



MedStar Franklin Square
Medical Center

Knowledge and Compassion
Focused on You

ANNUAL REPORT 2020

**The Department of Family
Medicine**

*“Improving Health Through Partnership,
Scholarship and Advocacy”*



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A YEAR IN REVIEW FROM DR. MELLY GOODELL

Chair, Department of Family Medicine



I'm proud to share the Department of Family Medicine 2019 Annual Report with you. With this report, we are now transitioning to a calendar year annual report instead of an academic year summary. Consequently, this report includes 18 months of events, dating back to July 2018, though with an emphasis on 2019.

Our department's core mission and values span excellence in clinical care, education, and scholarship. In the past 18 months, we celebrated key accomplishments in many different areas despite weathering expected and unexpected changes. We said goodbye to cherished colleagues but also welcomed strong new additions to our team. Overall, the department, clinic, and residency are thriving.

We continue to attract high quality residents in both our categorical Family Medicine Residency and the 4-year combined Family Medicine-Preventive Medicine program in collaboration with Johns Hopkins Bloomberg School of Public Health. Our faculty and residents hold regional and national leadership positions and present their academic work at regional, national, and international conferences.

In addition to our residents, we are a core teaching site for dozens of other learners throughout the year: medical students, pharmacy students, social work students, community health education students, and more. This interdisciplinary environment enhances our department.

We conducted over 30,000 visits in the Family Health Center this year and provided care to over 10,000 patients in the clinic, the hospital, nursing homes, and in their homes. We have maintained Level III Patient Centered Medical Home Status since 2011. Our care coordination team has helped address the most complex needs of our patients and reduced hospitalizations as well as ED visits in the process.

I am honored to lead this talented team and thank them for the hard work and dedication they demonstrate every day in support of our goals and those of MedStar Health.

FACULTY HIGHLIGHTS

FAMILY MEDICINE CORE FACULTY

The Heart of Our Department



Nancy Barr, MD
Medical Director,
FHC/Med Student Ed



Jill Cotter, DO
Faculty



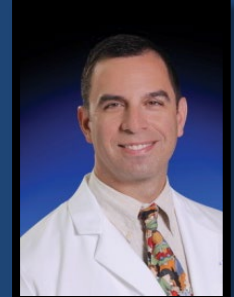
Lauren Drake, MD
Faculty



Michael Dwyer, MD
Program Director, FM
Residency



Uchenna Emeche, MD
Faculty, Associate Medical
Director



Lee Fireman, MD
Core Pediatrics Faculty



Andrea Gauld, PharmD,
BCACP, BCPS



Melly Goodell, MD
Chair, FM



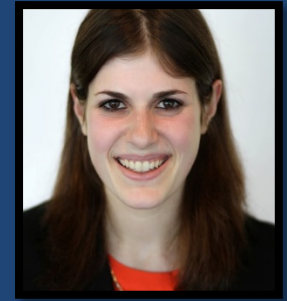
Claudia Harding, LCSW-C, BCD,
Dir of Behavior Science/
Comm Med



Martha Johnson, MD
Faculty



Joy ce King, MD
Director of Inpatient
Training



Shira Lerner, MD
Faculty



Sasha Mercer, MD
Core Pediatrics Faculty



Michael Niehoff, MD
Director of Musculoskeletal
Programs



David Pierre, DO
Faculty



Kelly Ryan, DO
Faculty & Sports
Medicine



Katherine Stolarz, DO
Faculty



Elise Worley, DO
Faculty

FAMILY MEDICINE ADJUNCT FACULTY



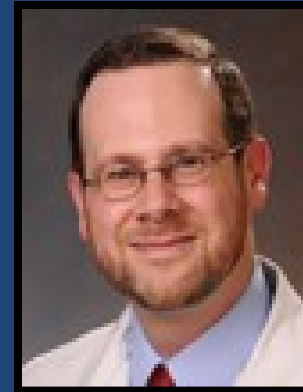
Britt Gayle, MD



Lauren Gordon, MD



Kendal O'Hare, MD



Jay Weiner, MD



Mozella Williams, MD

PEDIATRIC COMMUNITY FACULTY



Tia Medley, MD
Pediatrics Faculty



Jessica Noorian, MD
Pediatrics Faculty



Ari Silver-Iserstadt, MD
Pediatrics Faculty

Family Medicine Welcomes:



Shira Lerner, MD
Faculty
Joined Aug 2020

Shira Lerner, MD, completed medical school at Case Western Reserve University School of Medicine and residency training at Lawrence Family Medicine Residency, a four-year family medicine residency program based out of a federally qualified community health center in Lawrence, MA. During her residency she completed an area of concentration in HIV Medicine and is passionate about caring for patients with HIV and viral hepatitis while continuing to practice full-scope family medicine, including obstetrics. She is excited to be on the faculty at MedStar Franklin Square Family Medicine Residency and is looking forward to helping to train residents in both the outpatient and inpatient settings as well as on labor and delivery.



Kimberley Jones
Residency
Coordinator
Joined July 2020

Kim Jones started as our residency coordinator in July; she has taken the responsibilities of aiding the residents in completing their years at Family Health Center with great strides. Kim has been with the Family Health Center since 2011 she has shown her capabilities in each position she has held and even outshined everyone's expectations.

Family Medicine Growing Family:

Dr. David Pierre and family welcomed a new baby boy; Zavier was born happy and healthy. His two older brothers Zion (8) and Zander (2) are extremely excited.

Dr. Michael Niehoff welcomed his first granddaughter, Beatrix.

Dr. Lauren Drake welcomed her second daughter, Nora Grace on 10/23. Everyone is happy and healthy.

Engagements: Jeremy, Tory, Cortney??



Family Medicine Says a Fond Farewell:

In July 2020, our dedicated residency coordinator, Nora Kellner, retired from her position. We are extremely sad she has left our department but overjoyed with the 23 years she devoted to our residents, faculty, and staff. Nora started working part time for the Family Health Center in 1997. In 1999, she took a position with medical records and then in 2001 she trained as a patient registrar learning different stations along the way, until 2004 when she trained to work on clinic schedules and templating. This led to her new position in 2007 as the FHC Scheduling Coordinator. From this position she was offered, in 2009, the Family Medicine Program Residency Coordinator where she thrived until her retirement.

Currently Nora is enjoying her retirement by spending time at her shore house, with her grandson, planning for one of her daughter's weddings, and vacationing.



COVID-19 AND THE FAMILY MEDICINE DEPARTMENT: AN OVERVIEW

The Department of Family Medicine providing Sports Physicals

The Department of Family Medicine faculty was going to hold their annual retreat in March; however, Covid-19 changed all that. Our annual department retreat, resident retreat and intern retreats also were cancelled/modified to be virtual if we could make them virtual. We navigated all different platforms of virtual meetings from WebEx to Teams to Zoom- conferences were held on all three at some point. A positive to this, we were able to host speakers from all over the country because they didn't have to travel.

Our summer program for 1st year medical students became completely virtual and was a total success- both women became a part of the care coordination team, established meaningful relationships with patients, learned a lot about family medicine and primary care research without ever setting foot in FHC. They both reported a wonderful experience they would recommend to other students. Medical student education pivoted to a core rotation site (the LIC was put on hold for the first semester) and we doubled the number of students rotating through each month to meet the demand for clinical experience as many other sites were not available to them. Dr. Jeremy Parsons, chief resident, assisted Dr. Bar in teaching telehealth to 3rd and 4th year medical students as part of their virtual learning curriculum. Hands on learning continued as it always has on FMI and at FHC.

Patient education as well as staff education was a top priority. We educated ourselves on the latest COVID guidelines and gave accurate information to our patients with our same day providers leading the charge in educating patients on proper mask wearing, PPE, quarantining and testing.

Medstar joined 100 hospital systems representing thousands of hospitals, in this campaign making an urgent plea for everyone to wear masks.

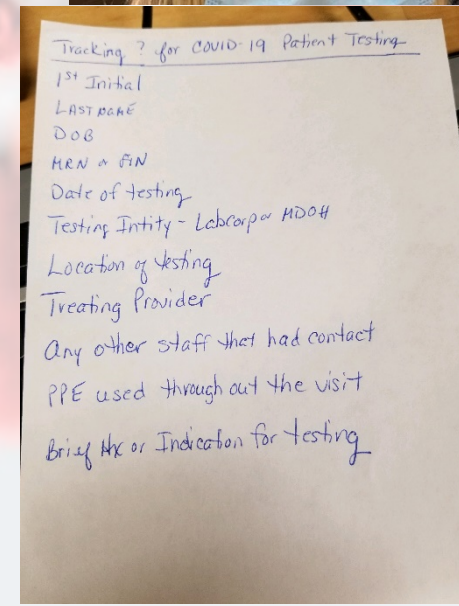
Here's the MedStar press release:

<https://www.medstarhealth.org/mhs/about-medstar/newsroom/>

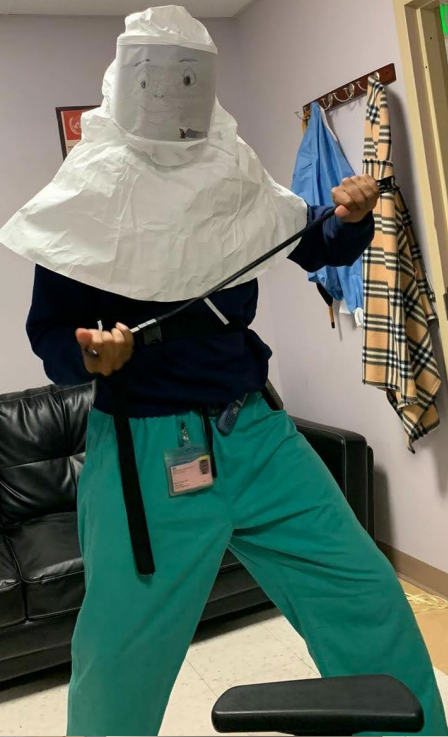
the bottom of the press release lists the other hospital systems joining the effort.

Here's the link to the YouTube video directly:

<https://www.youtube.com/watch?v=WTkuNXJnrLw&feature=youtu.be>



THE NEW DRESS CODE

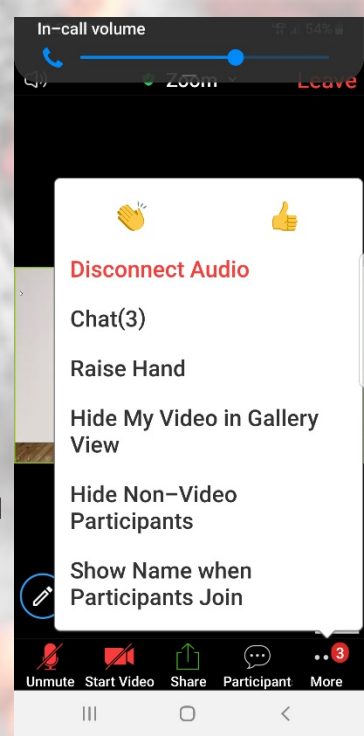
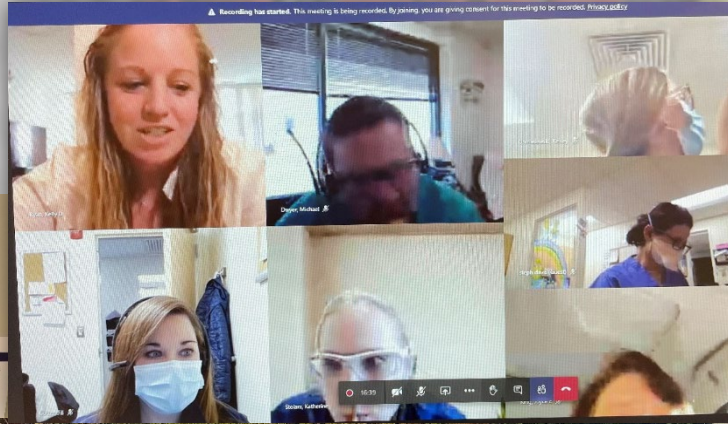


COVID-19- Residency Impacts

When Covid-19 impacted our lives during the majority of 2020, we had to adapt and adjust schedules, rotations, conferences, learning experiences, and our everyday practices to foster and create the most equivalent experiences for our residents during this time.

There were multiple impacts changing our routine within the MedStar system.

