting a rural site was 2.75 on the scale of 1-5 discussed above. On the post survey after review of the database this score increased to 4.10, $p<0.0001$ by paired T test. This indicates a statistically significant increase in how informed residents feel about rural site selection when a database of past resident experiences is provided to them for review.

Effect of change: The significant increase in resident scores after reviewing the resident-driven database supports the database as a helpful tool for informing rural site selection. 85% of residents surveyed reported that a resident-driven database of rural site experiences is “very helpful” for ranking rural training experiences. The remaining 15% reported that it was “helpful.” No residents reported that the database was “neutral,” “unhelpful,” or “very unhelpful.” One respondent commented that the database could be overwhelming to an intern, given the amount of information in the database. This was not brought up by other respondents but is an important consideration going forward. A couple respondents made suggestions to make the database more reader-friendly, as it is currently a very basic Google Sheet that is derived and automatically updated as residents submit Google Forms about their rural experiences.

Lessons learned: The biggest challenge to maintaining such a database of resident experience is to disseminate the survey to residents on a regular basis to keep it updated and ensure a breadth of experiences at each site. The database would likely be more user friendly if formatted differently. The database has the potential to both provide useful information to residents when selecting rural sites, but could also be overwhelming given the amount of information provided.

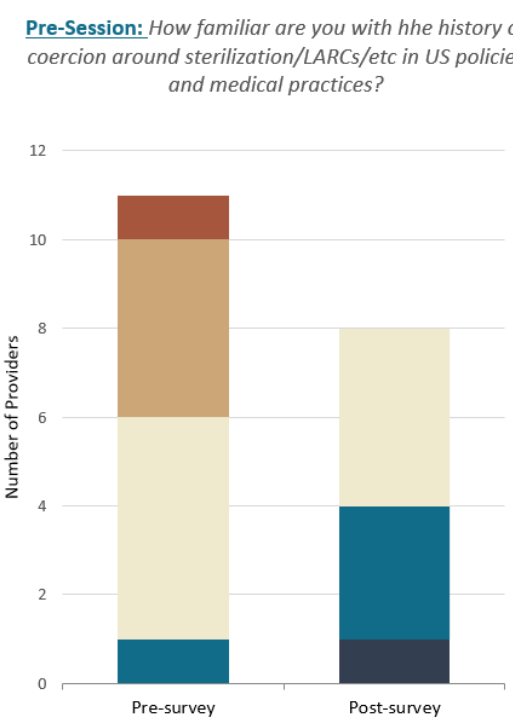
QI PROJECT
Author: Cecilia Weeks, MD
Project Title: Non-directive pregnancy counseling training for medical providers

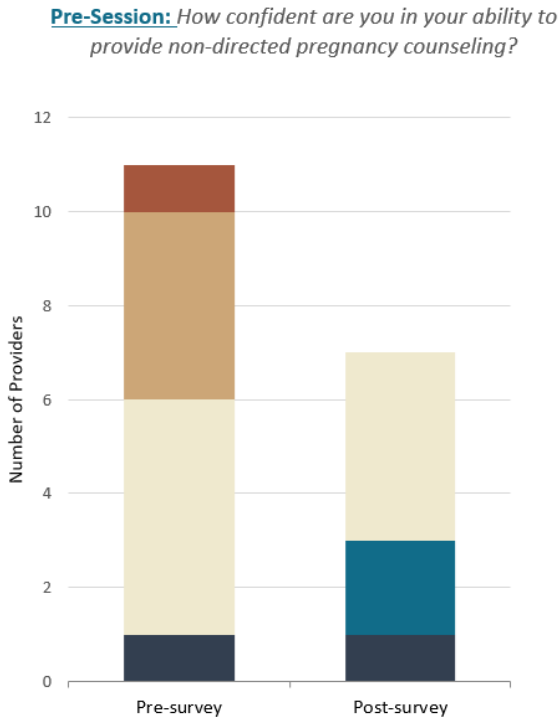
Background: There is a longstanding history of coercion around sterilization and contraception in the United States. From 1907 to 1932, thirty-two states passed eugenics laws allowing for the government to sterilize the "insane, feebleminded, dependent, and diseased." The Relf v. Weinberger case in Montgomery, AL in 1973 revealed that 100,000+ mostly Black, Latina and Indigenous women were sterilized under U.S. government programs over decades. From 1991-1993, numerous proposals were made to mandate long-acting reversible contraception (LARCS) such as an IUD or implant or at least provide financial incentives to obtain LARCs for women receiving public assistance. In light of this history, non-directive pregnancy counseling involves counseling patients on all their pregnancy options (parenting, adopting, termination, etc) without bias so that patients are able to make informed decisions without interfering with their reproductive rights. One method of non-directive pregnancy counseling involves "ASA cycles" of (1) acknowledging and affirming patients' emotions and insight (2) sharing a digestible amount of information directly related to the patient while correcting any misinformation (3) asking follow-up questions.

Aim: The goal of the 45-minute didactic session was to improve providers' familiarity with the history of coercion around sterilization and contraception in the United States while also increasing confidence in providers' abilities to provide non-directive pregnancy counseling through an interactive and discussion-based session including role-playing real-world pregnancy counseling scenarios.

Data collection: Data was collected via an anonymous and optional survey administered online via Qualtrics. Residents and faculty completed pre- and post-surveys before and after the 45-minute session. Data was also collected from a didactic evaluation form, which is routinely completed for all didactic sessions and provided to the presenter.

Analysis: In total, eleven respondents completed the pre-survey and eight respondents completed the post-survey. Overall, 50% of respondents felt very or quite a bit familiar with the history of coercion around sterilization and contraception in the United States after taking the session compared to only 9% prior to the session. Additionally, 43% of respondents felt very or quite confident with their ability to provide non-directed pregnancy counseling after taking the session compared to only 9% prior to the session. Qualitative responses mentioned the challenges regarding providing non-directive pregnancy counseling to patients with chronic health conditions. Additional feedback provided insight in ways to improve the session including incorporating more everyday examples of phrases that can be misconstrued as coercive and alternative choices while providing non-directive pregnancy counseling and including more history on coercive birth control practices in Montana specifically.





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2. https://rhntc.org/resources/exploring-all-options-pregnancy-counseling-without-bias-video-series

Class of 2025

MISSOULA

Nicholas Booker DO

Ilana Buffenstein MD

Julie Eggleton MD

Neha Malhotra MD

Emily Young MD

KALISPELL

Emily Balon MD

McKenzie Keeling-Garcia DO

Connor Rogan MD

Class of 2025 QI Work

QI PROJECT
Author: Emily Balon, MD
Project Title: Consolidating Resources: Website for Residents by Residents

Problem: Materials are scattered about multiple sources including Box (forms), Slack (didactic materials), resident room turnstile (patient handouts), and emails (dates/info in chief emails, past conference recordings / journal clubs).

Project Aim: Consolidate materials from scattered sources above into central, easy to navigate, location.

Key Measures for Improvement: Level of ease finding needed resources from prior sources vs. on website.

Gathering Data: Two surveys assessing feelings on available resources (Table 1) and feelings on new website (Table 2).

Analysis and Interpretation:

- 19 submissions (68% response rate) on initial survey
    - On a scale of 1-5, with 1 indicating hating the source and 5 indicating loving the source, Box averaged 2.4 (Figure 1), Slack averaged 3.3 (Figure 2), and Turnstile averaged 2.8 (Figure 3).
    - Overall ease of the finding needed resources on the above sources (Figure 4), with 1 indicating difficult and 5 indicating easy, was 2.8.
    - Commentary on Box (Table 3) skewed negative and included difficulty/disliking logging in, unclear organization, overwhelming amount of information.
    - Commentary on Slack (Table 4) was more equally balanced. Main pro was its use for causal things; main cons were that content got deleted after a period of time and that it felt like another thing to check.
    - Commentary on turnstile (Table 5) highlighted its utility for certain handouts such as BH forms. Negative commentary included disorganization and certain forms being out frequently.
- 14 submissions (50% response rate) on secondary survey; suspect that there was decreased number of responses on second survey was due to survey fatigue given that many other residents were sending out surveys within the same time period
    - On a scale of 1-5, with 1 indicating hating it and 5 indicating loving it, the website averaged 4.8 (Figure 7) >> 1.5 points higher than the highest rated source on the initial survey
    - Overall ease of the finding needed resources on the website (Figure 6), with 1 indicating difficult and 5 indicating easy, was 4.0 >> 1.2 points higher compared to ease of finding needed resources on the sources evaluated on the initial survey.

Outcome: Compared to prior sources, residents found the website to be more likeable (4.8 vs. 2.4 Box, 3.3 Slack, 2.8 turnstile) and easier to find needed resources on (4.0 vs. 2.8 prior sources).

Limitations: The initial survey did not assess residents' feelings on the chief email; however, the website ended up incorporating a lot of information found in chief emails.

Future Steps: Things to consider moving forward include: how extensively will the website be utilized, could other sources be phased out now that the website exists, who is best suited to keep website up to date.

Table 1. Survey questions on available sources

		Corresponding Figure/Table	Average rating
1.	On a scale of 1-5, how do you feel about Box?	Figure 1	2.4
2.	Comments on Box (organization of Box, materials within Box, ease of accessing Box, etc)	Table 3	
3.	On a scale of 1-5, how do you feel about Slack?	Figure 2	3.3
4.	Comments on Slack (use of Slack, channels on Slack, if Slack is good way to share resources, etc)	Table 4	
5.	On a scale of 1-5, how do you feel about the turnstile in the preceptor room?	Figure 3	2.8
6.	Comments on turnstile/folders (how often using, what forms useful vs. not, etc)	Table 5	
7.	Overall, current level of ease finding needed resources from above sources	Figure 4	2.8
8.	On a scale of 1-5, how do you feel about the idea of a website for resident resources that would consolidate materials from Box (rotation information, BSQs), Slack (didactic materials), the turnstile/folders (patient education, consent forms)	Figure 5	4.3
9.	Comments on idea of a website for resident resources (what other materials would be beneficial to have on a website, potential downsides to a website, etc)	Table 6	
10.	Space for other thoughts	Table 7	

Table 2. Survey questions on new website

		Corresponding Figure/Table	Average rating
1.	Overall, current level of ease finding needed resources on website	Figure 6	4.0
2.	On a scale of 1-5, what are your initial impressions of the website?	Figure 7	4.8
3.	Do you feel that keeping this website updated & using it as a central hub would be helpful?	Figure 8	
4.	Would you rather use this website than Box?	Figure 9	
5.	What else would you like to see added to the website? Feel free to paste any of your favorite resources here (links you have bookmarked or webpages you frequently look up when you're in clinic or in the hospital)		
6.	Other questions / comments / concerns about the website?	Table 8	

Figure 1. Feelings on Box; average rating 2.4

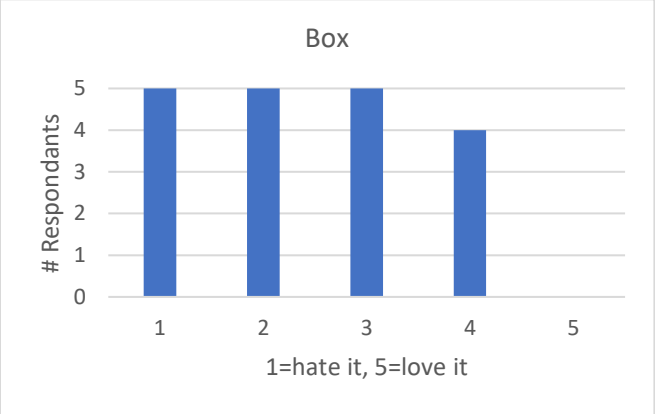


Figure 2. Feelings on Slack; average rating 3.3

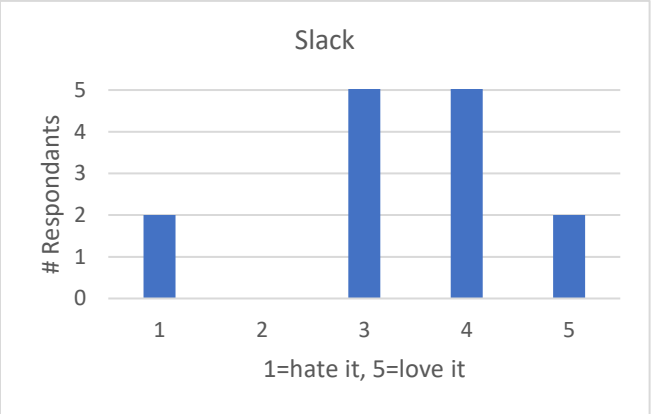


Figure 3. Feelings on turnstile; average rating 2.8

Figure 4. Overall ease of above; average rating 2.8

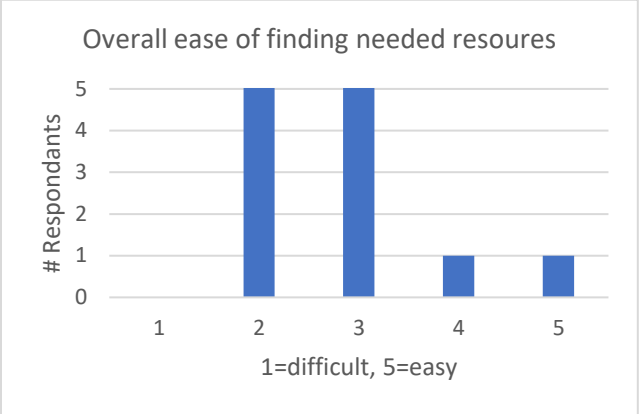


Figure 5. Feelings on website idea; average rating 4.3

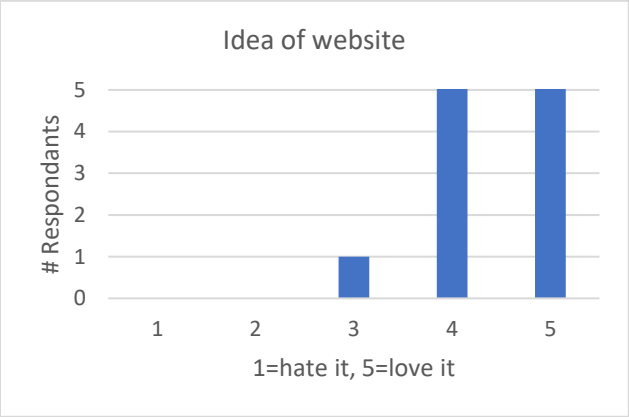


Figure 6. Overall ease of website; average rating 4.0

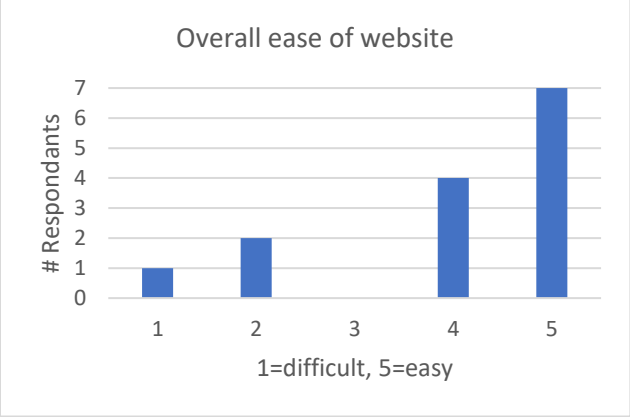


Figure 7. Overall impression of website; average rating 4.8

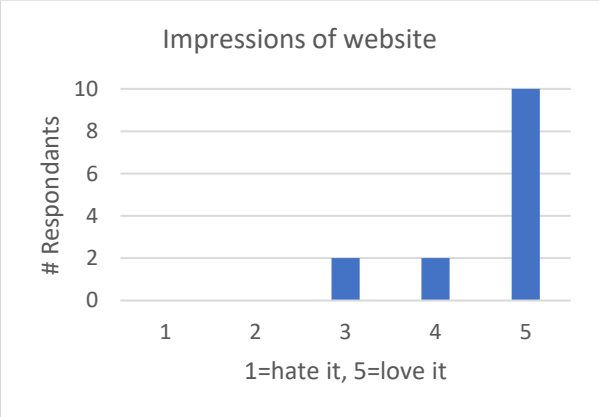


Figure 8. Do you feel that keeping this website updated & using it as a central hub would be helpful?

Figure 9. Would you rather use this website than Box?

Table 3. Commentary on Box

Comments from respondents who rated Box 1/5
- Folders are frequently deleted and I spend more time looking for folders, I also hate logging into box - To be honest, I never use it. I don't know where things live and half the time can't log in - I do not ever use it. It is just one more platform. Can we stick with new innovations? I literally never use Box. - Doesn't work on my computer well, often signed out/no access. Also does not have all the info, seems redundant to Slack and new innovations.
Comments from respondents who rated Box 2/5
- Very unclear organization and annoying to navigate - Lots of info, kinda overwhelming - Pain in the butt to access and no way of knowing what's on there without exploring - Can't seem to access it outside of my work laptop? Like at the hospital when starting a new rotation, would be nice to get rotation resources without needing to open my laptop.
Comments from respondents who rated Box 3/5
- Fine, well organized. - Sometimes I'm not sure if box is going to be up to date. I find it easy to access - Materials can be hard to find. not sure if something is under a "rotation" or "resident resources." For instance, BH items have some folders in both. Also there is a lot of old and outdated material in box, making the relevant stuff hard to access. I generally like the idea of having a shared space to share materials/resources, but I find it hard to find what I need in box. Also hard to access if you're not at PHC or don't have your PHC computer. - I do not use it and do not have strong feelings - Difficult to find specific things at times. Hard to navigate the web version.
Comments from respondents who rated Box 4/5
- I actually use it pretty regularly. It is nice to have access to rotation specific material from anywhere - Easy to access, mostly just using the search function. - No issues with Box, I have found it organized and easy to navigate so far

Table 4. Commentary on Slack

Comments from respondents who rated Slack 1/5
- Another thing that we have to check - I feel a lot of administration fatigue, it just feels like another thing I have to check. I also feel like having slack on my phone is not the greatest work life balance.
Comments from respondents who rated Slack 3/5
- I rarely use it but occasionally it's helpful - Slack deletes old stuff which I don't love, but also is better than some other options. Tbh we could be using Google platforms or Teams. Teams is being very underutilized. - Nice for none work related stuff - Slack is good for communicating events and general communication/reminders, not so much for sharing resource I think because it's hard to find something again once more comments are added in a slack channel. - I do not like how things drop off after 90 days. Good way to share resources otherwise.
Comments from respondents who rated Slack 4/5
- Like that slack is less formal and a good way to connect on variety of things (including fun, non-work related things) - Only thing I don't like is that it deletes things after 90 days - Hate that things delete after 30d. Bummer that not everyone is on it. Wish we could use it for more announcements and fun events. I tried to get folks to come to a baseball game with me and a bunch of other things and got ignored. Realized a lot of folks don't even look at it. Like that I can mute notifications. - Great diversity of options and amazing way to ask/share info. - I like it for casual things. I certainly don't get notifications for it (by choice) so I don't like it for actual important things - Good for didactic info, not great for clinic updates. - Would be nice to have something that everyone actually uses consistently, Slack does not seem to be used by everyone. Like it in general. Except didactics materials files don't show up after 90 days
Comments from respondents who rated Slack 5/5
- I have used it before for a previous job so I would say it is pretty straightforward

Table 5. Commentary on turnstile

Comments from respondents who rated turnstile 1/5
- Never use it, seems out of date
Comments from respondents who rated turnstile 2/5
- It nice that the document is already printed but I don't know all of the documents that are there - I have a few go-to that I use frequently (pack wraps, AA meetings, stress reduction). Some seem outdated or just not my style or don't have enough stuff to be useful I feel (thinking of one little cigarette infographic). Think this could definitely be optimized (ie, info on common medical things-- DM, HTN, headaches, ADD) - I honestly don't use it very much and am not sure what resources are available on it - Too many resources to sift through vs googling what I want and printing.
Comments from respondents who rated turnstile 3/5
- Helpful docs in there but often hard to find quickly and I don't know what is there and what is evidence based - Never used it - Like that it's easier to find things - Use the pack wrap mostly. Kind of overwhelming amount of stuff. - The turnstile is not very well organized so it is hard to find things unless you already know the thing you're looking for. Also the sleep hygiene handout is always empty. I was told that there is someone responsible for refilling those but I haven't noticed that that's been done. I do like having the paper resources to hand to patients available and accessible, but it needs to be better organized, it feels kind of random now. - I rarely use it - Would like more common patient handouts to be included- sleep hygiene, diet and exercise recommendations, etc. - Sometimes have what I need, sometimes don't. They get disorganized
Comments from respondents who rated turnstile 4/5
- There are a handful of specific mental health ones I use from it, but it doesn't have any of the other stuff I commonly print out, like fodmap diet, exercises for pregnancy pain, DASH diet, etc. - I feel like the handouts I want are frequently out. I would like someone to be assigned to making sure there are enough handouts in the tower. - Great for the behavioral med forms.

Table 6. Commentary on idea of website

Comments from respondents who rated idea of website 1/5
- I don't want more resources in more places
Comments from respondents who rated idea of website 3/5
- Feels like just one more thing…
Comments from respondents who rated idea of website 4/5
- Would like to be able to access it from anywhere (ie NOT have to sign into global protect or the wiki which takes so much time). One problem I would be concerned about: too much information and therefore being hard to find or just not knowing what is on there. - I do like having paper copies easily available for patient handouts, but I guess we only really need those for the most commonly used things. Otherwise it'd be nice to have something we can print from. I still like slack for general communication things, but I don't think didactic materials should be shared on slack, because you're always looking at it on your phone not the computer (at least that's the case for me), and we don't really share any other resources through slack. I like the idea of a consolidated resource as long as it doesn't become just a mush of everything else that is still disorganized. - If we could get electronic copies of the sports med book for patient exercises that we can look up by tittle and print off rather then making photo copies everytime that would be wonderful. - No real comments, I would use it, also feel like it could be consolidated onto something that already exists like the box - Organization would need to be better than box, but would be able to be more comprehensive than the turnstile cluster.
Comments from respondents who rated idea of website 5/5
- Website done right would be more accessible on restricted networks at various hospitals than Box or Slack and could be better organized, which would be helpful - As long as we aren't adding yet ANOTHER website, that would be ideal. - Sounds great! Making things easier to find in one place definitely makes it less confusing as for where to find things. - Only downside is not accessible offline - YES - Excited about consolidation of everything

Table 7. Space for other thoughts

- Figuring out where to find all the information during orientation was a nightmare. I would really like our resources consolidated in one place. - Thank you for doing this! - Thank you for investigating this area of the residency program!

Table 8. Other questions / comments / concerns about the website?

- LOVE - Overall: amazing idea, looks beautiful and easy to use, love having a centralized hub for everything and amazing job tracking down all the links (especially the recorded FMMC!) concerns: who would update this? will it just pitter out and become outdated and overwhelmingly full like NI and Box? would people check it? (most people rarely/never check slack) can I access it easily from my phone? - This is amazing. Sifting through box is a complete headache. - I think that this is great and a very direct/streamlined way to view important information, but I'm not sure it takes the place of box. I feel like we still need box because there are just SO many things on there and what I like most about this website is that you have pulled out a lot of the most important/highly utilized resources so I wouldn't want to overcrowd it with adding everything to it that box has - Can we phase out slack with this? - It looks amazing! I hope this replaces other resources we have and is maintained by chiefs - Anyway to minimize multiple locations would be helpful - This is dope as fuck, love that you put this together Emily!!

QI PROJECT
Author: Nicholas Booker, DO
Project Title: Urgent Bean Communication

Problem: Whenever there is an urgent bean that needs to be addressed, it is marked as a red bean and is sent to the intended provider's bean inbox. The bean remains in the provider's inbox and is red until the provider opens the bean, interacts with the bean and either sends it to the next appropriate intended person or addresses the bean. There is an expected timeframe in which a red bean should be reviewed and addressed. There is no system in place to notify providers that there is an urgent bean that needs to be managed.

Rationale: There have been multiple occurrences when I have been seeing patients in a busy clinic and have received a red bean and did not have time to address it until the end of the day. Often these are messages that would have ideally been managed and responded to earlier; needing urgent medication refills, patients desiring adjusting their appointment from in person to phone, triage etc. Due to these messages needing timely responses, I want to reduce the amount of time it takes for these messages to be acted on.

Aim of the project: To reduce the amount of time it takes for an urgent patient need to be addressed by 50% by May of 2024.

Key Measures for Improvement: The amount of time in minutes from the time an urgent TE was first addressed by an MA or nurse to the time it was first addressed by myself.

Process of gathering information: I accessed all of the urgent telephone encounter beans regarding my patient panel since starting residency. To do this, I went under the "T" bean in ECW, I changed the "Provider" to myself "Booker, Nicholas A" and changed the "assigned to" to "All." I then looked through each date since I started residency. (Figure 1). I looked at each urgently marked TE and only included beans that I had time stamped myself. The initial timestamp used was the first timestamp from an MA or nurse, the second timestamp used was my first timestamp on the TE. This therefore gave the amount of time from when the MA initially addressed the TE to when I initially addressed the TE.

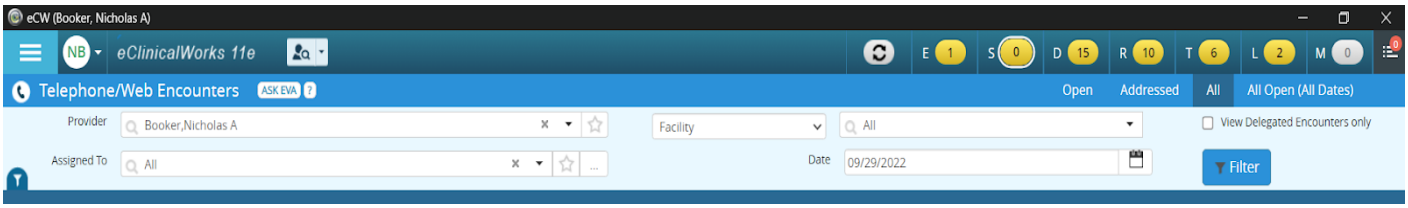


Figure 1: A visual of how I set up my search through ECW to obtain my raw and experimental data.

Analysis and interpretation: I looked at data from 31 urgent TE beans which I had personally managed as documented by a timestamp. The raw data from these beans can be seen in table 1. Data after January 1st, 2024 was considered interventional data. Averages for raw baseline and interventional data can be seen in figure 1. Please note, these data do not include a large outlier from the raw data set from August to September of 2023 which was when I was on a rural rotation. Figure 1 clearly shows a decreased amount of time in initially addressing urgent beans with the intervention compared to baseline. However, there were still four notable outliers in the baseline group that had over 4000 minutes due to those data sets including weekends. To see if these overtly skewed the data, these outliers were removed from figure 2. Figure 2 still demonstrates decreased amount of time in initially addressing urgent beans with the intervention compared to baseline. The four outliers were also manipulated to subtract the total time in a weekend. The total number of minutes for all four outliers with the 3780 minutes of the weekend subtracted were still more than the average of the baseline data set. Therefore, correcting for the weekend time did not normalize those data sets and they continued to be considered as outliers. Regardless, there does appear to be a decreased amount of time in initially addressing urgent beans in the intervention group compared to baseline group.

Strategies for change: I provided my phone number to my MA and panel manager and asked them to call me or text me whenever they sent me an urgent bean. I also requested that they do a warm hand off in clinic if I was in clinic when they sent me an urgent bean.

Effect of change: There was over a 50% reduction in the amount of time it took to initially address an urgent telephone encounter bean after I asked my panel manager and MA to provide me with some form of a warm hand off. This is both including outliers from baseline data and excluding outliers from baseline data. There were also no data points in the intervention group that spanned the course of a weekend.

Date of Red bean	Timestamp of bean from MA or nurse	Timestamp from me	Total time (minutes)	Time fo bean to be responded to (hours)
9/29/2022	**1405**	**0830 on 10/3**	**5425 (1645)**	**90.42 (27.42)**
10/18/2022	1500	1830	210	3.5
12-Dec	1122	1626 on 12/14	3184	53
12/20/2022	939	1313	214	3.5
12/23/2022	**1142**	**0812 on 12/27**	**5610 (1830)**	**93.5 (30.5)**
1/23/2023	1128	0550 on 1/24	1042	17.5
1/25/2023	1108	1407	179	3
2/21/2023	1241	1940 on 2/23	1319	55
3/10/2023	834	859	25	0.5
4/28/2023	**1404**	**1809 on 05/01**	**4915 (1135)**	**82 (19)**
5/22/2023	1653	1940	173	3
5/26/2023	1147	1235	48	0.75
7/14/2023	**1500**	**2055 on 7/18**	**6115 (2335)**	**102 (39)**
8/14/2023	1446	1900	254	4.25
~~**8/29/2024**~~	~~**1356**~~	~~**1936 on 9/4/23**~~	~~**10410**~~	~~**173.75**~~
8/31/2023	1427	1955	328	5.5
9/26/2023	944	0508 on 9/27	1164	19.25
10/6/2023	948	1331	223	3.75
10/6/2023	1136	1630	294	5
10/25/2023	1306	1956	410	7

10/31/2023	1041	2100	619	10.25
11/27/2023	1036	1513	277	4.75
1/2/2024	1425	0550 on 1/3/24	925	15.5
1/25/2024	1741	2103	139	2.25
2/5/2024	1400	2000	360	6
2/12/2024	1109	1700	351	6
3/4/2024	915	1302	227	3.75
3/15/2024	1216	1226	10	0.25
4/29/2024	1529	0442 on 4/30	793	13.25
4/29/2024	1215	1406	111	1.75
5/7/2024	1520	1536	16	0.25

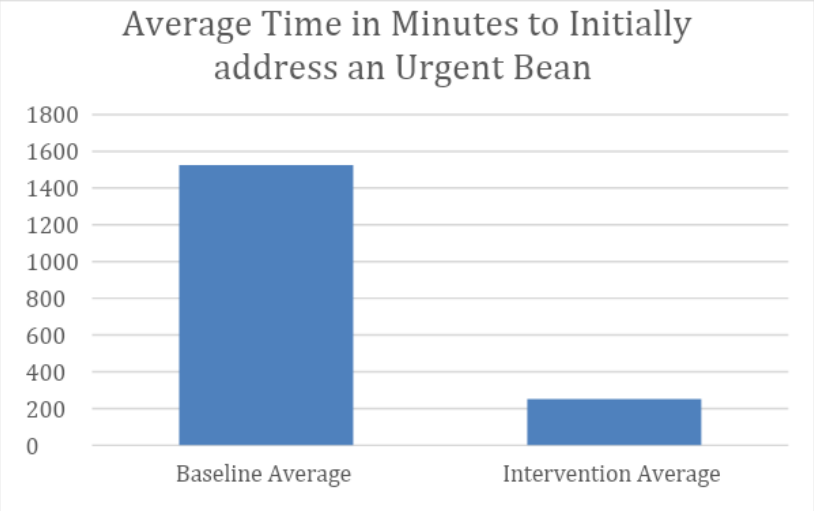


Figure 2: Bar graph depicting the average time in minutes to initially address an urgent bean including the four outliers bolded in table 1. This shows a decreased amount of time in the intervention group compared to the baseline group. The average for the baseline group was 1525 minutes and the average for the intervention group was 250 minutes.

