MedStar Franklin Square Medical Center

Knowledge and Compassion
Focused on You

ANNUAL REPORT
2017-2018

The Department of Family Medicine
"Improving Health Through Partnership, Scholarship and Advocacy"

A YEAR IN REVIEW FROM DR. MELLY GOODELL

Chair, Department of Family Medicine

I'm proud to share the Department of Family Medicine 2017-2018 Annual Report with you.

This year saw us continue our successful clinical and educational journeys while navigating changes in the local healthcare landscape. You will be impressed by the outstanding work done by our residents and faculty, and those who support them, in striving to improve the health of our community, provide the highest quality patient care, achieve excellence in resident and student education, and to represent MedStar locally, regionally, and nationally.

RESIDENCY HAPPENINGS

We are very pleased with our past academic year for 2017-2018.

We were successful with our recruiting season and we filled in the match with high quality residents. Our four-year Combined Family Medicine and Preventive Medicine program in collaboration with the Johns Hopkins Bloomberg School of Public Health continues to attract talented residents.

Our residents and faculty hold numerous national and regional leadership positions and present at local and national conferences. We have been a level 3 PCMH since 2011 and continue to improve the quality and cost of care that we deliver in the Family Health Center.

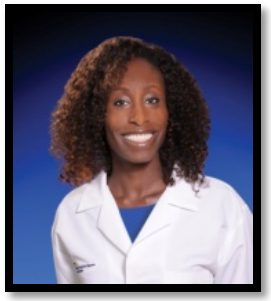
FAMILY MEDICINE CORE FACULTY

The Heart of Our Department

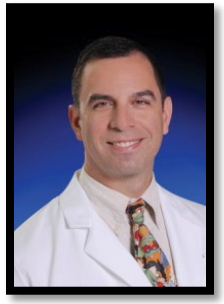
Nancy Barr, MD
Medical Director ,
FHC/Med Student Ed

Lauren Drake, MD
Faculty

Michael Dwyer, MD
Program Director, FM
Residency



Uchenna Emeche, MD
Faculty, FM
Associate Medical Director



Lee Fireman, MD
Pediatrics Faculty

Andrea Gauld, PharmD,
BCACP, BCPS

Britt Gayle, MD
Faculty

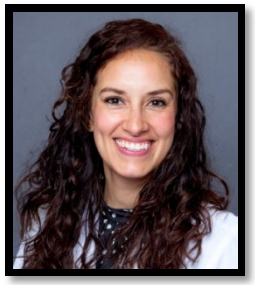
Melly Goodell, MD
Chair, FM

Lauren Gordon, MD
Director of Women's Health

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

Martha Johnson, MD
Faculty

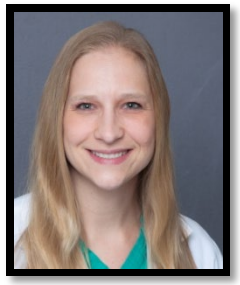
Joyce King, MD
Director of Inpatient
Training



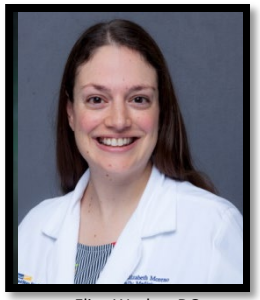
Laura "Eli" Moreno, MD
Faculty

Michael Niehoff, MD
Director of
Musculoskeletal
Programs

Kelly Ryan, DO
Clinical Faculty &
Sports Medicine



Katherine Stolarz, DO
Faculty

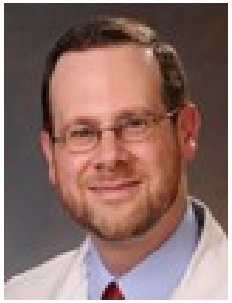


Elise Worley, DO
Faculty

FAMILY MEDICINE ADJUNCT FACULTY 2017-2018

Kendal O'Hare, MD
Adjunct Faculty

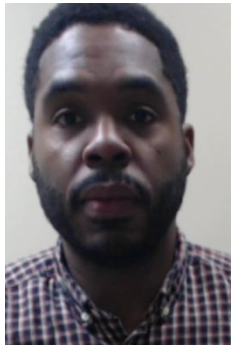
Tobie Lynn Smith, MD
Medical Director,
HCH-BC



Jay Weiner, MD
Adjunct Faculty

FAMILY MEDICINE FALL 2018 ADDITIONAL FACULTY

Sasha Mercer, MD
Faculty



David Pierre, DO
Faculty

Ari Silver-Isenstadt, MD
Pediatrics Faculty

Stephanie Hemm, MD
PediatricsFaculty

Tia Medley, MD
Pediatrics Faculty

Jessica Nooralian, MD
Pediatrics Faculty

GOODBYE SALLIE

The Heart of Our Department

In August we said goodbye to Dr. Sallie Rixey. Dr. Rixey's contributions to the department of Family Medicine spanned over 20 years as she served as Program Director of the Residency Program, Founder and Program Director of the Combined Preventive Medicine Program with Johns Hopkins Bloomberg School of Public Health, and Vice Chari of the Family Medicine department.