- Specialist offices and rotations had to change due to COVID restrictions.
- On-site electives had transformed to virtual, if they could be accommodated, but still had to focus on meeting the resident areas of interest and need.
- All conferences transitioned to virtual conferences using multiple platforms from WebEx, to Zoom, to Teams.
- The interview process was highly impacted for potential incoming interns
 - Nothing in person, no tours of the hospital/department, interviews and meetings had to be virtual
- Additional support both mentally and emotionally was needed for resident wellness



COVID-19- Clinical Care Changes

Headache is no longer a headache

A cold can keep you out of work for a few days

Challenges to clinic changes- no strep test, no nebulizers

Clinical care changes:

How we provide care now

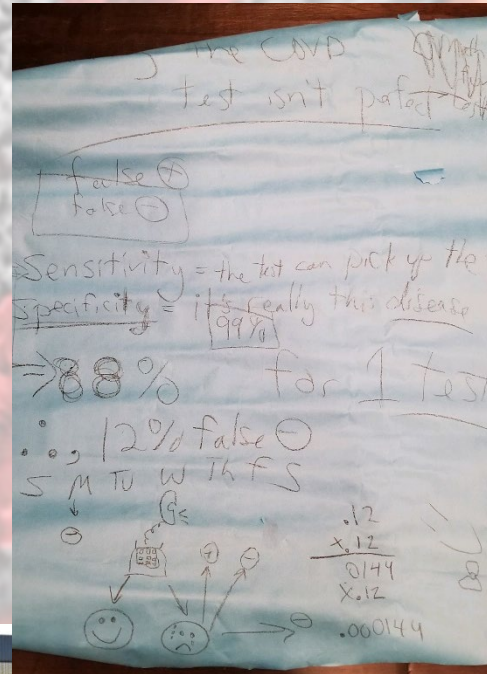
Telehealth

Encouraging patients not to physically come in but to be virtual

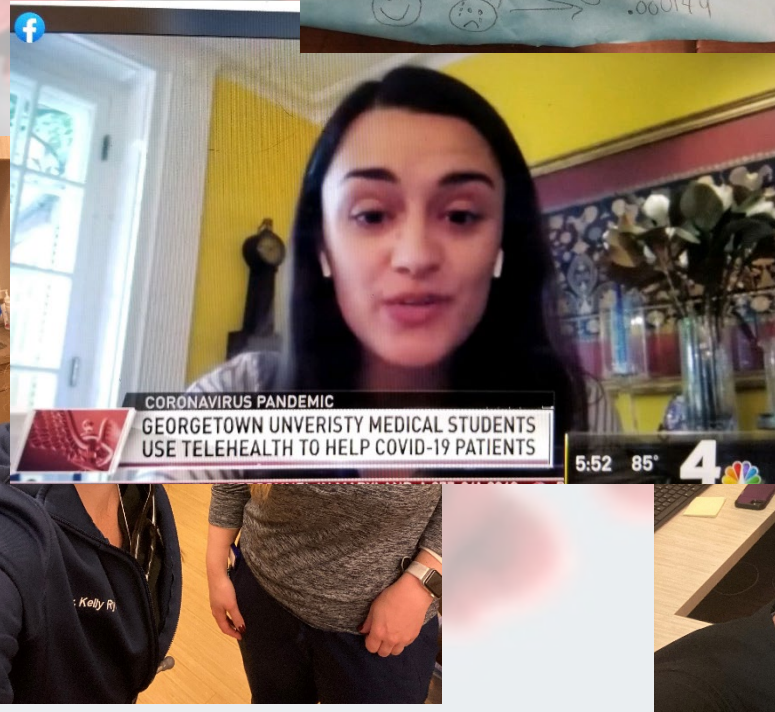
Waiting room changes

Visitor policies

Medical student changes



| | E | F | G |
|-----|---|--------------|----------------|
| 146 | | 5/1 negative | |
| 147 | | 5/1 negative | |
| 148 | | 5/1 negative | |
| 149 | | 5/1 positive | |
| 150 | | 5/2 Negative | |
| 151 | | 5/2 Negative | |
| 152 | | 5/2 Negative | |
| 153 | | 5/2 positive | |
| 154 | | 5/2 Negative | |
| 155 | | 5/4 Positive | 48 -72 f/u? |
| 156 | | 5/4 negative | |
| 157 | | 5/4 Negative | n/a |
| 158 | | 5/4 Negative | appt 5/8 |
| 159 | | 5/5 Negative | |
| 160 | | 5/5 negative | 5/7 retested - |
| 161 | | 5/6 negative | |
| 162 | | 5/6 negative | |
| 163 | | 5/6 Negative | |
| 164 | | 5/6 positive | |
| 165 | | 5/6 negative | |
| 166 | | 5/6 negative | |
| 167 | | 5/7 negative | |
| 168 | | 5/7 negative | rpt from 5/4 |
| 169 | | | |
| 170 | | | |
| 171 | | | |
| 172 | | | |
| 173 | | | |



COVID-19- Medical Students and LIC

Our summer program for 1st year medical students became completely virtual and was a total success- both women became a part of the care coordination team, established meaningful relationships with patients, learned a lot about family medicine and primary care research without ever setting foot in FHC. They both reported a wonderful experience they would recommend to other students. Medical student education pivoted to a core rotation site (the LIC was put on hold for the first semester) and we doubled the number of students rotating through each month to meet the demand for clinical experience as many other sites were not available to them. Dr. Jeremy Parsons, chief resident, assisted Dr. Bar in teaching telehealth to 3rd and 4th year medical students as part of their virtual learning curriculum. Hands on learning continued as it always has on FMI and at FHC.

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COVID-19- Wellness in FHC



The President of MedStar Franklin Square Medical Center, Stu Levine, MD, welcomes the Covid-19 Vaccines just in time for the holidays. We are so grateful for the opportunity to receive the vaccines so we can continue to care for our patients!



2020 WELLNESS



Food donations to Healthcare Hero's: Mount Everest, Pho Bac, Moo-licious, Argie's Thumbs up Greek, bubble tea, Bread from Bakery



The COVID pandemic has undeniably impacted MedStar Franklin Square Medical Center. It has also revealed the unequivocal support our community has for our associates and caregivers. From March 2020 through January 1, 2021, our community and philanthropic partners provided 9,670 meals to associates at MFSMC. We also received kind bars, AHA waters, energy drinks, Dunkin' Donuts, and so much more. More recently, in conjunction with Cerner, who provided 250 meals for four different units, the MFSMC Board of Directors came together to support this effort by providing 322 meals for six additional units. The outpouring of support has truly been remarkable.



Gifts from faculty to staff, scavenger hunt for the holidays

MOUNT EVEREST RESTAURANT
INDIAN, NEPALESE & AMERICAN CUISINE
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Fax: 410-668-4669
E-mail: mt_everest4@outlook.com
Niranjan: 603-203-1443 (Owner & Chef) Prakash: 978-421-6020 (Owner & Manager)
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7927-C BEL AIR ROAD, NOTTINGHAM, MD 21236
WWW.MOUNTEVERESTRESTAURANT.COM



FACULTY SPOTLIGHT: Dr. Kathy Stolarz

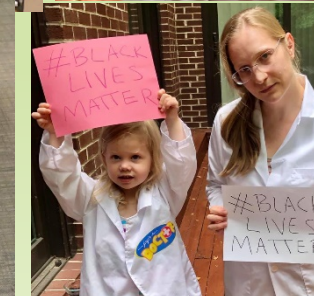
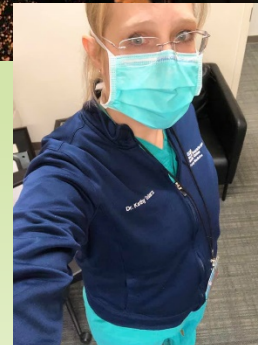
Kathy Stolarz, DO is in her 6th year at the Family Health Center. Since joining the faculty, she has created a Global Health track and expanded the Global Health curriculum, established an Osteopathic curriculum including the Osteopathic Manipulative Therapy clinic, and trained residents and faculty in completing Asylum Evaluations. She loves teaching from obstetrics to office procedures and enjoys serving the residents through her role as Associate Program Director.

Dr. Stolarz was published in the Journal of Human Trafficking in June 2020 for her work in “Assessing Family Medicine Residency Program’s Training on Human Trafficking: A National Survey of Program Directors.”

Dr. Stolarz works tirelessly with refugees, trafficking victims, and asylum seekers in multiple settings including working in refugee camps and volunteering locally to educate other providers. In March, she was invited to speak on Refugee Care to Georgetown Medical Students. In October, she was invited to participate in a Human Trafficking Panel highlighted in the 2020 Academy of Violence and Abuse Global Health Summit. She teaches Obstetric Simulations annually for the Georgetown Global Health Boot Camp.



“My most important role is as a mother to Lila (3) and Luke (1). I hope to lead by example in my role as a working mother, personally promoting the areas of breastfeeding and babywearing.” “I’m an avid hiker and love being outside as much as possible with my family.”



FACULTY HIGHLIGHTS



Lauren Drake, MD completed her Masters of Science degree in Health Care Management at Johns Hopkins Carey Business School. She tackled this master's program in any "free time" she had, while balancing being a new mom and a busy stretch faculty which included participating in and completing a project for the Society of Teachers of Family Medicine Emerging Leaders program and receiving a small MedStar grant to design and implement a pilot mentoring program for women. The STFM fellowship program is focused on developing leadership skills and implementing them through a practicum.



UPDATE: SPORTS MEDICINE, DR. RYAN, AND HORSEMEN'S HEALTH

The Maryland Jockey Club is a sporting organization dedicated to horse racing, founded in Annapolis in 1743. Pimlico Racecourse, Home of the Preakness, opened in 1870 and is now undergoing a revitalization, and Laurel Park Racecourse opened in 1911. MedStar Sports Medicine has provided medical coverage at the tracks (plus Timonium during the State Fair fortnight) on race days since September 11, 2015. Our MedStar Health medical team covers races two to four days per week, and before Covid-19 there was racing all year round, no matter the weather! Our Primary Care Sports Medicine Physicians cover each day, including Frank Dawson, Kelly Ryan, Christian Glaser, Jason Pothast, and Jeff Mayer.

Since 2015, with this great team in place, MedStar's Sports Medicine has become one of the leaders in Jockey Health across the country and, with our guidance, Laurel was one of the first racetracks to implement a concussion protocol. Medical Directors Frank Dawson and Kelly Ryan have also worked with the track and jockey club to implement weather and much needed trauma policies.

Most recently, these doctors have been instrumental in developing Covid-19 policies to ensure safety at the track. To the surprise of none of our doctors, the racetracks were the last of our sports partnerships to close due to Covid-19 and the first to reopen.

MedStar has become the primary care physicians for many of the backstretch workers and their families. We also care for the trainers, valets, exercise riders, and a gate crew who all are critical to the industry.

In the world with Covid-19, these close quarters were particularly challenging and high risk, like any community living facility with shared bathrooms etc. Education on safety can also be very challenging in this environment, particularly when English is sometimes the patients' second language.

After a few weeks of better understanding Covid-19 and progressing through the state and local phased safety plans, we worked with the track and the jockeys to develop protocols to return to racing.

Thanks to brilliant help of Kori Hudson, Pegeen Townsend, Katie Watson, Andy Tucker, Richard Hinton, and many others, and continuous recommendations for management of our patients by Liz Delasobera, this group under the direction and leadership of Sean Huffman established protocols which we felt to be the safest possible.

As there is plenty of space at a "no-fans allowed because of Covid-19" racetrack, the jockey's quarters and locker room was moved to the huge open restaurant and every jockey area was spread out. Jockeys wear masks to the starting gate, which is disinfected between races. With those and many other precautions in place, horse racing was the first MedStar partner sport to resume activity with racing on May 30.

The horse racing community is tight knit and while we sometimes hear crazy stories, we all can say this experience has taught us a lot. Horseracing is not as well represented in the sports medicine world as football or softball, but they the jockeys and backstretch heroes are some of the toughest athletes around!



LEADERSHIP & ACHIEVEMENTS

We continue to support the involvement of our faculty in leadership roles outside of MedStar Health. This provides professional and faculty development opportunities for our faculty and role models leadership and service for our residents.



Michael Dwyer continues to serve on the ABFM in-training Exam Committee and is an item writer for the certification exam for the ABFM.



Michael Niehoff is the current secretary and a Specialty Society representative on the Board of Trustees for MedChi (Maryland State Medical Society). This is the statewide professional association for licensed physicians, whose mission is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health. Dr. Niehoff is also a delegate for the Baltimore County Medical Association and on the Board of the Center for a Healthy Maryland, which is the philanthropic foundation associated with the state medical society.



Kelly Ryan currently Co-Chairs the Education Committee of the Maryland Academy of Family Physicians.



Katherine Stolarz serves as the current President of the Board of Directors for Companion Community Development Alternatives, a non-profit which is devoted to the mission of cooperating in projects for democratic, community-based social and economic development in Central America, including public health and water projects, and promoting awareness and social responsibility in the United States for more just relations with Latin America.



Mozella Williams is the President of the American Academy of Family Physicians until February 2021, when she will transition to be the Board Chair of the American Academy of Family Physicians.

LEADERSHIP & ACHIEVEMENTS



Nancy Barr is a voting member of COME committee at Georgetown; clinical advisor at Georgetown School of Medicine; and a voting member of Clerkship Director Committee Georgetown



Elise Worley is the Lead Physician of the MedStar House Call Program in Baltimore as of January 2020.



Andrea Gauld is currently the Vice Chair of the Assessment Committee and Chair of the Mentor of the Year Taskforce.



Uchenna Emeche is on the Executive board of Express Igbo, an organization dedicated to promoting and preserving the Igbo language and culture. She was also on the host committee for this year's Family Medicine Education Consortium 2020 Conference

MedStar ACADEMIC AFFAIRS WORKING GROUP FOR RACIAL JUSTICE (WGRJ)

PURPOSE:

The purpose of the MedStar Academic Affairs Working Group for Racial Justice (WGRJ) is to create a more diverse and inclusive environment within MedStar Health Academic Affairs for our trainees, faculty and associates, as well as, eliminating health inequities and barriers for our patients and the communities we serve. WGRJ consists of six working groups focused on developing and implementing sustained positive change in our clinical learning environments.