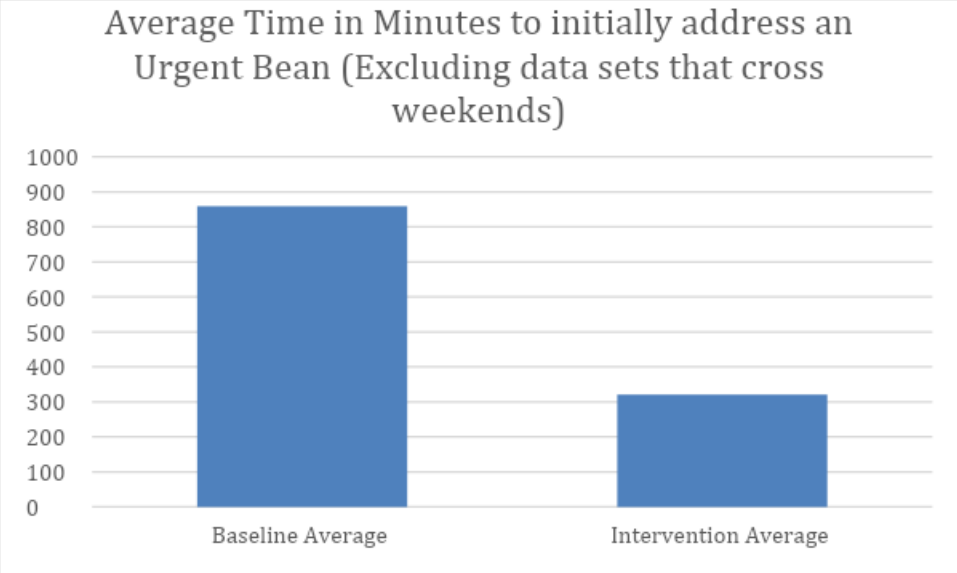


Figure 3: Bar graph depicting the average time in minutes to initially address an urgent bean excluding the four outlier's bolded in table 1. This shows a decreased amount of time in the intervention group compared to the baseline group. The average for the baseline group was 859 minutes and the average for the Intervention group was 320 minutes.

Lessons learned: System changes are very difficult. When I initially started thinking about this project, I was a part of a team of MA's and one nurse panel manager all of whom initiated telephone encounters for multiple providers. My hope was to improve communication within this team. As planning for this project was underway, our clinic adjusted to only having one MA per provider initiate telephone encounters. However, this was never clear cut and different MA's from different teams would be sending me telephone encounters. Due to this, I never consistently got warm hand offs from MA's and panel managers as only my MA and Panel manager had been asked to give me warm hand offs. Even with my asking my MA and panel manager to contact me, they did not always reach out to me with urgent telephone encounter beans. I think this speaks to how busy clinic can get and might hint that expecting as close contact between providers and support staff as I was hoping for may be unrealistic.

In reviewing the urgent beans as part of this project, it became clear that many things are marked as urgent or "high priority" beans that are not actually high priority or do not require urgent attention. More clarification needs to be made for all individuals throughout our teams as to what should qualify as an urgent/ high-priority telephone encounter bean. In this vein, while I did not receive communication on every urgently marked telephone encounter bean, I did notice a great improvement in the amount of communication I received from both my MA and panel manager regarding truly urgent matters. In reviewing my historical urgent beans, I also noticed that some previously marked urgent telephone encounter beans were no longer marked as urgent, as the situation had been resolved. These encounters were acted on in a prompt manner. It seems that less urgent matters could be less likely to have the urgent marker removed. This may be a source of bias that was introduced to my baseline data and could help explain the longer response time seen there.

All of this being said, even without perfect adherence to the warm handoff's, there was a clear decrease in my response time to urgent beans. It's hard to say that this is strictly because of my intervention, but likely has something to do with me being more mindful of my bean management during this project. I have also gotten in the habit of checking beans early Friday afternoon's to ensure there is nothing urgent needing a response before the weekend; this habit definitely skewed my interventional data towards having a decreased response time. There could be something said to keeping bean management at the forefront of people's minds, and I would be curious if having a hand out taped at peoples desks with a reminder to do warm hand offs with their providers would show an improvement in urgent bean responsiveness similar to what was seen in this project.

QI PROJECT
Author: Ilana Buffenstein, MD
Project Title: Creating A Systematic Sign-out Process for FMRWM Resident Labor & Delivery Sign-Out

Problem: FMRWM residents currently have an Excel spreadsheet that does not have a standardized reporting process. The new addition of 24-hour resident coverage on L&D presents a unique opportunity to improve patient safety outcomes. However, the lack of a consistent and streamlined signout process still presents a patient safety issue, given different residents may have different opinions about what is actually important to convey via signout.

Aim of the project:
Specific: to create a concise and effective sign-out process for patients covered by FM residents on L&D, including for antepartum, laboring, postpartum, and newborn patients

Measurable: Will submit before- and after- survey to residents who have been on OB ranking: overall satisfaction with sign-out process, if they feel templates are helpful or not, what they feel is most important (and not important) in signout, and ranking of overall sense of safety in correlation with templated signout

Achievable: A variation of template already exists, this project will hopefully be a series of small PDSA cycles of the templates to create one that is practical for residents to update

Relevant: Residents care about maternal and newborn safety and positive health outcomes

Timebound: My goal is to have this implemented by the end of my R2 year, after we have had >6 months of night shifts

Key Measures for Improvement: See analysis section; use of templates, updates/improvement to existing templates; resident satisfaction with signout process

Process of gathering information:
An initial survey was submitted assessing the following questions:
1. Would it be helpful to have templates for the signout sheet?
2. Do you use the current antepartum, labor, postpartum, or newborn templates on the spreadsheet?*
3. What are things you like and dislike about our current OB signout process?
4. What are some things you find important in signout?
5. Rate your overall satisfaction with the current sign out process* (out of 5)
6. Free text area for suggestions/concerns*

Then, the current interation of spreadsheet/templates was modified based on resident feedback, with addition of standardized templates as well as a column for disease/illness severity. This was reviewed by an independent reviewer (an alternate resident from the OB committee), with modifications suggested and implemented.

Finally, a post-QI survey was submitted assessing several of the same questions (marked * above), as well as the question(s) below:
1. Do the spreadsheet/templates feel better, worse, or about the same as a) old version of templates, or b) however people (or you!) were using the spreadsheet before?

Analysis and interpretation:

Fig. 1: Would it be helpful to have templates for the signout sheet?

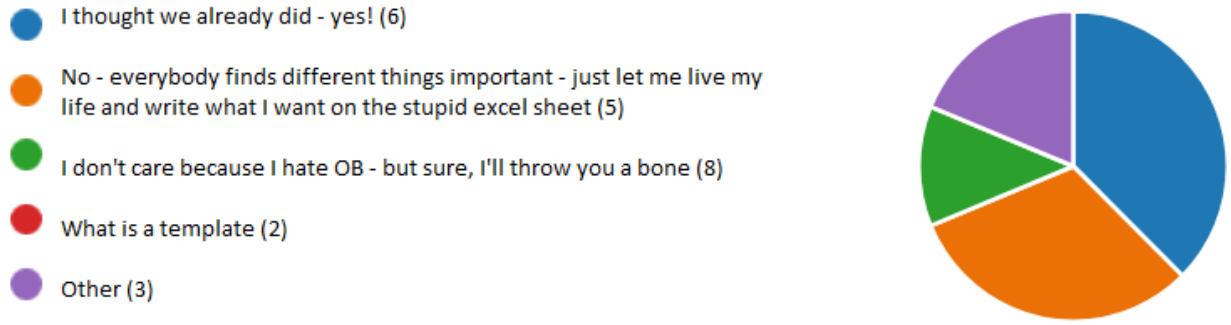
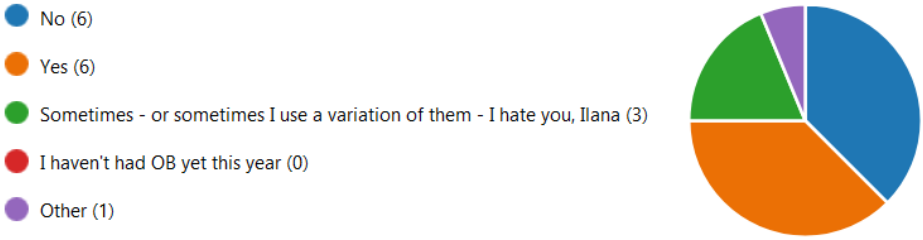
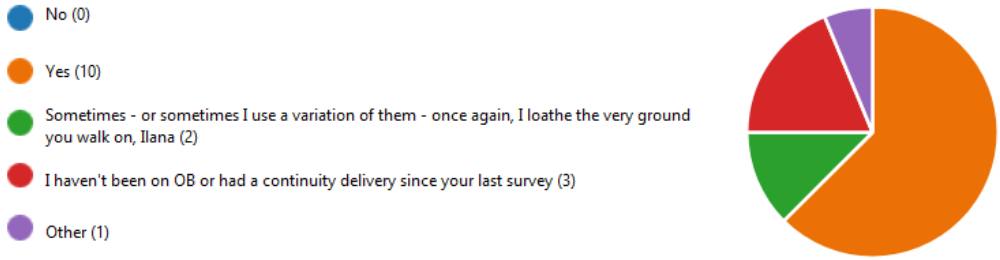


Fig 2: Do you use the current antepartum, labor, postpartum, or newborn templates on the spreadsheet? (Pre- and post-survey)





Other: Kalispell specific templates

Fig. 3: What are some things that are important in sign out?

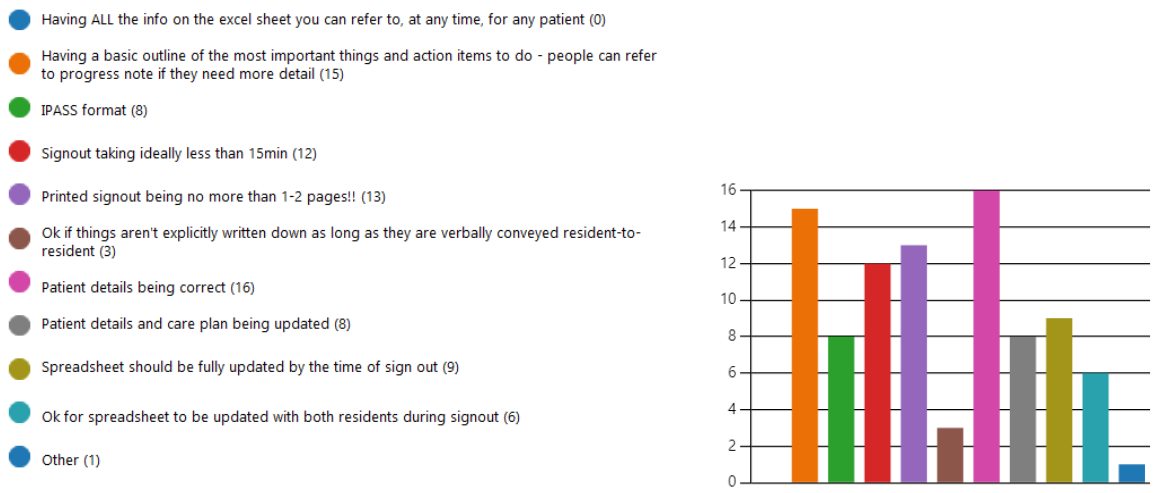


Fig. 4: Do the spreadsheet/templates feel better, worse, or about the same as a) old version of templates, or b) however people (or you!) had been using the spreadsheet before?

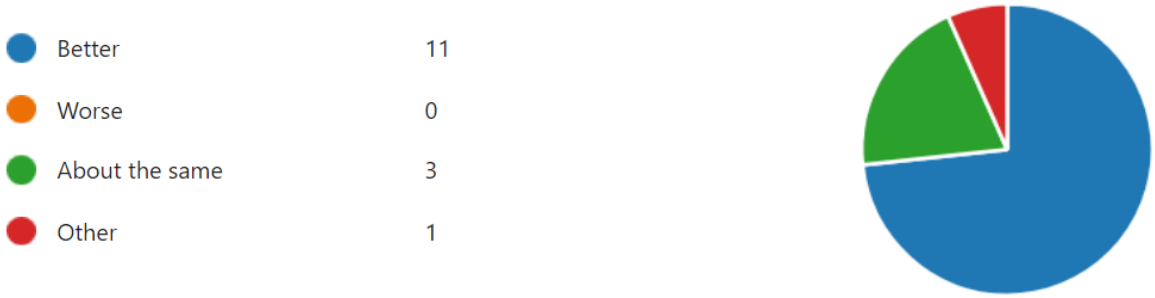
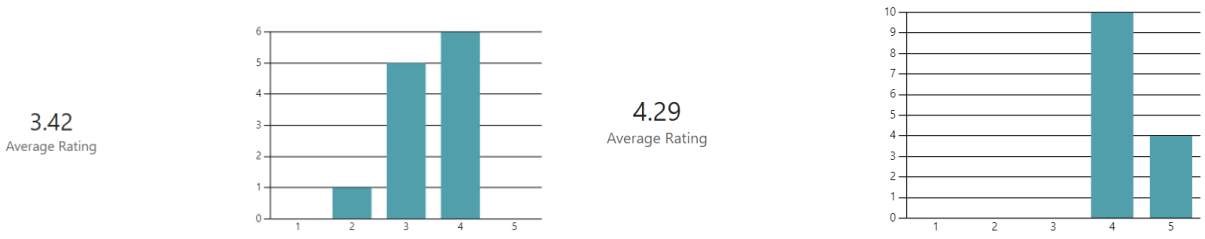


Fig. 5: Rate your overall satisfaction with the current sign out process (pre- and post-survey)



General pre-survey concerns about sign out/templates:

- Updating sheet taking too long
- Too much pre-filled in, signout also not getting updated appropriately/regularly/accurately during shift transitions
- Need for IPASS either in verbal signout
- Concise/relevant info e.g. G/Ps, PNLs, age, basic data
- +/- helpfulness of having partner + baby names included
- Role of seniors in training interns on efficient/safe signout methods
- Need to include postpartum pain meds
- Not applicable for Kalispell residents

General post-survey concerns:

- Things to potentially EXclude from templates (not urgent to know, can look in progress notes): rubella and varicella status
- Specifically, discrepancies in what people found important to include - some wanted a note on postpartum pain meds ordered, others specifically felt this was not necessary
- Templates still too wordy/long/burdensome

Strategies for change: Multiple measures, including an online data collection form, were instituted. 16 residents responded to the pre-survey, and 14 residents responded to the post-survey.

Effect of change:
Notable findings included:
- about half of residents (50%) felt a template system would be helpful in pre-survey
- a significant increase in percentage of residents who used the templates (from 38% to 63%) in pre- vs post-survey
- 73% of residents felt that the templates were better in post-survey
- resident satisfaction with signout process increased (3.42 to 4.29) in pre- vs post-survey

Lessons learned: This was a project that was very near and dear to my heart. A continued challenge, which I haven't yet found a workaround for, is that different residents find different things to be important (i.e. important to know in the moment, and to have the info on their person at all times). I expect that these templates will continue to evolve (and likely become shorter/more succinct as they get used). I recognize that it was, and is, a big ask of my coresidents to use these templates - it runs the risk of adding extra work/resident fatigue to an already challenging and often unpredictable work environment on labor and delivery. Moving forward, continued use of these templates will likely require support from both our chief residents, our FMRWM faculty - and, of course, whoever the senior is on OB orienting future interns. However, I feel strongly that templating of sign out will ultimately result in overall improved resident experience on the OB rotation, improved patient safety, as well as better relationships with our OB faculty and staff.

QI PROJECT
Author: Julie Eggleton, MD
Project Title: Obstetrics Orientation Handbook Efficiency and Quality Improvements

Problems: The current Resident Obstetrics (OB) Handbook, while comprehensive, suffers from two key limitations. First, its extensive length can be overwhelming for busy residents, potentially hindering its effectiveness as a quick reference guide. Only 28% of initial respondents had ever used the existing 77-page handbook. Second, the content is oriented towards interns only which does not allow for guidance of senior residents in how to train incoming interns on the service. This lack of standardization has caused differences in preparation and knowledge of each intern based on the senior resident that is training them. This lack of tailored information for senior residents could be a missed opportunity to optimize learning and clinical decision-making. Additionally, it should be noted there are several old versions of handbooks that are accessible to residents, leading to confusion and outdated information.

Aim: This project aims to revitalize the Resident Obstetrics Handbook to better serve residents throughout their training. By streamlining and standardizing the content, the aim is to create a user-friendly and efficient resource that residents can readily access during their OB rotation. Additionally, the handbook will encompass the needs of all residency years. Providing senior residents with a template to train incoming interns on the OB service will promote consistency in resident practices.

Key Measures of Improvement:
- Increased use of the OB Handbook
- Decreased OB Handbook length
- Overall perceived usefulness by residents

Process of Gathering Information: The current resident classes (2024, 2025, and 2026) were sent a survey via email and asked to respond.

Analysis Interpretation: Of the 13 respondents that are current residents, 12 either agreed or strongly agreed that the new handbook was easier to use when compared to the old handbook, while one respondent was neutral (Figure 1). These same response ratios held true when respondents were asked, pretending they were new interns, if the new OB Handbook would have been more helpful than the previous OB Handbook (Figure 2).

Of the eight applicable residents, all but one responded that they planned to use the new OB Handbook when orienting interning residents in the future (Figure 3).The other five respondents either do not need to train interns on OB because they will be moving to our Kalispell track or are graduating this year.

The new OB Handbook included a “Senioring Checklist” on page 18 that provided a simple yet detailed list of senior resident responsibilities and a standardized guide for training new interns on the OB service. This list was not included in the old handbook, and is a new resource for the residents. When asked if respondents felt the Senioring Checklist is helpful and will improve efficiency and standardize training for interns, 84% agreed or strongly agreed while 15% were neutral, none disagreed.

To additionally assist residents in accessing and making the OB rotation more efficient, respondents were asked the best locations to post the new OB Handbook for easy access which is being used to ensure residents can quickly find it in the future.

All respondents were also encouraged to add written feedback or suggestions which have been incorporated into the final version of the new OB Handbook.

Figure 1

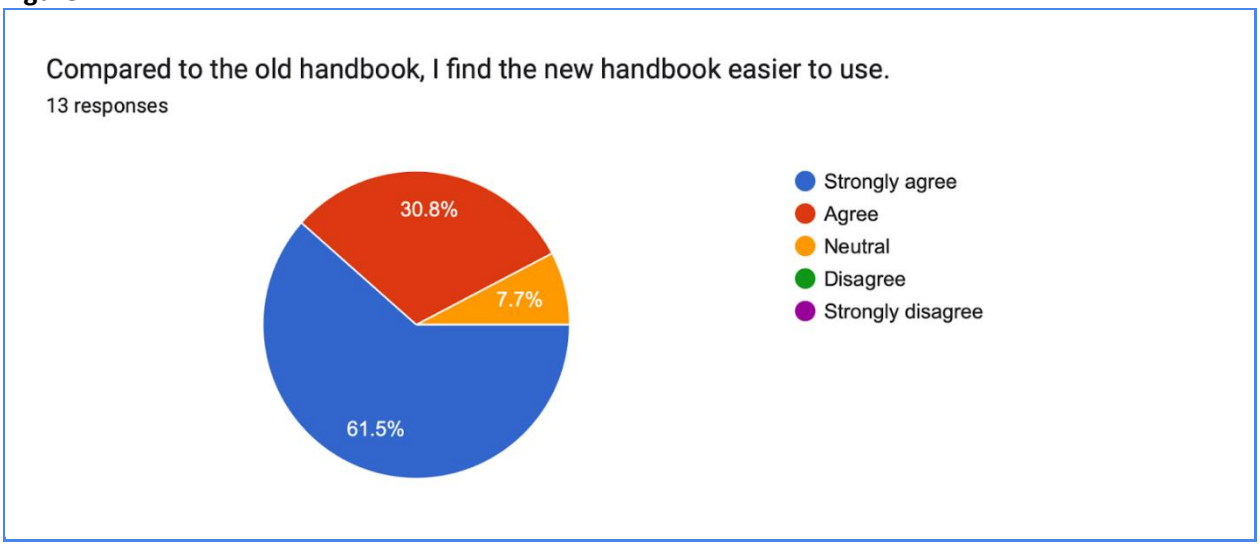


Figure 2

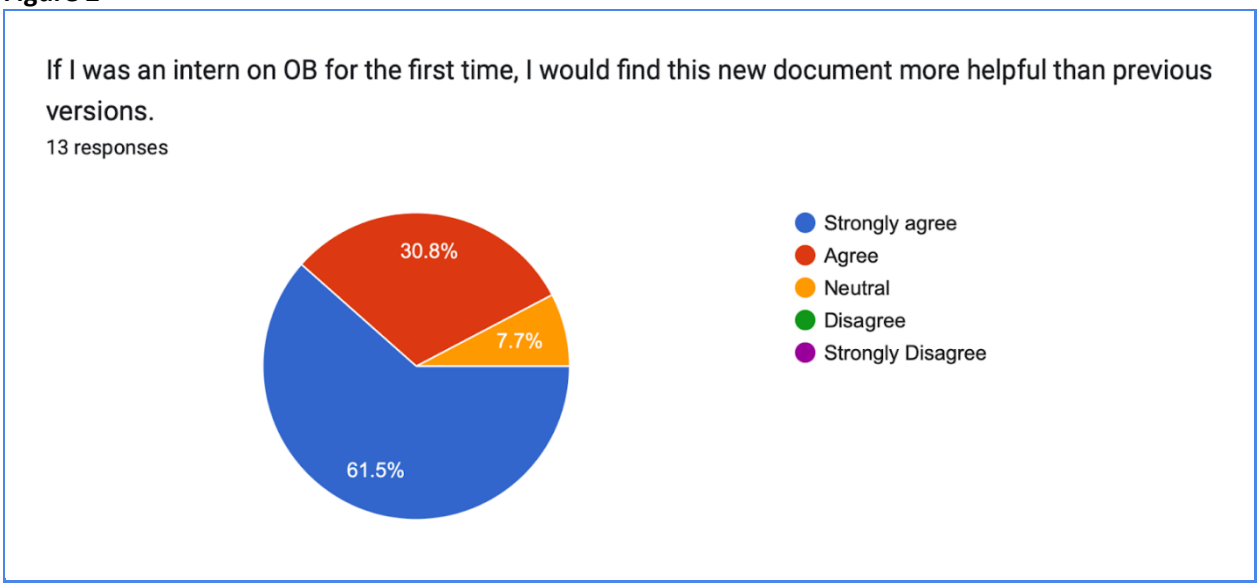


Figure 3

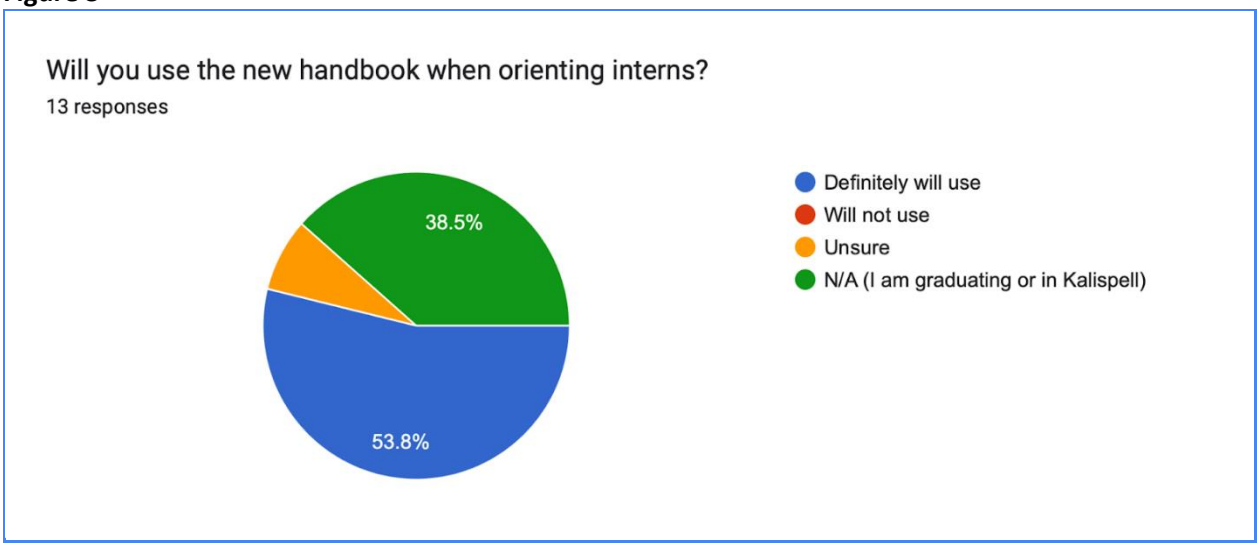


Figure 4

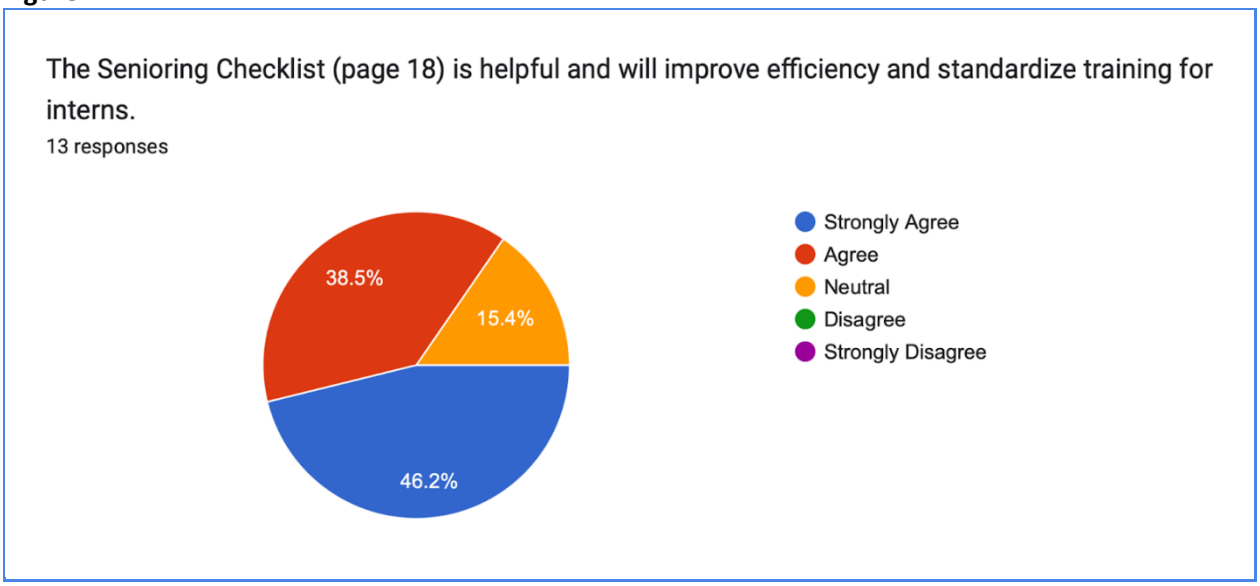
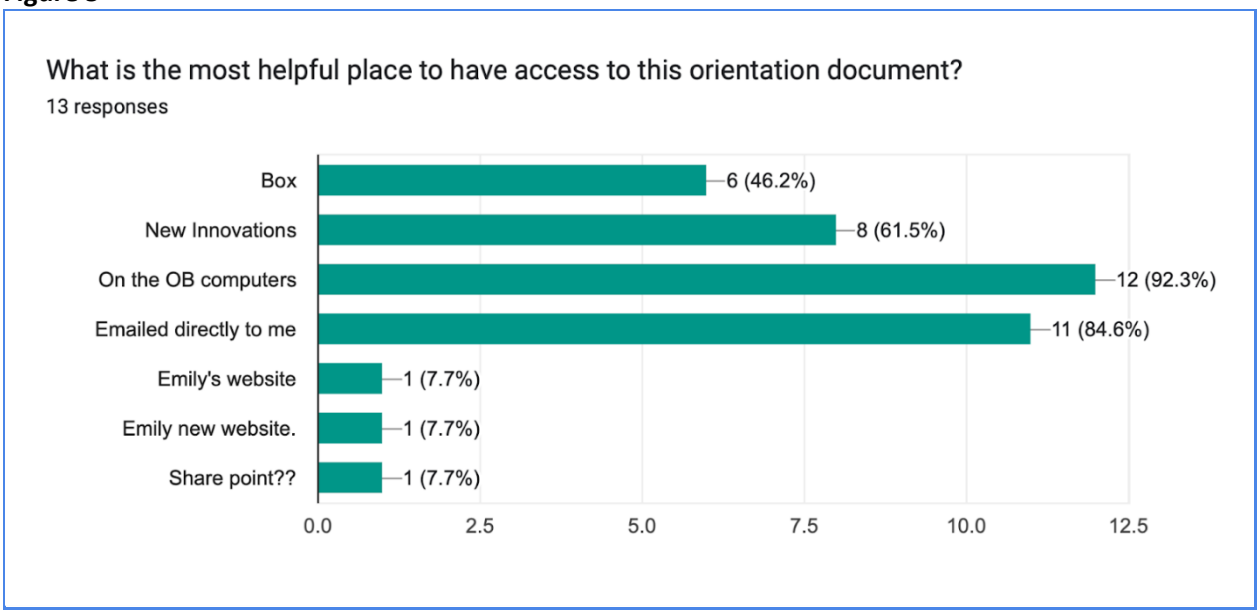


Figure 5



Effect of Change and Lessons Learned: During the creation of this new handbook, I began to understand why so many were outdated and unused old handbooks. Even during the single academic year we had several changes on how to complete computer orders, our resident templates, and our OB faculty members. However, this allowed me to modify the new handbook to exclude items that change regularly, allowing for a more succinct handbook that is likely to remain relevant for longer. The new OB handbook is 22 pages compared to the previous which was 77 pages; this is 71% fewer pages for residents to read while on a busy service. Compared to 28% of respondents who used the prior version, 87% plan on using the new version in the upcoming academic year. The new OB Handbook also includes a "Senioring Checklist" which provides a simple yet detailed list of resident responsibilities and a standardized guide for how to train new interns on the OB service. This list was not included in the old handbook, and is a new resource for the residents. Overall, 84% of responding residents believe this resource will help improve overall consistency between training residents on the OB rotation. A total of 92% of the responding residents agree that the new OB handbook is easier to use. The new OB Handbook met all aims; residents see it as an improvement over the previous handbook by being more concise, helpful, and adding guidance for residents of all levels.

QI PROJECT

Author: Mckenzie Keeling-Garcia, DO

Project Title: Effect of Prenatal Chart Review to Reduce Missed or Delayed Prenatal Care Items

Problem: Important prenatal care items get missed due to a variety of circumstances (patients leaving before items complete, swiss cheese type misses, etc). The current process needs improvement because it is allowing for too many missed PNC items resulting in lapses of important care such as screenings, tests, etc. Baseline data to be reviewed is closed prenatal charts over the past 6 months, compare the PNC items collected to a standardized care schedule, and identify any missed or delayed items. Then, we will implement a system of chart review at 2 standardized times in the pregnancy, and collect data over the next several months of any missed or delayed items.

Aim: By implementing a process of chart reviews at 14-16 week mark and 24-26 weeks EGA, reduce the number of missed or delayed (>2 weeks) PNC items (from a standardized list of PNC items) by 30% when compared to the 6 months prior to implementing the system. These items will be clearly documented in the appropriate sections of the prenatal chart including having new items built in ECW if needed.

Key Measure for Improvement:
Number of delayed (>2 weeks beyond expected timeline) or missed prenatal care interventions included in prenatal care checklist below.

Prenatal Care Checklist: Type and screen, 1st CBC, rubella, HIV, syphilis, hepatitis B, hepatitis C, gonorrhea, chlamydia, NIPS, pap, dating ultrasound, urine culture, anatomy scan, GTT, CBC, Tdap, Rhogam, GBS

Process of Gathering Information: Prenatal charts were reviewed via ECW and prenatal care items checked against prenatal care checklist using an excel spreadsheet. Patients who entered prenatal care beyond 12 weeks or transferred prenatal care to another facility were excluded.

Analysis/Interpretation:

	Pre-implementation	**Post-implementation**
Charts Reviewed	5	1
Missed Items	5	7
Total Items Reviewed	67	8

Effects of Change: The implementation of a chart review process did not result in a decrease in missed prenatal care items over the intervention period. There were a total of 5 patients that met inclusion criteria for chart review prior to the intervention period, and 1 patient who met criteria for chart review during the intervention period.

Lessons Learned: There were a number of factors which contributed to negative results of this intervention. The first was a relatively low volume of OB patients during the intervention period. The single patient that met inclusion criteria during the intervention period had abnormal circumstances which led to a delay in certain care items. Additionally, there was not a consistent way of determining when new patients transferred in and out of care without checking the list of OB patients which is in a separate system than the charts. If continuing the prenatal chart review process in the future, it could be beneficial to have scheduled actions sent to the chart reviewer when the pregnancy is opened in the chart. A longer intervention period would also more accurately reflect the value of the chart review process because it would be less sensitive to abnormal situations such as our single patient having personal factors delaying her care.