In addition Dr. Rixey contributed numerous decades of care to our patients, guidance and advice to residents as well as students, and friendship to fellow providers. Although she is no longer practicing with the Family Health Center, we all cherished the time she was able to share with us.

CLASS OF 2018 GRADUATES

Julian Barkan,
DO, MPH

Jasmeen Gill, MD

Jordan Gottschalk, DO

Suchi Nagaraj, MD

Melissa Nicoletti, MD

Jamille Taylor,
MD, MPH

Grace Cho
Wessling, MD

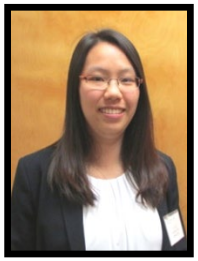
Max Romano,
MD, MPH
FM-PREV MED
Class 2019

Hasan Shihab,
MBChB
FM-PREV MED
Class 2018

FAMILY MEDICINE RESIDENCY CLASS OF 2019

Candice Bainey, MD

Melanie Connah, MD



Kai Chen, MD

Michelle Dutkin, MD

Janelle Hinze, MD

Nithin Paul,MD
FM-PREV MED
Class of 2020

Farrah Siddiqui, MD

FAMILY MEDICINE RESIDENCY CLASS OF 2020

Mariam Antonios, DO

Chelsea Backer, DO

Annie Bailey, MD

Sadhika Jamisetti, MD

Allen Jian, MD

Samantha Kurzrok, MD

Priya Raghavan, MD

Joseph Brodine, MD
FM/Prev Med
Class of 2021

2017-2018 FAMILY MEDICINE INTERVIEW STATS

	Invited To Interview	Interviewed
FM Program	166	116
Dual Program	12	7

Welcome New Interns! Retreat 2018

"It was through AAFP and MDAFP conferences in conjunction with my family medicine rotation at Franklin Square during medical school, I was drawn to become a family physician. It was then through policy-making in the AMA and MedChi, namely around community health workers and housing instability, I was motivated to pursue further efforts in domestic health care policy and a Master of Public Health degree. I am so grateful to be at Franklin Square and Johns Hopkins learning to become a skilled generalist and public health practitioner. I am excited to learn more about how multidisciplinary, integrative health services are an avenue for more cost-effective care and wider social support for underserved populations. I honestly cannot think of a better city than Baltimore in which I could learn, grow, and serve."
Sydney Kraemer, M.D. 1st Year Resident

"Going through med school, I naturally gravitated towards family medicine. Being able to connect with patients on many levels is how I envision myself as a physician. When I interviewed at Franklin Square, I immediately could tell that the physicians working here modeled my vision. Everyone treated me like I already belonged, and I knew I wanted to come here to complete my training."
Jeremy Parsons, M.D. 1st Year Resident

"It took me one week into my Family Medicine rotation to decide that I wanted to choose Family Medicine as a specialty. The diversity of the specialty and the lasting relationships with the patient, instantly captured my interest. While I was on my interview trail as a 4th year medical student, Franklin Square constantly stood out in my mind. I kept on remembering the faculty and residents- their kindness, support, and eagerness to teach and learn from each other. So when it came time to make a decision, it was an easy one and I couldn't imagine being anywhere else."
Adwoa Adu, M.D. 1st Year Resident

WELCOME FAMILY MEDICINE RESIDENCY CLASS OF 2021


Adwoa Adu


Ankita Ambasht


Linda Ataifo


Sarah Hakkenberg


Jeremy Parsons


Matthew Shapiro


Angele Wafo


Sydney Allison Kraemer
Fam Med/Prev Med
Class of 2022

PREVENTIVE MEDICINE
It Happens Here

Michael Dwyer, MD, current Program Director of the categorical Family Medicine Program, will serve as co-director of the combined Family Medicine and Preventive Medicine program with Dr. Clarence Lam, Program Director of the Johns Hopkins General Preventive Medicine Program.

Richard Bruno (graduate 2017) has been keeping quite busy since graduating last year. He began his career as an independent family physician at Baltimore Medical System's Belair-Edison Family Health Center, a federally qualified health center caring for underserved patients in Northeast Baltimore City. He also ran for Maryland State Delegate in District 41 (Northwest Baltimore), and continues to engage politically, giving testimony and participating in events and rallies. He serves on the board of directors of the American Academy of Public Health Physicians, Sugar Free Kids Maryland, Hampden Family Center, and the Roland Park Civic League.