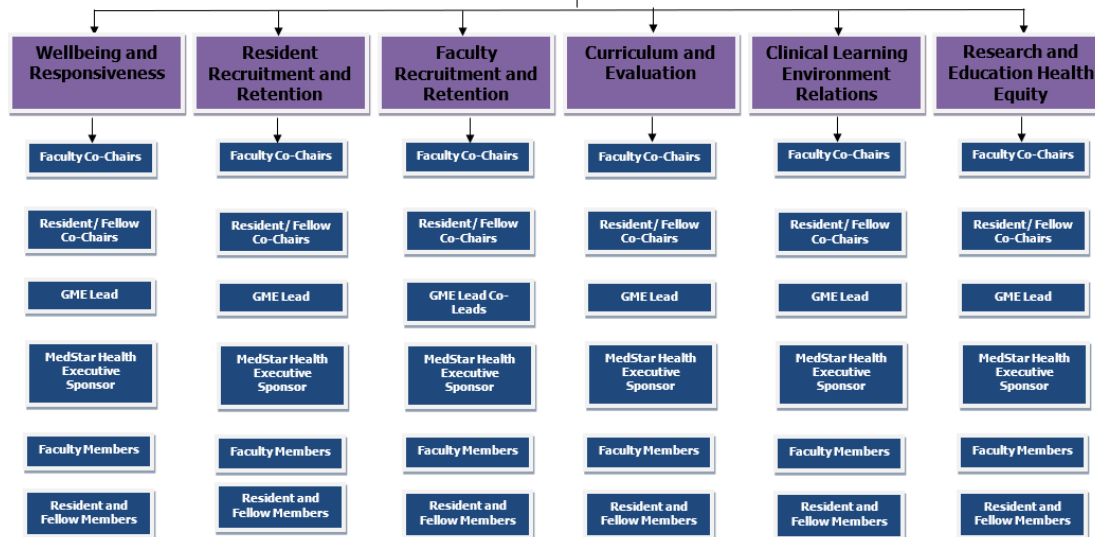
The objectives of this working group include:

- Address resident/fellow/teaching faculty **well-being** on an individual level when future tragedies occur.
- Provide ongoing recognition of, and support for the needs of our academic community, including **prompt communications**, as part of the critical national conversation regarding racial inequities.
- Improve the **recruitment, selection and retention** of Black and URM residents/fellows/teaching faculty for our GME programs by identifying their specific challenges and providing enhanced support and development.
- Evaluate the **curriculum** to dismantle elements of systemic racism through curricular changes
- Incorporate race and ethnicity education into the GME curriculum and **faculty development**.
- Foster **longitudinal discussions** geared toward reconciliation about race and racism
- Create a diverse and inclusive community and **clinical learning environment**.
- Facilitate efforts of our academic community to make a positive and sustainable impact on **health disparities** in the communities that we serve.
- Partner with Georgetown School of Medicine to assure **integration** of these efforts across the continuum of education.
- Provide **transparency and accountability** regarding these objectives.

Working Group for Racial Justice Organizational Chart 2020

Steering Committee: 1
Subcommittee: 6
Faculty: 50
Residents/Fellows: 50
Executive Sponsors: 7
GME Leads: 7
Admin Leads: 2

Steering Committee

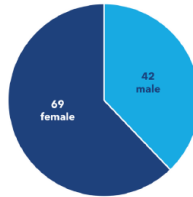


Family Health Center Members:

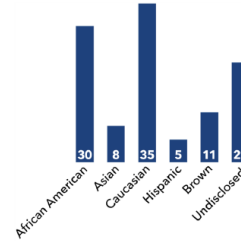
- Linda Ataifo, MD
- Adwoa Adu, MD
- Katherine Stolarz, DO
- Ilyssa Moore, MD
- Martine Randolph, MD
- Nancy Barr, MD
- Chrystal Pristell, DO
- Sasha Mercer, MD, MPH

Working Group for Racial Justice Composition

Gender Diversity



Ethnic Diversity



Programs Represented

- | | | |
|---------------------------------|--------------------------------|------------------------------------|
| Anesthesiology | Internal Medicine - Pediatrics | Pediatrics |
| Cardiology | Neonatology | Physical Medicine & Rehabilitation |
| Child and Adolescent Psychiatry | Neuroscience | Plastic Surgery |
| Dermatology | Obstetrics & Gynecology | Podiatry |
| Emergency Medicine | Ophthalmology | Psychology |
| ENT | Orthopedic Surgery | Radiology |
| Family Medicine | Orthopedics | Research |
| Hematology/Oncology | Pathology | Surgery |
| Internal Medicine | Pediatric Critical Care | Urology |

Hospital & Entity Representation

- MedStar Franklin Square Medical Center
- MedStar Georgetown University Hospital
- MedStar Health Research Institute
- MedStar Montgomery Medical Center
- MedStar National Rehabilitation Hospital
- MedStar Union Memorial Hospital
- MedStar Washington Hospital Center

MedStar Health Academic Affairs

Working Group for Racial Justice



We're all in this. Together.

| STEERING COMMITTEE | WELLBEING AND RESPONSIVENESS | RESIDENT RECRUITMENT AND RETENTION | FACULTY RECRUITMENT AND RETENTION | CURRICULUM AND EVALUATION | CLINICAL LEARNING ENVIRONMENT RELATIONS | RESEARCH AND EDUCATION HEALTH EQUITY |
|---|--|---|---|--|--|---|
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2020



We're all in this. Together.

Dr. Katherine Stolarz was chosen as a faculty member for the Wellbeing and Responsiveness subcommittee.

Dr. Nancy Barr was chosen as a faculty member for the Curriculum and Evaluation subcommittee.

Sasha Mercer, MD, MPH was chosen as a faculty member for the Research and Education Health Equity subcommittee.

Dr. Adwoa Adu and the Working Group for Racial Justice

Dr. Adwoa Adu has gone to great lengths and worked extremely hard to become the Co-founder for fighting racism at Franklin Square, Curriculum Chair for the Working Group for Racial Justice, and present at Family Medicine Grand Rounds on: A Review of Racism in Medicine. She is still working on implementing change at the Family Health Center. Dr. Adu strongly believes people here recognize the impact of systemic racism and want to make change. As we all know, recognition of the problem is the first step to change. So, this is just the beginning and she is inspired by her colleagues and their actions towards racial justice.

“Social media is a powerful tool, it has helped bring to light racial injustices that are experienced by people of color. We saw this summer and the world responded in outrage. Personally, I was frustrated, hurt, and scared mixed with a lot of other emotions. Even though, I had a hard time conceptualizing my emotions towards the events, I realized the power of my voice and how I can use it to enact change. This is why joining the Working Group for Racial Justice was an easy decision for me.”- Dr. Adwoa Adu, MD, PGY3



In order to work towards change, there were multiple steps taken to get us where we are. The events of the summer highlighted racial injustices that have been going on for centuries. It also motivated our residents to develop a group focused on systemic racism in medicine and how we can fight it within the Family Health Center. The group is lead by our faculty and residents and we have had several Grand Rounds presentations as well as open discussions based on Ted Talks. In the future, we are hoping to make this topic a part of the longitudinal curriculum.

The Fighting Racism at Franklin Square was started this summer, meeting every 2nd and 4th Thursday on Microsoft Teams. At our first meeting we developed our mission statement, which reads: For the medical providers at the Family Health Center our group will work to educate on the various forms of racism, will create spaces for interactive and self-reflective to work to combat implicit bias, and constantly assess and advocate against systemic racism. We then met with leadership at the Family Health Center who advised we had their full support. They have held true to their initial statement. To make sure our mission statement holds true, we have done multiple things. This includes starting an excel document with educational resources facilitating the conversation on race, having Grand Rounds speakers who have done research on this topic, having an open discussion on race with residents and faculty, and finally writing an open letter and hosting a meeting with/to Dr. Stuart Levine, the President of our hospital.

WGRJ

The residents and faculty wrote a letter to Dr. Stuart Levine. This letter was focused on changes that can be made within Franklin Square Medical Center as it pertains to racial injustice. Dr. Levine was extremely receptive to the letter and invited the residents and faculty to hear his response. He provided information about what has been done, what is being done and what he hopes to do in the future. This was the start of a conversation, that can lead to real change at Franklin Square Medical Center.

The residents and faculty watched the Ted Talk "Allegories on Race and Racism" by Dr. Camara Jones. This talk helped to facilitate an open discussion on race between residents and faculty. They also participated in a presentation by Dr. Susan Chang on implicit bias in the workplace. Journal club also had a session on "Combination of Isosorbide Dinitrate and Hydralazine in Blacks with Heart Failure". There were multiple articles, podcasts, other antiracist resources, text message threads available to share events in the community.

Family Medicine Grand Rounds guest speaker Brian Williams, MD presented the topic of "Race, Violence and Medicine: Showing up for Justice". In his presentation he discussed his personal experiences with racial discrimination in the medical field, violence and how it affects every single person whether they realize it or not. An example he gave was of the police shootings in Dallas, TX and how his trauma team were the responders for the horrific attack.

Dr. Adu gave a Grand Rounds presentation "A Review on the Impact of Race in Medicine". This talk highlighted the roots of racism in medicine and how it impacts the care we provide patients today. It created a safe space for providers to discuss what can be done to provide better care to our patients of color. This was our second in-person/virtual grand rounds presentation. It was held in the Kotzen auditorium and complied with all of the hospital standards for COVID-19 physical distancing guidelines.



Family Medicine Grand Rounds guest speaker Brian Williams, MD



2020 EVENTS



Dr. Nithin Paul and Dr. Nancy Barr participate and support the White coats for Black Lives Matter movement



As part of White Coats for Black Lives, many of the residents, faculty, and staff marched in DC as well as showed support on campus. Many of them made local news in DC due to their participation.



RESIDENCY HIGHLIGHTS

RESIDENT GRADUATION & FUTURE PLANS CONGRATULATIONS TO THE CLASS OF 2020

Annie Bailey, MD, MPH
Urgent Care

Samantha Kurzrok, MD
Outpatient Care, IL

Chelsea Backer, DO
Sports Medicine Fellowship,
Christiana, DE

Priya Raghavan, MD
Academic Fellowship,
University of Tennessee, TN

Mariam Antonios, DO
Family Med/ OB at Northside
Hospital Gwinnett,
Lawrenceville, GA

Nithin Paul, MD, MPH
Primary Care at Thundermist
Health Systems, RI

Allen Jian, MD
Urgent Care/Primary Care at
North East Medical Services,
San Francisco, CA

Sadhika Jamisetti, MD
OB Fellowship at University of
Alabama, AL

Here is the link to the special video our faculty compiled since we could not have graduation in person. Congratulations class of 2020, we will miss you!

<https://drive.google.com/file/d/14cCbX7jQ5lYiq0AKqrJhfdoZ53UibfWp/view?usp=sharing>



Resident Awards:

2020 Best Scholarly Project: Priya Raghavan, MD

Lee Rome Award: Residency Class of 2020

Global Health Scholar: Annie Martha Bailey, MD, MPH

Outstanding Resident Teacher Award: Priya V. Raghavan, MD

Resident Award for Scholarship: Nithin J. Paul, MD, MPH

Reichel Award for Geriatrics, Resident: Chelsea B. Backer, D.O.

Reichel Award for Outstanding Teaching Award, Attending: Lisa Uncles, C.N.M.W.

Faculty Teaching Award: Elise D. Worley, D.O.

Faculty Excellence Award: Claudia Harding, LSW-C, BCD

Pediatric Teaching Award: Fernando V. Mena, M.D.



Bronchiectasis in Pregnancy: A Case Study

Mariam Antonios, DO
Medstar Franklin Square S

Introduction

Respiratory Changes Associated with a Normal Pregnancy

Numerous anatomic and physiologic changes occur during the course of a normal pregnancy which affects the respiratory system. The enlarging uterus can cause up to a 4cm elevation in the diaphragm, although this is not associated with an effect on diaphragmatic function. To offset this, the anteroposterior and transverse diameters of the thoracic cage are increased by approximately 2cm. The disposition of the diaphragm upward leads to a decrease in residual volume and expiratory reserve volume, resulting in a decreased functional residual capacity by approximately 10-25% which is a change that leads to decreased maternal tolerance to infection (Graves, 2010). Inspiratory capacity increases and tidal volume increase by over 40% baseline value (Graves, 2010) so that vital capacity and total lung capacity are unchanged. (Leighton, 2008). Normally, FEV1, Forced vital capacity, and flow rates do not change.

Dyspnea commonly affects 60-70% of pregnant women with no previous history of cardiac or pulmonary disease. Increased progesterone levels commonly lead to a 20-50% increase in minute ventilation at the end of the first trimester and remains increased throughout the remainder of the pregnancy. This occurs because progesterone increases the respiratory center's sensitivity to carbon dioxide. This is related to an increase in tidal volume. (Leighton, 2008)

Bronchiectasis

Bronchiectasis is an abnormal, chronic enlargement of the bronchi that is usually resultant from infection, although non-infectious etiologies may contribute to its development. More than half of cases of Bronchiectasis has no known cause or association. It is estimated that 30 to 35% of cases occur following a lung infection that damages the bronchi for the first time (Aksamit, 2010). It is more common in women rather than men, especially when idiopathic. It occurs in every age group. Bronchiectasis may be localized to one part of the lung or be diffuse bilaterally. It is the major lung abnormality of cystic fibrosis and is often associated with abnormal cilia. The damaged cilia leads to inefficient clearance of mucus which subsequently becomes a nidus for infection. Its symptoms vary widely with each affected individual.

Although treatable, bronchiectasis is rarely curable. The two most important strategies for limiting disease progression are clearance of airway secretions and prompt treatment of lung infections.

Pregnant women with a history of bronchiectasis are typically able to undergo a successful pregnancy, but may encounter complications for both the mother and fetus. Monitoring of pulmonary status is important throughout the pregnancy, especially in the third trimester when the enlarging uterus has most effects on lung functional capacity. Spirometry is important to identify any reversible cause of hypoxemia to prevent development of IUGR in the fetus. With cystic fibrosis, a decrease in FEV1 throughout the pregnancy has been shown to be associated with lower infant birth weights as well as preterm delivery. Any sign of infection with maternal bronchiectasis should lead to prompt treatment (Bhatia, 2000). Infection with pseudomonas may lead to additional complication as it will necessitate IV antibiotics and hospitalization for monitoring. The frequency of infection and the need for imaging may pose another risk as exposure to radiation may be increased.