QI PROJECT

Author: Neha Malhotra, MD

Project Title: Increasing resident comfort with OB clinic workflow by creating and implementing a reference tool

Problems: Multiple re reports of confusion navigating OB clinic workflow, including how to use the OB spreadsheet in the EMR, how to schedule inductions, and other clinic related workflow.

Aim:

1. To improve average comfort with clinic flow in three target areas: OB visit workflow, navigating the OB spreadsheet in the EMR, and scheduling inductions.
2. To create an effective reference tool for OB clinic workflow

Key measures for improvement:

Aim #1- Successful intervention would be defined as an average increase (1 point on likert scale) in comfort within our three target areas

Aim #2- Successful intervention would be defined as an average positive opinion of the tool's effectiveness (likert scale average >3, which is neutral)

Process of Gathering Information: Information was gathered using two de-identified surveys in google forms.

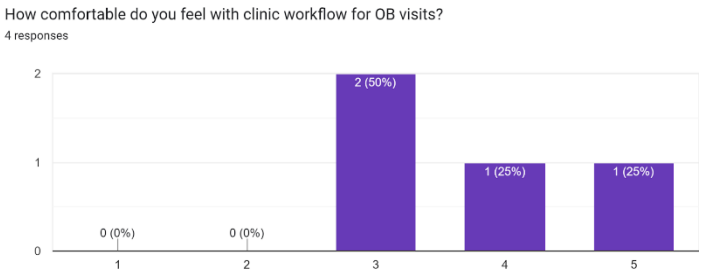
The first survey ("pre survey") was intended to be taken prior to using the OB Continuity Workflow document. It contained a series of questions about comfort levels in the three target areas listed above. Comfort level was quantified using a 5 point Likert scale, with 1 being "Not comfortable at all", and 5 being "Very comfortable". Additional information gathered included year in residency and whether the surveyee had completed an OB rotation yet.

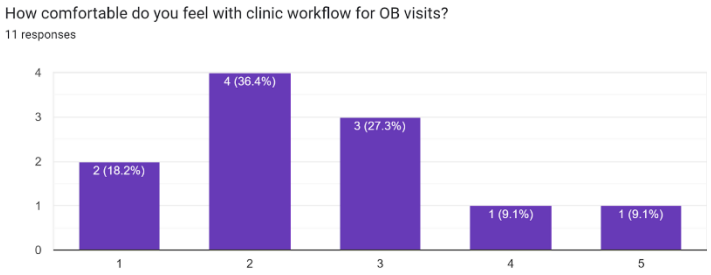
The OB Continuity Workflow document was first developed and sent to a faculty member for editing. Once approved, it was sent out to residents along with the pre survey.

The second survey ("post survey") was sent out three months later. Three months was chosen to give residents time to utilize the tool. This survey included the same questions about comfort levels in the three target areas. Additionally, it included a series of opinion questions about whether or not the OB Continuity Workflow document increased comfort in three target areas. This was measured using a 5 point likert scale with 1 being "Totally disagree" and 5 being "Very Much Agree". At the end of the survey, residents were invited to give feedback for improvements to the OB Continuity Workflow document.

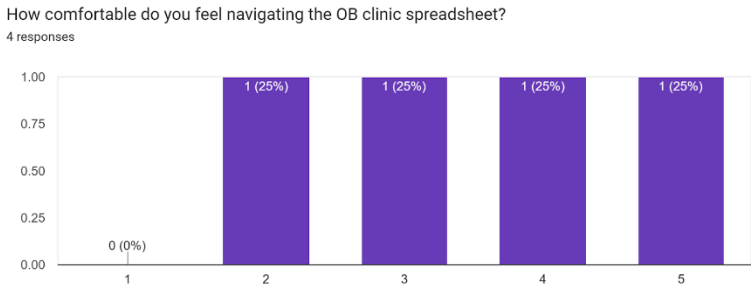
Analysis and Interpretation: 11 people answered the initial survey and 4 answered the post survey. Results are listed below.

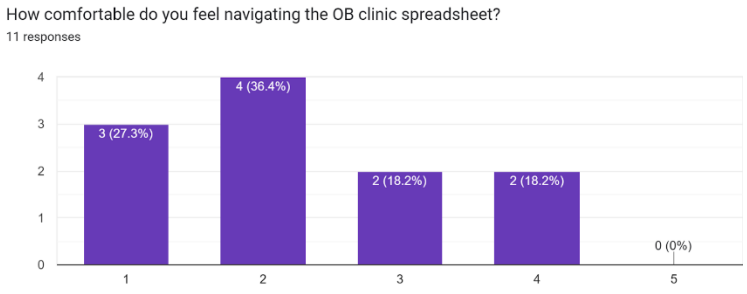
Comfort with clinic workflow for OB visits, pre and post survey.:



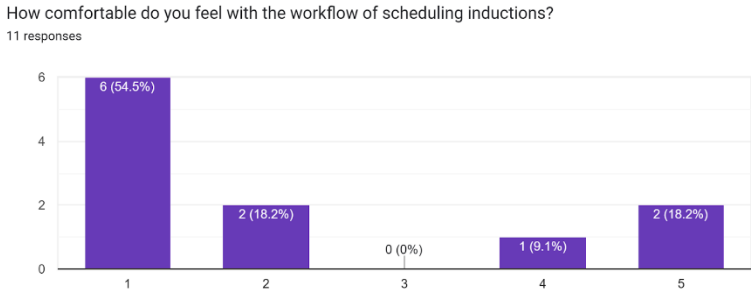


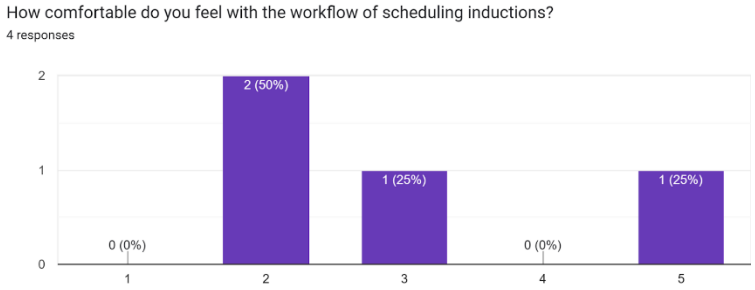
Comfort with Navigating the OB clinic spreadsheet, pre and post survey.:





Comfort with workflow of scheduling inductions, pre and post survey.:





Compilations of data averages:

	Average comfort score per target area		Average reported helpfulness of clinic tool per target area
Category	**Pre survey**	**Post survey**	*(post survey only)*
Clinic workflow	2.5	3.75	3.5
Clinic spreadsheet	2.3	3.5	3.5
Scheduling inductions	2.2	3	3.5

Discussion: Based on the numbers, data suggests an overall improvement in comfort in our three target areas. The data also shows an overall positive opinion of the OB Continuity Workflow document. These results however, are skewed due to the low sample size of the second survey. As such, it is difficult to draw useful conclusions from this QI project.

75% of participants in both the pre and post survey were interns. When intern data was isolated from responses of residents in the R2 and R3 classes, it showed an increase in comfort within our three target areas as well as overall positive opinions toward the OB Continuity tool. This suggests that even though data may have been skewed due to high attrition rate, the OB Continuity workflow document was a helpful tool for interns.

The three month time period in between surveys was intended to give residents an opportunity to utilize the tool in practice. However, this time period may have contributed to the high attrition rate. The natural progression of skill growth during those three months may have also skewed data positively. Additionally, all interns had completed an OB rotation by the time of the second survey. These variables may have accounted for the improvement in resident comfort with clinic workflow.

If repeated again, the two surveys would be offered at the same time to optimize responses and remove the previously stated confounding variables. Simultneous administration of pre and post surveys would not give residents an opportunity to utilize the tool in practice, but would improve data collection and analysis.

Effects of Change: There is now a succinct document that can be utilized for reference if residents have questions about navigating OB clinic. This tool is faculty approved and can be updated as needed. This was especially shown to be helpful for interns.

Lessons learned

- We have also now identified areas for improvement in the OB workflow, most importantly more information on the hospital aspects of continuity deliveries. This is currently being addressed by my colleague Dr. Julie Eggleton, who is consolidating the OB handbook. Responses from this project add further evidence for the importance of her QI project.

- Future interventions would need to mitigate the attrition rates for resident surveys in order to draw firmer conclusions

QI PROJECT
Author: Connor Rogan, MD
Project Title: Integration of visual communication aids into the clinical setting to optimize limited/nonverbal patient interactions.

Problems: Communication is a key part of the job of the physician. In clinical practice, most of our decision making is based on the history given to us by the patient, with additional details filled in with a physical exam and subsequent tests. Any changes in the ability to gather history from a patient can make this process much more difficult. Patients can be unable to give history for numerous reasons and it is not uncommon for a non-verbal patient to present to clinic. Without an efficient way to interpret, clinic visits can take exceedingly long to complete, and the quality of care can be impacted. In other office settings visual communication boards are often implemented to augment the communication with non-verbal patients.

Aim: *I will integrate visual communication boards into the clinical setting and provide provider education on the topic of patients who have difficulties communicating. This will increase the confidence and the ability of providers to utilize these tools in the clinical setting by 25% over 3 months after implementation.*

Key measure for improvements: Perceived provider experience in visit time and effectiveness with history gathering when using communication boards vs without.

Process of gathering information: The medical staff at Greater Valley Health Center were surveyed about their perceived comfort in managing visits with patients who are nonverbal. A pre survey focused on perceived comfortability during these interactions, and whether respondents had any training with these types of interactions. During this project, it was discovered that the clinic did have a digital tablet-based communication board that was quite underutilized and a majority of those surveyed did not know of its existence. A collaboration with the care navigation team at the clinic subsequently occurred, and an update about this digital system was given at a medical staff meeting to make providers aware of the software and encourage its usage. Following the meeting, a post-survey was sent out to the medical staff with the information obtained that will be used to hopefully inform the next steps of the project.

Analysis and interpretation:
Pre-survey
The pre survey was answered by 9 clinicians. The survey identified that many respondents find communicating in non-verbal patient encounters to be uncomfortable (Figure A). Factors identified that contribute to this include Understanding patient needs (89%), interpreting non-verbal cues (44%), finding appropriate visual aids (78%), time constraints (67%), lack of training (79%). In terms of training, 0% of respondents reported receiving specific training on communication with non-verbal patients, and 100% of respondents reported they would be interested in additional training or resources to help improve the communication barrier. Resources identified were the use of visual communication boards (67%), training workshops (67%), online resources (33%), peer support groups (11%). The perception that the integration of a visual communication board into a clinic visit with a nonverbal patient would be somewhat difficult (55%), or not difficult (33%) with few thinking it would be very difficult (11%)

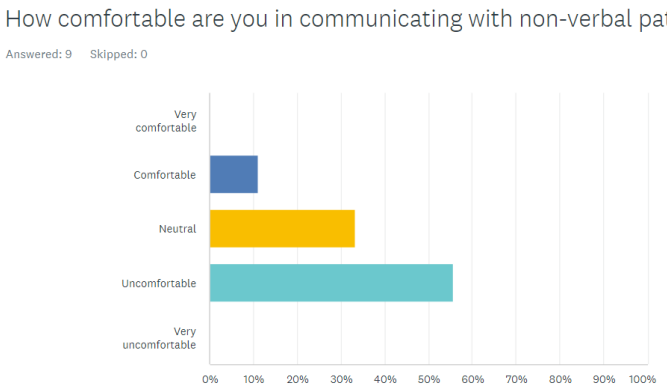


Figure A.

Post-survey

Following the software communication board status update by the Clinical Care Navigator, a follow up survey was sent out to assess further information. The follow up survey was answered by 11 clinicians. The vast majority of respondents (91%) reported having 0-1 nonverbal patient encounters each month with only 1 respondent (9%) reporting 2-5 nonverbal encounters each month (Figure B). Approximately half of respondents (55%) attended the medical staff meeting to hear the update. Prior to the meeting, 27% of respondents were aware of the software, with 36% being made aware of it during the meeting, and 36% still not aware of its existence. None, (0%), of the survey respondents reported having ever used the software. In terms of communication board preference, 72% reported no preference with either software or paper based boards, with 18% preferring paper and 9% preferring software. Respondents reported similarly on their perception of integrating either a paper or software-based communication board into a clinic visit, with 40-50% reporting not difficult at all or somewhat difficult, and only 10% believing it would be difficult to do so.

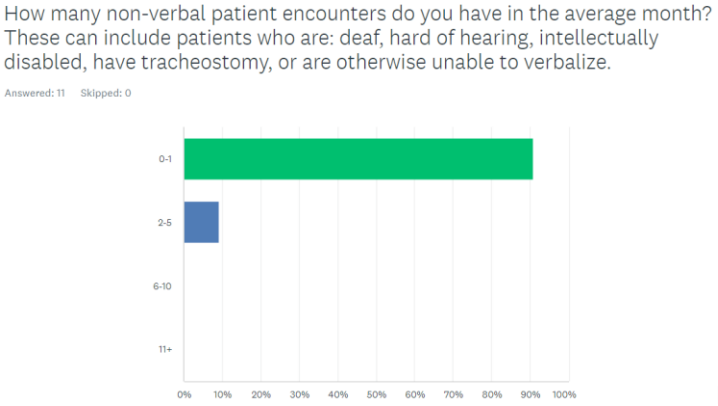


Figure B

Outcome: The project is currently a work in progress with a phase 2 to be completed as next years QI project.

Lessons Learned: The surveys were incredibly useful to help gather data on both the number of non-verbal encounters experienced, the perceived difficulty of these encounters for clinicians, and preferences on how to improve these encounters. During the initial research into the project, it was identified that the clinic owns a software that can show communication boards. It is interesting to note that prior to collaborating with the Clinical Care Navigator to provide an update, very few of the staff knew of the software existence, with nobody utilizing the software. I did myself try the software during a non-verbal patient encounter and found it difficult to use without prior training on the specific software, in terms of finding the correct symbols for the conversation (This data was omitted from the results above as I did not respond to my own survey). I do not know who the one respondent was who experiences 2+ visits per month, and whether they are a school-based provider as this could provide a different perspective.

Effects of change: The next step of my project will involve utilizing this data to better incorporate a communication board into our clinic. Initially, my idea was to introduce a paper communication board. Now that it was discovered that the clinic owns a software version it may be simpler to create a digital version, given that many providers in the clinic have no preference for the format. With the small number of these encounters experienced by our clinic, it takes a long time to collect data around these visits and I anticipate assessing future changes will be difficult due to the small volume. Given that any sort of communication board will typically require at least a small amount of training to be comfortable using, I would consider reaching out to the Speech Language Pathologists that we work with on FCM to try and collaborate further on this project.

QI PROJECT
Author: Emily Young, MD & Dan McCarthy, DO
Project Title: Improving OMT Access through Scheduling Education

Problem: Confusion about whether patients are allowed to access OMT at PHC has led to decreased OMT visits, which leaves patients who could benefit without treatment, and residents who need to practice and learn without patients to work on.

Aim of the project: Increase the number of OMT billing incidents in my clinic from 0.4 per half day during PGY-1 to between 0.8-1.2* per half day from January 2024-May 2024. Additionally, aim to increase the number of OMT patients per OMT Specialty Clinic half day from 2.4 patients per half-day to between 3.2-3.8 per half day from January 2024- May 2024.

Key Measures for Improvement: Number of OMT patients on my own clinic schedule. Number of patients seen in OMT Specialty Clinic. Balancing measures were having a cap on the number of OMT patients per half-day in my own clinic.

Process of gathering information: Compared data from PHC helpdesk team on the number of times I billed for OMT to the number of clinic half days worked in eCW. Similarly, I requested data from the helpdesk team on the number of patients who "checked out" (aka completed) an OMT Specialty Clinic visit per half day of said clinic. Unfortunately, this was flawed because OMT Specialty Clinic visits are under multiple different provider names (sometimes Dr. McCarthy, sometimes the resident) so I manually went through each OMT Specialty clinic day in eCW and looked for each provider's data.

Analysis and interpretation:

OMT Specialty Clinic Visits per Half-Day:
Pre-Intervention (Jul 1-Dec 31): **2.8** (47 visits in 17 half-days)
Post-Intervention (Jan 1-Mar 31): **3.5** (28 visits in 8 half-days)

Emily Young's Clinic number of OMT Billing Events per Half-Day
Pre-Intervention (Jul 1-Dec 31): **0.46** (19 billings in 41 half-days)
Post-Intervention (Jan 1-Mar 31): **0.80** (12 billings in 15 half-days)

I was successful in both endeavors! I continue to be hopeful I can increase my OMT visits per half day closer to 1, which is what is now blocked in my schedule.

Strategies for change: The measure I implemented was initially reaching out to OMT residents to learn who needed more OMT patients to reach the goal of one per half-day and sharing information about our role in filling OMT specialty clinic with patients we want to work on with Dr. McCarthy. Next, I shared education with other PHC providers through email and Tuesday morning provider meeting about a) what OMT Specialty Clinic is and the appropriate use and b) which resident OMT providers were open to new referrals.

However, there were additional helpful changes in the same time window. OMT resident clinic schedule templates were updated to include one OMT appointment per half-day. Subsequently, Dr. Wright improved the scheduling workflow for OMT by educating then opening up scheduling privileges to all PSRs.

Effect of change: OMT clinic was significantly closer to fully booked; 3.5 visits per half-day means that, on average, every other clinic is fully booked. This is great for learning and optimizing the time already set aside for working with Dr. McCarthy. Because these are hour-long appointments, there is not a compromise in patient care for a fully-booked OMT Specialty Clinic. Separately, I successfully saw more OMT patients in my own clinic. It was a combination of patients who were booked with me primarily for OMT and patients who came in with MSK complaints who were appropriate to treat with OMT.

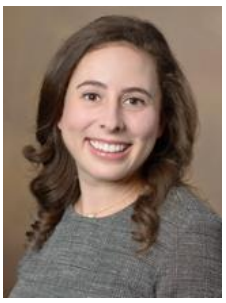
Lessons learned:

1. Data gathering through eCW is challenging. Having a set way of logging encounters for OMT Specialty Clinic (whether under the resident or under Dr. McCarthy) would be helpful.
2. Being a "squeaky wheel" is helpful! Change came from multiple avenues: the creation of one OMT slot per clinic half day into OMT residents schedule templates, Dr. Wright's discussion with and ultimate change in how (and which) PSRs schedule OMT visits, proposal of reciprocal referrals with Brittany Wiseman for patients who would benefit from OMT as well as dry needling.

Class of 2026

MISSOULA

Christine Belluomini



Cassandra Wammen

Cecilia Heck

Alexis Ziebelman

Chiara Lawrence

KALISPELL

Samantha Clark

Annalise Mann

Nicole Green

Talia Sopp

George Pope

Class of 2026 QI Work

QI PROJECT
Author: Christine Belluomini, MD
Project Title: Impact of Nightly Stretching on Pain Relief

Background: For as long as I can remember, my flexibility has been below average, ranging from difficulties touching my toes to feeling chronic tightness in my hips and lower back. Sitting or stagnantly standing during workdays has compounded this problem, leading to chronic discomfort that makes finding comfortable positions to rest in a challenge. Thus far, my way to tackle this has been to intermittently stretch or use a foam roller when the pain becomes a constant nag throughout the day. I have never tried a daily stretching routine.

Aim Statement: Stretch for 10 minutes prior to bed at least 5 nights per week over the course of six weeks.

Key Measures for Improvement: Subjective pain rated on a scale from 1 to 10; 1 was "did not bother me", 5 was "intermittently noticed during the day, but did not need to adjust position", and 10 was "constant toothache pain throughout the day unrelieved by position". Measurements of lateral leg raise height bilaterally from side-laying position and forward waist flexion were record on day one and upon completion of the project.

Process of Gathering Information: Prior to nightly stretching, I assessed my average level of hip discomfort throughout the day on a scale from 1 to 10. This was subjectively tracked in a notebook. If I noticed any areas of specific tightness, I made an annotation, as well as if I intentionally exercised that day. I measured my flexibility on day one and at the end of six weeks. Hip abduction was measured with a digital tape measure. Waist forward flexion was measured with a measuring stick.

Data:

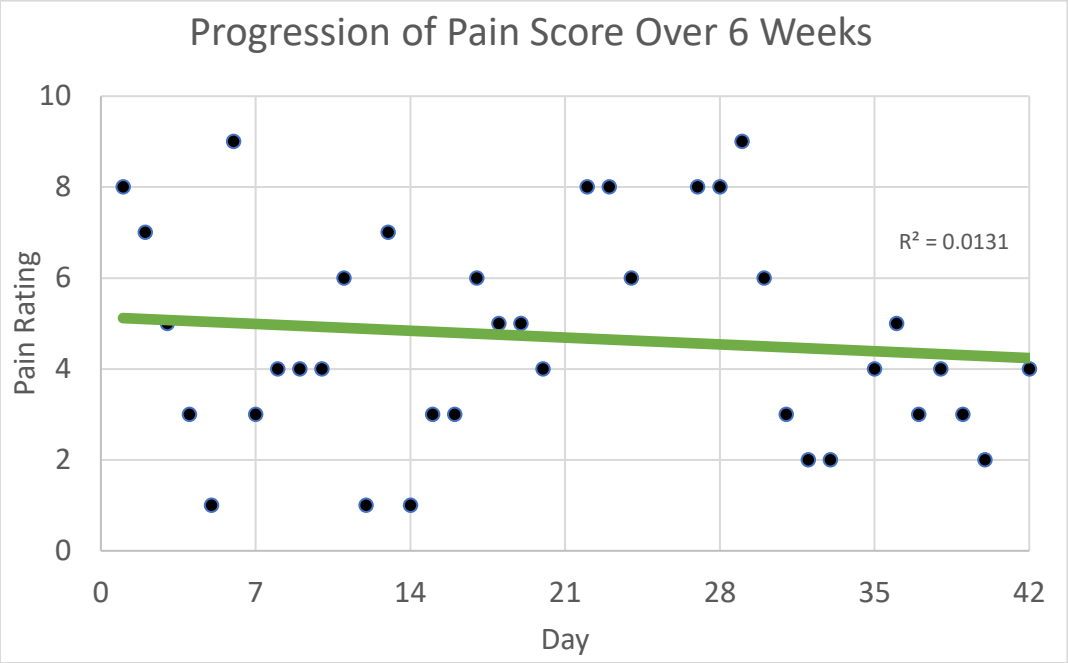


Figure 1: Daily pain ratings plotted for 6 weeks with a R-squared value of 0.013

Stretch	Starting	Ending	% Change
Forward Hip Flexion	0	4.5	
R Lateral Leg Raise	28.14	45.8	163 %
L Lateral Leg Raise	34.72	54.2	156 %

Table 1: Measurement in inches of mobility gained before nightly stretching was implemented and at the end of six weeks. Lateral leg raise measurement was based on abduction height of designated leg. Zero was considered leg in a neutral position, resting on the ground. The initial measurement for hip flexion was deemed as zero and any flexion beyond that was positive inches gained in mobility.

Data Analysis: Based on the scatter plot, a conclusion may be drawn that consistent stretching over time did not significantly impact pain based on a low R-squared value. The pain ratings were all subjective and easily confounded by numerous variables during the day including, but not limited to, hydration status, intentional exercise, hours standing versus sitting during the day, and emotional status at time pain ratings were recorded. There was no formative way to standardize how pain was rated, nor a way to reliably and realistically account for all confounding variables in each day. Although, a low R-squared coefficient can still suggest a meaningful change, especially when used to decipher subjective data. As discussed by Hamilton et al. (2015), R-squared is measured with the assumption that variables, outside of the dependent and independent variables, remain fixed.[1] Since independent variables can be impacted by a multitude of factors in clinical scenarios, there are currently no steadfast rules to interpret R-squared values and even a low value can help predict data trends.[1]

The table displays an apparent significant change in measured mobility as both lateral leg raises changed by more than 150% and forward flexion improved by 4.5 inches. This measurement was objective rather than subjective as measurements were taken in the same fashion with a digital tape measure.

Strategies for Change: Most nights it was difficult to find motivation to stretch. I began my stretching routine when I was doing an Emergency Medicine rotation, which meant I was getting home between 11:30 pm and midnight. If I were to do this study again, I would find a way to stretch either before work if I was on a rotation with afternoon shifts, or immediately upon arriving home after a day in clinic. Additionally, I would attempt to account for confounding variables by using multiple linear regressions for data analysis as this may provide more statistically significant results.

Effects of Change: Overall, I believe that daily stretching improved my chronic pain and limited mobility. This is reflected in the negative linear regression line and significant change in measured mobility.

Lesson Learned: Based on my reflection and pain ratings, as I began to consistently stretch prior to bed, I progressively felt better the next day. Additionally, it became easier to fall asleep because I did not have to spend 10-20 minutes trying to find a comfortable position. Furthermore, I noted as my hip discomfort improved, working out felt less daunting because it did not start with me already having aches. So, while this project was aimed to directly measure my improvement in flexibility, it overall helped me see the global impact of nightly stretching on my well-being. It became a great way to decompress, relax and wind down prior to bed.

Citations:

1. Hamilton DF, Ghert M, Simpson AH. Interpreting regression models in clinical outcome studies. Bone Joint Res. 2015 Sep;4(9):152-3. doi: 10.1302/2046-3758.49.2000571. PMID: 26392591; PMCID: PMC4678365.

QI PROJECT
Author: Samantha Clark, MD
Project Title: Holding the Line: Maintaining Adherence to Wellness through Movement

Problem: The transition from student to resident is challenging, and one of my main mechanisms for managing stress is movement. I discovered early in my first year that during time-intensive rotations (Medicine and OB), I greatly decreased or even stopped making time for movement in my schedule. I suspect that this very likely compounded the inherent stress of these rotations and left me feeling fried, frazzled, and burnt out during these rotations. This left me feeling less able to cope with the rigors of these rotations. I also struggled to re-integrate movement once these rotations ended after falling away from them.

Aim of the project: My goal for this project was to increase the consistency and frequency of movement for 30+ minutes during a period of time (January 1-May 12, 2024), and assess my self-perceived coping with this intervention.

Key Measures for Improvement:

1. Number of qualifying movement activities for a period of 30+ minutes during each week (Monday-Sunday).
2. Self-perceived coping scores recorded each week, on a scale from 1-10.

Process of gathering information: I used a combination of my Apple Watch fitness app and a sticker chart system to record days that included a qualifying movement episode. Once each week I reflected on my subjective mood, any emotional breakdowns, ability to keep up with clinic responsibilities, if I had been staying in touch with loved ones/participating in social activities, getting sufficient sleep, and staying current on chores at home. These elements together were how I subjectively determined my ability to cope score for that week.

Analysis and interpretation:

Dates	Rotation	Week	# Movement Episodes	Self-Perceived Coping (Score 1-10)
1/1-1/7	Medicine*	1	2	4
1/8-1/14	Surgery	2	2	6
1/15-1/21	Surgery	3	4	8
1/22-1/28	Newborn	4	2	7
1/29-2/4	Newborn	5	3	7
2/5-2/11	GYN	6	2	6
2/12-2/18	GYN	7	3	7
2/19-2/25	Vacation	8	4	8
2/26-3/3	GYN	9	4	8
3/4-3/10	OB*	10	3	6
3/11-3/17	OB*	11	2	5
3/18-3/24	OB*	12	2	4
3/25-3/31	OB*	13	2	6
4/1-4/7	Medicine*	14	5	8
4/8-4/14	Medicine*	15	1	3
4/15-4/21	Admits*	16	5	6
4/22-4/28	Medicine*	17	4	7
4/29-5/5	FCM	18	4	8
5/6-5/12	FCM	19	4	8
Average:			**3.052631579**	**6.421052632**
Average for *intense weeks:			**2.8889**	**5.4444**
*= intense rotation				

Table 1: Number of movement episodes and self-perceived coping scores by week and rotation. Intense rotations noted with *. Calculated averages noted for both total data set and sub-group of intense rotations only.

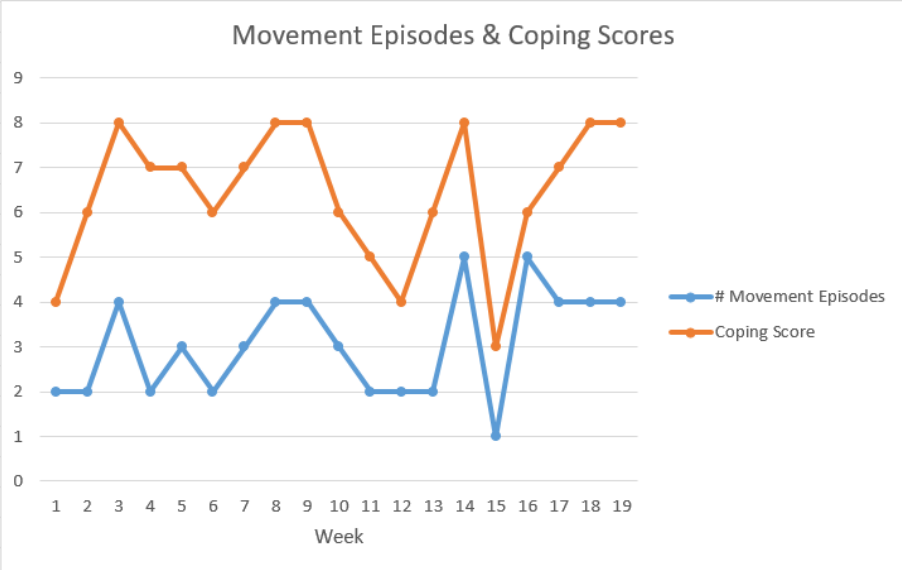


Figure 1: Graph demonstrating the relationship between number of movement episodes in a week and the coping score.

Strategies for change: I chose to use a broad definition for what counted as movement to increase the likelihood that I could find something that seemed appealing on any given day. Some days that meant a vigorous yoga practice or brisk walk outside, and other days it meant doing several extra trips to the fourth floor by stairs at St. Patrick's hospital. I also embraced the motivating power of a sticker chart, which created a visual of how well I was adhering to my goals week by week.

Effect of change: Prior to beginning my project, I assigned coping scores to the OB and medicine rotations that had already taken place, which were 3 and 4, respectively. My hope was that this intervention would increase these scores to a minimum of 5. I hoped to achieve an average of 4 movement episodes per week.
In reviewing the data, I found that the average number of movement episodes was 3.05, and for the weeks of intense rotations was slightly lower at 2.89. While this was lower than my goal of 4, I believe it was higher than it would have been without this project, which made me more intentional about finding time for movement even on busy rotations. My overall average coping score was 6.42/10, which shows that overall I am coping with the various demands of residency fairly well. For the more intense rotations, I had an average coping score of 5.44/10, which surpassed my goal of increasing my coping score to 5 or greater.

Lessons learned: I suspect that the increase in my coping scores was due in part to the intervention of increased movement, but also represents a natural increase in efficiency and competency that comes with progressing in residency, and improved mental health from seeking additional support for my anxiety starting during the study period. Being on the time-intensive rotations for a second time was also less stressful than the first round as I knew better what to expect. Though I cannot confidently say how much of my improved self-perceived coping is due to the movement intervention, it was certainly a contribution.

Overall, this project reminded me that I can and should make time for important things like movement even on time-intensive rotations. Doing so, in combination with other wellness-promoting activities, makes me more competent as a physician and also more effective and happy in other aspects of my life.

QI PROJECT
Author: Nicole Green, DO
Project Title: The Mountains Are Calling, and I Must Get Out of the Hospital

Problem: Residency is a challenging transition from medical school and requires a significant adaptation in our ability to manage stress. I have always been an active person but during residency, this may not be enough.

Aim of the project: To improve stress management and overall mood through increasing activity outside. Goal is to reduce perceived stress score by 10% with at least 6 hours per week of exercise that is outdoors.