Case Description/Treatment Plan

27year old G1P0 with history of bronchoscopy-diagnosed mycobacterium avium complex status post triple antibiotic therapy with azithromycin, rifampin, and ethambutol from 2010-2017, with resulting bronchiectasis complicated by recurrent infections with pseudomonas aeruginosa. Prior evaluation for cystic fibrosis included a negative sweat test. Previous workup also included lab testing for various immunodeficiencies with resultant normal results. High Resolution CT scan performed prior to conception showed mild, diffuse dilated bronchioles with tree-in-bud changes. Pregestational medications included azithromycin 250mg MWF, Claritin 10mg daily, Symbicort 160mg-4.5mg 2puffs once daily, and albuterol inhaler as needed.

Pulmonary function tests performed prior to pregnancy showed FEV1 of 97%, FVC of 81%, FEV1/FVC of 71%, and PEF of 81%.

At 9 weeks gestation, patient developed respiratory infection with associated fever, shortness of breath and increase in productive cough. Patient was started on 14-day course of cefdinir and sputum cultures returned showing infection with Acinetobacter baumannii that was sensitive to cephalosporins. Patient recovered well from acute illness and pregnancy continued without incident and with normal prenatal lab work, screening, and anatomy ultrasound.

Patient developed an acute respiratory infection at approximately 19 weeks gestation which once again resolved with a 14-day course of cefdinir. Sputum cultures were not taken during this episode of symptoms. The patient also underwent genetic testing for cystic fibrosis during the second trimester which was negative.

Spirometry was repeated at 32w4d when patient reported gradually progressing respiratory symptoms including increased shortness of breath and worsening productive cough which began at approximately 29 weeks. Results showed decreased FVC by 21%, FEV1 by 23%, TLC by 9%, PEF by 8%, as well as DLCO by 25% from study done 8 months prior. Patient was initially treated once again with a course of cefdinir, however, symptoms persisted despite treatment. Sputum culture performed at this time showed pseudomonas aeruginosa which was sensitive to fluoroquinolones, ceftazidime, gentamicin, tobramycin, Zosyn, as well as carbapenems.

At this time treatment with ceftazidime via PICC line was considered and an infectious disease specialist was consulted for recommendations. The decision was made to delay treatment as this was thought to be colonization unless symptoms became acutely worse or if patient developed fever. Treatment was initiated with hypertonic saline in conjunction with flutter valve, and scheduled use of albuterol nebulizer twice daily to help with clearing secretions. Azithromycin was also increased to daily for anti-inflammatory effects. Patient was closely monitored and returned for repeat spirometry approximately one month later where she reported no meaningful change in symptoms. She did endorse that the hypertonic saline was helpful in clearing secretions. Her repeat pulmonary function tests showed FVC improved by 10%, FEV1 improved by 11%, PEF improved by 13%. The treatment plan at this time was to continue current pulmonary toileting regimen.

After this visit, patient gave birth vaginally to an average for gestational age female infant at full term (36weeks 6 days) after an elective induction. Patient was able to tolerate labor well and did not experience shortness of breath during delivery. In the weeks following her delivery, patient reported resolution of her symptoms and did not require antibiotic therapy until experiencing another acute exacerbation of respiratory symptoms 3 months postpartum.

Patient returned for repeat spirometry results at 11 months postpartum, at which time she reported that she was asymptomatic. Spirometry results at the postpartum visit showed similar results to that done at 37 weeks gestation. FVC was essentially unchanged, FEV1 decreased by 1%, and PEF improved by 2%.

Of note, the infant born to patient has met appropriate growth and developmental milestones at one year of age and did not experience any illnesses during first year of life that required hospitalization.

Figures

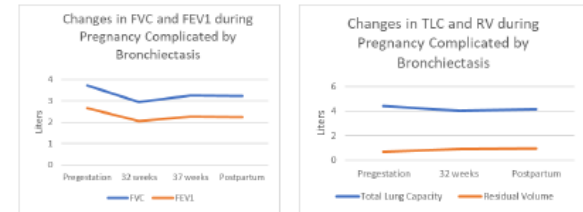


Figure 1
Changes in measurements of Lung Function during the course of a pregnancy in a patient with underlying bronchiectasis.

Discussion

The changes seen during the course of this patient's pregnancy are not the typical findings one would expect in pregnancy. She did experience a decrease in FEV1 and FVC which is routinely unchanged in an otherwise normal pregnancy.

The sputum culture positive for pseudomonas in the third trimester may be related physiological modification of cellular components to allow survival of the fetus (Graves, 2010). Specifically, accumulation of pregnancy zone protein, a t-cell immunosuppressant believed to prevent the rejection of fetal allograft during pregnancy has been linked to colonization with pseudomonas aeruginosa (Finch, 2019). The patient's marked improvement in symptoms following delivery without antibiotic treatment further supports this notion. We hypothesize that the displacement of the enlarging uterus on the diaphragm may have also compromised the ability to clear mucus and secretions as effectively.

It is a point of interest that although FEV1 and FVC did decrease throughout the pregnancy, the infant's birth weight was average for gestational age and did not have growth restriction. The infant's birth weight was in the 25th percentile although it is unclear if that was affected by maternal respiratory changes as the infant remained in the 25th percentile for growth throughout the first year of life. This may be a constitutional finding rather than one affected by maternal bronchiectasis.

In conclusion, our case demonstrated that physiologic respiratory changes during pregnancy did exacerbate our patient's bronchiectasis symptoms. These symptoms, however, did not affect outcome of the pregnancy or seem to impact infant developmental growth as far as 1 year of life.

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Acknowledgements

Thank you to Drs. Johnson, King, and Ryan for all your help and support.

RESIDENT RESEARCH POSTERS

Chelsea Backer, MD



MedStar Franklin Square Medical Center

Perspectives on Exercise

Chelsea Backer, DO
MedStar Franklin Square Medical Center, Baltimore, Maryland
Department of Family Medicine

Abstract

- Physical activity is an important component for the prevention, treatment and management of many chronic diseases. However, 80% of adults do not meet the Physical Activity Guidelines.
- The aim of the project was to determine whether patients at the Family Health Center were exercising
- A survey was created using existing models surrounding motivational interviewing to assess exercise amount, duration and attitudes toward exercise.
- A total of 29 surveys were collected and only 5 participants met the Physical Activity Guidelines. In general, half of participants were either not exercising or thinking about starting, yet were confident that they could start. Participants with a BMI in the 30-35 range reported being unconcerned with their health or weight.
- This information could be used in the future to create tailored exercise prescriptions.

Background

- The 2018 Physical Activity Guidelines released by the Department of Health and Human Services recommends adults complete either 150 minutes of moderate intensity or 75 minutes of vigorous intensity activity a week.
- Only 20% of men, 19% of women and 20% of adolescents reported meeting the Physical Activity Guidelines. 28% of Americans are physically inactive.
- Sedentary behavior has shown to increase the risk of all-cause mortality.
- Benefits to exercise include improved mood, cognition, sleep, cardiovascular outcomes, reduced falls, decreased anxiety, etc.
- Motivational interviewing and office based interventions through programs like Exercise is Medicine have been shown to be effective ways to get people moving

Methods

Round 1:

- A survey given to adult patients (18+) of a single 3rd year resident at the Family Health Center
- MA's handed out surveys while rooming patients during 7 clinic sessions during 2019-2020
- Acute and continuity
- Survey created based on existing data using motivational interviewing and Exercise is Medicine modeling

Round 2:

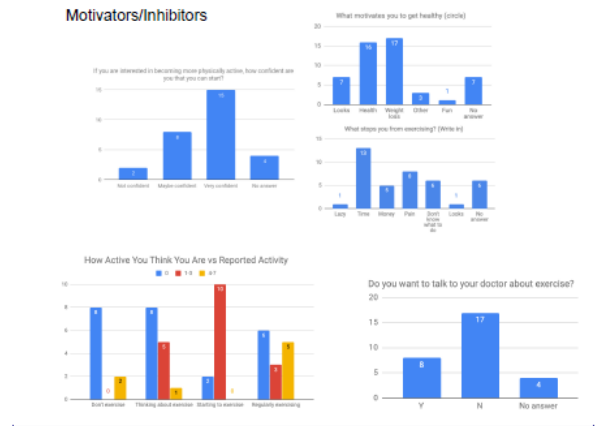
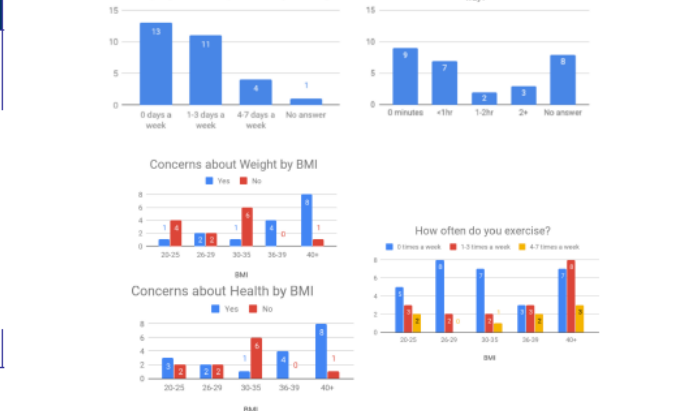
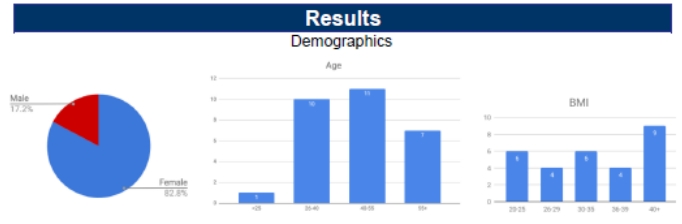
- Follow up phone call during COVID-19 to ask whether patients were exercising (yes/no)

Data:

- Collated based on survey results
- Key findings analyzed by BMI (obtained from patient chart)

Objectives

- To determine if adult patients at the Family Health Center exercise?
- To determine whether those that exercise meet the Physical Activity Guidelines?
- If patients do exercise, why? If not, why not?
- Can the information obtained be used to create successful exercise prescriptions?



Discussion

In 2018, the Department of Health and Human Services (HHS) released new Physical Activity Guidelines, but most adolescents and adults are not meeting them. As medical providers, how do we motivate patients to exercise?

- 29 surveys were collected from patients at the Family Health Center from 2018-2019. The survey was used to determine whether patients were meeting the Physical Activity Guidelines as well as their motivations or barriers to exercise.
- Only 5 (17%) patients met the Physical Activity Guidelines, consistent with the data reported by HHS.
- Over half of those surveyed are currently not exercising or are only thinking about starting to exercise, yet half of participants felt very confident they could begin.
- Responders from the 30-35 BMI group stated they were not concerned about their health or weight. This appears to be a group that could be easily targeted for intervention and education.
- In general, the data can be used to help motivate patients to exercise. For example if weight loss was a motivator, exercise prescriptions could be focused on weight loss goals rather than blood pressure measurements or A-1c targets as opposed to those who listed health as a motivator.
- Unfortunately however, most surveys indicate that patients do not want to talk to their doctor about exercise.

Limitations: One PGY-3 resident panel, COVID-19
Future studies would include follow up with exercise prescriptions targeted to patients based on survey results. Prescriptions could include graded activity level for new exercisers and physical therapy exercises to those who endorse pain. There would ideally be consistent check in between patient and provider to create accountability.

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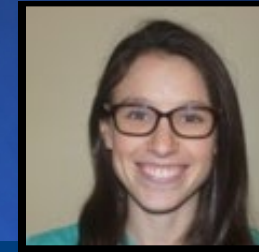
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Poster produced by Faculty & Curriculum Support (FACS), Georgetown University Medical Center

RESIDENT RESEARCH POSTERS



Annie Bailey,
MD and
Samantha
Kurzrok



MedStar Franklin Square
Medical Center

Pilot Study : Correlations Between Personality Types, Burnout, and Resilience Among Family Medicine Residents

Samantha Kurzrok, MD; Annie Bailey, MD; Claudia Harding, LCSW-C; Michael Dwyer, MD
Department of Family Medicine

Introduction

As the acknowledgement of physician burnout continues to rise, the identification of innovative approaches to safeguard provider wellness is critical. There is no data describing how physician personality traits can be utilized for early identification in predicting burnout rates or resiliency factors. This study examines personality type, its relationship to burnout rates and resiliency factors amongst family medicine resident physicians. Our aim is to prospectively identify individuals at risk for burnout, promote personal awareness, and facilitate team communication as a means to reduce physician burnout rates.

Methods

Residents completed the DISC personality profile to determine their predominant personality type.
Residents then completed the Maslach Burnout Inventory (MBI) and the Short Grit Scale.
Correlations were studied amongst resident predominant personality type and MBI burnout scores.
Correlations were studied amongst predominant personality type and GRIT score.
Correlations were studied amongst PGY-level and MBI burnout scores.

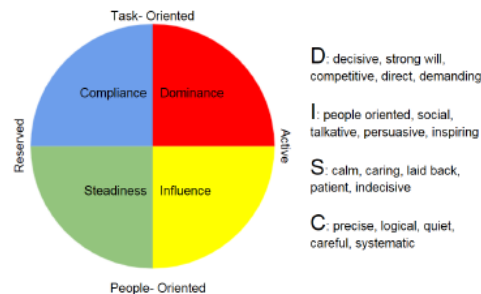
Definitions

Personality: refers to individual differences in characteristic patterns of thinking, feeling, and behaving. The study of personality focuses on two broad areas: one is understanding individual differences in particular personality characteristics; the other is understanding how the various parts of a person come together as a whole.

Burnout: a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy, an occupational phenomenon.

Grit: tendency to sustain interest in and effort toward very long-term goals.

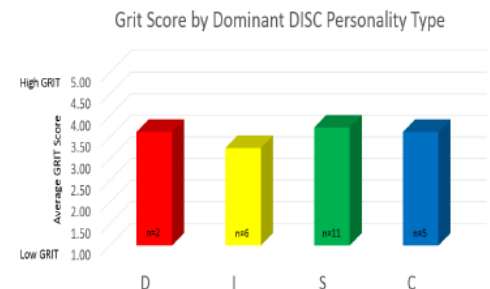
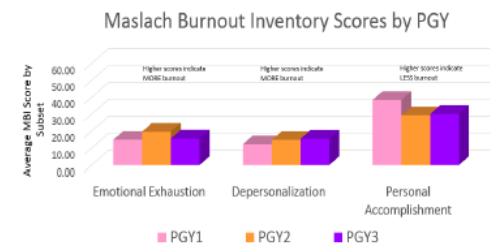
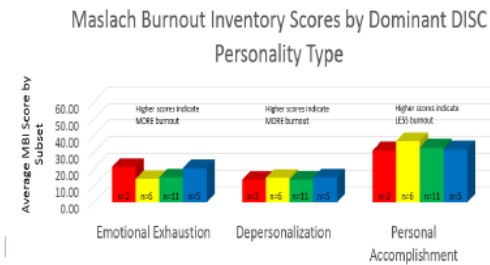
DiSC Profile



Results

Among residents who completed the survey, the results noted variability in personality type (in descending order of prevalence): steadiness, influence, compliance, and dominance. For emotional exhaustion, higher scores were noted among "dominant" and "compliant" personality types. Depersonalization showed minimal variation by personality type. "Influence" correlated with slightly higher scores in personal accomplishment but was also noted to have the lowest average GRIT scores. In considering year of training, PGY-1's were noted to have higher personal achievement scores. There were no clear associations between year of training and levels of burnout. Conclusions pending ongoing statistical analysis.

Figures



Next Steps

The primary goal of this pilot was to evaluate method of design as well as review possible correlations between personality types, resilience, and burnout. Through this pilot, we learned there were limitations with both the survey and self-report aspects as well as the low number of respondents. Confounding factors may also include stage of training and current rotations at the time of report. However, we believe this is an under-studied area within the discipline of medicine and with a deeper dive there is opportunity for early intervention for burnout and implications for improved communication along with understanding among peers and faculty / residents with insight into personality types. Moving forward we will be taking the following steps to broaden study and validity.

1. Survey will be redesigned to include DISC assessment, MBI, Grit and demographics in a way that calculates and correlates data. In addition we intend to review potential protective factors associated with personality type.
2. Survey will be distributed to family practice faculty as well as residents to determine if years in practice/training factor into resilience/burnout.
3. Survey will be distributed outside the area of family medicine to 1100+ fellows/residents and 1000 physician attendings across the MedStar / Georgetown system to evaluate burn out and resilience across specialties with the secondary goal of researching correlations between personality types and areas of specialty.

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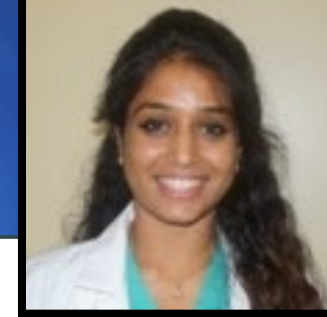
Background

The DISC profile is a tool used for discussion of people's behavioral differences. The model provides a common language that people can use to better understand themselves and to adapt their behaviors with others. The tool highlights four personality traits: dominance, influence, conscientiousness, and steadiness. See Figure for detail.

The Maslach Burnout Inventory (MBI) is recognized as the leading measure of burnout and is validated by 35+ years of research. It measures burnout as defined by the World Health Organization.

The Grit Scale is a set of measures designed to measure trait-level perseverance and passion for long-term goals

Sadhika Jamiseti, MD



RESIDENT vs PATIENT PERCEPTIONS OF VISITS

SADHIKA JAMISETTI, MD
LAUREN DRAKE, MD

BACKGROUND

- Patient feedback for residents is a valuable learning tool and a way of performing a needs assessment for individual residents and for our program overall regarding communication and interpersonal skills.
- Patient feedback is not readily available at our residency program.
- Our aim is to implement the Communication Assessment Tool (CAT) survey for patients to give residents feedback as well as a modified CAT survey for resident self-reflection. Using these tools we will identify areas of communication that need improvement and implement didactic and interactive learning activities to meet those needs.

RESEARCH DESIGN AND METHODS

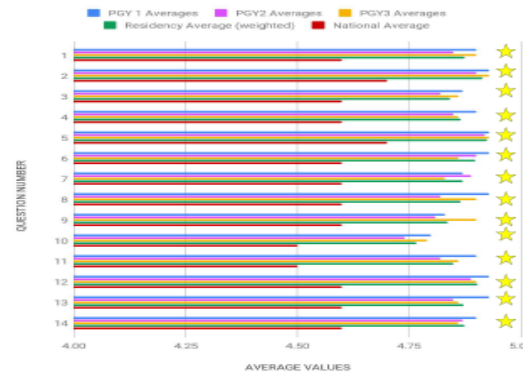
- A single center, multi-year study
- Twice annually, residents' adult non-pregnant patients will be asked to provide feedback following resident encounters using the CAT survey. Residents will complete a modified CAT questionnaire developed for this project that will mirror the questions on the patients' feedback forms.
- Residents will receive their feedback scores in a report following data collection. Residents will be able to trend their feedback over the course of their residency training and compare it to their self-assessment
- Aggregate data will be used to identify areas where residents would benefit from further training in communication.
- Teaching interventions will be implemented to address communication deficits. Resident feedback scores will be compared before and after teaching interventions.

Residents will be provided their personal feedback twice a year to trend personal progress and tailor individual teaching. Data is analyzed using a two-tailed t-test with an $\alpha=0.05$

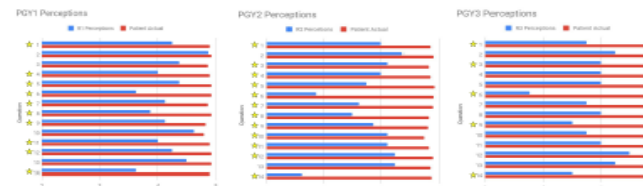
RESULTS

Preliminary data from first quarter of 2019.

COMPARISON OF RESIDENCY TO NATIONAL AVERAGES



Statistically Significant Values:
PGY1 (n=30) PGY2 (n=62)
Residency (n=121)
National Data (n=1881)



| Question | Resident | Mean | SD | Lower | Upper | Percentile | National |
|---|----------|------|------|-------|-------|------------|----------|
| Checked me in a way that made me feel comfortable | 3 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Explained things to me | 5 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Checked my vitals in a way that was comfortable | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Spent enough time with me to get my concerns | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Spent enough time with me to get my concerns | 3 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Spent enough time with me to get my concerns | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
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| Spent enough time with me to get my concerns | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
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| Spent enough time with me to get my concerns | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Spent enough time with me to get my concerns | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |
| Spent enough time with me to get my concerns | 4 | 1.90 | 1.00 | 0.90 | 2.90 | 100% | 31.1% |

DISCUSSION

- Our residency program as a whole scored statistically significantly higher than the national average for all questions in the survey. Our preliminary data includes 121 surveys, so as the number of surveys increases, our program might come close to the national average.
- Within our program, PGY 2 scored lower than PGY 1 and PGY3 residents on patient surveys, though this was not statistically significant.
- Residents scored themselves lower than their patients in all questions. This difference was statistically significant on questions 1, 6, 9, and 14.
- PGY3 residents scored themselves more accurately than PGY 1 and 2 residents
- Certain biases that are inherent with our study design include:
 - o Extreme responding bias: with most patients choosing "5" on the scale, as is commonly seen with Likert scales and has been observed with this survey in the national data as well.
 - o Selection bias: Medical assistants were asked to hand out the surveys, and there could be been some selection based on their interactions with patients.

CONCLUSIONS

- As a residency program, our averages were significantly higher than the national average.
- All residents scored themselves lower than their patients. These values were statistically lower across all years for questions #1, #6, #9, #14.
- PGY 3 residents more accurately scored themselves
- Different methods of patient survey distribution should be tried to improve validity of our data so that it better reflects national trends.

ACKNOWLEDGEMENTS

- This research project was made possible by the Medstar Franklin Square Family Medicine Residency residents and clinic staff.
- This project was deemed exempt by the Medstar Health Research Institute IRB who reviewed the protocol.
- We would like to thank Gregory Makoul who developed the CAT survey and has permitted us to use his research tool.

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Communication Assessment Tool

The purpose of this survey is to help us understand more about your experience in the MedStar Franklin Square Family Health Center.

Completing this survey is optional. You decide whether or not to complete this survey and we will not share your data. Your individual responses will not be shared with your doctor.

This survey is being conducted as part of a study that has been reviewed by our institutional review board, and we will publish the findings. Your completion of the survey will serve as our consent to take part in this study.

| | 1 | 2 | 3 | 4 | 5 |
|--|------|------|------|-----------|-----------|
| | poor | fair | good | very good | excellent |
| The doctor | | | | | |
| 1. Checked me in a way that made me feel comfortable | 1 | 2 | 3 | 4 | 5 |
| 2. Explained things to me | 1 | 2 | 3 | 4 | 5 |
| 3. Showed interest in my ideas about my health | 1 | 2 | 3 | 4 | 5 |
| 4. Understood my main health concerns | 1 | 2 | 3 | 4 | 5 |
| 5. Paid attention to me (looked at me, listened carefully) | 1 | 2 | 3 | 4 | 5 |
| 6. Let me talk without interrupting | 1 | 2 | 3 | 4 | 5 |
| 7. Cared me on search information as I wanted | 1 | 2 | 3 | 4 | 5 |
| 8. Talked to me so I could understand | 1 | 2 | 3 | 4 | 5 |
| 9. Checked to be sure I understood anything | 1 | 2 | 3 | 4 | 5 |
| 10. Encouraged me to ask questions | 1 | 2 | 3 | 4 | 5 |
| 11. Involved me in decisions as much as I wanted | 1 | 2 | 3 | 4 | 5 |
| 12. Discussed next steps, including any follow-up plans | 1 | 2 | 3 | 4 | 5 |
| 13. Spent enough time with me | 1 | 2 | 3 | 4 | 5 |
| 14. Spent the right amount of time with me | 1 | 2 | 3 | 4 | 5 |

RESIDENT RESEARCH POSTERS



Allen Jian, MD



Increasing PrEP Use at the Family Health Center

Bao Lin Jian, MD
 MedStar Franklin Square Medical Center, Baltimore, Maryland
 Department of Family Medicine

Abstract

HIV pre-exposure prophylaxis (PrEP) awareness remains low among the general patient population and up-take remains low in the high-risk groups. 20 high-risk patients at the Family Health Center (FHC) were identified using criteria from the USPSTF for a 6-month period. They were educated encouraged to initiate prophylaxis based on their risk. Those that declined initially were given educational materials and contacted 6 weeks later to re-discuss. Only 6/20 identified were agreeable to starting PrEP even after follow-up. Part 2 surveyed residents at the FHC regarding their familiarity and prescribing experience for PrEP. Most cited knowledge and criteria for screening as a barrier. Educational and online materials were provided and they were surveyed again after 4 weeks. They reported increased discussion with patients following educational interventions. This was directly correlated with increased familiarity regarding PrEP, however most continued to cite time needed to screen and follow-up as a barrier. Patients that declined use expressed the need to take a pill-daily as a major barrier, in addition to the stigma behind taking an HIV medication. Future directions can be made on assessing patients' adherence to PrEP.