Key Measures for Improvement: Minutes of time spent exercising outdoors tracked with Strava. Stress levels to be measured with Perceived Stress Scale. This is a questionnaire that assesses how certain situations affect our mood and perceived stress. This assessment helps quantify perceived stress and measure change.

Process of gathering information: Activity will be tracked through Strava and measured in minutes. This app tracks exercise. I will record physical activity with my Garmin watch and upload it to Strava immediately after completing exercise. I plan to complete the Perceived Stress Scale questionnaire after eight weeks of inpatient medicine where I will be working six days/week. During my intern year, this occurs on two occasions. My first eight weeks will consist of working in the Pediatric Emergency Department and OB. During my 2nd eight week stretch of inpatient medicine, I will be on Silver and OB. During this time, I will be intentional about increasing my exercising outdoors with a goal of 6 hours/week.

Analysis and interpretation: The data was collected over two periods of time from 9/17/2023-11/11/2023 and from 1/8/2024 to 3/4/2024. The total minutes of weekly activity were extracted from Strava. The average weekly minutes outdoors during the first time period was 109 minutes (1.81 hours) and during the second period was 278 minutes (4.63 hours). This is a 61% increase. See Figure 2. The Perceived Stress Scale score during each time period decreased from 26 to 10, which was a 62% decrease. See Figure 3. Confounding variables that were not accounted for in this data include an ankle sprain in October of 2023 which significantly limited by ability to exercise. During this time, I was able to exercise indoors on a stationary bike or with weight training. To better understand the effect specifically of exercising outdoors, it may have been helpful to track amount of indoor exercise and compare the difference in time spent exercising indoors between the two time periods. I suspect there was a larger amount of indoor exercise during the first time period than the second time period. Extracting this data would help me better understand if increased volume of exercise affected my reduced stress score rather than specifically exercising outdoors.

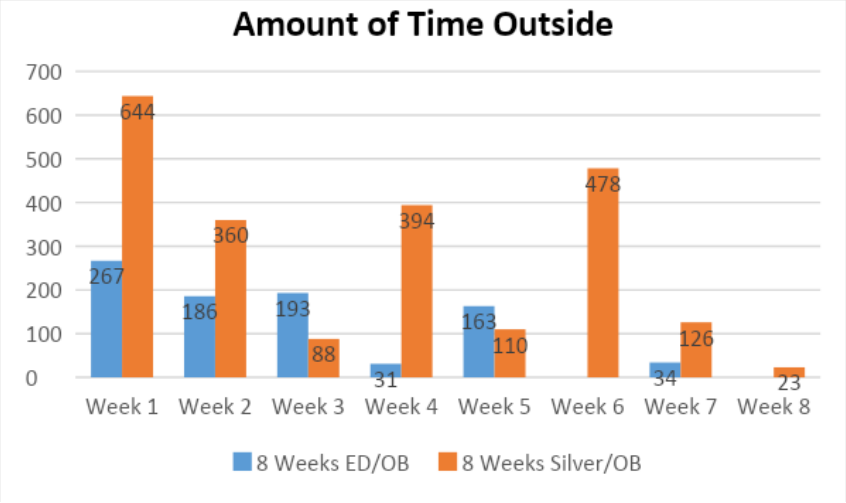


Figure 1: Amount of Time Spent Outside Each Week

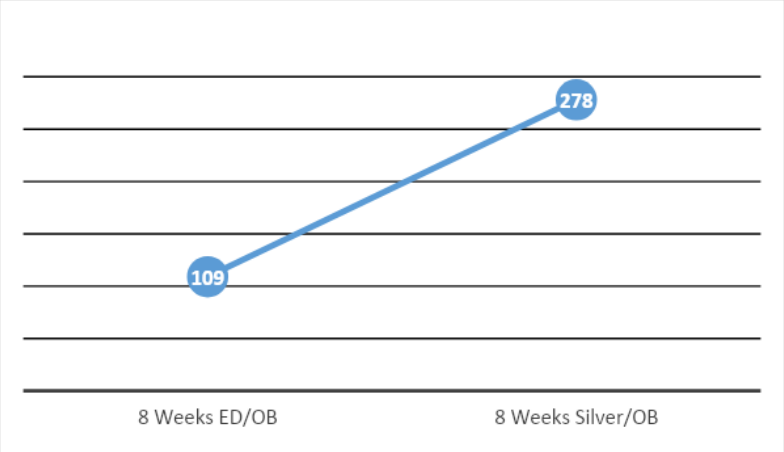


Figure 2: Average Minutes Spent Outside Each Week

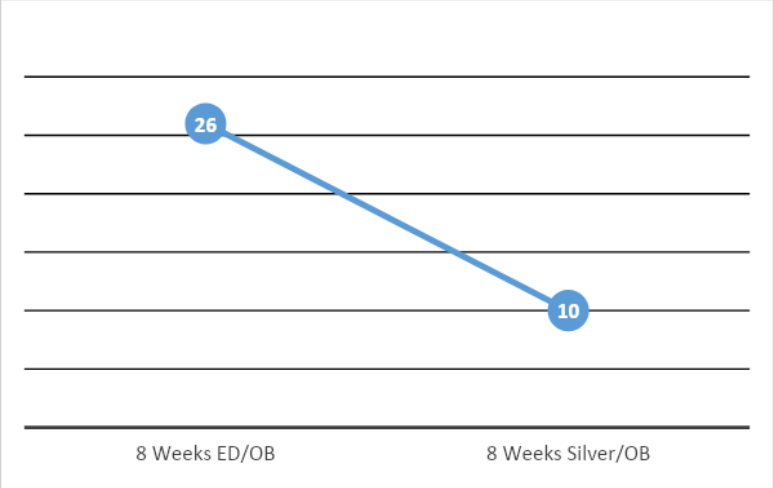


Figure 3: Perceived Stress Score

Strategies for change: To motivate myself to get outside, I signed up for a triathlon that required a significant amount of training. This motivated me to spend time outside exercising. While at times it was a little overwhelming to have a big race hanging over my head, overall it was a strong motivator. In order to continue exercising outdoors, signing up for races or setting specific fitness goals will help me get outside more.

Effect of change: Intentionally exercising outdoors reduced my perceived stress. My goal was to exercise six hours/week outdoors. This was somewhat challenging, however by increasing exercise to 4.5 weeks outdoors, I was able to significantly reduce my perceived stress.

Lessons learned:

- Exercise is known to play a significant role in improving mental health. My project showed that specifically exercising outdoors can improve perceived stress. During my eight weeks of inpatient in the fall, I was mostly exercising indoors due to an ankle injury. During the eight weeks in winter, I spent a significantly greater amount of time outdoors. This showed a significant reduction in my perceived stress.
- Six hours of exercise outdoors is not necessary to reduce stress. I was able to increase my average outdoor exercise to 278 minutes or just over 4.5 hours and notice a significant improvement in perceived stress.
- Signing up for a triathlon was a great motivator for regular exercise outdoors. In order to continue these habits, I plan to set fitness goals for myself, such as races or specific trails.

QI PROJECT
Author: Ceely Heck, MD
Project Title: Physical health in residency

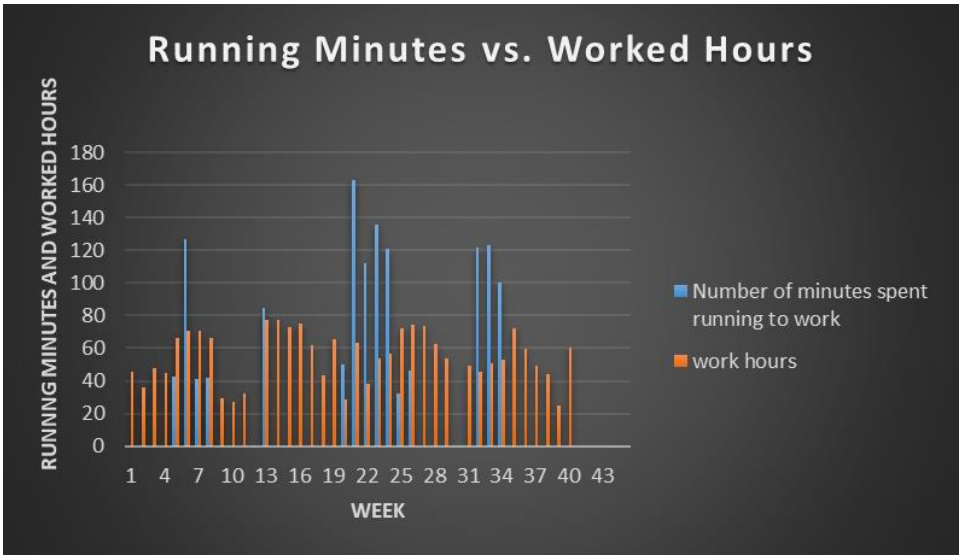
Problem: Currently, on tough rotations especially, I have been unable to exercise or cook for myself due to time/fatigue constraints. I would really like to have a regular exercise regimen that is maintained consistently throughout my residency.

Aim of the project: *I will meet my exercise goal of 150 minutes active time weekly (per my garmin watch) for 80% of the next 12 weeks by actively commuting to work via bike or running in order to create a sustainable level of physical fitness throughout my residency.*

Key Measures for Improvement: Exercising >150 min a week provides overall decreased cardiovascular health risks, improved mental health and more time spent outdoors.

Process of gathering information: Information collected via garmin smartwatch running minutes and New Innovations working hours for the week as well as which rotation worked.

Analysis and interpretation:



The value of R is 0.172.

Although technically a positive correlation, the relationship between the variables is weak (nb. the nearer the value is to zero, the weaker the relationship). This means that on the weeks I ran more, I also worked more (weak correlation).

The P-Value is .28857

The value of R^2, the coefficient of determination, is 0.0296.

Strategies for change: I will continue to implement run commuting into my daily schedule. I hope to be able to use the experience gained based on the past 12 weeks to further build my life around implementation of physical activity into my daily life.

Effect of change: Unclear, measures were subjective at this time. I did increase amount of time spent outside and subjectively can report increased sense of confidence during the weeks that I ran.

Lessons learned:

-running worked best:

1. on the days where I was not required to be at two or more clinics or hospitals in one day
2. when running to a location that provided meals
3. when running to locations that provided locker rooms for changing or showers

-running did not work when:

1. I had continuity deliveries (3 of the weeks)
2. When I had a vacation (9 of the weeks). Of note, any week where I worked less than 50 hours included one or more days of vacation.

QI PROJECT

Author: Chiara Lawrence, MD

Title: Impact of Weekly Dance on Wellbeing and Joy

Problem: Lack of routine and desired scheduled activities that add joy, predictability and non-medical connections to my life since moving into a new community and beginning residency with a highly variable schedule, loss of participation in activities that feel non-competitive, promote embodiment and mindfulness, and involve participation in a community

Aim: To attend weekly hip-hop dance class at least three weeks out of every month for six months, to monitor the impact of going to a weekly hip-hop class on mood, self-perception, and sense of community

Process of gathering information, barriers and results: My intent was to gather information on my mood, self-perception and sense of community on the day prior to, on, and after weekly hip-hop class (every Wednesday) regardless of attendance and to examine the relationship between attendance and mood, self-perception, and sense of community. Although I estimate that for these six months I attended hip-hop for a third of the total weeks possible (less than the goal), I found I rarely actually recorded the dependent variables to allow me to track the impact of this attendance in a measurable and reliable way. In this sense, I was not ultimately able to use data to demonstrate that my mood, self-perception, and sense of community were improved by going to weekly dance class. However, I can say that on reflection over the last six months, the weeks where I chose to attend I had an overall improved sense of community and improved mood during and immediately after the class. Additionally, the more regularly I attended the more notable that sense of community became. I still go semi-regularly and when I do not attend for multiple weeks I notice the absence of that grounded, joyful feeling.

The barriers to monitoring going to class as well as monitoring the impact of class are most notably: challenge maintaining routine, challenge with following through on going to class due to a variety of factors: unpredictable schedule, lack of motivation before class, exhaustion, low mood, lack of commitment, lack of formalizing the data collection, and forgetting to collect data.

Lessons learned: It is difficult to draw clear conclusions from this QI project as I failed to appropriately gather the data necessary to do so. Regardless, I feel and notice a clear improvement in all three of these dependent variables when I attend class. For this reason, it would still be useful to track this experience in a more accessible way and with the aim of promoting a positive feedback loop where I could notice the improvement in my wellbeing and increase my attendance. Additionally, I re-learned that for me, a project without very clear structure, formalization and multiple mid-point goals, will not likely lead to useable data and reliable conclusions. Future QI projects will require this of me.

QI PROJECT

Author: Annalise Mann, DO, MPH

Project Title: Three small positive things to improve work and life fulfillment

Problem: It's not pretty to admit, but I tend to be a glass half empty person. Focusing primarily on the challenges of any given day or situation has probably improved my productivity and helped me get to where I am today. However, I realize it has become somewhat maladaptive and encourages a negative interaction with the world which is not consistent with the person I would like to be. The first year of residency is a potent time to be making this active change because every day comes with both challenges and successes as I navigate functioning as a physician. There is a lot of opportunity for positive change.

Aim statement: During the second half of my first year as an intern, I will write down three small positive things that happened at the end of each day. At the end of each week, I will record my feeling of fulfillment with my home life, work life, and overall. I hypothesize that noticing and writing down three positive things that happen each day will shift the way my brain views the world into a more positive light, and with that will come improved fulfillment in my home and work lives.

Key Measures for Improvement: Level of perceived fulfillment measured on a Likert scale rating job fulfillment level, home fulfillment level, and overall life fulfillment level. Likert scale ratings were 1-10 with 1 being a low score and 10 being a high score. While these outcomes are subjective, it's really my perception that is what is important in this QI project. The frequency with which I record three good things per day will measure how often I am performing the intervention.

Process of data gathering: I completed a small weekly survey asking about my fulfillment level at work, at home, and overall on a scale of 1-10. For my own interest, I also included the number of hours I spent painting and watching television, and the rotation I was on to aid in interpretation of results. At the end of the project, I gathered all stickies and counted the number completed per month.

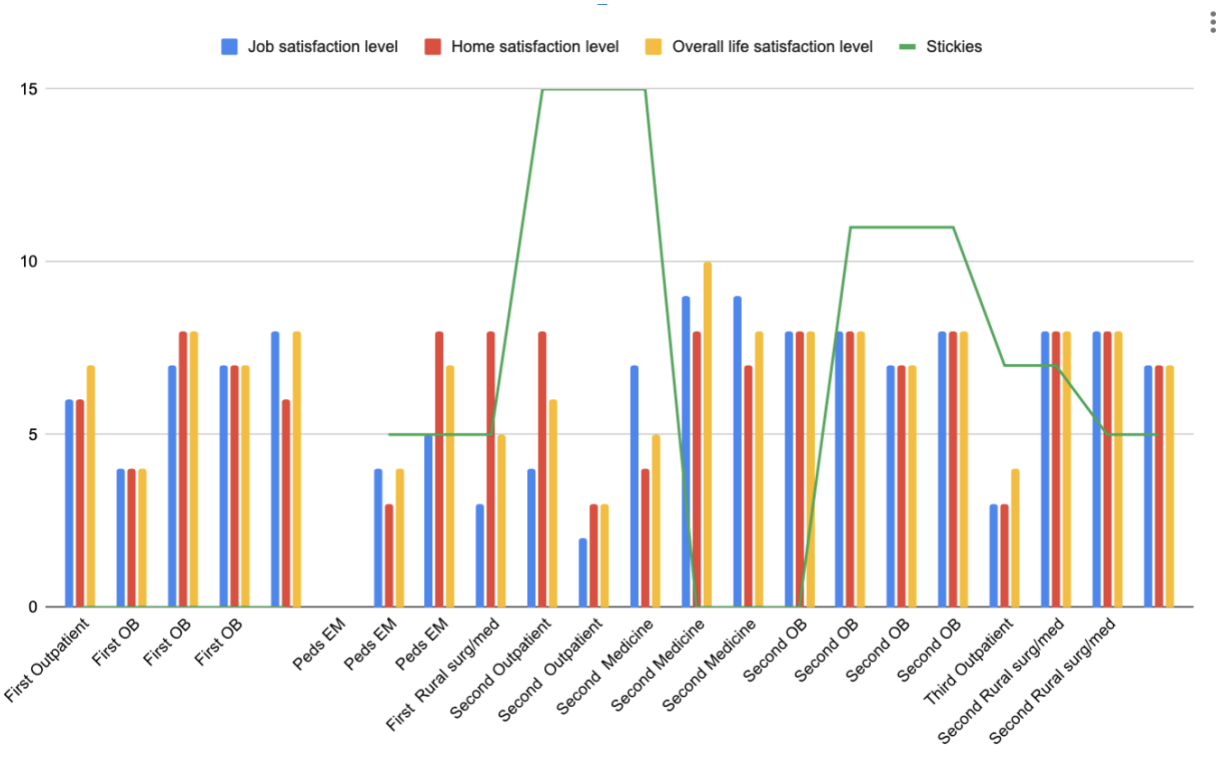
Analysis and interpretation: I began creating stickies with "three good things" during the Peds EM rotation in late December. There was no significant change in fulfillment in any domain before versus after the intervention. Home, work and overall life fulfillment scores were tightly correlated and rose and fell together over the course of the project. I created the following quantity of stickies: 4 in December, 19 in January, 0 in February, 11 in March, 7 in April, and 5 in May.

The highest scores across all domains were during my second month on the inpatient service (avg 8.67, 7.67, 8.67) and behavioral health (avg 8.0 across all). However, only one entry was recorded during Behavioral Health. The highest single score was 10/10 in overall life satisfaction during the second inpatient rotation. Interestingly, I did not write any stickies during the month of February.

The lowest scores for work fulfillment were during Addiction Medicine (avg 4.0) and Rural Surgery/Medicine (avg 4.0). The lowest scores for home fulfillment were during Family and Community Medicine (avg 3.5) and Addiction Medicine (avg 4.0). The lowest scores for overall fulfillment were during Addiction Medicine(4.0) and Family and Community Medicine (4.0). I created the most stickies during January when I was on Peds ED, Rural Surgery/ED, and FCM. The lowest single score was in Job Fulfillment during FCM, during this time I had a combination of challenging patients with complicated symptoms I was struggling to diagnose, and an unprecedented number of no-shows.

Job Title	Avg Hours Painting/Drawing	Avg Job Satisfaction	Avg Home Satisfaction	Avg Life Satisfaction	Avg TV Hours
First Medicine	1.0	6.0	6.0	7.0	5.0
First Outpatient	4.0	4.0	4.0	4.0	12.0
First OB	5.0	7.33	7.0	7.67	7.67
Peds EM	0.5	4.5	5.5	5.5	-
First Rural surg/med	0.0	4.0	8.0	6.0	10.0
Second Outpatient	3.5	4.5	3.5	4.0	3.0
Second Medicine	1.33	8.67	7.67	8.67	3.67
Second OB	0.0	6.5	7.5	7.5	2.5
Third Outpatient	1.0	8.0	8.0	8.0	1.0
Second Rural surg/med	3.0	7.5	7.0	7.5	1.5

There was no correlation between average hours painting and any fulfillment domain, or average hours watching TV and any fulfillment domain.



Strategies for change: Remembering to write down three good things every day was sometimes a challenge. I put sticky notes on the counter between my front door and living room so they would be one of the first things I see when coming

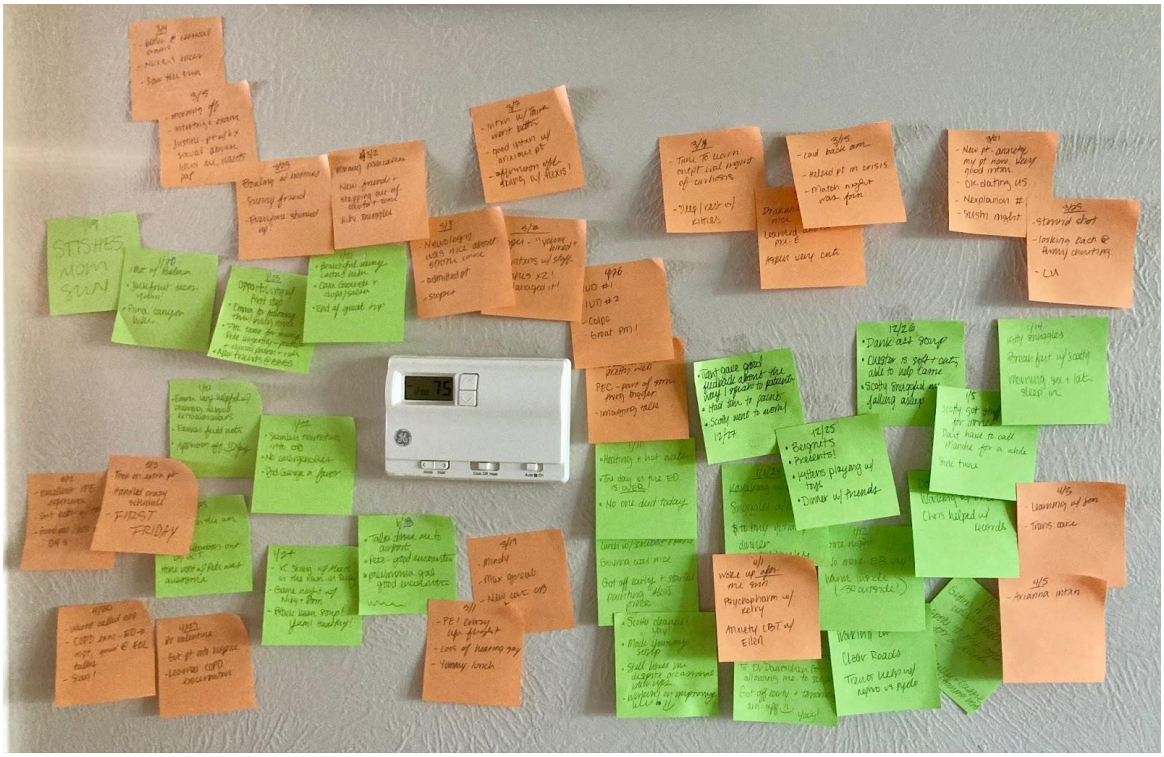
home. I also placed them on an easily visible wall in my home to a) remind me to keep creating them, and b) have a reminder of all the positives so far. Challenges with this approach included that the stickies fell off the wall, so I had to tape them. It took a while to buy tape, then kept misplacing it and that became a barrier to completing the stickies. The sticky note pads themselves also kept being misplaced after we had company over and cleaned that counter on a few occasions during the study period.

Effect of change: Getting tape and keeping it closeby was helpful to eliminate a barrier to creating the stickies. Keeping the stickies in a visible location was initially helpful, but as time went on their presence faded into the background of the house decor.

Lessons learned: I was surprised that scores were lower on outpatient rotations compared to inpatient rotations. I think there are three reasons for this. First, I experienced a "hangover" effect from the more demanding rotations where I worked harder and longer hours. Coming off that, it took me some time to recover and that translated to lower fulfillment scores. Second, I spent more time at home on outpatient rotations which actually created more difficulty in my relationship with my partner, as differing work loads created some resentment on my part. Third, I feel better about the care I provide and my competency as a resident physician when I put more hours and effort into learning. This is harder to do on outpatient rotations because it is 100% self-motivated when time could be otherwise spent sleeping, being outside, spending time with friends, etc. I recognize that balance is important and this is my response to varying workloads.

The hardest time I've had in residency was between March and April. I struggled with several things in my personal life which spread to struggling with patient connection at work. I did not complete the weekly questionnaire for at least 3 weeks during this time, and had not been engaging in the intervention. Looking back, this was the time that I really needed to be engaging with the project. This project gave me a low-barrier tool to call upon to adjust my perspective during particularly negative times in the future.

The cross-sectional nature of my weekly questionnaire introduced bias into my responses. For example, if I completed it on a day I was feeling better my scores were higher than they might have been earlier in the week. I had considered this variability at the start of the project and it was acceptable to me, however, it likely led to some bias.



QI PROJECT
Author: George Pope, DO
Project Title: BUILDING A BODY WHILE BUSTING THE MIND, a resident guide to fitness during Internship

Problem: A need for lowering of body mass habitus alongside a decrease in overall muscular strength impacting the propulsion of a Medical Resident through the hospital.

Aim of the project: To improve physical fitness as a multifaceted approach for improving physical strength for wrestling with a canine, ascending stairs at Saint Patrick's Hosptial to visit patients on the 5th floor, and to prepare the medical resident for Spring/Summer activities in Montana including Hiking and Swimming.

Key Measures for Improvement:

- Body Mass Index
- Muscle Group Strength

Process of gathering information:

- Body Mass Index: The participant's weight will be tracked and recorded in an Excel spreadsheet. This data alongside the participant's height will then be used to calculate the participant's BMI. This data will be tracked over time.
- Muscle Group Strength: The Participant will attend a strength-based facility and incorporate specific weight-lifting exercises into the routine. The heaviest lift for each of the chosen exercises will be recorded and tracked over time.

Analysis and interpretation:

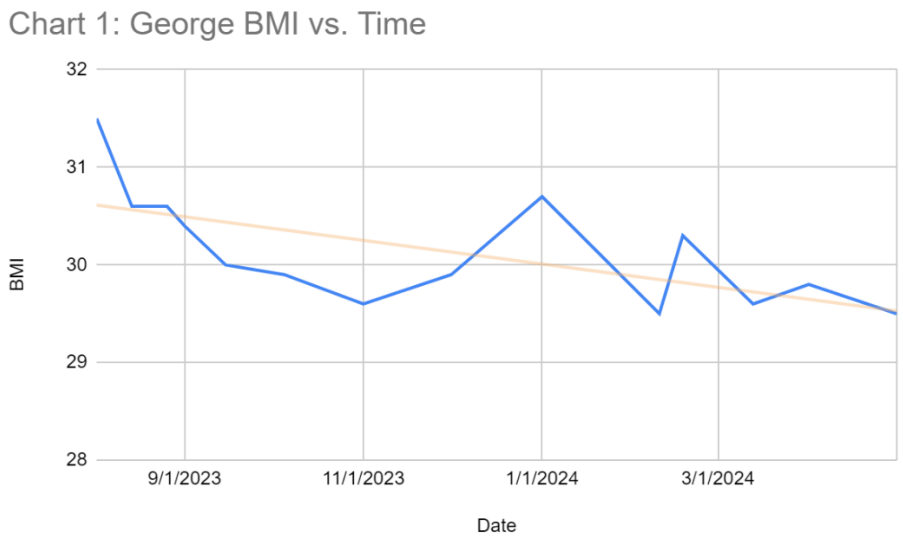


Chart 2: George Weight Vs Time

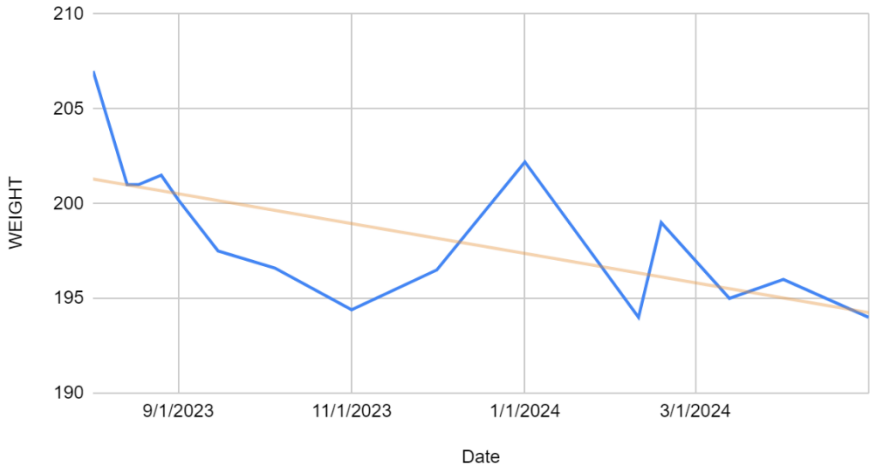


Chart 3: Dumbbell Bench Press Vs Time

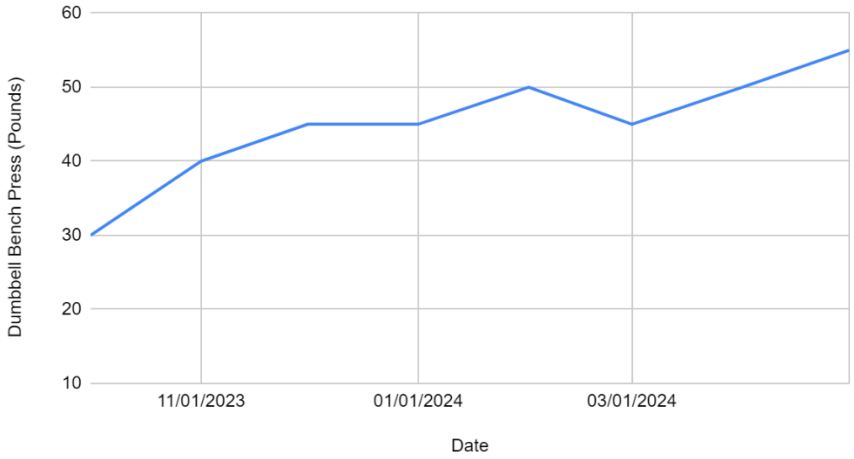


Chart 4: Dumbbell Shoulder Press vs. Date

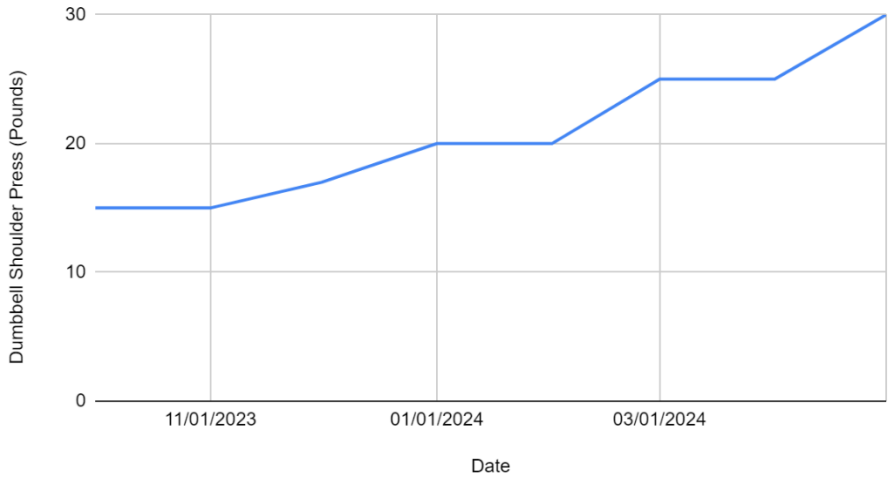


Chart 5: Lateral Shoulder Raises vs. Date

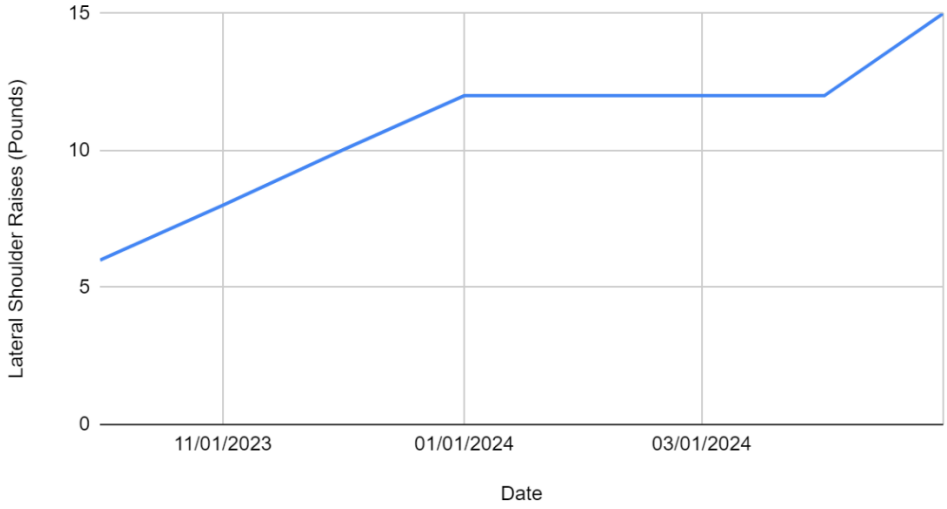


Chart 6: Lat Pull Down vs. Date

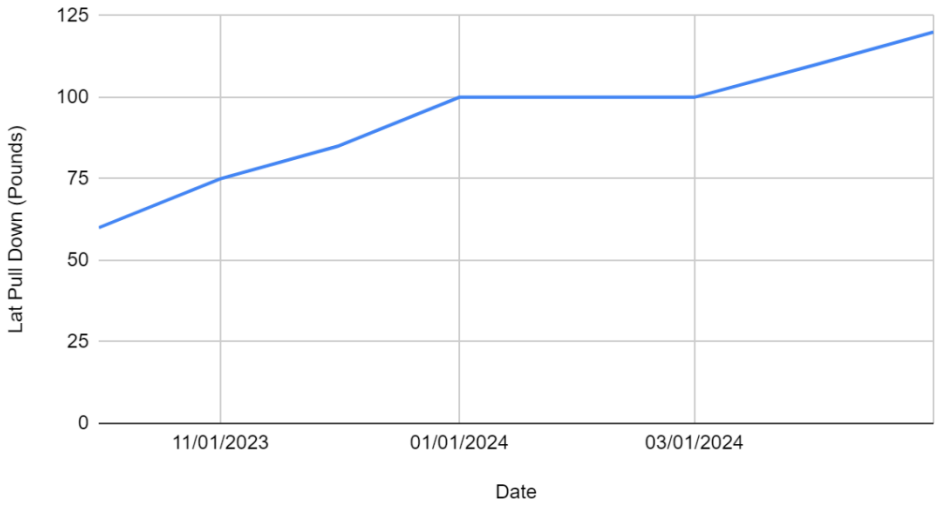


Chart 7: Under Hand Grip Row vs. Date

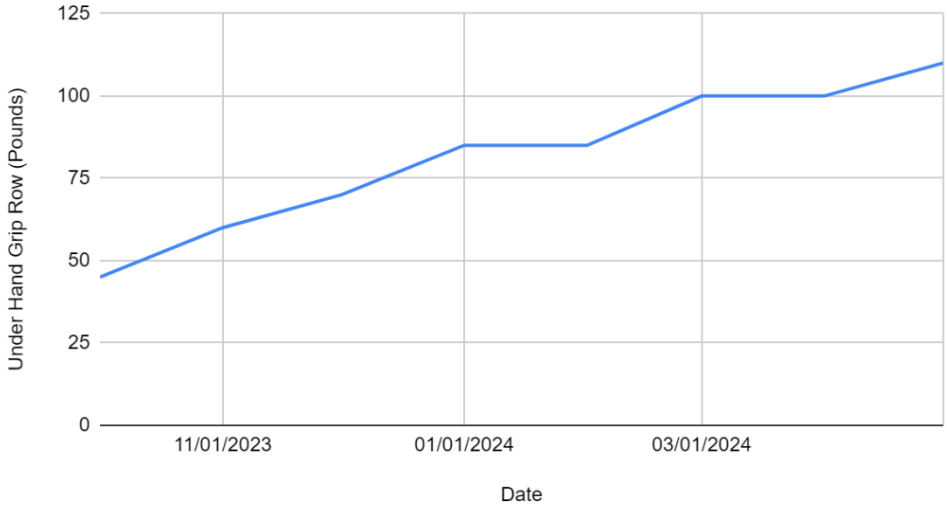


Chart 8: Back Squat vs. Date

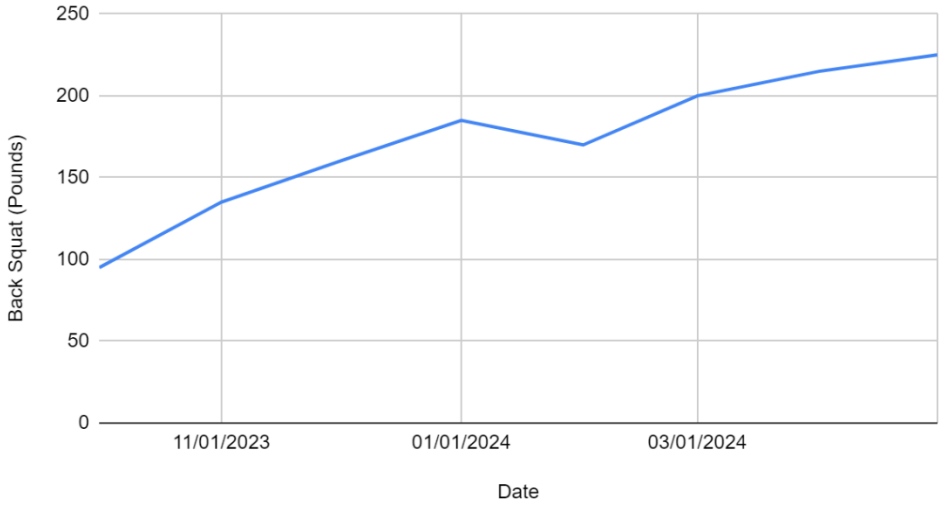


Chart 9: Leg Extension vs. Date

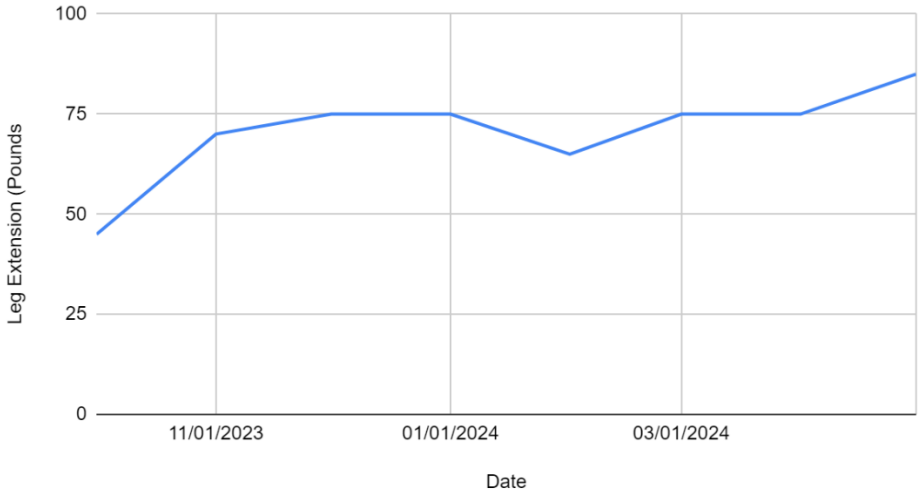
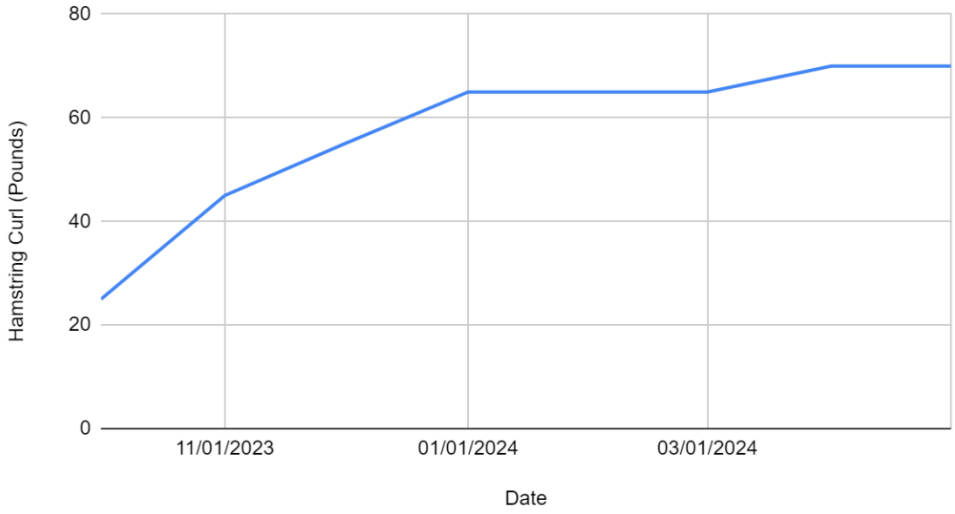
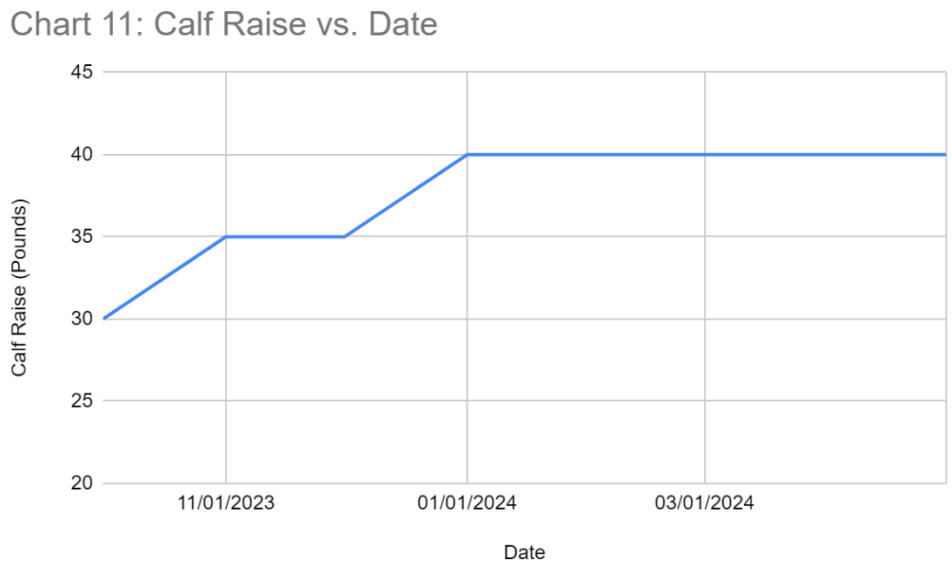


Chart 10: Hamstring Curl vs. Date





Strategies for change:

1. Participation in strength/aerobic activities at a designated location (Locations included Planet Fitness followed by PEAK Missoula)
2. Having a partner to assist in Motivation and Drive
3. Monthly strength/ weight assessments to reduce mental strain/ fatigue/ injury risk
4. Participate in Nature-based activities/ exercises on weekends to improve morale and motivation

Effect of change:

- **Body Mass Index**: Through this Quality Improvement project Participants noted a Decrease in BMI from 31.5 to 29.5.
- **Strength**
    - Upper Body
        - Dumbbell Bench Press: Increase in 25 Pounds
        - Dumbbell Shoulder Press: Increase in 15 pounds
        - Lateral Shoulder Raises: Increase in 10 pounds
        - Lat Pull Down: Increase in 60 pounds
        - Under Hand Grip Row: Increase in 65 pounds
    - Lower Body:
        - Back Squat: Increase in 130 pounds
        - Leg Extension: Increase in 40 pounds
        - Hamstring Curl: Increase in 45 pounds
        - Calf Raise: Increase in 10 pounds

Lessons learned:

1. Sustainability: Taking on a quality improvement project that required drive, commitment, and consistency was an undertaking and at times depending on the rotation/ season was more difficult to Sustain. What I found effective was having a motivating partner to complete these activities with and also creating variety within the program.
2. Injury Recovery: Throughout this experience the physicality of the quality improvement led to some strains in the musculature when the limitations of the muscle strength was pushed. This caused some set backs in terms of short term improvements but taking the time to heal rather then continuing the brutality led to increased long term gains

3. Objective data vs Subjective data: Throughout this process it was noted that objectively there was a decline in BMI. While this should directly correlate with a incline in the subjective opinion of self it was noticeable that this was more of a waxing and waning opinion. It taught me that the subjective note of self appearance should not be a highly weighted factor but rather the subjective opinion on the completion of activities of daily living such as Hiking, Strength when playing tug of war with a Dog, or ability to move furniture up flights of stairs should be weighted more heavily.
4. Facilities Matter: Having spent time exercising in a multitude of locations including but not limited to Nature, Planet Fitness, and PEAK I learned that the facility/location of exercise can directly impact your ability to exercise. For example Planet Fitness only had Smith Machines for the exercise of Back squat. This directly impacted range of motion for the exercise and comfortability with the lift so the weight able to be lifted was severely impacted. When transferring to a free squat rack at PEAK there was a dramatic rise in back squat weight as not only was more comfortable but there was an ability to increase the load.

QI PROJECT
Author: Talia Sopp, MD
Project Title: Decreasing time spent after clinic hours on notes

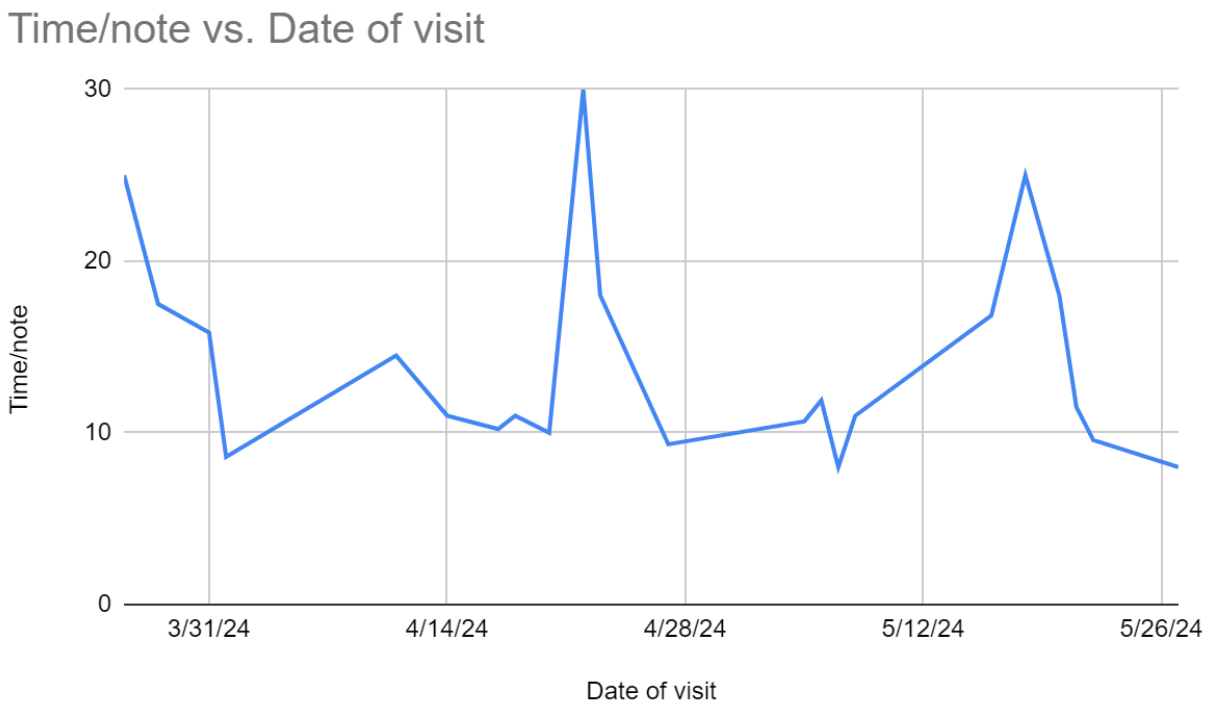
Problem: Though I enjoy my primary care clinic, I am often overwhelmed with a backlog of notes by the end of my clinic day and I find myself spending more time charting at home than I would like. I would like to avoid taking work home with me as much as possible, and feel less burdened in clinic by the backlog of notes.

Aim of the project: My aim for this project is to identify strategies and develop habits to reduce the time I spend on notes outside of my assigned clinic hours.

Key Measures for Improvement: Time spent on notes after clinic.

Process of gathering information: I used an app called Simple Time Tracker to track the amount of time I was spending on patient notes outside of my clinic hours. I did not include time spent on notes in the exam room or between visits/precepting if it was for notes for the same day. I also noted what strategies I used each day to try to reduce note time.

Analysis and interpretation: Because the amount of time I spent on notes after clinic depended on the number of visits I had that day and the number of no-shows as well, I changed my parameter to time per note (after clinic). On average, I spent 14 minutes on each note after clinic, with min and max times ranging from 8-30 minutes. The graph below is a representative snapshot of data collected throughout the year.



As you can see, the time per note varied greatly day to day, and while I hoped to see an overall downward trend of time per note as I progressed in the year, that was not the case.

While I did intermittently track which strategies I was using to reduce note time (for example, copying forward old notes, using templates, finishing the HPI in the room, writing the A&P immediately upon leaving the room, using Dragon

to dictate, and staying at clinic at work until I finished notes), I struggled to consistently apply each strategy, which made tracking their effects more difficult.

Though I do not have the data I was hoping to acquire to support it, I did, subjectively, find the following strategies most helpful. 1) Typing the HPI while I was in the room, including only the most pertinent parts so I was not taking my focus away from the patient interaction to type, and not going back to it afterwards. 2) Using templates for common chronic conditions/presentations that I could pull forward to keep track of monitoring and avoid repeating my work in future notes (for instance, for diabetes). 3) Briefly outlining the steps of my plan in the few minutes after the visit, which was often sufficient for the entirety of my A&P unless there was significant diagnostic uncertainty. 4) Finishing the notes at the end of the day, the same day of the visit, rather than at a later date.

Lessons learned: In the midst of a busy clinic day, it was somewhat challenging to collect data and apply strategies for reducing note time consistently. In an ideal world I would be able to apply one strategy at a time for all clinic visits over several weeks to understand the effects of each individual intervention. While this project prompted me to think more specifically about how I was using my clinic time and seek advice from my seniors and attendings about strategies, I did not gather the type of data I was hoping for.

QI PROJECT
Author: Cassandra Wammen, MD
Project Title: Animal Interaction Guided Wellness

Problem: My goal is to address and better improve resident mental health by looking at ways in which one can interact animals to better aid in alleviating feelings of burnout and by decreasing stress.

Aim of the project: In order to decrease feelings of burnout, I will spend 7 hours per week with my support bunny Chester between December 2023 and May 2024. I will measure burnout on a monthly basis.

Key Measures for Improvement: The U Penn Authentic Happiness Inventory was used to measure feelings of happiness and wellbeing after engaging with Chester. Thousands of people have taken the test online, with an average score of 3.24 out of 5.

-https://www.authentichappiness.sas.upenn.edu/user/login?destination=node/423

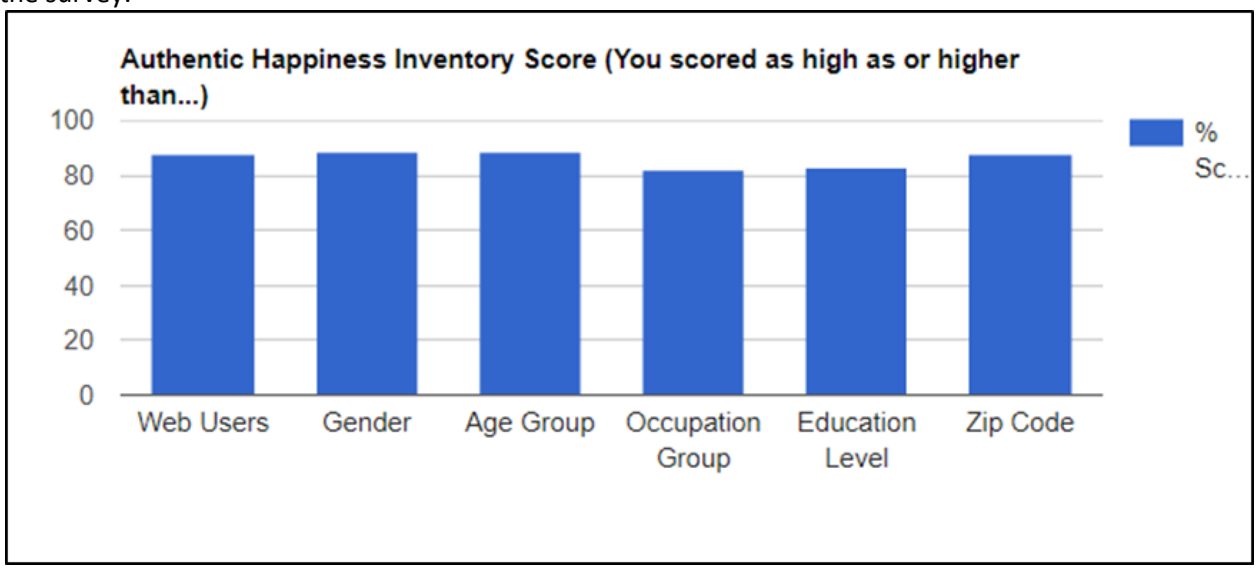
Process of gathering information: By utilizing the U Penn website, I was able to take several assessments, one per month, to gauge where my "Happiness Inventory" was landing.

Analysis and interpretation: The data collected over 6 months was averaged, as displayed below:

Score Range: 1 to 5
Authentic Happiness Inventory: 3.75
Authentic Happiness Inventory Score: As high as or higher than other web users.

My lowest score was 82%, that reflects I scored higher than 82% of other people in my occupation who have also taken to survey.

My highest score was 89%, that reflects that I scored higher than 89% of people in my gender group who have also taken the survey.



Label	% Score
Web Users	88
Gender	89
Age Group	89
Occupation Group	82
Education Level	83
Zip Code	88

Strategies for change: The survey results were promising in showing my overall happiness ratings after spending time with my rabbit and further shows the effectiveness of having a rabbit as an emotional support animal that can aiding in stress relief and improvement of mood.

Effect of change: I think if other health professionals also had a support animal at home, it could help decrease the rates of burnout that so heavily impact physicians and other healthcare workers as a whole.

Lessons learned: I further learned the importance of setting aside time each week to bond with an animal, such as my bunny Chester, to help in restoring my energy, drive and wellbeing.

QI PROJECT
Author: Alexis Ziebelman
Project Title: The Early Bird Catches the Worm

Problem: Residency is well known for being a time where one has very little control of their time and nearly no flexibility. Of those years, intern year is perchance the one where that is most true. Even in my most busy times of life, creating time to engage in activities that are fulfilling has given me more energy and overall improved my work ethic and effectiveness and my well-being as a person. In the beginning of residency I found myself mentally planning to engage in these activities at the end of the work day but more often than not found myself at work longer than intended or too mentally exhausted to complete the theoretical plan I had made. There were too many variables at the end of the day that could potentially cause my plan to go awry and I wanted to find a way to alter this course.

Aim: I aim to wake up earlier and do an activity that brings me joy prior to beginning the work day. By doing so I expect to feel more grounded in who I am as a person in intern year.

Key Measures for improvement: At the end of each of the days that I do wake up early and set time aside for something I enjoy I will answer the following question: Do I feel that my day was made better by doing so? Possible answers were reduced to "yes" or "no" with the option to record an explanation for the reason if desired.

Process of data gathering: Throughout the year I tallied if the answer to the stated question was "yes" or "no." The simplicity of the information collection to a simple tally-mark allowed for a large sample size to be collected as there did not feel like a large barrier to overcome. Yet the ability to make a comment on why I marked as I did that day allowed me to feel like there was a level of nuance I could record if I desired, but that it was not required with each entry. I collected data throughout the year to ensure many data points. Informally I also noted trends in how my answer changed with different months.

Analysis and interpretation: I successfully collected many data points in the primary question I was investigating. By an overwhelming majority the days that I woke up early and engaged in an activity that I enjoy I felt my day was made better by doing so. There were only 6 days out of 123 data points collected where the answer was no.

Based on the data collected I concluded that it is most certainly worth waking up a little earlier to have that guaranteed time doing something I enjoy.

Strategies for change: On the days I completed a pre-work joyful activity I ended my day feeling grounded and happy that I had done so. If I were to continue this study I would do further sub-analyses. I had aspirational thoughts of performing secondary analyses on if there were trends based on inpatient compared to outpatient rotations, seasonal differences, social compared to solo, athletic compared to creative. While not enough quantitative analysis was performed on these potential subdivisions there are qualitative assessments I can suggest in reflection.

Effects of change: My strategies for change were quite effective. By creating time before work I was able to ensure I actually engaged in activities that bring me joy. There were far fewer variables or excuses to prevent me from engaging. I ended those days by feeling at peace with how I used my time and with more flexibility and grace for what I do after work. I found myself less fixated on what I would do at the end of the day and more able to adapt to others plans and desires which allowed me to be more social and meet more people after moving to a new place. Often my morning was filled with a physical activity I enjoy. This helped me to sleep better at night and eat well throughout the day.

Lessons Learned: Waking up earlier than you are required in residency felt like a daunting task and I did not know if by doing so I would be making myself feel more energized or more depleted. I had a feeling that it would be energizing based on some similar experiences in medical school, however it was by no means a given.

In the first few months of the academic year it felt easier to rise early and exercise; the sun had already risen and it was notably cooler than other times in the day. This helped to get me onto a sleep schedule where I transitioned to going to

sleep earlier and therefore was able to wake up earlier without cutting my hours of sleep. I think this gave me good momentum in heading into the darker months. In the colder months my morning activity was almost always climbing at the gym before work. On reflection there were some unintentional benefits to that gym time: (1) I made new friends with the few, regular 6 am climbers who have become some of my best climbing partners, (2) the quiet of gym in the morning compared with afternoon chaos was calming and made it feel less overwhelming to go in even if I wasn't feeling my best.

Another unintended benefit was increased time to connect with family and friends in different time zones. The 5-6 am range in Missoula seemed to be an ideal time to catch my east coast contingent as well as my friends in Israel and Europe. In addition to this being a time that shockingly worked for all parties, it also was a time where being on the phone did not take away from engaging with the time and place at present.

Notably on inpatient rotations it was a harder task to wake up early. Needing to be ready to go at 06:00 meant that for any activity before that I would really need to wake up before 05:00 and the gym does not open until 06:00 so in the colder times this was less compelling. The type of activity based on weather was notable for something outdoors if it was pleasant (and the roads were not icy) whereas in the dead of winter the activity was almost always inside. In January I returned to making ceramics, a creative outlet that I enjoyed in medical school a great deal, and that also started to be a wonderful peaceful morning creation time. I did not find a notable difference if my morning activity was physical exercise or a creative endeavor.

FMRWM Faculty

Brett Bell, MD

Darin Bell, MD

Ellen Bluett, PhD

Leah Carlburg, MD

Rob Cruikshank, MD

Samantha Greenberg, MD

Kerry Haney, PharmD

Emily Heid, MD

Amy Matheny, MD

Elizabeth Paddock, MD

Christi Richards, MD

Jen Robohm, PhD, MPH

Rob Stenger, MD, MPH

Trent Taylor, MD

Jeff Walden, MD

Emma Wright, MD

Faculty Scholarly Activity

FMRWM SCHOLARLY WORK **FACULTY**

Name: Brett Bell, MD, MPH

CONFERENCE PRESENTATIONS

Project Title*: Saying No Gracefully - Addiction Medicine Network Meeting, Red Lodge MT*

Details of the project: Presented to the Addiction Medicine Network annual meeting, a state network of addiction professionals from around the state, on strategies for navigating difficult conversations with patients. Auigust 17 2023

Outcome: Success, presentation was well received

Reflections: next time, would like to make sure I block off sufficient time to attend both the meeting and the pre-meeting CME

Project Title*: Success Stories and Lessons from Treating Opioid Use Disorder in the Hospital Setting - Addiction Medicine Network Meeting, Red Lodge MT*

Details of the project: Presented to the Addiction Medicine Network about my work in educating the inpatient hospitalist teams at St Patrick Hospital on improving care for patients with opioid use disorder and transitioning patients to medications for opioid use disorder.

Outcome: Success

Reflections: I presented with some other physicians practicing addiction medicine in the inpatient and outpatient settings and I enjoyed hearing ideas from them about how they educated the medical community in their areas about treating opioid use disorder with buprenorphine

Project Title*: Updates on Medication Assisted Treatment for Opioid Use Disorder - Team Training for Transformation Meeting*

Details of the project: Provided education for the T4TT meeting, November 3 2023

Outcome: Success

Reflections: I was surprised at the hostility towards medication assisted treatment from some of the addiction counseling professionals, although I was taken aback by this, I think I handled it professionally and kindly.

OTHER PRESENTATIONS

Project Title*: Care of the Hospitalized Patient with Opioid Use Disorder*

Details of the project: Friday Morning Medical Conference, Western Montana AHEC, September 15 2023 - presented on the evidence behind initiation of medications for opioid use disorder in the hospital as well as recommendations on improvement in care for patients with opioid use disorder.

Outcome: Success, there was a lot of engagement in the presentation

Reflections: I'd like to find a way to more formally implement some of these recommendations, perhaps as a hospital QI initiative. This was also a lot of work to put the evidence together

***Project Title**: Care of the Hospitalized Patient with Opioid Use Disorder, Nursing Eduction*

Details of the project: Presented on optimal evidence-based care for patients with opioid use disorder in the hospital setting from a nursing perspective. St Patrick Hospital Nursing Education Series - November 11, 2023

Outcome: Success, presentation was well received

Reflections: I find it hard to gauge audience engagement in a topic over zoom

***Project Title**: Treatment of Alcohol Use Disorder in Primary Care*

Details of the project: This was a presentation for ongoing provider education lunch series at Bitterroot Health in Hamilton, MT - April 18, 2024

Outcome: Success, presentation was well received and participants were engaged in the presentation

Reflections: it is much easier to engage an audience when you can be present in person

***Project Title**: Treatment of Opioid Use Disorder in Primary Care*

Details of the project: Presentation for provider education at the Confederated Salish & Kootenai Tribes Tribal Health clinic in St. Ignatius, MT - April 16 2024

Outcome: Success, people were engaged in the presentation and there was a lively discussion afterwords.

Reflections: I enjoyed collaborating with Dr. Coram to meet the needs of the tribal health clinic

***Project Title**: Street Design and Pedestrian Safety: Public Health Implications of the Built Environment*

Details of the project: Friday Morning Medical Conference, Western Montana AHEC, May 3, 2024 - presented on the relationship between street design, pedestrian/bicyclist safety and physical activity and discussed how small changes in the built environment have a large role to play in both injury prevention and promotion of physical activity

Outcome: Success

Reflections: I enjoyed reviewing the evidence supporting street design, walkability and physical activity since I wrote my MPH thesis on a similar topic.

GRANT LEADERSHIP

***Project Title**: Primary Care Training and Enhancement - Co-Investigator*

Details of the project: I am a co-investigator for the PCTE

Outcome: Ongoing

Reflections: This has been an enjoyable collaboration between multiple people in the residency, I have enjoyed contributing to the development of this project as well as providing education on addiction medicine topics to our rural partners.

LEADERSHIP OR PEER REVIEW ROLE

***Project Title**: Open Aid Alliance Board of Directors*

Details of the project: I serve as a member of the board of directors of the Open Aid Alliance, a local harm-reduction organization in Missoula

Outcome: ongoing

Reflections: This has been an opportunity to learn about nonprofit management, I wish I could do more to help the organization, but my time is stretched pretty thin right now.

Project Title*: Bike Pedestrian Advisory Board*

Details of the project: I volunteered to join the Missoula County Bike Pedestrian Advisory Board, a citizen advisory board made up of pedestrians and bicycle riders who formally advise the city council on projects and concerns about pedestrian and bicycle rider safety

Outcome: Ongoing

Reflections: I enjoy contributing to the community in this way, I also feel like it allows me to advocate for my patients who may not be able to afford a car or be able to drive due to a disability.

FORMAL COURSES

Project Title*: Using Buprenorphine to Treat Opioid Use Disorder*

Details of the project: Presentation as part of a continuing education course for the University of Montana School of Pharmacy - Recent Drug Developments Continuing Education Program - March 3, 2024

Outcome: presentation was a success

Reflections: Enjoyed collaborating with the School of Pharmacy, hopefully it will be in person next year!