Background

- An evidence-based way to prevent new infections among HIV-uninfected patients at greatest risk.
- When taken daily, can be 99% effective at preventing HIV infection
- Efficacy is highly correlated with adherence
- Grade A USPSTF Recommendation (6/11/2019)
- There is general low awareness of PrEP among at-risk populations which has lead to low uptake
- Most Primary Care providers are aware of PrEP but not many are familiar with the process of prescribing it.
- Most cited knowledge and insurance coverage as a main barrier
- 90% of PCPs stated with appropriate knowledge, would initiate conversations about PrEP

Objectives

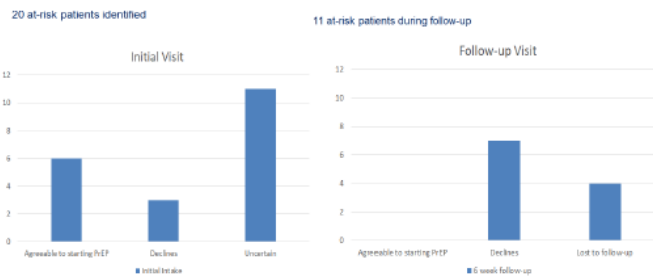
1. Increase PrEP use among high-risk patients at FHC by 50% using quality improvement approach
2. Increasing familiarity in prescribing PrEP among resident physicians at FHC by 50% using quality improvement approach

Methods

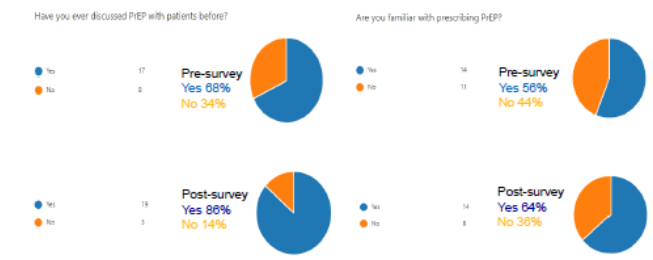
- Identify high risk sexually active patients from FHC clinic presenting on my schedule for physicals or acute visits for STIs (June 2019-Dec 2019)
- High-risk patients were defined with criterion per USPSTF
- Provide brochure and patient hand-out to those uncertain about initiation of prophylaxis treatment
- Follow-up those at-risk patients in 4-6 weeks for those that initially declined via phone or visit to discuss initiation again (June 2019- Dec 2019)
- Review barriers or reasons to starting PrEP
- Survey FHC family medicine residents on PrEP awareness, comfort and prescribing experience (Mar 2020 – April 2020)
- Provide educational handouts and quick-texts on MedConnect to increase knowledge and prescribing practice to eligible patients
- Post-survey using same questions measuring improvements

Results

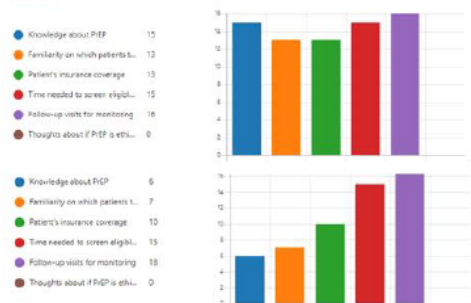
Results of Patient Goal #1



Results Resident Goal #2



What are some of your barriers on prescribing PrEP? (if none, leave blank)



Discussion

- Almost all at-risk patients were unaware of the existence of PrEP
- Many were interested in starting PrEP after brief educational intervention
- No patients were agreeable on follow-up
- Did not achieve 50% QI goal, but did increase to 30% (6/20)
- Main reasons for decline: The need to take a pill daily for prevention, lack of self-perceived HIV risk, negative perceptions of PrEP
- All residents were familiar with PrEP
- Almost all had no issues with conducting PrEP related activities
- One of the major barriers was knowledge regarding PrEP and patients to screen and discuss it with
- Improvements seen during post-survey of barriers led to a trend in increase in discussion and familiarity
- Trend towards increase in discussion and familiarity with patients
- Major barriers of time needed to screen patients and time needed for follow-up remains same in post-survey
- Limitations: Small sample size for both parts, interest may vary depending on provider, relatively small time frame
- Future directions: Assess adherence of patients on PrEP, Rates of STIs in patients before and after on PrEP, expand sample size on provider surveys

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Standardizing Resident Sign-Out for Improved Patient Safety



MedStar Franklin Square
Medical Center

Priya Raghavan, MD
MedStar Franklin Square Medical Center, Baltimore, Maryland
Department of Family Medicine

Objectives

To use a multi-stage quality improvement approach to standardize resident inpatient written and verbal sign-out for the purpose of improving patient safety

Background

The purpose of sign-out is the passage of patient information from one caregiver to another with the purpose of continuity of care. The Joint Commission and ACGME have advocated for all hospital services to have a standardized hand-off process. In 2017, the ACGME reported that approximately 60% of hospital learning environments lack a standardized sign-out. An article from the Joint Commission in 2017 reported that approximately 30% of malpractice claims can be linked back to a hand-off communication failure. Standardized sign-out practices like I-PASS and SBAR have been shown to reduce hand-off communication errors, including identifying patient activity, follow up tasks and providing contingency plans. Studies have shown that not only providing a standardized sign-out, but also providing training in verbal sign-out improves patient safety and improves resident confidence in the sign-out process. The resident sign-out process is a critical component in the safe hand-off of patient data from shift to shift. Currently, there is no standardized process in place on the family medicine inpatient team at Medstar Franklin Square, Baltimore, MD.

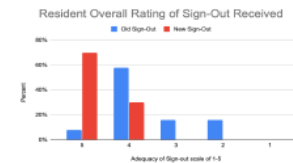
Methods

This study consisted of a multipronged intervention on a Family Medicine Residency inpatient team based on quality improvement methods from May 2019 to May 2020.

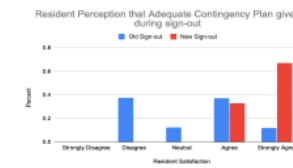
- **PDSA Cycle 1:** Created standardized verbal and written hand-offs based on recommendations from the Joint Commission and I-PASS. Emailed new sign-out structure to faculty and residents (July 2019). Trialed new sign-out for 4 weeks and documented verbal feedback
- **PDSA Cycle 2:** Timed duration of patient sign-out based on old patient hand-offs for 73 patient sign-outs. Had residents complete survey pre-intervention. Timed duration of patient sign-out based on new patient hand-offs for 81 patient sign-outs. Re-distributed survey post intervention
- **PDSA Cycle 3:** Evaluated feedback from prior surveys updated the new sign-out. Sent out new PowerPoint and recording of sign-out. Timed duration of patient sign-out based on old patient hand-offs for 60 patient sign-outs. Had residents complete survey pre-intervention. Timed duration of patient sign-out based on new patient hand-offs for 59 patient sign-outs. Re-distributed survey post intervention
- **PDSA Cycle 4:** Reviewed Cores Daily for 2 weeks to assess consistency of use of standardized sign-out

Results

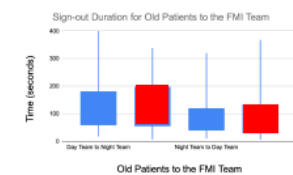
Results: Resident survey of overall satisfaction of Sign out received.
Pre-intervention (N=12) Post-intervention (N=10)



Results: Resident survey on if adequate contingency plan provided
Pre-intervention (N=8) Post-intervention (N=8)

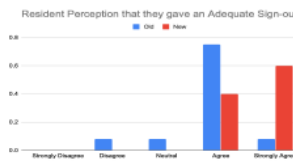


Results: Duration of sign-out for patients not new to the inpatient service
Pre-intervention (N=82) Post-intervention (N=86)



Results: Sustainability of written sign-out structure over 2 week period (N=50) = 100%

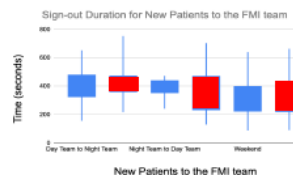
Results: Resident survey of overall satisfaction of Sign out given
Pre-intervention (N=12) Post-intervention (N=10)



Results: Resident survey on if adequate task list provided
Pre-intervention (N=8) Post-intervention (N=6)



Results: Duration of sign-out for patients new to the inpatient service
Pre-intervention (N=51) Post-intervention (N=54)



Results: Verbal Feedback (N=11)

- "New sign-out better for contingency plan, new patients and new team."
- "Format helpful to get key points across adequately."
- "The If/Then is super helpful."
- "I think it takes a little to get used to, but if you follow the format, nothing gets missed. I like that we only talk about the actual medical problems and not the extraneous stuff like reflux med for GERD that's number 10 on the list."
- "I remember before we started this - there would be days that I would leave and realize I forgot to tell the team the most important thing because it was problem 4 on the list and I got distracted by something else."
- "I haven't done day to night yet, but from what I've watched - the interns are doing a really good job and nothing is missed."

Study Limitations

- Time of initiation: Parts of new sign-out already implemented at time of study
- Learning curve for learning the new sign-out system
- Consistency of timing duration of hand-offs
- Ability to train all residents on standardized verbal sign-out
- The ability to consistently observe and confirm that the new verbal sign-out was being completed consistently and correctly

Discussion

- New Sign-out written standardization was sustainable for residents on the inpatient team
- New Sign-out did identify sickest patients
- New Sign-out did NOT reduce the duration of individual sign-outs
- New Sign-out did reduce resident perception of improved patient safety
 - Consistency of task hand-offs
 - Consistency of if/then for acute issues
- New Sign-out did improve resident overall confidence in the sign-out process

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CURRENT PGY3 RESIDENTS: CLASS OF 2021



Adwoa Adu, MD



Ankita Ambasht, MD



Linda Ataifo, MD



Sarah Gray, MD



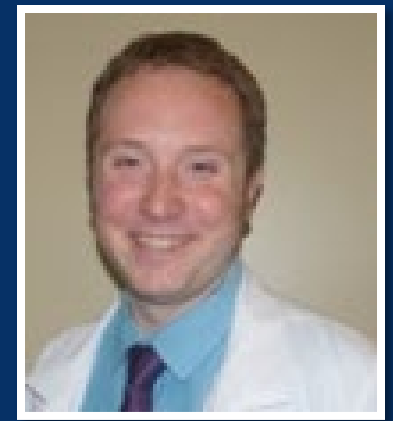
Jeremy Parsons, MD



Matthew Shapiro, MD



Angele Wafo, MD

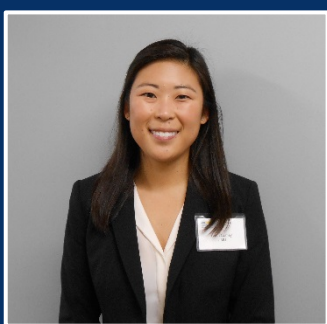


**Joseph Brodine, MD, MPH
FM/Prev Med**

CURRENT PGY2 RESIDENTS: CLASS OF 2022



Sydney Allison Kraemer, MD
Fam Med/Prev Med class of
2022



Anna Conley, MD
University of Maryland



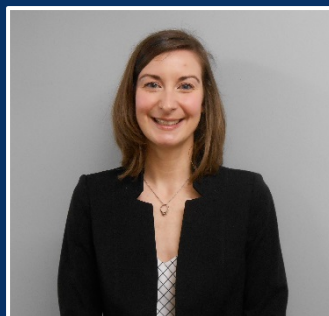
Christopher Favero, MD
Medical University
of the Americas



Laura Kurata, MD
University of Hawaii



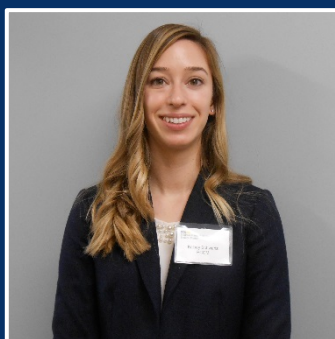
Allyson Lynch, MD, MPH
Drexel University



Ilyssa Moore, MD
Saba University



Julie O'Donnell, DO
Lake ERIE College of Osteopathic Medicine



Kelsey Schwartz, DO, MS
Philadelphia College of Osteopathic
Medicine



Andrew Shaw, DO
Edward Via College of Osteopathic
Medicine



Jarett Beaudoin, MD
Fam Med/Prev Med
Thomas Jefferson University
(Class of 2023)

WELCOME FAMILY MEDICINE RESIDENCY CLASS OF 2023



Chrystal Pristell, D.O.



Dylan Lindauer, MD



**Michael Harding, MD
FM/ Prev Med
(Class of 2024)**



Martine Randolph, MD



Peyton Kremer, D.O.



Sarah Robinson, D.O.



Seychelle DeVries, MD



Stephanie Davis, MD

Franklin Square Family Health Center felt like home from the moment I met the people who comprise it. As a 4th year Georgetown student who thought "Franklin Square" referred to the park in mid-town DC, rotating at FSH was a very fortunate misunderstanding. I was most struck by the open-mindedness of FHC providers, their incredible wealth of knowledge, and their seemingly endless ability to welcome my questions and teach. I was so struck, in fact, that I left the rotation determined to go into Family Medicine. I resonate strongly with their motto: "go where the learning is best". For me, that place is FSH!

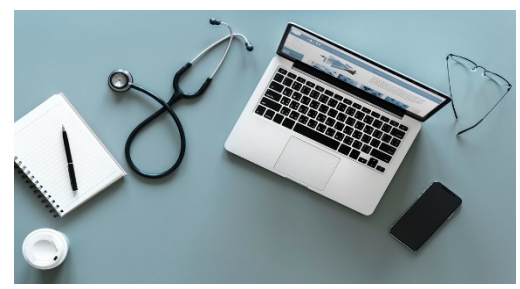
- Stephanie Davis, MD, PhD, 1st year Resident

Picking a residency is a difficult decision, but I could not have been happier with my choice of Franklin Square Family Health Center. The faculty's commitment to our education is tireless and the environment has been incredibly supportive. I am looking forward to continuing to build relationships with my family here at Franklin Square!

- Peyton Kremer, DO, 1st year Resident

2019-2020 FAMILY MEDICINE INTERVIEW STATS

| | <u>Invited To Interview</u> | <u>Interviewed</u> |
|---------------|-----------------------------|--------------------|
| FM Program: | 195 | 118 |
| Dual Program: | 10 | 8 |



Total number of applications received: 1505 (FM); 1410 active, 637 reviewed (FM), 195 (FM/Prev Med); 39 reviewed

Family Health Alumni News

In August, Governor Larry Hogan announced new senior leadership for Maryland Department of Health's Public Health Administration. In this announcement, Dr. Sohail Qarni, a graduate of our Family Medicine Residency, was appointed Medical Director of the Prevention and Health Promotion Administration (PHPA). In this role, he will develop operational policies, evaluate services, coordinate and analyze data, and make recommendations and decisions to improve clinical service delivery. Dr. Qarni is a Public Health and Board-Certified Family Practice physician and served as Chief of the Communicable Diseases Division at the Baltimore County Health Department. Dr. Qarni previously provided care in a private practice and was a medical consultant at the Anne Arundel County Health Department.

Kelly Ryan- we know about her stuff!

Melanie Connah- now an attending at a brand-new residency in South Carolina

Katie Jacobson- clerkship director for family medicine at University of Maryland

Janelle Hinze Leuschen- private practice MedStar

Max Romano- health care for the homeless

Richard Bruno- medical director, chase brexton

Melanie Grady- quality and safety officer for medstar

Sadhika Jamisetti- OB fellowship, Alabama

Melissa Nicoletti- sports med fellowship, Miami

Jordan Gottschalk- joined a new family medicine practice Orlando, FL

Hasan Shihab- hospitalist peoria, IL

Courtenay Morrow- private practice GBMC

Rob Levine, primary care, Kaiser in Towson

**COMBINED FM/
PREVENTIVE MEDICINE
RESIDENCY**

COMBINED FAMILY MEDICINE/PREVENTIVE MEDICINE RESIDENCY PROGRAM UPDATES:

The Combined Family Medicine-Preventive Medicine Residency is a four-year residency program leading to board certification in both Family Medicine and General Preventive Medicine. The program is a collaboration between MedStar Franklin Square Family Medicine Residency and Johns Hopkins Bloomberg School of Public Health (JHSPH) General Preventive Medicine Residency. The goal of the program is to train leaders in family medicine and public health to improve health through partnership, discovery and advocacy.

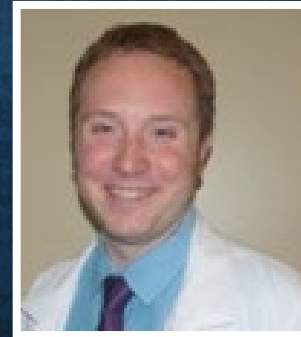
OUR FAMILY MEDICINE/PREVENTIVE MEDICINE RESIDENTS:



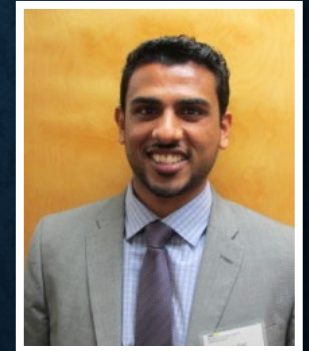
Jarett Beaudoin, MD
Fam Med/Prev Med
Class of 2023



Sydney Allison Kraemer, MD
Fam Med/Prev Med
Class of 2022



Joseph Brodine, MD, MPH
FM/Prev Med
Class of 2021



Nithin Paul, MD, MPH
FM/Prev Med
Class of 2020

COMBINED FAMILY MEDICINE/PREVENTIVE MEDICINE RESIDENT UPDATES:

Joseph Brodine, MD, MPH (PGY4):

- Co-Authored a review article with faculty, Dr. Kelly Ryan "Medicine in the Sport of Horseracing" in Current Sports Medicine Reports
- Served as Course Co-Director for "Problem Solving for Public Health", a graduate course taught at the Johns Hopkins Bloomberg School of Public Health
- Invited to rotation with NIAID Division of Global Research (Spring, 2021)

S. Alison Kraemer, MD (PGY3):

- During a rotation with the International Association of Fire Fighters, assisted headquarters with COVID-19 operational policies and updated the brain cancer science document while also writing a contributing factors letter for an individual firefighter's legal case
- Led a meditation and mindfulness session for fellow residents during Preventive Medicine Admin Rounds
- Continued efforts to involve medical students in climate change and nuclear war activism as a Board Member with Chesapeake Physicians for Social Responsibility.

Jarett Beaudoin, MD (PGY2):

- Served on US healthcare pricing research group through JHU Bloomberg School of Public Health
- Completed Masters in Public Health at Johns Hopkins Bloomberg School of Public Health
- Served as TA for "Problem Solving for Public Health" Course
- Continued to help with implementation of an Ultrasound Curriculum at Franklin Square Family Health Center

CURRICULUM HIGHLIGHTS

Updates to the Pediatrics Curriculum

Fit Family is a program started at FHC. It is a Pediatric Group Visit model, and was a huge success!

- 9/10 families participated in 4 group sessions, including transitioning to virtual sessions
- All participating families received 2 months of FREE home delivery of fresh fruits and veggies (which continued during the pandemic)
- Group visits were facilitated by Dr. Mercer, Dr. Raghavan, and Dr. Ling
- MedStar nutrition and athletic training were also a part of the visits with live cooking demonstrations and “Simon Says” physical activity



Dr. Uchenna Emeche, Dr. Sasha Mercer, Dr. Lee Fireman, Dr. Priya Raghavan, and Dr. Laura Ling have worked with residents, students, and other faculty to create “Fit Families”. This project provided different pediatric family patients to participate in group virtual support meetings discussing obesity, activity, getting fit and staying healthy. These groups provided healthy foods, different recipes, activities, and support. Each participant also received a box gift to get them started on their fit family journey.

Updates to the Curriculum

MAT Clinic

We launched our Medication Assisted Treatment specialty clinic for our patients with substance use disorder in January. Despite volume losses seen in the pandemic, we have seen several patients thus far for evaluation and treatment through the clinic. There are substance use treatment provider shortages locally and nationally. The launch of this clinic allows for us to help address this care shortage as well as train our residents to provide addiction care in their future practices. This clinic has been made possible thanks to interdisciplinary collaboration and support both from within our department and organization as well as community partners.

LIC / MEDICAL STUDENTS

MEDICAL STUDENT EDUCATION

Teaching Is Our Passion

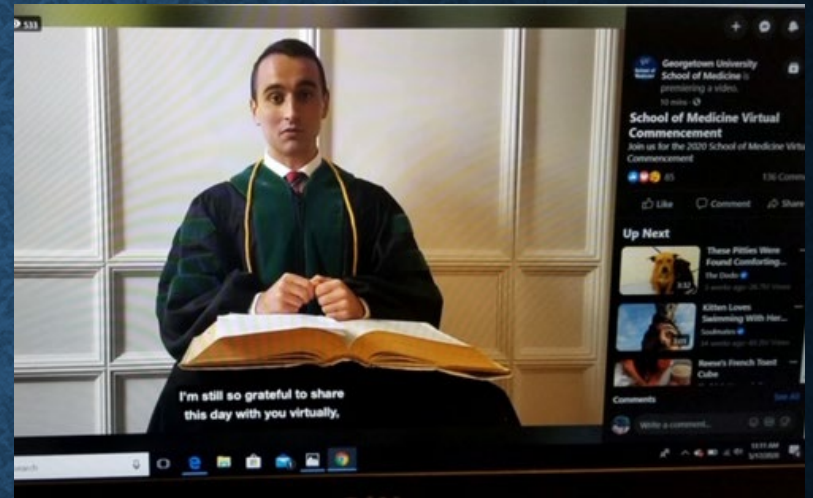
The Department of Family Medicine and Family Medicine Residency at MedStar Franklin Square Medical Center have many opportunities for medical students at all levels of training interested in Family Medicine. We are a site for family medicine core clerkship for Georgetown University School of Medicine third year students. We accept students from various LCME accredited institutions in the United State for elective rotation. Rotations are four weeks in length in an outpatient setting. In addition to medical students, we also host students in other related fields such as pharmacy and social work.

The Family Health Center also houses the Longitudinal Integrated Clerkship (LIC) for Georgetown University School of Medicine. In this program, third year medical students learn internal medicine, family medicine, pediatrics and obstetrics / gynecology simultaneously while caring for a panel of their own patients over an extended period of time. More than 40 students have completed the LIC to date.





Georgetown graduate Lindsay Thimmig has Dr. Barr “hood” her signifying that she is now an MD during the medical school’s virtual graduation. Lindsay send this picture to Dr. Barr so they could have a real time graduation experience despite the COVID pandemic. As you can imagine, Dr. Barr cried her eyes out!



Our own LIC student, Jack Pollack, giving the student remarks speech virtually at graduation.

- Due to COVID, Dr. Nancy Barr conducted two deep dive sessions for the 4th year medical students on Clinical Ethics. Each session was two weeks; she designed and taught the course on her own, as well as volunteered with small group sessions for pediatrics- development and obesity.
- The 3rd year medical students did all didactics virtually and Dr. Barr taught four 1-hour sessions for the pediatrics clerkship.
- The 4th year medical students were also taught a two-week telehealth course where Dr. Barr directed the course, designed the curriculum and taught many of the sessions.
- The 3rd year medical students also took the telehealth course as the Deans at Georgetown decided to make it part of the virtual curriculum for the 3rd year students.

YEAR 4 OF THE GEORGETOWN LONGITUDINAL INTEGRATED CURRICULUM A HUGE SUCCESS!



Our last LIC class before the pandemic became quite a cohesive group- they even took a holiday vacation photo in front of their tree! Lizzie, Shannon, Joanna, John, Stephen, and Kellie became an important part of our family too. Now they are moving on to become an otolaryngologist, a pediatrician, a urologist, an obstetrician, and two-family physicians. We have no doubt they will take holistic care of their future patients, as they learned in the LIC!

TEAM BUILDING, FUN, AND WELLNESS

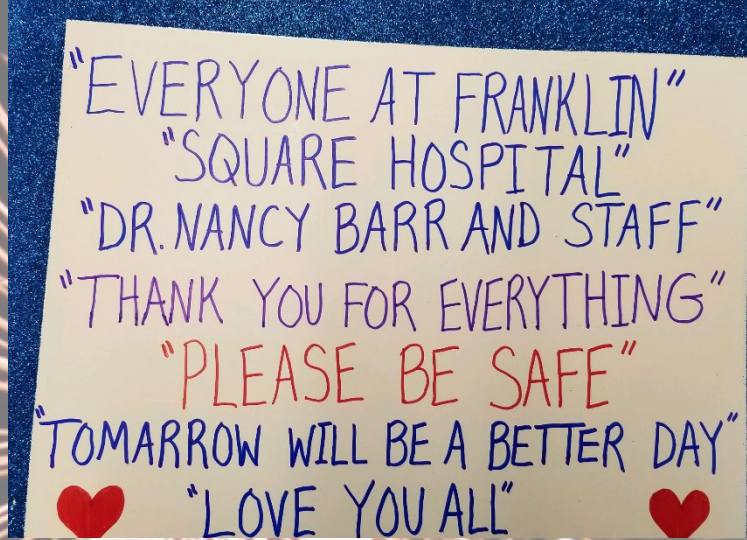
Celebrations!

Despite the Pandemic, we still found ways to support each other and keep up morale during 2020.

- We celebrated CMA day with bath bombs, and the holidays with chocolate bombs.
- We learned how to socially distance
 - Pandemic appropriate birthday celebrations
 - Telehealth and teaching virtually
 - "Road Shows" to inform staff and keep them entertained
 - Still managed to dress up for Halloween
 - Reunions with former workers training us on the latest COVID testing devices/ techniques

Some of the changes we had to adjust to included:

- Cancelling our annual Family Health Center Retreats
 - Faculty Retreat
 - Annual FHC Retreat
 - New Intern Retreat
 - Resident Retreat
- Working short staffed
- Trying to avoid burn out
- Comply with regulations for patients, family, and staff



Celebrations Pre-Covid



Celebrations- Post Covid

Dr. Barr kindly created poems with COVID instructions and emailed them to our FHC family so we better understood rules, regulations, policies, etc. These poems kept morale in the office up and brought smiles to everyone's faces while helping to navigate the ever-changing environment. Here is her first poem and the most recent:

I was asked to do a wrap-up email
Cause trying to read them all word for word is an epic failure.
We're going to go over 5 things that are relevant,
Which still results in an email the size of an elephant.

First off- E-visits! We're starting off good.
Now we got to get more up here in our 'hood.
Docs and PA's, go through your panels,
And see which patients can be "seen" in their fuzzy socks and flannels.
Also go through your schedules that already exist,
And write down who's good for video to create a list.
Give the list to your team secretary and she'll get on the phone,
To let our patients know they are not alone.
Staff, please write the cell number in Cerner where it can be seen,
So, we're not calling the rotary land line circa 1918.
Anybody that calls with any kind of complaint,
Offer an e-visit! The patient can say it's a go or it isn't.
If it's not the patient's preference, then offer only audio,
Not nearly as good, but way better than zero!

Subject 2: PPE, no changes here.
Keep doing your thing and wear that gear!

Thing 3: COVID testing, no change, so it goes,
Docs, please make sure patients know beforehand the swab goes up the nose!

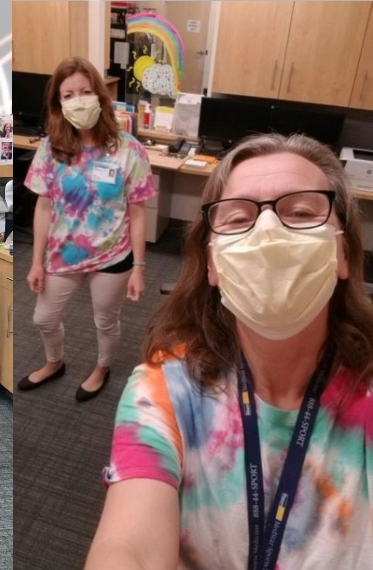
Last subject: Our own stress in this crazy time.
It's understandable to wish this was the corona that comes with lime.
Until we get through this, there's help for us all,
EAP is at **866-765-3277**, that's the number to call.
If you're more a do-it yourselfer, this is also without fee:
For healthcare workers, the Headspace App is free!

Mr. MedStar made a new rule for our eyes,
Wearing a face shield or goggles has been deemed most wise.
If you need a new shield, please see Mindy for it,
Got to wear it whenever you see patients,
til we'll done with this #&@(!* (rhymes with it.)