Project Title*: Curriculum Development for Family & Community Medicine rotation*

Details of the project: Ongoing work on curriculum development and refinement of the Family & Community Medicine rotation – a longitudinal family medicine clinic and community medicine rotation

Outcome: Ongoing

Reflections: working as part of a team is great, I also really see how the accountability systems Emma and I have developed for each other are helpful and keep us on track

FMRWM SCHOLARLY WORK **FACULTY**

Name: Darin Bell, MD

PEER REVIEWED PUBLICATIONS

Project Title*: A Typology for Rural Training; Randal Longenecker, Darin Bell, Davis Patterson*

Details of the project: There is a need for standardization in the classification and nomenclature of different types of rural training models in residency education. Standardization allows for more consistent collection and comparison of research data when evaluating effectiveness of rural training and outcomes. It also allows for comparison of training processes for students to use when evaluating and selecting residency programs.

Outcome: Submission declined by initial journal. Reformatted and resubmitted to a second journal, with 3 subsequent revisions based on editorial comments. Awaiting response.

Reflections: Model is now in use by the RTT Collaborative and is being used as the framework for several rural research grant applications. Learning patience with journal review processes.

CONFERENCE PRESENTATIONS

Project Title*: Building Something New with Old Friends: Community Engagement in Program Development and Maintenance. Darin Bell, MD; Randy Longenecker, MD; Amanda Vaglia, DO*

Details of the project: Presentation at RRPD 2023 Annual Grantee Meeting, September 12, 2023. Objectives: Identify friends, stakeholders, and resources in your local community to engage for development of a residency program; Generate ideas for initial engagement to develop support around residency teaching and program development; Develop ongoing engagement and relationship strategies for sustaining and growing programs, and addressing challenges over time

Outcome: Successful presentation with audience engagement, participation, and idea generation

Reflections: The value of community partnerships and engagement is high for small rural training programs in order to maximize their effectiveness and success.

Project Title*: The Emerging Landscape of Rural Residency Training: Defining ProgramTypes and Assessing Their Value. Darin Bell, MD; Randy Longenecker, MD; Davis Patterson, PhD*

Details of the project: Presentation at RTT Collaborative Annual Meeting, April 11, 2024 . Abstract: Investments in diverse rural residency training options are growing. Important differences in rural training experiences include residency location (rural or urban) and degree of resident participation in rural training (e.g., through a “track” or elective rotations). Experts and board members of The RTT Collaborative have developed a framework that defines six types of residency programs based on rural training configurations and rural practice yields. In this session, we describe the typology and invite feedback from session participants. We also describe a study to quantify the number of each program type in family medicine, the distribution of resident positions by type, and the yield to rural practice for graduates of each type.

Outcome: Successful presentation with a packed audience and lively discussion.

Reflections: There is both a need and interest in rural education focused research and ways to quantify efforts across the country.

GRANT LEADERSHIP

***Project Title**: PI: Enhanced Rural Access and Training*

Details of the project: 5-year HRSA Sponsored Primary Care Training and Enhancement – Rural Training in Primary CareGrant. Projects focused on nine HRSA identified areas of need and additional program specific training needs. Includes development of new rural curricula for residents (Rural Continuity Clinic, Rural Intensive Track, AI Healthcare track), rural site and faculty outreach and development, recruiting efforts, and specific training advancements.

Outcome: Completed year four of the five year grant. All major projects developed and completing pilot year of implementation. Collecting large amounts of data for future projects and research opportunities. Beginning data analysis.

Reflections: Hurdles remain when working with outside partners. Projects require ongoing time, attention, and resources to continue to refine and ensure optimal operation. Each effort has developed a series of new potential opportunities.

LEADERSHIP OR PEER REVIEW ROLE

***Project Title**: Associate Director/Medical Director: Rural Medical Training Collaborative*

Details of the project: The RTT Collaborative is a national non-profit organization, focused on developing and supporting rural training programs in medical school and rural residency programs, while helping connect students interested in rural training with those programs focused on rural healthcare.

Outcome: Filled position for over 2 years and helped the organization grow and develop in numerous ways. Recently resigned from position due to time constraints.

Reflections: Learned about the benefits of working on a national scale to help rural training and education. Also reevaluated the importance of time and resources to ensure that projects are done well and do not become overwhelming.

***Project Title**: Co-Chair – Rural Collaborative: Society of Teachers of Family Medicine.*

Details of the project: Collaborative within STFM bringing together people interested in rural medicine and training.

Outcome: ongoing

Reflections: recruited new co-chair this year to help think about directions moving forward for a largely disengaged group.

***Project Title**: Board Vice-Chair – Simulation in Motion, Montana*

Details of the project: Montana non-profit mobile simulation training organization. Travels to rural and remote areas of the state to provide high fidelity simulation training for EMS services, clinics, hospitals, and educational institutions.

Outcome: ongoing role

Reflections: organization continues to navigate logistics and challenges of providing training opportunities that are otherwise not available or cost prohibitive for rural healthcare professionals.

FORMAL COURSES

***Project Title**: Rural Medical Training Collaborative Annual Meeting*

Details of the project: Worked with a team to organize the Annual Meeting of the RMTC. A national meeting bringing together rural medical educators from across the country. The spring 2024 meeting was hosted in Asheville, North Carolina, adding logistical challenges of planning an event across the country.

Outcome: Success - another record attendance with over 225 participants from across the country. Improved processes for planning and production of future meetings

Reflections: This is the second year with highly positive feedback. Significant process improvements in planning were implemented, and notes taken on process to ease the planning for future years.

Project Title*: Rural Residency Consultant Learning Community*

Details of the project: Worked with a team to facilitate a learning community of current and new consultants for rural residency programs. Project designed to develop and encourage consultants to increase education opportunities for new and developing residency programs in rural locations or with a rural focus.

Outcome: Third and final year completed with 16 participants in the cohort. Program to be retired after this year due to funding limitations.

Reflections: Self-directed learning communities provide some unique logistical challenges to continue running effectively for extended periods. The program was valuable but could have benefitted form increased guidance and direction from experts in the field.

Project Title*: FMRWM Rural Retreat*

Details of the project: Organized an annual regional meeting for rural medical and health educators in Montana.

Outcome: Disappointing registration resulted in last minut change to virtual programming.

Reflections: A variety of factors likely contributed to decreasin attendance over the last few years. Working on ways to improve outreach to partner rural institutions in a fashion that better serves their needs and capabilities.

Project Title*: Rural Program Directors University*

Details of the project: Completed the second cohort of a monthly learning community of rural residency leadership across the country. Designed to supplement other learning opportunities for those new to rural residency education with topics focused on rural specific issues.

Outcome: successful completion of cohort 2. began recruitment of cohort 3, with limited interest.

Reflections: Self-directed learning communities require significant efforts to continue engagement, enthusiasm and interest. Could likely use more direction and guidance from content experts and more formalized curriculum.

Project Title*: Life Support Courses: ACLS, PALS, AWLS*

Details of the project: Helped teach Life support courses for residents, attendings, APPs, nurses, and pharmacists, at both FMRWM and partner rural sites.

Outcome: Success.

Reflections: Good courses - will continue to provide

OTHER

Project Title*: Rural Residency Consulting Program - RMTC*

Details of the project: Helped coordinate consultations for rural residency programs through the Rural Medical Training Collaborative. Consults focus primarily on design and development for new and developing rural residency programs.

Outcome: ongoing process as new programs request consultations.

Reflections: Coordination and provision of consultations is a highly time intensive process, and working with sponsoring institutions to navigate contracting for consultations requires patience and perseverance. The process can be months long (or even years) of development without arriving at a final agreement.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Ellen Bluett, PhD

PEER REVIEWED PUBLICATIONS

1. **Blanchard BE*, Bluett EJ*,** Johnson M, Zimberoff A, Fortney JC.(May 2024) Trauma exposure correlates among patients receiving care in federally qualified health centers. Journal of Traumatic Stress. doi: 10.1002/jts.23055. Epub ahead of print. PMID: 38743483.

***denotes co-first authorship**

2. Journal of Contemporary Clinical Trials (accepted)
   Title: Sequenced Treatment Effectiveness for Posttraumatic Stress (STEPS) Trial: A Protocol for a Pragmatic Comparative Effectiveness Trial with Baseline Results
   Corresponding Author: Dr John Fortney
   Co-Authors: Debra L. Kaysen; Charles C. Engel; Joseph M. Cerimele; John P Nolan; Erin Chase; Brittany E. Blanchard; Stephanie Hauge; Jared Bechtel; Danna L. Moore; Ashley Taylor; Ron Acierno; Nancy Nagel; Rebecca K. Sripada; Jacob T. Painter; Bryann B. DeBeer; **Ellen Bluett**; Alan R. Teo; Leslie A. Morland; Patrick J. Heagerty

PUBLICATIONS

1. ***Project Title:*** **Bluett, E. J** (October 2024). The screener that saves lives. *Montana AFP journal.*

   Details of the project: Article published in the Montana AFP magazine. The article reviewed the use of the CSSRS to assess risk for suicide.

CONFERENCE PRESENTATIONS

1. **Bluett, E.J.,** and Schleichler, H. (February, 2024). Health Behavior Assessment and Intervention Codes. Presented for the Montana Healthcare Foundation Integrated Behavioral Health initiative. Presentation was given virtually.
2. **Bluett, E.J.** (September, 2023). From Wellness to Flourishing. Clinical Innovations Lecture and Discussion at the 44th Annual Forum for Behavioral Science in Family Medicine in Milwaukee, Wisconsin.

OTHER PRESENTATIONS

3. **Bluett, E.J.** (June, 2023). IBH Clinical Skills. Co-led a two-hour clinical intensive at the Integrated Behavioral Health Summit at the Meadowlark Conference held by the Montana Healthcare Foundation. Helena, MT.
4. **Bluett, E.**J., (April 2024). SBIRT for Eating Disorders. Led a 1 hour workshop/didactic for Lewistown, MT providers.
5. **Bluett, E.**J., (April 2025). SBIRT for Eating Disorders. Co-led a two-hour clinical intensive for the PHC behavioral health staff on disordered eating screening and treatment in primary care.

GRANT LEADERSHIP

Project Title: **Sequenced Treatment Effectiveness for Posttraumatic Stress**

University of Washington Department of Psychiatry & Behavioral Sciences

Division of Population Health

Details of the project: I am the Site PI for the coordination and implementation of PCORI funded "Comparative Effectiveness PTSD Trial of Sequenced Pharmacotherapy and Psychotherapy in Primary Care*"* at our community health center. The primary aim of this study is to learn whether providers in primary care clinics should recommend medications or written exposure therapy to treat posttraumatic stress. In addition, for patients who do not respond to the first treatment, we want to determine what treatment providers should recommend next.

Outcome: Recruitment is closed. We have published the first of many papers for this study. Outcome data will be available July 2024. TBD on results.

Reflections: Wow! Doing a real life research project in primary care is difficult for many reasons. We struggled to get buy in from the clinic to a) screen patients for trauma and b) remember the study. I think that a one question trauma screener would benefit all patients and providers to providing a broader understanding of the patients life and how this might relate to their physical health complaints. We have a long way to go and I think this study will move the needle and highlight the importance of considering trauma in the primary care environment.

Project Title: **SBIRT for Eating Disorders**

Details of the project: I am the site co-PI to oversee and implement a supplemental awarded through the PCTE (Primary Care Training Enhancement) grant to train primary care providers in screening, brief intervention and referral to treatment for eating disorders. The goal is to expand awareness, knowledge and skills of eating disorders and treatment in the primary care environment.

Outcome: Drs. Jen Robohm, Ellen Bluett and Sarah Potts completed a train-the-trainer with Caitlin Martin Wager for the screening and treatment of eating disorders in primary care. We have conducted several trainings including:

BH staff: (2) 2 hour trainings on SBIRT and CBT-E for eating disorders.

Residents: Mini-theme day completed. Very positive feedback from attendees

Faculty Development: Conducted 1 hour training for faculty on SBIRT for eating disorders

Rural Sites: Completed 1 hour training for Lewistown providers.

Reflections: There was strong interest in this topic amongst our residents and providers. I am grateful we had the opportunity to learn about the SBIRT screener for eating disorders and have the resources to be trained by an expert in our community.

LEADERSHIP OR PEER REVIEW ROLE

Project Title: Elected Co-Chair of the WWAMI Behavioral Scientist Committee

Details of the project: I will co-chair the WWAMI Behavioral Scientist network with Dr. Emily Traupman this year and chair it in 2025-2026.

Outcome: TBD

Reflections: Excited to be in this role.

Project Title*:* University of Washington Practice Research Network (WPRN)- Steering Committee Member

Details of the project: WPRN is an incredible resource/learning environment for WWAMI programs. I am serving on the steering committee (year 3) providing feedback and input on practice based research projects.

Outcome: Will continue to sit on the committee. I love participating in this committee, it is a very practical way to engage in research without the heavy lift of doing your own original study.

Reflections: I find this to be a very valuable role in my continued pursuits to engage in research/scholarly work.

FORMAL COURSES

Project Title*: CBT-E training*

Details of the project: I am in the process of completing an online training on cbt-enhanced for eating disorders.

Outcome: In progress.

Reflections: It is hard to find patients in primary care that are interested and willing to engage in treatment for an eating disorder.

Name: Leah Carlburg. MD

OTHER PRESENTATIONS:

Project Title*: MCI to ACP: Practical Dementia May 15, 2024*

Details of the project: Didactic session

Outcome: TBD

Reflections: I want to work on my skills in didactics in the future. I think there are definite skills in effective teaching that I want to gain.

OTHER:

Project Title*:* Clinic Quality Improvement Work-HIV

Details of the project: I have taken on the care of patients with HIV at Greater Valley Health Care associated with the Ryan White HIV Care grant. I am working with clinic staff on a QI project to assess and evaluate our HIV management in primary care.

Outcome: In process

Reflections: I am learning lot about the QI and clinic processes.

Project Title*:* Clinic Quality Improvement Work-Refugee Care

Details of the project: Developing and supporting processes for refugee care at GVHC

Outcome: In process

Reflections: Brand new project

Project Title*:* Curriculum Development-FCM

Details of the project: Working to overhaul FCM curriculum to reflect changes in our community.

Outcome: In process.

Reflections: I will be interested to see how the new curriculum is received by the residents. Will also need to ensure that the curriculum changes meet requirements of ACGME

Project Title*:* Curriculum Development- Geri/Pal Med

Details of the project: Our prior Geri/Pal Med/long term care curriculum was not functional. After discussion with residents, staff, community stakeholders and financial staff, I decided to take on primary medical care for 12 patients at our local SNF/LTC as well as start to build a home visit practice. Our residents and I will care for those patients together.

Outcome: Starts in August. In process.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Robert Cruikshank, MD

CONFERENCE PRESENTATIONS

Project Title*: STFM Poster:* More POCUS! Further incorporation of point-of-care-ultrasound at the Family Medicine Residency of Western Montana.

Co-authored with E. Paddock, T. Caramore, and S. Greenberg

Details of the project: We used a team based monthly scavenger hunt theme to increase familiarity of residents and faculty with use of POCUS.

Outcome: Residents and faculty had increased use and confidence in using POCUS. The team based scavenger hunt theme help drive participation. The poster was presented at the 2024 STFM annual meeting in Los Angeles.

Reflections: Increased exposure to POCUS has been really helpful to feeling more comfortable and confident with this. Time constraints in clinic are challenging. A mix of dedicated time for POCUS training and clinic based practice is a good model for training.

Quality Improvement Project

Project Title*:* **Family Medicine Clinic Field Note Process Evaluation and Improvement Project.**

Co-authored with E. Wright, K. Haney, T. Caramore, J. Hall

Details of the project: The quantity of field notes per resident is often sparse and delayed outside of a timeframe when it would be most actionable and is not always well-aligned with milestones. We wanted a more robust understanding of the needs (both those of the program and residents) we are trying to meet with field notes. Faculty and resident surveys were used to evaluate our current system and gather input on the desired future state of field notes.

Outcome: Many residents requested more frequent feedback and more timely feedback, at the end of the clinic when possible.

Reflections: Consider ways to create planned time and space for giving feedback in person. Consider ways to reduce barriers to writing field notes and prompting cues for milestone specific feedback Specific and actionable feedback that is aligned with milestones should be given when possible. As a program, we need to determine whether field notes are intended to be a place to document formative feedback, summative feedback, or both. Our next steps for field note improvement will be impacted by the program's decisions about incorporating EPAs and CBME, as well as any changes that we may make to the remediation process as our needs for this specific type of feedback will likely evolve based on these broader changes.

Educational seminar: Game Day Simulation

Details of the project: 60 students from a variety of training programs including FMRWM residents and UM athletic training and paramedic students participated in a 4 hours simulation. We had four different stations which re-enacted various on field and off field medical scenarios with rapid response teams composed of a mix of professional program trainees.

Outcome: Students really appreciated the simulated scenarios that gave them an opportunity to test their skills and also learn from students with other training backgrounds.

Reflections: Consider how to duplicate this with other training scenarios that would work well for mixed professions student teams. It would be ideal to be able to have 3 different scenario themes that we could cycle through once every 3 years.

Name: Samantha Greenberg, MD, MPH

CONFERENCE PRESENTATIONS

Project Title*: Primary Care for the Peripartum Patient*

Details of the project: Oral presentation at Montana Academy of Family Medicine Winter Conference in Whitefish, MT 1/24/24

- Pregnancy related care is often not a scope of care non-obstetrics providers feel comfortable or confident providing. As a family physician that does OB, I find I am often asked by non-obstetrics providers about care of patients in the primary care setting that happen to be pregnant. The aim of this presentation as to highlight common presentations during pregnancy that primary care providers may encounter and provide tools to increase confidence. Additionally, this presentation was designed to highlight the high-risk or non-to-miss diagnoses that are specific to pregnancy and post-partum that primary care providers may be less familiar with

Outcome: Overall, presentation seemed well received and was also published with AudioDigest for their CME content. Also presented to medical staff at Greater Valley Health Center.

Reflections: I think this would be a high yield didactic presentation in the future

Project Title*: Setting Families up for Success: Treatment of Opiate Use Disorders in Pregnancy*

Details of the project: Oral presentation at Montana Perinatal Association annual conference in Pray, MT 4/25/24

- Person-centered pregnancy care is a passion of mine, especially how that can be applied to marginalized patients/populations.

Outcome: Presentation well received. Served as an opportunity for me to pursue further education on evidence-based practices of caring for patients/families experiencing SUD in pregnancy

Reflections: Hope to use this as a catalyst to continue to strengthen of clinic's care of SUD and position ourselves to be a referral resource for patients in our area. Completed several CME courses on the topic prior to giving this presentation

Project Title*: When Everything is Not Fine: Addressing Peripartum Mood and Anxiety Disorders*

Details of the project: Oral presentation at Montana Perinatal Association annual conference in Pray, MT 4/24/24

- Increasing awareness of and incorporating care for peripartum mood and anxiety disorders into my clinical practice has been a large focus of mine over the last 5 years including pursual of my peripartum mental health certification through Postpartum Support International in 2022. Being able to present at a state conference on this topic and highlight the resources in our state was a culmination of this work.

Outcome: The presentation was well received and following this I was invited to give a talk on the same topic at the Montana Maternal mental Health Annual conference sponsored by Healthy Mothers, Healthy Babies this fall

Reflections: I hope to find avenues to continue to elevate this topic both on a local and larger scale

***Project Title**: More POCUS! Further incorporation of point-of-care-ultrasound at the Family Medicine Residency of Western Montana*

Details of the project: Poster presentation at STFM in Los Angeles, CA May, 2024. Joint project with Dr. Paddock, Caramore, Cruikshank

- Poster presentation on our prior year's QI project

Outcome: Lots of traffic at our poster, many programs experiencing similar needs

Reflections: Appreciative to be part of a well organized group with a successful and manageable project and opportunity to present at a national conference

OTHER PRESENTATIONS

***Project Title**: Mastitis: A New Treatment Protocol*

Details of the project: Presentation at Logan Health OB Grand Rounds 11/16/23

- Breastfeeding medicine continues to be a clinical focus and place where I am focusing my own education over the last 5 years. I often care for patients who received non-evidence based care for mastitis. In 2022 new evidence based protocols were released. This presentations aim was to bring forward this educational resource

Outcome: I was glad to have the opportunity to present.

Reflections: This would be a good didactic topic. I continue to have a passion for creating a referral based breastfeeding medicine practice through GVHC and create a lactation elective for residents to participate in. Continuing to consider pursuing my IBCLE

OTHER

***Project Title**: MotherLove Podcast: Longitudinal Continuity of Care and Building Trust Over Time*

Details of the project: Guest speaker on MotherLove: A Podcast about Motherhood Season 3, Ep 19 on 2/26/24

- Shared some of my personal journey with peripartum anxiety as well as my approach as a care provider when caring for patients and families affected by peripartum mood and anxiety disorders

Outcome: Success! My first foray into personal story telling and talking about my care psychosocial in a social/non-academic space

Reflections: I was honored to be invited to speak among other women and care providers that share a passion with me. Speaking in this forum really provided a confidence boost in this work and make me realize my work as paid off!

FMRWM SCHOLARLY WORK **FACULTY**

Name: Kerry Haney, PharmD

LEADERSHIP OR PEER REVIEW ROLE

Project Title*: College of Health IPE Steering committee, member*

Details of the project: This committee is comprised of health training program unit representatives across UM/Missoula College. The group works to foster collaborations on campus for IPE training of students and coordinates workgroup efforts to develop IPE activities.

Outcome: This group has been successfully working together since 2016 to meet unit accreditation standards relating to IPE, sustaining efforts, and continuing to revise and develop new training opportunities.

Reflections: Serving as a representative for FMRWM and a past committee co-chair

Project Title*: College of Health IPE didactics workgroup, co-chair*

Details of the project: This workgroup aims to create and offer IPE training opportunities in the didactic portion of curricula.

Outcome: This group has been successfully working together since 2016 to meet unit accreditation standards relating to IPE, sustaining efforts despite global pandemic, and continuing to revise and develop new training opportunities.

Reflections: We will be managing leadership transitions and updating offerings for AY 23-24

Project Title*: Journal Article Peer Reviewer – Family Medicine*

Details of the project: Article entitled 'Toward a Professional Identity as a Faculty Developer: A Qualitative Assessment of Key Factors and Considerations'

Outcome: The article required major revisions and required two rounds of review.

Reflections: *I enjoy the opportunity and experience of peer reviewing articles.*

FORMAL COURSES

Project Title*: IPE Practice Skills – 1 credit*

Details of the project: This course was redeveloped and offered synchronously via Zoom for Spring 2024. It was a collaboration with MSU, UM and AHEC.

Outcome: We successfully re-envisioned and revised the course to offer it to UM/MSU students.

Reflections: AHEC is offering a stipend to course coordinators to offer IPE training experiences for AHEC scholars. Course offerings will be continued to be revised now that using Zoom rather than online modules or f2f format.

Project Title*: Friday Morning Medical Conference - 1 credit*

Details of the project: This seminar course is hosted by Western MT AHEC. Students from a variety of health professional disciplines are enrolled each semester.

Outcome: Successfully offered since 2018. An option for UM AHEC scholars to complete annual requirement for certificate completion.

Reflections: Collaborations with WMT AHEC have continued to be successful to offer college level credit for attending and participating in class discussion and post-class reflection.

Project Title*: Annual Fall and Spring IPE seminars*

Details of the project: These 3 hour learning activities have been offered since 2018 on the UM campus. We typically have students from several university systems in Western Montana attend either in-person or virtually to participate. Student numbers have ranged from 130-250 students from 6-7 disciplines.

Outcome: These trainings are a large UM collaborative effort by the IPE didactics group and hosted by the COH and MTGEC. They continue to be a unique training opportunity in our state.

Reflections: As the pandemic ended, this year we transitioned from offering trainings solely virtually to a hybrid model again.

CURRICULA

Project Title*: Game Day Simulation training*

Details of the project: Faculty from FMRWM, AT and Paramedicine worked over 9 months to plan and develop an interprofessional Game Day sim training. 55 learners participated in the afternoon. 4 stations – Heat Illness, C spine injury (field management), Respiratory arrest s/p C-spine injury (Sim trucks), and cardiac arrest.

Outcome: Formal and informal learner feedback has been highly positive. Faculty are interested in future collaborations on additional trainings. The group is interested in presenting the training at a national conference

Reflections: By bringing faculty highly experienced in simulation together and finding common high yield topic areas for the afternoon, we were able to increase the scale of sim trainings on campus and offer a rich learning experience where learning was happening across disciplinary boundaries.

QUALITY

Project Title*: Field Note Faculty QI project*

Details of the project: Faculty workgroup developed a tool to evaluate current resident and faculty perspectives about our field note system. The survey was disseminated and data was collected and reviewed.

Outcome: The field note process is being reviewed and data has been informative for the program. The project is on-going and next steps will be to work as a program to revise field note process.

Reflections: We found the data collection was interesting – especially resident comments. There were some key differences between faculty views and resident desires for improved feedback.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Emily Heid, MD

CONFERENCE PRESENTATIONS

Project Title*: Shoulder Shortcuts. Presentation at the MAFP conference 1/25/24 in Whitefish, MT*

Details of the project: I was invited to speak on an MSK topic in primary care. I chose shoulder as shoulder pain is a common presentation in clinic and the residents find it somewhat difficult.

Outcome: Successful

Reflections: I continue to work on my public speaking skills.

LEADERSHIP OR PEER REVIEW ROLE

Project Title*: Peer Reviewer for the journals of the AOFAS (American Orthopaedic Foot and Ankle Society)*

Details of the project: I volunteered in 2019 after a request went out for more reviewers.

Outcome: Work in progress

Reflections: I have found this activity to be very helpful in making me a more critical reader of literature. I learn something new on every review.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Amy Matheny, MD, MPH

PUBLICATIONS

Project Title*:* Founding editor for the MAFP magazine, *Montana Family Physician* (2019 to present)

Details of the project: As editor of *Montana Family Physician*, I coordinate and edit content for this quarterly communication of the Montana Academy of Family Physicians. Editions highlight Montana family medicine clinical, policy, and practice management updates and the MAFP's work and value to members.

Outcome: We have completed 17 editions thus far with great feedback from MAFP members on the value of this regular communication from the chapter with updates relevant to our specialty across Montana.

Reflections: This has been a great project with which to stay engaged with MAFP and provide value to my fellow family physicians across the state.

CONFERENCE PRESENTATIONS

1) Project Title*:* "Navigating the CDC and IAS-USA PrEP Guidelines", University of Montana Hepatitis C ECHO, Missoula, MT, 8/15/23

Details of the project: I was asked to present on the topic of PrEP for this statewide ECHO program with a focus on Hepatitis C and HIV care and prevention. The audience was a mix of health professionals, from primary care providers to public health nurses and beyond. Individuals were in attendance from across Montana, and for some this was new information. The goal was to cater the presentation to meet the needs of those educating patients about PrEP to those treating patients as well.

Outcome: The presentation is new archived on the University of Montana Hepatitis C ECHO website for ongoing educational access for participants.

Reflections: This has been a great way to give back to ECHO programs that have otherwise supported my in my HIV and Hepatitis C knowledge. I was able to translate some information from the ECHO presentations I have seen to a practical summary for those who may be less familiar with PrEP previously.

GRANT LEADERSHIP

1) Project Title*:* Western Montana Area Health Education Director

Details of the project: I have served as the director of WMT-AHEC since July 2021, where I serve as the PI of multiple grants related to our work, including our core AHEC grant as well as additional supplemental grants. The work of AHEC spans career awareness programs, AHEC Scholars certificate program for health professions students in training, coordination of the Missoula WWAMI program, Continuing Education programming, Behavioral Health Workforce Education and Training program, Regional Health Equity Taskforce and Leadership, and various other supports for health professions students and professionals in practice. A major focus for WMT-AHEC in the past year especially has been the development of additional programming in the realm of health equity and DEIB, including a pilot student mentoring program based in health equity, a student stipend program, and various statewide partnerships and projects addressing cultural safety and maternal health in Indigenous birthing people. This includes collaborative efforts with Drew Babcock at FMRWM and our training for faculty and residents in Spring/Summer 2024.

Outcome: This has been a very enriching organization of which to be a part which help extends my own contribution to health professions workforce development beyond my day-to-day work in the residency. I work with an excellent staff

who are passionate about all of their individual realms and who contribute in countless ways to enhance health professions training in our region and health equity in our communities.

***2) Project Title**:* Co-Primary Investigator for the HRSA PCTE-RTPC Grant (Primary Care Training Enhancement – Resident Training in Primary Care)

Details of the project: I have continued as a co-PI on this grant awarded to FMRWM from HRSA. This is a five-year, 2.5 million dollar federal grant funding a variety of initiatives to enhance and expand training that supports rural as well as American Indian and Alaska Native populations, including research into curricular impacts on future practice patterns (7/2020 to present).

Outcome: Our grant team has had a number of successes in this project, including successful pilot and implementation of our rural continuity clinics as well as our Rural Intensive and American Indian Health Tracks. The addition of Drew Babcock on to our residency team through this grant has enhanced our relationships and service to AI/AN communities in Montana, including with collaboration with the WMT-AHEC team. Our program's ability to expand simulation training, ultrasound equipment, and other training opportunities have been funded through this grant's activities. We have also started to evaluate the data of our various surveys of residents, graduates, and employers to start to understand trends of the impact of our program curriculum.

Reflections: The FMRWM PCTE-RTPC grant has been an exciting opportunity to explore the work of a HRSA grant and to partner with University of Montana faculty from other departments to work on research questions and future scholarly work. We are learning a lot about our program impact while expanding learning opportunities in the process.

LEADERSHIP OR PEER REVIEW ROLE

***1) Project Title**:* Montana Academy of Family Physicians Board of Directors, Secretary-Treasurer 23/24

Details of the project: As a long-time board member and past chapter president, I have continued to remain engaged with the Montana Academy of Family Physicians through the Board of Directors as an officer this year. I also continue to serve as editor for the MAFP Magazine, *Montana Family Physician*. I have also worked on various advocacy issues from the state to national level, and work to support leadership development and education content for MAFP members.

Outcome: I have been an engaged member of the Board with minimal missed meetings over the years, working to continue to support leadership development within our board for the future.

Reflections: I have been involved with the MAFP Board since 2013 and hope to continue involvement with the Board and MAFP magazine. I hope to find additional ways to be involved in family medicine advocacy at the state and national level.

OTHER

***Project Title**:* Didactics Co-Coordinator

Details of the project: Through my role as a co-coordinator on the Didactics team, I continue to work to build our program's overall didactics curriculum, including Simulation training, Theme Days, and other content.

Reflections: This is a realm of constant growth and change as we continue to work to deliver a high-quality, hands-on, and adult-learner approach to didactics.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Elizabeth Paddock MD, FAAFP

CONFERENCE PRESENTATIONS

1. Guidelines Update 2024: Applications to Primary Care. *Montana Academy of Family Physicians Annual Winter Conference. Whitefish Montana. January 2024.*
2. More POCUS! Further Incorporation of Point-of-Care-Ultrasound. **Paddock E,** Greenberg S, Cruikshank R, Caramore T. *Poster Presentation at STFM annual meeting May 2024 (Los Angeles).*
3. Quality Improvement at FMRWM: A longitudinal QI curriculum that fosters resident and faculty engagement and wellbeing. **Paddock E**, Bluett E, Greenberg S. *Poster Presentation at the University of Washington Family Medicine Department Fair and Scholarship Forum. April 2024 (Seattle).*

Giving formal presentations allows me to become somewhat of an expert in the topic. Poster presentations are great opportunity to share to cool things we work on at FMRWM!

OTHER PRESENTATIONS

FMRWM Journal Club: POCUS in Acute Dyspnea. September 2023.

Article: Point-of-care ultrasonography in patients with acute dyspnea: An evidence report for a clinical practice guideline by the American College of Physicians. Ann Intern Med 2021;174(7):967-976.

PEER REVIEW ROLE

FPIN Peer Review for Help Desk Answers

September 2023 Reviewed: Are diets rich in unsaturated fats associated with decreased average fasting serum insulin concentrations in obese adults living in the United States?

Current status is "incomplete"

In my role as a reviewer for FPIN I am sent HDA submissions to review. I like this work because it pushes me to think about scientific writing, and how to translate and present data in an understandable format.

FORMAL COURSES

FMRWM Point of Care Ultrasound Course. Co-chair.

2 day introduction to point of care Ultrasound. August 2023. Missoula MT

This is a 2 day robust introduction to POCUS.

This is always an enjoyable course with eager engaged learners. For 2023 we made several updates to the course that were well received.

OTHER

1-FMRWM Faculty QI Projects. Leadership and coordination role.

After a successful first year of faculty QI projects we are continuing these. Time is protected during faculty meeting for groups to work on their projects.
This remains a great way for FMRWM to work on projects within our strategic goals.

Projects this year include inpatient POCUS, Advocacy curriculum, feedback for residents during/after precepting and screening for perinatal mood and anxiety disorders.

2-Resident QI presentations. Leadership and coordination role.

Drs Bluett, Greenberg and I have continued to refine this curriculum. This year we have added some additional structure and teaching points.

Select resident QI projects are highlighted in the quarterly Montana Academy of Physicians Magazine.

3-RHEDI. Leadership/coordination role.
Leadership of our reproductive health and advocacy curricular track.

4-WPRN Survey Research Panel. As a member of the panel I receive surveys from researchers who are interested in feedback from clinicians in community-based primary care settings in the WWAMI region.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Christi Richards, MD

OTHER PRESENTATIONS

Project Title: CHF: Etiology, Presentations, and Treatment. March 19, 2024.

Details of the project: I gave this talk as part of a series of nurse education talks St. Patrick Hospital arranges. Nursing staff had specifically requested an overview of CHF management.

Outcome: Difficult to tell since attendance is almost entirely virtual.

Reflections: It was challenging but interesting for me to think about management of CHF from a nursing perspective and decide what might be relevant for me to include. It was a good opportunity for me to review the evidence around various interventions for CHF.

OTHER

Project Title: Hospital Medicine Rotation Quality Improvement work

Details of the project: Worked with other faculty hospital medicine attendings to increase formal instruction and use of POCUS during the residency hospital medicine rotation.

Outcome: Use of POCUS has increased significantly during the residents' hospital medicine rotation but we have yet to make it a useful part of everyday practice.

Reflections: POCUS in the hospital is something that seems great in theory but there are many barriers to implementing it. I am hopeful that taking small steps to use it more will increase my skill to the point that I will feel comfortable using it for diagnosis and eventually lead to a formal process for certification of competency.

Project Title: Curriculum Development

Details of the project: I have assumed responsibility for the ICU rotation and the nephrology elective. I have already compiled resources for high yield topics for residents to review prior to and during their ICU blocks. I am working with the nephrology group to develop a rotation structure.

Outcome: Ongoing.

Reflections: The ICU rotation has been quite well-established and successful, while the nephrology elective has fallen by the wayside due to turnover within the nephrology group. I am optimistic that I can use my relationships with the physicians in each specialty to improve the experience for residents.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Jennifer Robohm, PhD, MPH

PEER REVIEWED PUBLICATIONS

Project Title*:* Robohm, J., Shih, G., & Stenger, R. (Under Review). Climate change curriculum in a network of US family medicine residency programs. *Journal of Graduate Medical Education.*

Details of the project: effort to publish the findings from my MPH thesis, in collaboration with Dr. Stenger and Dr. Shih, Director of the WWAMI FMRN.

Outcome: submitted revisions from the first peer review, awaiting feedback

Reflections: it will be exciting to finally get this published!

PUBLICATIONS

Project Title*: Climate Change and Environmental Health (Position Paper)*

Details of the project: Published on the AAFP website, in collaboration with other members of the STFM Planetary Health Collaborative.

Outcome: success.

Reflections: felt good to be part of a collaborative effort to increase awareness of the health impacts of climate change.

CONFERENCE PRESENTATIONS

Project Title*:* Beczkiewitz, L., Solomon, J., Gilkey, D., & Robohm, J. (2024, April 13). *What is Happening, and Can Happen, in Environmental & Public Health in Montana*.

Details of the project: Moderated panel for the "Climate & Health in the 406 Annual Conference," sponsored by Montana Health Professionals for a Healthy Climate in Billings, MT.

Outcome: Annual conference was a success – our numbers were significantly higher this year, and we had a wide range of effective speakers, including a number of national experts.

Reflections: I'd love to get some residents to next year's meeting.

OTHER PRESENTATIONS

Project Title*:* Robohm, J. (2024, May 6). *Climate Change & Mental Health.*

Details of the project: Workshop conducted with Young Southeast Asian Leaders Initiative (YSEALI) Fellows visiting the University of Montana in Missoula, MT.

Project Title*:* Klarich, C., Robohm, J., & Cooper, R. (2024, April 10). *Case Study: The Climate Impact on Anxiety and Panic Attacks.*

Details of the project: Guest presenter for episode #13 for the "Code Green: The Climate-Smart Health Professional" Podcast. Episode written by Phoebe Cunningham and Elizabeth Whidden, produced by Natasha Sood, and edited by Liana Haigis.

Project Title*:* Robohm, J. & Roop, M. (2023, December 6). *Integrating a Climate Change and Health Curriculum into Your Residency Program.*

Details of the project: Faculty development webinar provided for the WWAMI Family Medicine Residency Network, Seattle, WA.

Project Title*:* Robohm, J. (2023, November 6). *Mental Health, Resilience, and Climate Change.*

Details of the project: Presentation for "Introduction to Climate Change" course, University of Montana, Missoula, MT.

Project Title*:* Robohm, J. & Weiss, K. (2023, October 28). *Wresting with the Psychological Impact of the Climate Crisis: Strategies to Promote Client and Community Resilience.*

Details of the project: Full-day continuing education workshop provided for mental health professionals, sponsored by the University of Montana, Missoula, MT.

Project Title*:* Robohm, J. (2023, August 28). *Personal Resiliency in the Face of Climate Change*. ***Details of the project:*** Workshop provided for a leadership retreat for sustainability professionals in the Providence healthcare system, Missoula, MT.

Project Title*:* Robohm, J. (2023, June 13). *Climate Change and Health: Preparing Patients for the Summer Ahead.*

Details of the project: All-staff training provided to medical providers at Partnership Health Center, Missoula, MT.

Project Title*:* Robohm, J. (2023, May 30). *Climate Change and Mental Health.*

Details of the project: Presentation for the "Science on Tap" series sponsored by the Flathead Lakers and Flathead Lake Biological Station, Polson, MT.

Overall Outcomes: success!

Reflections: a variety of workshops on the physical and emotional health impacts of climate change for a broad range of audiences. Opportunities to leverage my platform as a mental health provider and educator to get the word out, get others involved.

LEADERSHIP OR PEER REVIEW ROLE

Position*:* Regional Coordinator, Climate Psychology Alliance of North America (CPA-NA)

Details of the project: Help promote CPA-NA's ability in Montana to educate and train mental health professionals in climate-aware practices, foster a collaborative community of climate- and environmentally-aware mental health providers, and inform the public about the varied and layered mental health aspects of the planetary crisis.

Outcome: mixed success.

Reflections: there is reluctance among Montana's mental health professionals to get involved, but slowly gaining some traction.

Position*:* Co-Lead, WWAMI FMR Network Climate & Health Interest Group

Details of the project: Facilitating group of network faculty and residents hoping to integrate climate change and health into the family medicine residency curriculum.

Outcome: on hold.

Reflections: pleased with our faculty development workshop in December, but Melissa and I have both been involved in other projects and opportunities. Hope to get things up-and-running again soon.

***Position**:* Expert Reviewer/Faculty Advisor, Climate Resources for Health Education.

Details of the project: Working with med students, residents, and faculty to develop climate/health curriculum for CRHE, an initiative of the Global Consortium on Climate and Health Education.

Outcome: success.

Reflections: fun opportunity to meet and collaborate with learners from other parts of the country.

***Position**:* Board Member, Montana Health Professionals for a Healthy Climate.

Details of the project: Represent the behavioral health sector on the Board of MHPHC, a non-profit representing health care professionals in Montana advocating for climate action.

Outcome: remain engaged.

Reflections: a lot of progress and success in Montana in the past year, including the plaintiffs' victory in the Held v. Montana court case.

Position: Montana AHEC HealthCARE Advisory Council.

Details of the project: Semi-annual meetings to provide input regarding regional needs and strategic direction, advocate for healthcare-related legislation, and provide guidance on workforce development in rural Montana

Outcome: remain involved.

Reflections: minimal commitment, but I like to stay involved.

FORMAL COURSES

***Project Title**: Climate Change, Mental Health, and Resilience*

Details of the project: New course offered through the University of Montana's Honor College during the Spring 2024 semester.

Outcome: Just submitted final grades! Very gratifying experience.

Reflections: engaging with undergraduates was very satisfying, but prepping a new course was a lot of work. Grateful that it will take a lot less time/energy the next time around.

OTHER

***Project Title**:* Lohof, W., Holloway, N., & Robohm, J. (2024, April 6). *Introduction to Community Disaster Mental Health.*

Details of the project: Helped to plan half-day training for interested Red Cross and other volunteers in Missoula, MT.

Outcome: Successful effort to increase volunteers and have a "deployable resource" in the event of a local disaster.

Reflections: Would love to explore ways to include interested residents in these volunteer efforts, as the Red Cross is hungry for health care provider volunteers.

***Project Title**:* Blackburn, H. & Robohm, J. (2023, June 30). *Climate Change & Health Mock "Table Top" Exercise.*

Details of the project: Simulation offered in partnership with Western Montana AHEC for students in medicine, psychology, pharmacy, and nursing. Local community partners included the Deputy DES Coordinator from the Missoula County Office of Emergency Management and the Public Health Emergency Preparedness Coordinator from the Missoula City-County Health Department.

Outcome: Success.

Reflections: Great interprofessional opportunity to work with local officials to anticipate health care needs of Missoula in the event of a climate disaster.

Project Title*: The Impact of Climate Change on Montanans' Mental Health (Phoebe Bean), Increasing Nature Connection and Decreasing Climate Change Distress in an Indigenous Population: The Development of a Traditional Ecological Knowledge Intervention (Olathe Bigknife Antonio)*

Details of the project: Serve on dissertation and master's committees for doctoral students in clinical psychology.

Outcome: Success: Dr. Bean just defended successfully, and Ms. Antonio is now working on her dissertation project.

Reflections: A time-limited but important way that I have been able to stay engaged with UM's Department of Psychology.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Rob Stenger, MD, MPH

CONFERENCE PRESENTATIONS

***Project Title**: Presenter AAFP RLS Conference – Navigating a Sea of Gray – Disability Accommodations in Residency*

Details of the project: A PD colleague and I presented on Disability Accommodations to the national AAFP residency conference.

Outcome: completed

Reflections: We got good evaluations on the session, will probably do again next year!

***Project Title**: Panelist WWAMI GME Summit – State GME Councils*

Details of the project: I was a panelist at a session for the WWAMI GME Summit in April 2024 that described how different states have coordinated GME growth and expansion through formal GME councils.

Outcome: completed

Reflections: none

***Project Title**: Panelist WWAMI GME Summit – Medicaid GME Funding*

Details of the project: I was a panelist at a session for the WWAMI GME Summit in April 2024 that described how different states have utilized Medicaid GME funding to support residency programs.

Outcome: completed

Reflections: none

LEADERSHIP OR PEER REVIEW ROLE

***Project Title**: Montana GME Council*

Details of the project: I'm the current chair of the MT GME council which is a voluntary group of stakeholders in the state with a mission to promote GME expansion in Montana.

Outcome: The council remains a productive dialog among stakeholders and also a way to keep group members focused on Graduate Medical Education. The Council has been successful in obtaining and maintaining a state investment in residency training.

Reflections: There is a lot of potential GME growth in Montana in the next several years.

***Project Title**: Missoula City-County Health Board*

Details of the project: I'm the current physician board member of our city-county health board. I've been on the health board since around 2015.

Outcome: It is interesting to see and help support all of the work that the health department does.

Reflections: None, I enjoy this role! Happy to talk with anyone who wants to consider working with a health department in the future.

Project Title*: Montana Academy of Family Physicians*

Details of the project: The residency program directors are standing members of the MAFP board. I've been a board member since 2011.

Outcome: We are a small chapter and state, so this is a good way to keep tabs on what is going on with family physicians in Montana. MAFP is hiring a lobbyist this year for the first time in many years.

Reflections: None. The resident spots on the MAFP board are a pretty easy way to get involved in organized medicine.

Project Title*: WWAMI Family Medicine Residency Network Salary and Program Surveys*

Details of the project: I'm working as an advisor to the FMRN staff who conduct the salary and program surveys that WWAMI programs use for internal benchmarking.

Outcome: We produce a benchmarking survey every few years that is used by all of the WWAMI FM programs..

Reflections: Data from the FMRN is one of the best sources of data nationally on the cost of training FM residents and the structure of residency programs.

FMRWM SCHOLARLY WORK **FACULTY**

Name: Trent Taylor, MD

PEER REVIEWED PUBLICATIONS

Project Title: CPCP Publication

Details of the project: Assess the efficacy of a statewide consultation program**.** Kim R, Broaddus M, Jandrisevits MD, Taylor T, DiFranceisco W, Chayer R. Expanding Psychiatric Treatment in Primary Care Settings: Improved Care Through the Wisconsin Child Psychiatry Consultation Program. Clin Pediatr (Phila). 2023 Nov;62(11):1369-1374. doi: 10.1177/00099228231158365. PMID: 37786368.

Outcome: Published

Reflections: I would've liked to carry this to the endzone, but I didn't. It was a fascinating learning process regarding data collection and transcript writeup, and I'm grateful someone took up the mantle to get it published.

LEADERSHIP

Project Title: OB Committee Chair

Details of the project: Direct bimonthly committee meetings regarding resident experience in the OB curriculum and incorporating resident feedback

Outcome: Ongoing

Reflections: Could use help creating agendas. This may be a good thing for 2 faculty to be in charge of together, or dividing curriculum and committee, in the future.

QUALITY IMPROVEMENT

Project Title: **Advocacy Curriculum Development**

Details of the project: Survey faculty/residents/staff regarding advocacy. Explore the role of an advocacy curriculum at FMRWM. Identify resources to utilize in a curriculum. Outline potential curriculum for implementation at the beginning of next year.

Outcome: Ongoing

Reflections: Still unclear of next steps for implementation/publication, but would like to turn this into a poster after it is implemented for our residents

OTHER

Project Title: **OB Didactic Learning**

Details of the project: Create and implement a semi-formal curriculum to improve quality and quantity of didactic learning performed on the OB Floor

Outcome: Ongoing.

Reflections: Continues to be rewarding and challenging. If I were to get there earlier may be convenient for residents but I don't want to get up any earlier than I am. Residents seem appreciative of the teaching, and would be great to expand to more faculty and/or MFM teachers on a consistent basis

FMRWM SCHOLARLY WORK **FACULTY**

Name: Jeff Walden, MD, FAAFP

SCHOLARLY ACTIVITY

Walden J. "Memory Sticks: A Humorous Review of Medical Training."

Fam Med. 2023;55(9):625-626. October 2023

LEADERSHIP

1. AAFP CGHI – Center for Global Health Initiatives Advisory Group.

   Selected to national Global Health group to help guide AAFP's direction in Global Health

FORMAL COURSES

1. Title: FMRWM Point of Care Ultrasound Course.

   Co-lead with Elizabeth Paddock MD. 2 day introduction to point of care Ultrasound. Aug 2023

   This is a 2 day robust introduction to POCUS. This is always an enjoyable course with eager engaged learners.

2. Title: Wilderness Medicine Curriculum
   Ongoing wilderness life supports weekend 3 times a year, including Advanced Wilderness Life Support every 18 months. This includes 2 – 4 Wilderness Medicine focused didactics per academic year as well.

3. Director, Integrative and Lifestyle Medicine Track

   Oversees two-year track for residents interested in alternative and complementary

   medicine as well as lifestyle medicine for themselves and their patients. Coordinated through the University of Arizona Weill Center for Integrative Medicine.

4. Project Title: Life Support Courses: ACLS, PALS, AWLS

   Led group of other faculty to help teach Life support courses for residents, attendings, APPs both in our residency and CSKT personnel

OTHER

1.East African Tropical Medicine Course Selectee, January 2024

Makerere University, Kampala Uganda/University of Minnesota

2.Board Member, Institute for Health and Humanities. University of Montana

FMRWM SCHOLARLY WORK **FACULTY**

Name: Emma Wright, MD

PEER REVIEWED PUBLICATIONS

Project Title: **What are effective interventions for recurrent yeast vaginitis?**

Details of the project: Help Desk Answer done during the faculty development fellowship. Citation: What are effective interventions for recurrent yeast vaginitis? Barker, Eve; Shepherdson, Nikole; Wright, Emma *Evidence-Based Practice.* 26(12):17-18, December 2023.

Outcome: Published.

Reflections: This was a lengthy process and not one that I would necessarily pursue again.

OTHER PRESENTATIONS

Project Title*: Getting Beyond "Are you sexually Active?" Tools for Effective Discussions about Adolescent Sexuality.* March 6, 2024.

Details of the project: Part of the adolescent health theme day this year which I coordinated. Covers important components of sexual history for adolescents. It is important to have a methodical way of understanding this topic.

Outcome: Success. Well-received based on resident feedback.

Reflections: It has been interesting to present this several times and to update it each time. I appreciate that the resident audience pushes me to be thoughtful about my approach to some of these topics. It is also humbling to reflect on how hard it is to translate the theoretical framework to my actual visits with teens.

Project Title*: Motivational Interviewing to Reduce Pediatric BMI*

Details of the project: Journal Club presentation of the article: "Outcome of BMI2: Motivational Interviewing to Reduce BMI Through Primary Care AAP PROS Practices." Authors: Resnicow K, Delacroix E, Sonneville KR, et al. *Pediatrics*. 2024;153(2):e2023062462

Outcome: Success. Prompted interesting discussion.

Reflections: It can be challenging to know what to do with the results of a study that suggests that an intervention is NOT helpful, especially when it is common practice and there is not evidence for specific alternatives.

OTHER

Project Title*:* **Clinic Quality Improvement work**

Details of the project: Ongoing work with the QI team at PHC and multiple small workgroups on clinic improvement. Recently did "White Belt Training" for the LEAN process for improvement. We are preparing to transition to a new EMR which has been a major focus (evaluating different EMRs and working through the approval process).

Outcome: Ongoing.

Reflections: This work remains so important and so challenging in the setting of such a complex organization even with a well-developed framework for quality improvement.

***Project Title**:* **Curriculum Development**

Details of the project: Development of the Family and Community Medicine rotational curriculum including goals and objectives, scheduling guide, rotational overview, and individual curricular activity descriptions. This year, I have spent significant time developing a tracking tool for all of the various data points we need to report to the ACGME and how we plan to meet those requirements. Plan to present work at an upcoming STFM or RPS conference once we have data after first year of implementation of the new curriculum. .

Outcome: Ongoing.

Reflections: Helpful to work with a team.

***Project Title**:* **Precepting Improvement**

Details of the project: Motivated to improve our precepting processes. Solicited information from residents and faculty on ways that we can improve our precepting processes. Created updated precepting rules document.

Outcome: Ongoing.

Reflections: Continue to think about ways to do faculty and resident development on precepting and clinical reasoning tools. Has been difficult to get community preceptors engaged in ongoing development.

***Project Title**:* **Field Note Improvement**

Details of the project: Worked with faculty QI group to develop and administer a survey to residents and faculty to provide input on improvements to feedback process utilizing fieldnotes.

Outcome: Ongoing. Continuing to review options for revision of the field note form.

Reflections: It was interesting to see the overlap in the goals and priorities of residents and faculty.

***Project Title**:* **Balint Group Formation**

Details of the project: Working to coordinate a faculty and community attending Balint group based on my experience in the Balint leadership training intensive that I participated in in January 2024.

Outcome: Ongoing.

Reflections: It can be challenging to coordinate the schedules of a group of professionals outside of work time.

***Project Title**:* **PHC Teams Meetings for Residents**

Details of the project: Collaborating with nurse manager to develop structure and topics for monthly meetings with nursing staff and residents.

Outcome: Ongoing. We have had to adapt given the fact that nursing staff are not always available on Wednesday afternoons.

Reflections: Figuring out the most effective delivery method for the significant amount of information that needs to be conveyed about clinic function and teams is an ongoing process.

Faculty QI Work

QI PROJECT

Authors: Babcock, D., Bell, D., Robohm, J., Taylor, T., and Stenger, R.

Project Title: DEVELOPMENT OF AN ADVOCACY CURRICULUM WITHIN FMRWM

Problem: Advocacy is an important skill set for family physicians, particularly as our society becomes more complex, and an important tool for addressing health inequities. The ACGME also requires training and experience in advocacy. Some of our residents are engaged in advocacy around abortion care, provision of care for transgender patients, etc., and some faculty and staff are involved in activities related to American Indian health and climate change. However, we currently have no formal advocacy curriculum within our program. Consequently, we want to improve our program's advocacy training and advocacy-related outcomes measurement. We hope to develop a comprehensive plan for development of an advocacy curriculum and then begin to implement it.

Aim of the project: Develop an outline for a comprehensive advocacy curriculum for FMRWM for the 2024-2025 training year by May 2024

Key Measures for Improvement:

Completion of the following:

1. Needs assessment,
2. Review of existing literature and resources,
3. Identification of key skills and interest areas to cover,
4. Development of learning objectives and tracking/evaluation tools, and
5. Development of a curricular schedule for 2024-2025.

Once we've implemented the advocacy curriculum, we also hope to measure and demonstrate changes in the following:

1. Extent to which our residents consider advocacy-related work to be part of the role of the family physician (increase);
2. Extent to which our residents see themselves engaging in advocacy-related work once they've graduated from residency training (increase);
3. How confident our residents (and faculty?) feel about engaging in advocacy-related work (increase);
4. Perceived barriers to engagement in advocacy-related work (decrease).

Process of gathering information: We distributed a needs assessment survey via Qualtrics in January 2024 to conduct a baseline evaluation of resident, faculty, and staff attitudes, knowledge, confidence, and intention to engage in advocacy-related activities. Many of the questions in the survey were based on a Likert scale, with ratings of 1 = "None/not at all," 2 = "A little bit," 3 = "A moderate amount," 4 = "A lot," and 5 = "A great deal". We collecting data from 19/28 (68%) of our residents, 11/16 (69%) of our faculty members, and 5/10 (50%) of our staff members.

In addition, we collected relevant resources and papers from the medical literature and related resources (e.g., STFM website and library, AAFP, AMA, NRHA, RTT, GME, RHAP, and WWAMI FMRN websites and resources). We organized the resources according to focus and topic, separating them into issue-based and activity-based resources. This allowed us to identify resources that would be responsive to the identified needs and objectives of our program. Additionally, we identified resources to assist in curricular development. Finally, we also reviewed the University of Montana's advocacy-related policies and procedures.

Analysis and interpretation:

Needs Assessment

<u>Role of the Family Physician</u>

We asked respondents to what extent they consider advocacy-related work to be part of the role of the family physician. Residents indicated "a great deal" (M = 3.63), faculty indicated "a lot" (M = 3.45), and staff indicated "a great deal" (M =

3.60). Given that our residents are more convinced than our faculty that advocacy is an important part of the family physician role, it will probably be important to engage in faculty development in this area.

Engagement in Advocacy

When asked to what extent they see themselves engaging in advocacy-related work once they've graduated from residency training (or in their current position, if staff or faculty), all groups indicated that they see themselves engaging "a lot" in advocacy-related work (resident M = 3.47, faculty M = 3.00, and staff M = 3.25).

Confidence

We asked respondents how much confidence they currently feel about engaging in advocacy-related work. Residents indicated "a little bit" (M = 2.26), faculty indicated "a moderate amount" (M = 2.55) and staff indicated "a moderate amount" (M = 2.74).

Prior Training

Our respondents all reported "a little" (resident M = 2.00, faculty M = 2.27, and staff M = 1.60) advocacy-related training in the past, suggesting the importance of engaging in faculty development in addition to resident training around advocacy. Open-ended responses demonstrated that respondents' prior training usually took place in medical school (e.g., a month-long elective working with a lobbyist, advocacy-related talks, community organizing opportunities), though some respondents engaged in on-line training or training during residency. When asked what would have made their prior training more useful to them, respondents expressed interest in more longitudinal, regular training that gave them practice in applying the skills learned (vs. "one-and-done" training opportunities), and exposure to a variety of advocacy skills or tools beyond engaging with legislators.

Barriers

We asked respondents what they see as the biggest barrier(s) to their engagement in advocacy-related work, and they indicated the following (presented in order of resident endorsement):

Barrier	Resident Freq.	Resident %	Faculty Freq.	Faculty %	Overall Freq.	Overall %
Lack of time or competing priorities	19	100.0%	11	100.0%	32	88.9%
Lack of skill	11	57.9%	6	54.5%	20	55.6%
Fear of burnout	11	57.9%	4	36.4%	15	41.7%
Lack of confidence	8	42.1%	3	27.3%	12	33.3%
Lack of role models	8	42.1%	1	9.1%	9	25.0%
Personality style	5	26.3%	6	54.5%	11	30.6%
Lack of interest	4	21.1%	3	27.3%	7	19.4%
Other:	0	0.0%	2	18.2%	3	8.3%

Not surprisingly, concern about lack of time/competing priorities was almost universally considered to be a barrier to greater engagement in advocacy. Over half of residents and faculty members also endorsed concern related to "lack of skill," and over half of residents expressed concern about advocacy-related "burnout," suggesting the importance of addressing advocacy-related stress and distress in the curriculum, in addition to skills development.

Notably, two faculty members specifically acknowledged concern and confusion about the University's advocacy-related rules under "other" barriers. When we asked all respondents how well they feel they understand the University's policies as they pertain to employee engagement in advocacy activities, residents and faculty reported "a little" (resident M = 1.94, faculty M = 2.36), whereas staff members reported "a moderate amount" (M = 3.00). Clearly, we will need to integrate training specific to UM's advocacy policy as part of our advocacy curriculum.

Interest Areas

We asked our respondents what areas of advocacy are of greatest interest them, and they could endorse more than one area. They endorsed the following (presented in order of highest to lowest frequency of endorsement by our residents):

Advocacy Area	Resident Freq.	Resident %	Faculty Freq.	Faculty %	Overall Freq.	Overall %
Social determinants of health	14 (1st)	73.7%	4 (4th)	36.4%	21	58.3%
Abortion training	12 (2nd)	63.2%	6 (2nd)	54.5%	20	55.6%
Climate change and health	11 (3rd)	57.9%	6 (2nd)	54.5%	20	55.6%
Rural health	11 (3rd)	57.9%	4 (4th)	36.4%	20	55.6%
LGB health (not including trans health)	10 (4th)	52.6%	2	18.2%	12	33.3%
Family medicine expansion/investment	9	47.4%	7 (1st)	53.6%	17	47.2%
Mental health	9	47.4%	5 (3rd)	45.5%	15	41.7%
Anti-racism/JEDI work	8	42.1%	4 (4th)	36.4%	15	41.7%
Transgender health	8	42.1%	3	27.3%	13	36.1%
Medicaid expansion	8	42.1%	6 (2nd)	54.5%	15	41.7%
Refugee health	7	36.8%	1	9.1%	9	25.0%
Native American health (only)	6	31.6%	5 (3rd)	45.5%	13	36.1%
BIPOC health (more broadly)	6	31.6%	4 (4th)	36.4%	10	27.8%
Workforce development	2	10.5%	2	18.2%	6	16.7%
Telehealth	2	10.5%	0	0.0%	2	5.6%
Other: Addiction	0	0.0%	1	9.1%	1	2.1%
Other: Maternal health	0	0.0%	1	9.1%	1	2.1%
Other: Pedestrian and bicycle safety	0	0.0%	1	9.1%	1	2.1%

Given expressed concerns around time and competing priorities, it will likely be important to identify ways to integrate advocacy tools and considerations into existing curricular opportunities (e.g., didactic slots dedicated to REACH, RHEDI, behavioral health, and rural concerns), in addition to creating space for advocacy-related training.

Skills

We asked our respondents which advocacy-related skills they would like to learn more about, and they could endorse more than one area. They endorsed the following interests (presented in order of highest to lowest frequency of endorsement by our residents):

Advocacy Skill	Resident Freq.	Resident %	Faculty Freq.	Faculty %	Overall Freq.	Overall %
Providing testimony to legislators	12 (1st)	63.2%	5 (4th)	45.5%	18	50.0%
Meeting with and making "asks" of legislators	10 (2nd)	52.6%	8 (1st)	72.7%	21	58.3%
Advocating with administrators and other decision-makers	10 (2nd)	52.6%	7 (2nd)	63.6%	21	58.3%
Engaging with the media (e.g., interviews, sounds bites, "elevator pitches")	10 (2nd)	52.6%	5 (4th)	45.5%	16	44.4%
Working with others informally to address a health problem or access-to-care issue in the community	8 (3rd)	42.1%	2	18.2%	11	30.6%
Conducting educational workshops in the community	8 (3rd)	42.1%	2	18.2%	10	27.8%
Serving in/on a local, state-wide, or national organization that engages in advocacy	8 (3rd)	42.1%	1	9.1%	12	33.3%
Writing Op-Eds	7 (4th)	36.8%	6 (3rd)	54.5%	14	38.9%
Engaging in QI at the clinic or in the hospital to enhance patient access or quality of care	7 (4th)	36.8%	1	9.1%	8	22.2%

Advocating on behalf of individual patients	7 (4th)	36.8%	0	0.0%	7	19.4%
Writing Letters to the Editor	6	31.6%	4	36.4%	11	30.6%
Advocating in a public forum	6	31.6%	4	36.4%	11	30.6%
Engaging in focus groups or research with members of underserved communities	5	26.3%	0	0.00%	7	19.4%
Advocating on social media	4	21.1%	2	18.2%	7	19.4%

Open-Ended Comments

Finally, we asked our respondents for any other thoughts that they'd like to share about advocacy or the advocacy curriculum that we hope to develop for FMRWM. One resident shared that, "(they) think it's a great idea but (they) think the time barrier (lack of time/competing priorities) is significant enough that (they) can't picture (themselves) engaging in advocacy work in any significant capacity as a resident." A faculty member also suggested, "I think advocacy should be built into the regular schedule with opportunities to do additional above and beyond".

As we prepare to develop an advocacy curriculum, we were pleased to see the following comments: "Really looking forward to an advocacy curriculum!" (resident), "SO GLAD YOU ALL ARE DOING THIS!!!!!" (resident), and "Glad to see we are starting to work on this a bit more here. Lots of our residents come out of med school with passions and they sometimes get lost during the craziness of residency. I hope that with role-modeling, faculty leadership, etc., we can help keep these passions strong" (faculty).

Review of Existing Literature and Resources

Our review of the literature helped us to appreciate some of the challenges inherent in developing advocacy curricula, as well as some of the strategies that others have already employed. We learned that key topics covered in most advocacy curricula include: (1) health policy and legislative advocacy, (2) persuasive communication (e.g., media advocacy, op-ed writing, testimony and public speaking), (3) health policy and legislative advocacy, (4) grassroots advocacy, (5) community partnership, and (6) research-based advocacy. In addition, we learned that the most commonly-used learning methods for advocacy curricula include: experiential learning, didactics, small group discussions, and project-based work. We gleaned that the most effective advocacy curricula are led by resident/faculty champions, supported by protected time, and both action-oriented and responsive to trainee interests. Finally, we identified a variety of resources (e.g., learning modules, webinars, PowerPoint presentations) that will assist us in the development of our curriculum (see Appendix A).

Strategies for change: Based on the findings from our needs assessment and the literature review, we will pilot a simple advocacy curriculum in 2024-2025 that prioritizes the skills and topic areas most frequently-endorsed by our residents, and that is sensitive to the barriers identified (particularly concerns about lack of time and burnout). See Appendix B for an outline of that curriculum.

We will then utilize PDSA cycles to assess the curriculum's efficacy in achieving our desired learning objectives and to adjust and enhance the curriculum accordingly. We will continue to adapt our curriculum to the changing needs of our resident population and the evolving needs of our community and state. Importantly, we will identify faculty and resident leaders who have the time and interest to "champion" these activities, to ensure their adoption and success.