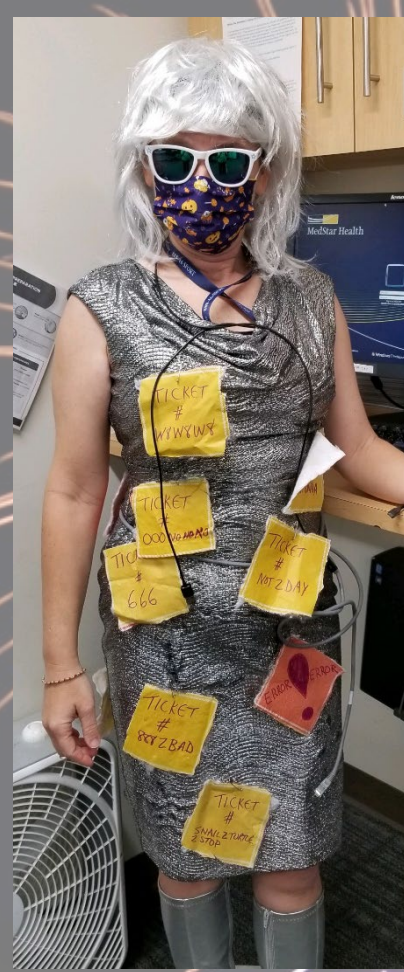
We've had a patient who refused to wear a mask,
No matter how many times and what words we used to ask.
This is completely against MedStar policy,
If we have a refuser, that patient we are not allowed to see.
They either wear the mask in the right way,
Or we tell them to go away.
This is not so for people who cannot,
Like a patient with dementia or a tiny tot.

The info on the portal is now much more,
The patient can read dang near anything,
from juicy info to a total snore.
If you write it down before November 2,
The patient needs to request to see what you did do.
But after that, then all your notes are viewable,
No need to change what you document but realize this is now doable.

We're all getting tired of this, experiencing mask life fatigue,
But we must stay vigilant, or we will forever be in this league.
Numbers is Maryland have ticked up a snick,
Keep social distancing and wearing masks,
that should do the trick!



Celebrations Post-Covid



Distanced birthday celebrations, baby showers and celebrations

COMMUNITY OUTREACH

ASYLUM EVALUATIONS

In 2019, there were 67,406 asylum hearings in the United States for people seeking refuge from persecution in their home countries. Faculty and residents in the Family Health Center are undergoing training through Physicians for Human Rights to aid persons seeking asylum by completing forensic medical and psychological exams documenting the severe physical and psychological trauma experienced by these asylees. Medicolegal affidavits are provided to Physicians for Human Rights lawyers in support of the asylum application; these affidavits significantly increase the chances of an asylee being granted asylum.



Please follow the link to read more information from the Physicians for Human Rights Report on the persistent psychological effects of family separation: <https://phr.org/our-work/resources/you-will-never-see-your-child-again-the-persistent-psychological-effects-of-family-separation/>

“It is heartening and powerful to see the multiple Family Medicine organizations stand together to advocate against family separation. Claudia, Annie, and I recently witnessed the harms of this policy firsthand when we completed a psychological asylum evaluation for an adolescent that was separated from his parent at the border. We actually referenced this PHR report in our affidavit to support the claims of psychological trauma. They may, in fact, use our affidavit to support future PHR reports as well. It is times like these that I am truly proud to be a Family Medicine physician, and a part of this team. Thank you everyone for supporting this work.” - Katherine Stolarz, DO

Physicians for Human Rights



“You Will Never See Your Child Again”

The Persistent Psychological Effects of Family Separation

February 2020



SPORTS MEDICINE IN THE COMMUNITY

Dr. Kelly Ryan and Dr. Joseph Brodine had their article, CSMR-D-19-00193R1 “Medicine in the Sport of Horse Racing”, published in Current Sports Medicine Reports for the September/ October journal issue for the American College of Sports Medicine.



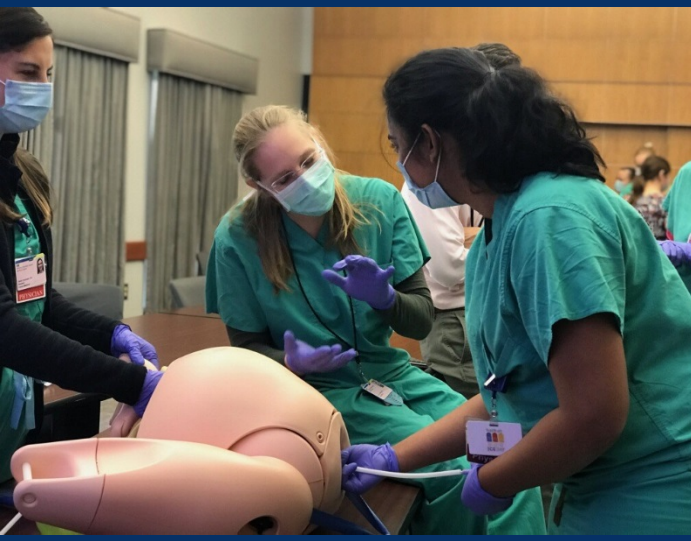
FAMILY MEDICINE AND OB SIMS



OB SIM at Franklin Square took place in September. Of note, resident feedback stated, "this was the best OB SIM in 3 years!" We are proud of the work the OB team has put into strengthening the OB experience. Kudos to all!



In February, Dr. Katherine Stolarz taught normal vaginal delivery and shoulder dystocia during the MedStar Global Health Bootcamp OB Simulation in DC.



FAMILY MEDICINE AND ALSO

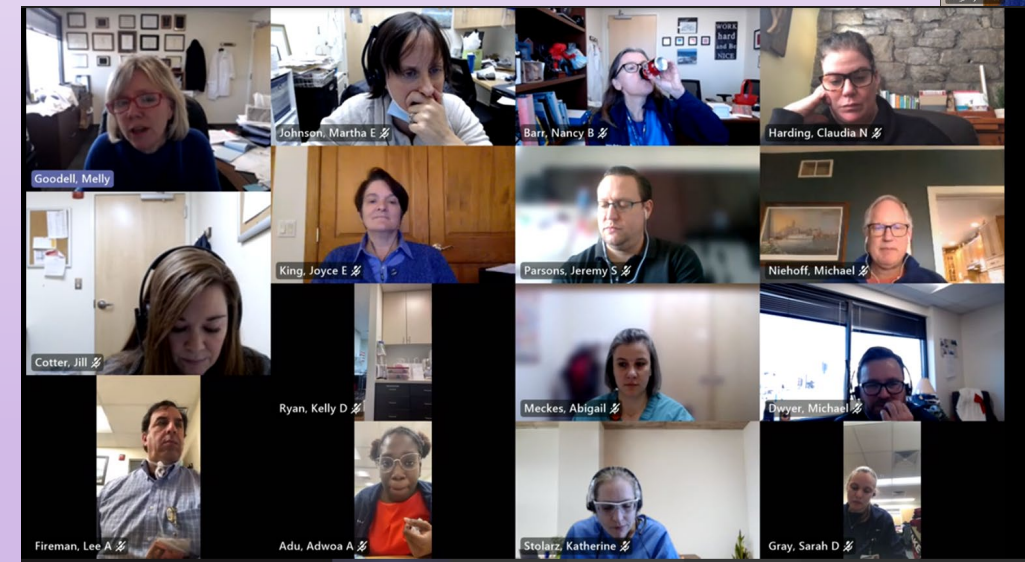
- Dr. Cotter and Dr. Stolarz teach in the AAFP Advanced Life Support in Obstetrics course in York, PA; teaching Family Medicine and Obstetric Interns from WellSpan York Hospital and MedStar Franklin Square Hospital.



SCHOLARS' CORNER AND CONFERENCES



Dr. L. Elizabeth Moreno and Dr.



Dr. Johnson presented a Family Medicine Grand Rounds lecture on “Using Disability Rights to Inform Care of Patients with Disabilities”. This was our first in person/virtual grand rounds presentation since Covid-19 pandemic hit. Everyone who attended in person, in Kotzen Auditorium, was socially distanced over the 6foot guidelines, wore proper PPE, and ensured proper hand hygiene when entering the auditorium and exiting.

FACULTY PUBLICATIONS AND PRESENTATIONS



Jill Cotter- Williamson M., Hogue G., **Cotter J.**, Roberman S., Neal G, Williamson B.. Suicide screening: How to recognize and treat at-risk adults. *J Fam Pract.* 2019 Nov; 68(9):505-510.



Katherine Stolarz- Ranit Mishori, Katherine Stolarz, Anita Ravi, Valeriy R. Korostyshevskiy, Ronald Chambers & Peter Cronholm (2020) Assessing Family Medicine Residency Programs' Training on Human Trafficking: A National Survey of Program Directors, *Journal of Human Trafficking*, DOI: [10.1080/23322705.2020.1780082](https://doi.org/10.1080/23322705.2020.1780082)



Joyce King- Textbook Chapter; Gastroparesis: Pathophysiology, Clinical Presentation, Diagnosis and Treatment, Editors: Richard W. McCallum, Henry P. Parkman, Chapter 27, *Psychiatric Aspects of Gastroparesis*, pg. 377-387.



Kelly Ryan- Ryan K, Garruppo G, Alexander K, et al. Injuries among Maryland jockeys during thoroughbred racing: 2015–2019. *BMJ Open Sport & Exercise Medicine* 2020;6:e000926. doi: 10.1136/bmjsem-2020-000926.

<http://bmjopensem.bmj.com/cgi/content/full/6/1/e000926>

Ryan K, Brodine J. CSMR-D-19-00193R1 “Medicine in the Sport of Horse Racing”. *Current Sports Medicine Reports*. September/ October 2020. American College of Sports Medicine.



Elise Worley- Presentation: Exploring the role of a clinical pharmacist on an interdisciplinary home-based primary care program. Annual Meeting Oct 2020 - American Academy of Home Care Medicine (virtual meeting)

Andrea Gauld- Kwon M, AE Moody, J Thigpen, AR Gauld. Implementation and Evaluation of Opioid Overdose and Naloxone Distribution Training in a Pharmacist Laboratory. *American Journal of Pharmacy Education*

2020, 84(2) 7179; DOI: <https://doi.org/10.5688/ajpe7179>

Bailey TM, Gauld AR. Premenstrual Syndrome and Premenstrual Dysphoric Disorder. In: O’Connell MB, Smith JA eds. *Women’s Health Across the Lifespan*, 2nd edition. New York, NY: McGraw-Hill; <http://accesspharmacy.mhmedical.com/content.aspx?bookid=2575§ionid=213570085>.

Presentation: Medical Cannabis and CBD: Understanding Its Role in Therapy and Legislation. CME accredited continuing education knowledge-based program-Maryland Academy of Family Physicians Winter Regional CME Conference



THE SOCIETY OF TEACHERS OF FAMILY MEDICINE ANNUAL SPRING CONFERENCE- PRESENTATIONS/POSTERS



Faculty and residents virtually attended STFM's Annual Conference August 24, 2020, through August 28, 2020.



Martha Johnson-Presentation: Chen K and Johnson M. Long Term Effectiveness of an Intensive Diabetic Bootcamp. Structured Scholarly Curriculum for Early Learners Within a Family Medicine Residency. Presented at Society of Teachers of Family Medicine Annual Conference, Salt Lake City UT, August 2020 (poster)
Barr N, Emeche U, Johnson M. Structured Scholarly Curriculum for Early Learners Within a Family Medicine Residency. Presented at Society of Teachers of Family Medicine Annual Conference, Salt Lake City UT, August 2020 (scholarly topic roundtable discussion)



Nancy Barr-Presentation: Barr N, Emeche U, Johnson M. Structured Scholarly Curriculum for Early Learners Within a Family Medicine Residency. Presented at Society of Teachers of Family Medicine Annual Conference, Salt Lake City UT, August 2020 (scholarly topic roundtable discussion)



Uchenna Emeche- Presentation: Barr N, Emeche U, Johnson M. Structured Scholarly Curriculum for Early Learners Within a Family Medicine Residency. Presented at Society of Teachers of Family Medicine Annual Conference, Salt Lake City UT, August 2020 (scholarly topic roundtable discussion)
Rebuilding OB Faculty Force: Shared University and Community. Presented at Society of Teachers of Family Medicine Annual Conference, Salt Lake City UT, August 2020
Family Medicine Education Consortium: "Perception of Health Among Patients in a Care Coordination Program"

FAMILY MEDICINE ADVOCACY & LEGISLATIVE

Dr. Mike Niehoff is on the Legislative Council of MedChi and the Health Insurance subcommittee. He also testified in Annapolis on several bills.

Dr. Chrystal Pristell participates in the MedChi resident working group, the Health Equity subcommittee of AAFP, and the Working GROUP FOR Racial Justice Curriculum subcommittee for Georgetown.



Advocacy day for Maryland academy of Family Physicians- our doctors, residents, and alum travel to Annapolis to speak with our state representatives (pre-covid)

Hospital Updates

The surgical pavilion opened
Stats on pavilion
Leap frog- grade A, info from
Mimi (embargoed?)

Neuro-interventional services
have been added



NEW TONIGHT Helipad Open At MedStar Franklin Square Med. Center



Helipad Ribbon Cutting and Test Flight a Success

The first test flight and ribbon cutting for MedStar Franklin Square Medical Center's helipad occurred yesterday, December 7. When the Tower was built over ten years ago, the infrastructure of the helipad was placed on the roof in the hopes that we would eventually be able to have a helipad on campus. Throughout the past ten years, we were able to access a field on a neighboring site, which required a ground vehicle transport leg between the hospital and the helicopter site. The newly constructed helipad's benefits are priceless and signify an investment in our campus and the start of a new era on our campus. [Visit this site to see the test flight landing.](#)



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<https://www.facebook.com/MedStarFranklinFMR/>

THANK YOU



MedStar Health