Effect of change: Once we pilot the new curriculum, we will be able to promote advocacy engagement amongst our residents and faculty and then assess the impact of their advocacy-related activities. After implementation of the curriculum, we will also be able to study continued barriers to engagement by our faculty and residents, in order to identify additional ways to boost their engagement in this essential role of the family physician.

Lessons learned: Advocacy is an ambiguous term that can refer to a variety of activities and apply to a number of interest areas. Our needs assessment survey clearly demonstrated that many of our faculty and resident physicians value advocacy, recognize that it is an important part of the physician role at all levels of training and experience, and are interested in learning more. However, these findings were incongruent with the amount of advocacy-related activity

being performed by our faculty and residents currently. Two substantial, modifiable barriers that we identified in our needs assessment survey were lack of confidence and lack of advocacy-related skills, barriers which can persist beyond residency training. By developing and implementing an advocacy curriculum for FMRWM, we endeavor to increase involvement by our faculty and residents in various forms of advocacy.

References:

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Appendix A: Advocacy-Related Curricular Resources

Introduction

- **MAFP:** https://mafp.org/page/advocacy-modules (Making an Advocacy Action Plan**)**
- **NPAF:** https://www.npaf.org/advocacy-curriculum/ (Introduction, Ethics and Principles of Patient and Health Advocacy)
- **University of Montana Lobbying policy:**
    - https://www.umt.edu/policies/browse/personnel/election-and-public-policy
    - **MCA 2-2-121:** https://leg.mt.gov/bills/mca/title_0020/chapter_0020/part_0010/section_0210/0020-0020-0010-0210.html
    - **Lucy France, UM General Counsel:** lucy.france@umontana.edu; (406) 243-6786
- **CCL:** Communicating with people of different political beliefs
    - https://community.citizensclimate.org/topics/communicating-across-the-aisle/conservatives
    - https://community.citizensclimate.org/topics/communicating-across-the-aisle/communicating-with-progressives
- **CCL:** https://community.citizensclimate.org/resources/item/19/504
- "Advocacy for Wellness" presentation from Forum for Behavioral Science
- **STFM Advocacy course (to support expansion of FM):** Learning to educate legislators; State and local advocacy; Skills: the "one-pager," the visit, and maintaining the relationship
    - https://stfm.org/advocacycourse

Health Policy and Legislative Advocacy

- **Citizens Climate Lobby:**
    - **The Levers of Political Will (Lobbying Congress, Media Relations, Grassoots Outreach, Grasstops Engagement, Chapter & Volunteer Development)**
        - https://community.citizensclimate.org/topics/lobbying-strategy/understanding-congress-basics
        - https://community.citizensclimate.org/topics/working-with-congress/lobbying-101
- **AAFP:** https://www.aafp.org/advocacy/fight/grassroots/lobbying-101.html
- **AAP:** https://www.aap.org/en/advocacy/advocacy-training-modules/ (Overview of the legislative process; working with decision-makers)
- **MAFP:** https://mafp.org/page/advocacy-modules (Preparing for legislative visits)

- **Medical Society Consortium on Climate & Health:** Weighing In on Policy: How to Testify and Provide Public Comment (PowerPoint and Recording)
- **STFM Health Systems Courses:** Advocating within your health system; Analyzing health systems data; The business of medicine; Systems and structure; Health system finance
    - https://stfm.org/facultydevelopment/otherfacultytraining/understandinghealthsystems/overview/

Persuasive Communication

- **Medical Society Consortium on Climate & Health:** Best Practices for Working with the Media (PowerPoints and Recordings)
- **Medical Society Consortium on Climate & Health:** Communications 101: How to Make the Case about Climate Change, Health, and Equity (PowerPoint and Recording)
- Advocating on social media
    - **CCL:** https://community.citizensclimate.org/topics/using-social-media/basics
    - **MAFP:** https://mafp.org/page/advocacy-modules (Using Social Media for Advocacy)
    - **Medical Society Consortium on Climate & Health:** Social Media: Getting Started and Being Strategic (PowerPoint and Recording)
- **AAP:** https://www.aap.org/en/advocacy/advocacy-training-modules/ (Advocacy communications)
- **MAFP:** https://mafp.org/page/advocacy-modules (Getting an Op-Ed Published)
- **CCL:** https://community.citizensclimate.org/topics/climate-communications/telling-compelling-stories (Telling Compelling Stories)
- **NPAF:** https://www.npaf.org/advocacy-curriculum/ (Storytelling)
- **Medical Society Consortium on Climate & Health:** Writing with Voice: Op-Eds and Letters to the Editor (PowerPoint and Recording)

Grassroots Advocacy and Community Partnership

- Working with others informally to address a health problem or access-to-care issue in the community
    - https://community.citizensclimate.org/topics/grasstops-engagement/grasstops-engagement-basics
    - https://community.citizensclimate.org/topics/grassroots-outreach/basics

Social Determinants of Health

- AAFP: https://www.aafp.org/family-physician/patient-care/the-everyone-project/health-equity-tools.html

Abortion Training

Climate Change and Health

- CCL: https://community.citizensclimate.org/topics/climate-change-science/basics (Climate Science Basics)
- AAFP: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/health-equity-toolkit/climate-change-module.pdf
- Medical Society Consortium on Climate and Health: Climate & Health Advocacy Bootcamp (https://www.youtube.com/playlist?list=PLmsUrIKadycdWwLvct7jjF9kVVWPdVlzf)

Rural Health

- National Rural Health Association: "How to Advocate for Rural Health Change" (https://nysarh.org/wp-content/uploads/2022/03/Advocacy-Guide-FINAL.pdf)
- American Hospital Association: "2024 Rural Advocacy Agenda" (https://www.aha.org/rural-advocacy-agenda)
- National Patient Advocacy Foundation: "Rural Health" (https://www.npaf.org/initiatives/rural-health/)

LGB Health

Family Medicine Expansion/Investment

- STFM Resources and Issues: https://stfm.org/about/advocacy/resourcesandissues/

    - GME, Primary Care Research, Title VII Primary Care Training and Enhancement
- STFM Talking Points: https://www.stfm.org/about/advocacy/health-systems-talking-points/
- STFM Advocacy course (to support expansion of FM): https://stfm.org/advocacycourse
    - Learning to educate legislators
    - State and local advocacy
    - Skills: the "one-pager," the visit, and maintaining the relationship

Appendix B: Proposed Advocacy Curriculum

In the 2024-25 year, we intend to pilot a formal curriculum that identifies particular didactic slots for the delivery of advocacy-related content. In addition, we plan to explore the possibility of developing more of a longitudinal curriculum that integrates advocacy content into a number of existing training opportunities (e.g., journal club, QI projects, Super-Rotation activities). If there is sufficient interest, we could also explore the possibility of an advocacy track, overseen by faculty "champions," for those residents who plan to make advocacy a significant part of their professional identity and activities (e.g., residents who would like to serve on PHC, local, or state-wide committees or in advocacy organizations such as Montana Health Professionals for a Healthy Climate, the WWAMI Steering Committee, or Montana Chapter of the Reproductive Health Project).

Key Skills and Interest Areas:

Our needs assessment indicated that our residents are most interested in the following advocacy-related skills:

- Legislative advocacy (e.g., providing testimony to legislators, meeting with and making "asks" of legislators)
- Administrative advocacy (e.g., advocating with administrators and other decision-makers)
- Community advocacy (e.g., working with others informally to address a health problem or access-to-care issue in the community, conducting educational workshops in the community)
- Organizational advocacy (e.g., serving in/on a local, state-wide, or national organization that engages in advocacy)
- Persuasive communication (e.g., writing Op-Eds)

Our plan is to cover these skills in the pilot curriculum, and then to assist our residents in applying those skills to their priority interest areas (e.g., SDoH, abortion, climate change, etc.). In addition, we plan to review the University of Montana's advocacy-related policies, since that was a clear area of concern identified by our needs assessment.

Learning Objectives:

The primary objectives of FMRWM's advocacy training curriculum are to:

1. Improve residents' knowledge of advocacy, the importance of advocacy-related work to the role of the family physician, and its importance in improving patient and community health;
2. Improve residents' use of tools and strategies for engaging in advocacy-related work on behalf of patients, service systems, and communities; and
3. Increase residents' confidence in being able to advocate on behalf of patients, service systems, and communities.

Tracking/Evaluation Tools:

We will develop tools that incorporate the Family Medicine Milestones and evaluate the following:

- Trainee perceptions and satisfaction:
    - Extent to which our residents consider advocacy-related work to be part of the role of the family physician (annual)
    - Extent to which our residents see themselves engaging in advocacy-related work once they've graduated from residency training (annual)
    - How confident our residents feel about engaging in advocacy-related work (annual)
    - Perceived barriers to engagement in advocacy-related work (annual)
- Trainee knowledge and skills acquisition:
    - Pre- and post-didactic surveys

    - Success at publishing an Op-Ed or Letter to the Editor (?)
    - Focus groups or interviews to elicit feedback from residents or stakeholders (?)
    - Provision of workshop in the community (?)
    - Engagement with community partners/stakeholders (?)
    - Testimony in front of the legislature or other decision-makers (?)
    - Advocacy-related QI project (?)
    - Super-Rotation (?)
- Trainee behavior:
    - Leads innovations and advocates for populations and communities with health care inequities (SBP2, Level 5)
    - Advocates for or leads systems change that enhances high-value, efficient, and effective patient care and transition of care; participates in health policy advocacy activities (SBP3, Level 5)
    - Describes how stakeholders influence and are affected by health policy at the local, state, and federal level (SBP4, Level 3)
    - Accesses advocacy tools and other resources needed to achieve (or prevent a deleterious) policy change (SBP4, Level 4)
    - Identifies that advocating for patient populations is a professional responsibility (SBP4, Level 1)
    - Identifies that advocating for Family Medicine is a professional responsibility (SBP4, Level 2)
    - Develops a relationship with stakeholders that advances or prevents a policy change that improves individual or community health (SBP4, Level 5)

Curricular Schedule for 2024-2025: Because the didactic calendar has already been set for 2024-2025, we will need to identify existing slots (e.g., RHEDI, REACH, EBM, Humanism, M&M, Adventure-Select, Community & Culture Retreat) in which we can integrate advocacy-related content. We propose including 4 advocacy-related didactic sessions in the coming program year, while also identifying additional places in the curriculum that we could add longitudinal curricular elements.

QI PROJECT

Authors: Sam Greenberg MD, MPH, Ellen Bluett, PHD, Amy Matheny MD, MPH

Project Title: PMADs SBIRT (Screening, Brief Intervention, Referral to Treatment) - Phase 1

Problem: Mood and anxiety disorders in the peripartum and postpartum period affect a significant number of parents with well documented adverse effects on pregnancy outcomes, outcomes on children and parents. Perinatal Mood and Anxiety Disorders (PMADs) are under-recognized, diagnosed and treated. While a majority of the literature focuses on postpartum depression, postpartum anxiety is associated with similarly documented adverse maternal and child outcomes. Expert consensus is PMADs can affect birthing people up until at least 12mo after birth. Nearly 40% of birthing people miss their routine postpartum care, which usually only extends to 6 weeks postpartum, with those more likely to forgo routine postpartum care often being the most at risk for PMADS. Additionally, current screening during routine postpartum care, even if performed ideally, is inadequate, missing diagnoses that manifest later in the postpartum period. Literature has identified screening during routine well child care as a successful and well accepted avenue to enhance screening opportunities.

While there is not consensus on the best methodology for screening, screening with tools already employed in the primary care setting reduces barriers to screening, enhancing the likelihood a screening program can be successfully implemented.

Aim of the project:

Initial Aim: To improve screening and detection for PMADS, after an educational intervention and streamlined screening process implementation, we expect a 20% increase in screening during well child visits and and a 10% increase in detection of PMADS within 3 months of the intervention.

Revised Aim: To discover how the data currently exists in well-child visits conducted by residents and faculty physicians, by first identifying the frequency of screening at 1, 2, 4, 6 month well child visits at Partnership Health Center and Greater Valley Health Center between 4/25/23 and 10/25/23.

Key Measures for Improvement: To identify the frequency of PMADs screening at 1, 2, 4, and 6 month well-child visits.

Process of gathering information: We requested a data pull from Partnership Health Center IT. Specifically, we requested a data pull of all charts over the last 6 months that included:

a) evidence of screening:

- Edinburgh or PHQ-9/GAD

b) evidence of detection

- F53.0 postpartum depression
- Puerperal psychosis F53.0
- O90.6 peripartum mood disturbance

Analysis and interpretation:

Total Well-Child Visits at PHC 4/23-10/23	Well-Child Visit with PMADs diagnosis in Chart
91	11

Of the 11 who had a PMADs diagnosis, 9 of them were coded as postpartum depression, 1 was coded as transitory postpartum mood disturbance and 1 was coded as postpartum mood disturbance. Residents were responsible for 3 of the PMADs diagnoses and faculty responsible for 8. No diagnosis was detected for puerperal psychosis. Furthermore, no postpartum anxiety was detected as there was no specific code to utilize to pull this data.

A full chart review of the 91 patients was not conducted as it was unclear how accurate this data pull would be in identifying patients that were screened during this period of time. The PHQ-9 and GAD-7 are routine screeners in the clinic and therefore maybe not the most accurate to determine if PMADs screening was conducted at a well-child visit.

Strategies for change: The initial goal was to identify how frequently patients were screened for PMADs during well-child visits and to identify which screener was most commonly used. Once this data was gathered, the goal was to implement a work flow that would require PMADs screening at all 1,2, 4 and 6 month well-child visit. The goal was to then measure whether there was an increase in PMADs identification in our patient population.

Effect of change: We were unable to detect any specific change in screening, as we only gathered baseline data at one site. We did not implement a work flow this annual year nor were we able to determine which screener was most frequently used across sites.

Lessons learned: Our initial goal to implement SBIRT for PMADs was beyond the scope of a 1-year PDSA cycle. Fortunately, were able to scale down our project and focus on gathering baseline data of PMADs in our well-child visits. It was difficult to determine the best way to gather baseline data across sites and therefore we requested a data pull that focused on diagnostic coding. We also requested data for PHQ-9/GAD-7 and the Edinburgh. These data may or may not have been recorded into the child's chart during the well-child visit, therefore we primarily focused on charts that included a PMADs diagnostic code. Unfortunately, relying on diagnostic code only identify 11/91 charts with a positive PMADs screen. It is possible that more informal screening occurred or that screening was conducted on the birthing parent but not entered into the child's chart. Therefore, the data might not be an accurate reflection of the actual frequency of screening that occurs at well-child visits at Partnership Health Center. Third, we were unable to conduct a chart review of all 91 charts to determine a) what screener was used b) when the diagnosis was made and c) how this impacted care. If our team were to conduct another PDSA cycle we might focus on the best ways to track PMADs screening in well-child visits in order to gather more accurate baseline data. A second iteration might then include an intervention to require screening at all 1, 2, 4, 6 mo visits using the same screener across PHC and Greater Valley. Lastly, a resident completed a QI project that was similar in nature and we had a difficult time syncing our projects, which might have led to improved data collection and outcomes for our PDSA cycle.

QI PROJECT

Authors: Elizabeth Paddock MD, Christi Richards MD, Brett Bell MD, Jeff Walden MD

Project Title: More POCUS! Part 2. Increasing inpatient POCUS training and hands on skill building

Problem:

Point of Care Ultrasound (POCUS) is becoming an increasingly important and useful tool in the delivery of medical care including in outpatient primary care and hospitalist medicine. The American Academy of Family Physicians (AAFP) in 2019 created curricular standards for residency training in POCUS emphasizing that POCUS is a valuable tool in these settings.

The Family Medicine Residency of Western Montana (FMRWM) has identified POCUS training as a curricular priority. However, currently residents at FMRWM do not receive much POCUS training during their inpatient adult medicine rotations, and many hospital attendings lack the skill or ability to teach them. Challenges to incorporating teaching and hands-on skill building include attending knowledge and confidence in POCUS, as well as time constraints, and at times inertia.

Currently, at FMRWM we do have a robust didactics based POCUS training, but we do not have a formal process for teaching POCUS in the inpatient setting, nor have we tracked exams residents are doing on their own.

We believe that in order to continue to grow POCUS skills at FMRWM a next step is to formalize POCUS training in the inpatient setting.

AIM of the Project:

Our aim for this project was that over a time period of 8 months we will formalize POCUS teaching for the inpatient resident team on adult medicine. Residents will have at least one teaching session of instruction in use of POCUS per inpatient rotational block by the end of this academic year.
In addition, residents will use POCUS at least once on a patient during their inpatient block.

We will achieve this by incorporating hands-on short (15-20 minute) training sessions Wednesday mornings before 9:30 patient care rounds when we (FMRWM faculty who attend in the hospital) are on service. We will utilize previously created skills workshops, as well as quizzes, presentations and other learning modalities.

We will encourage residents and attendings to use POCUS during admissions and on weekend walking rounds.

In addition a secondary aim is to help non-faculty hospitalist attendings become more comfortable with teaching POCUS. We will do this by inviting them to attend faculty POCUS training sessions, as well as offering short sessions at periodic hospitalist education meetings. We will know we met this aim if we successfully hold these sessions and other hospitalists attend.

Key Measures for Improvement:

Primary:
Did residents get any POCUS training during their adult inpatient medicine blocks?
Did residents use POCUS on a patient during their adult inpatient medicine blocks?

Secondary:
Number of hospitalist POCUS training sessions held.

Process of gathering information:

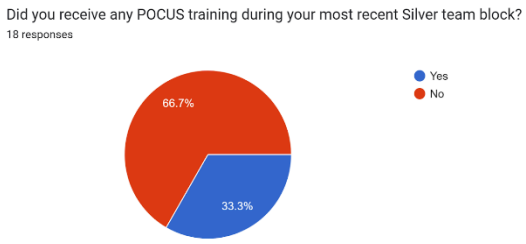
Pre-intervention: In order to get more objective data regarding if any POCUS training or use on patients is occurring we sent a very brief survey to residents who had completed an adult inpatient medicine rotation in the prior 3.5 months (July-Mid October 2023). The survey questions were: 1. Did you receive any POCUS training during your most recent adult in patient medicine block? 2. Did you use POCUS on a patient during your most recent adult inpatient block? 3. Do you have any ideas or thoughts about incorporating more POCUS training and skill building during your inpatient rotations?

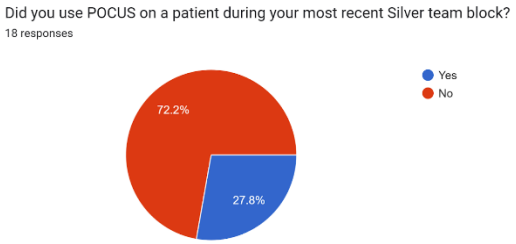
Intervention: We started our intervention October 16 2023 (the beginning of block 9 in the 26 block academic year), and at that time we added those same questions to the evaluation that residents complete at the end of each rotation.

Analysis and interpretation:

Pre-intervention: 18 of 19 residents responded to the pre-survey. This was sent out to all residents who had completed an inpatient rotation between July 1 and mid-October 2023 which was the start of our intended intervention. Prior to our intervention the majority of residents have NOT received any POCUS training (66.7%). The majority also did NOT use POCUS while on the inpatient team (72.2%).

Residents also supplied numerous suggestions on how to incorporate more POCUS teaching, as well as using the US while seeing patients.





Resident suggestions:

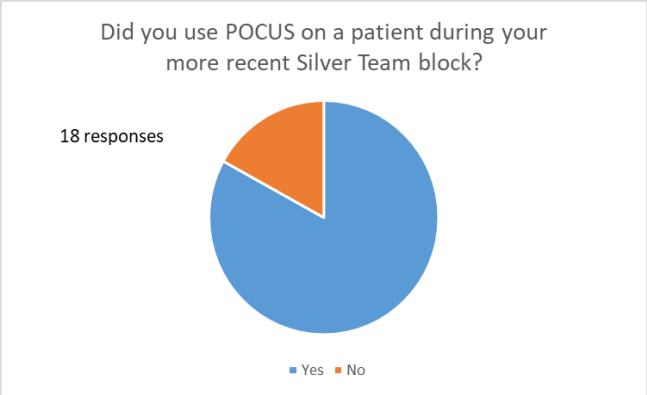
Recommendations from residents to increase POCUS on the inpatient service included:

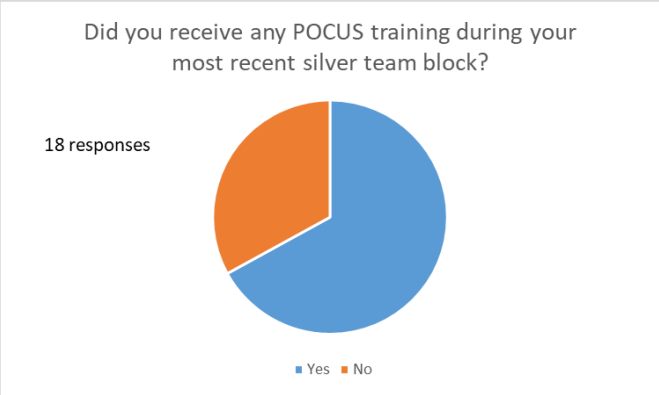
-Identify a POCUS theme for each week with a goal to scan that system.
-Ensure the hand-held US (Lumify) is brought on walking rounds. Identify in advance who should be scanned.
-At least one afternoon a week the team should plan to go scan 1-2 patients on the service. This needs to be attending and senior resident led. This needs to be required and at a set time.
-Create a scavenger hunt, have small prizes as incentives.

Post-intervention:

The final response rate was 18/40 (45%), although this was in part since first year residents received separate surveys for the first two weeks and last two weeks of their four week block, and many of them only filled out one survey for the entire four week block. In contrast, the prior survey was only sent once to each resident who had been on the inpatient service regardless of whether they spent two or four weeks on service.

After the intervention, there was a clear improvement in the number of residents who received POCUS training. 67% said they received formal training, and 83% reported using POCUS on a patient.





Hospitalist trainings:

This is a work in progress. We have completed one session for the non-faculty hospitalists and hope to continue to work on this.

Strategies for change moving forward:

- Bring handheld ultrasound (Butterfly) or Lumify on bedside rounds
- Bring handheld ultrasound to all admissions
- Formalize POCUS teaching as a regular part of the weekly schedule of learning activities (resident chalk talks, Friday Morning Medical Conference, Case Conference, Journal Club, etc)
- Continue regular training for hospitalist attendings and hospitalist faculty to improve familiarity and comfort with POCUS
- Incorporate activities like POCUS scavenger hunts or challenges with prizes to incentivise participation

Lessons learned:

- Change in daily routines on the inpatient service, such as incorporating POCUS into patient evaluation, should preferably be attending lead. Residents commented that it was more difficult for them to motivate their peers.
- Despite a focused push by motivated faculty, there were still struggles to incorporate POCUS into a busy inpatient teaching service.
- Takeaway challenges:
    - Time
    - Equipment (e.g. limited battery life of tablet)
    - Energy and motivation (both attending and resident)
    - Team coordination
    - Attending and resident familiarity with using POCUS to answer clinical questions that arise in the inpatient setting

QI PROJECT

Authors: *E. Wright, K. Haney, T. Caramore, R. Cruikshank, J. Hall*

Project Title: Family Medicine Clinic Field Note Process Evaluation and Improvement Project

Problems: The quantity of field notes per resident is often sparse and delayed outside of a timeframe when it would be most actionable and is not always well-aligned with milestones.

Rationale: We have a programmatic requirement of faculty to submit one field note per precepting shift. These expectations are not always being met. It is unclear whether or not the current field notes are valuable for residents. Entrustable Professional Activities (EPAs) are a newer ACGME requirement and we will need some way to measure these. Faculty advisors feel that there is a lack of information for advising and CCC, especially milestone specific information.

Aim of the project: We hope to develop a more robust understanding of the needs (both those of the program and residents) we are trying to meet with field notes. Faculty and resident surveys were used to evaluate our current system and gather input on the desired future state of field notes with a target of 60% of faculty and residents completing the survey.

Key Measures for Improvement: Improve understanding of resident satisfaction with the field note process. Understand barriers to faculty completing them. Better understand advisor perspectives on helpful feedback from clinic time to better inform advising/CCC.

Process of gathering information: An online survey of 13 questions was sent to faculty and 11 questions to residents. We received an 80% response rate from faculty and 45% response rate from residents.

Analysis and interpretation:

Faculty Survey - Most complete field notes during or directly after the precepting shift. Stand out or disappointing resident performances were most likely to trigger field notes. Remembering and finding time were the most common barriers. Lots of variability in whether post clinic debriefing was happening and in how likely preceptors were to communicate the content of field notes to residents. Lack of time, privacy, and planning were the most common barriers. Ideas for improving the timeliness of post clinic feedback included creating protected time and private space for this and setting an expectation that it would happen. Many preceptors felt that feedback could be improved if New Innovations was more user friendly with less time spent navigating. Faculty felt that specific and descriptive field notes were most helpful for assigning milestones.

Resident Survey - No residents were very satisfied with the timeliness of field notes. Most were somewhat satisfied or neutral.

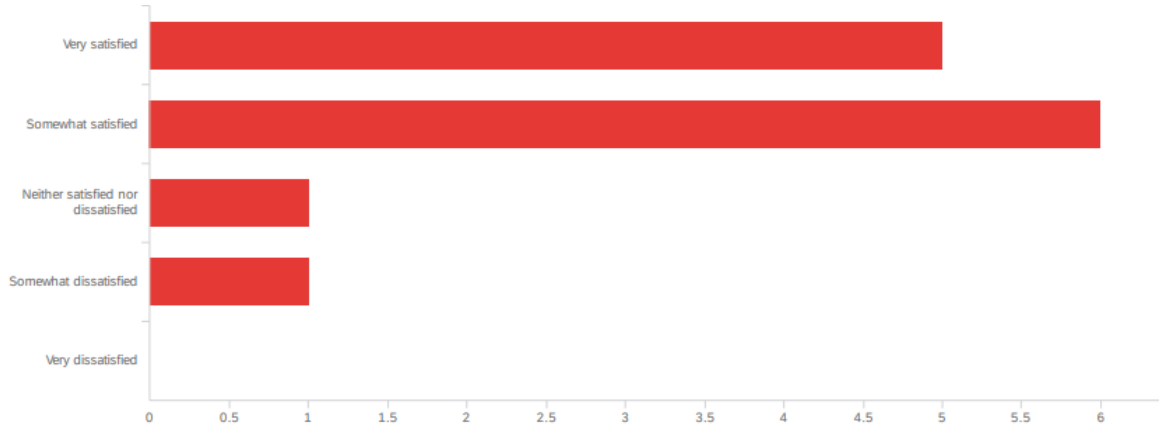


Figure 1. Resident satisfaction with the quality of preceptor feedback. Resident satisfaction with the quality of feedback from field notes was high.

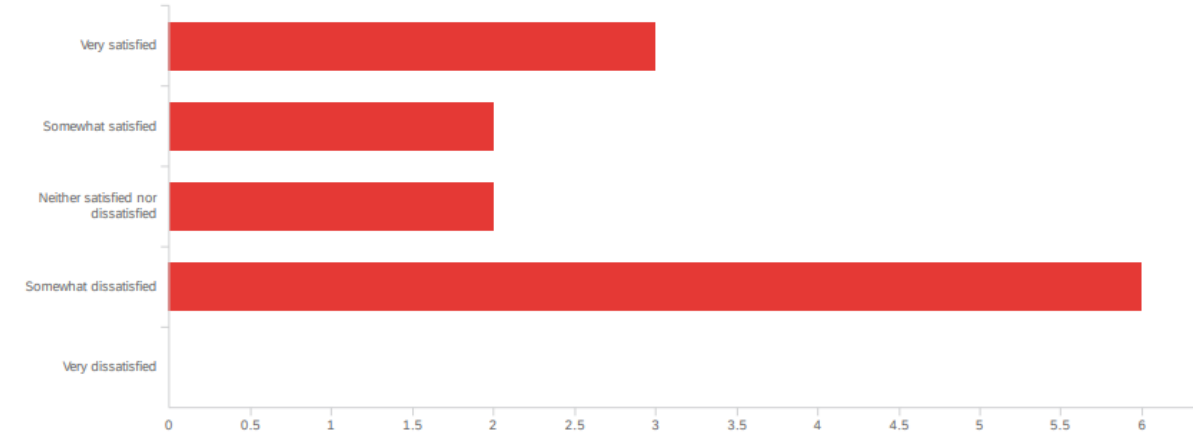


Figure 2. Resident satisfaction with the volume of feedback. Most residents were dissatisfied with the volume of feedback received through field notes.

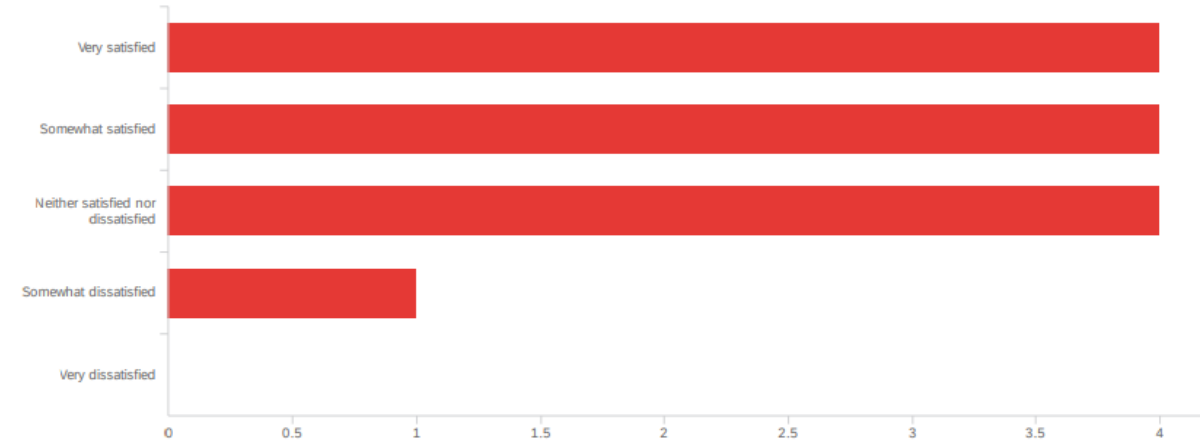


Figure 3. Resident satisfaction with the balance of positive and constructive feedback. Opinions were mixed about the balance of positive and constructive feedback. Many residents requested more frequent feedback and more timely feedback, at the end of the clinic when possible.

Strategies for change: Main areas of focus for intervention next year should be aimed at increasing the quantity and timeliness of feedback. Consider ways to create planned time and space for giving feedback in person. Consider ways to reduce barriers to writing field notes and prompting cues for milestone specific feedback Specific and actionable feedback should be given when possible. As a program, we need to determine whether field notes are intended to be a place to document formative feedback, summative feedback, or both. Our next steps for field note improvement will be impacted by the program's decisions about incorporating EPAs and CBME, as well as any changes that we may make to the remediation process as our needs for this specific type of feedback will likely evolve based on these broader changes.

Effect of change: This will be measured with a post-survey after our intervention next year.

Lessons learned: Residents appreciate the quality of the feedback they get, but they want more of it and in a more timely way. Preceptors find it challenging to find the time and private space to give feedback.

Post script:

Daring Greatly "Engaged Feedback Checklist" by Brene Brown 2020

I know I'm ready to give feedback when:

I'm ready to sit next to you rather than across from you.

I'm willing to put the problem in front of us rather than between us (or sliding it toward you).

I'm ready to listen, ask questions, and accept that I may not fully understand the issue.

I want to acknowledge what you do well instead of picking apart your mistakes.

I recognize your strengths and how you can use them to address your challenges.

I can hold you accountable without shaming or blaming you. I'm willing to own my part.

I can genuinely thank you for your efforts rather than criticize you for your failings.

I can talk about how resolving these challenges will lead to your growth and opportunity.

I can model the vulnerability and openness that I expect to see from you