Hasan M. Shihab, MD, MPH (PGY-4, Grad July 2018) in the last year as part of his Preventive Medicine rotations completed a one month rotation at the International Center for Diarrheal Diseases Research in Dhaka, Bangladesh. This is the premier research hospital and training institution in the region and sees over 200,000 patients per year. In addition to learning about clinical care of patients with severe diarrhea in a resource limited setting, he was involved in writing the protocol for a study to assess the impact of proper hand washing behavior in children with diarrhea and their household contacts on the neurodevelopment and cognition in children. He also trained Field Research Assistants on using the Ages and Stages Questionnaire to assess neurodevelopment in children under the age of 5. While in Dhaka, he gave a lecture on Global Aging Epidemiology.
Dr. Shihab then completed a three month rotation with Baltimore City Health Department which is the oldest continually functioning Health Department in the country. He has been involved in increasing lead testing rates in children attending Federally Qualified Health Centers. He has also been increasing the outreach for smoking cessation in prenatal clinics as well as carrying out restaurant and convenience store inspections in Baltimore City from Food Control under the Environmental Health Services Division.
Dr. Shihab has a recent publication and summary of the Global Health work he has participated in.
http://hopkinsglobalhealth.org/funding-opportunities/past-grant-winners/shihab-hasan/
Patient Perceptions of Readmission Risk: An Exploratory Survey.
https://www.ncbi.nlm.nih.gov/pubmed/29578549
Prehospital Spine Immobilization/Spinal Motion Restriction in Penetrating Trauma: a Practice Management Guideline from the Eastern Association for the Surgery of Trauma (EAST)
https://www.ncbi.nlm.nih.gov/pubmed/29283970

Max Romano (PGY-3) completed preventive medicine rotations working with the Baltimore City Health Department and Public Citizen's Health Research Group. With the Baltimore City Health Department he continued with Dr. Shihab's work to develop a citywide plan to increase pediatric lead screening incorporating data analytics, public health education, and regulatory interventions. At Pubic Citizen Max co-authored a citizen's petition to the Food and Drug Administration requesting removal the gout medication febuxostat from the US market due to cardiovascular toxicity. Max also presented his work analyzing individual survival benefit of clinical preventive services at MedStar Health's 6th Annual Research Symposium in Bethesda, MD and the American College of Preventive Medicine's annual conference in Chicago, IL, where he won an award for Best Preventive Medicine Poster. He published articles on preeclampsia screening in American Family Physician, on racism in medical education in the Annals of Family Medicine, on hypertension guidelines in the Baltimore Sun, and on long-acting reversible contraceptives in the journal Contraception. He also serves on the board of the Baltimore Ethical Society.

Nithin Paul (PGY-2) completed his Master's in Public Health at the Bloomberg School focused on community organizing/development and global health. His studies included coursework on geospatial analysis, global health, and community health interventions. He also became more involved in community health projects focusing on empowerment at the neighborhood level in Baltimore City's 1st City Council district, including knocking on doors and meeting city residents to better understand their health and wellness priorities.

Joseph Brodine (PGY-1) completed his internship at MedStar Franklin Square Medical Center and prepared for his second year of preventive medicine rotations. He earned the Thomas Holcomb award as the "exemplary family medicine intern" for his work in Pediatrics. He looks forward to working with the Baltimore City Health Department, Johns Hopkins Community Physicians, and the Johns Hopkins Evidence-Based Practice Center in the coming year.

S. Alison Kraemer (incoming PGY-1) matched in to the Program as our 6th resident since the programs' inception. Alison is a graduate of Johns Hopkins University School of Medicine and brings with her a passion for multidisciplinary, integrative health services as an avenue for more cost-effective care and wider social support for underserved populations.

PEDIATRIC CHANGES

In April, 2018, MedStar Franklin Square Medical Center announced a decision to close the inpatient pediatrics service and dedicated pediatric emergency room at the hospital. Changes in the delivery of pediatric hospital based care were the foundation for this decision. This was difficult news for our department, since our clinical and educational activities have always been tightly integrated with pediatrics. This change also resulted in the departure of many members of the department. We made sure to celebrate and thank our talented friends and colleagues who have dedicated years to the education of our family medicine residents and to the care of children in our community. We spent the next several months reevaluating all aspects of our pediatric curriculum and implementing a plan to ensure high level education of our residents and students continues. These changes were implemented with the start of the 2018-2019 academic year and will be highlighted in more detail in next year's annual report. In brief, the resident and medical student inpatient experiences have been moved to Sinai Hospital's Herman and Walter Samuelson Children's Hospital in Baltimore. Pediatric emergency rotations continue at MFSMC and we are exploring additional local opportunities. Newborn nursery and NICU rotations continue to occur at MFSMC. We have also addressed the gaps in pediatric ambulatory faculty as indicated on the faculty pages. Finally, Drs. Eli Moreno and Nithin Paul are faculty and resident representatives to the newly formed Children's Community Health Task Force. This is an interdisciplinary task force which includes hospital and community members tasked with the goal of assessing the health and medical needs of children in our community and provide recommendations intended to improve the long term health of children in the community MedStar Franklin Square Medical Center serves. The task force final report is expected soon.

FACULTY RETREAT

Island Escape

The Department of Family Medicine faculty held their annual retreat in March.
Guest speakers included Jamie Pfeiler and Jennifer Johnson on “Increasing Efficiency through Cerner Learning and Updates” and MedStar billing specialists on “Improving Billing Accuracy, and Enhancing Revenue”

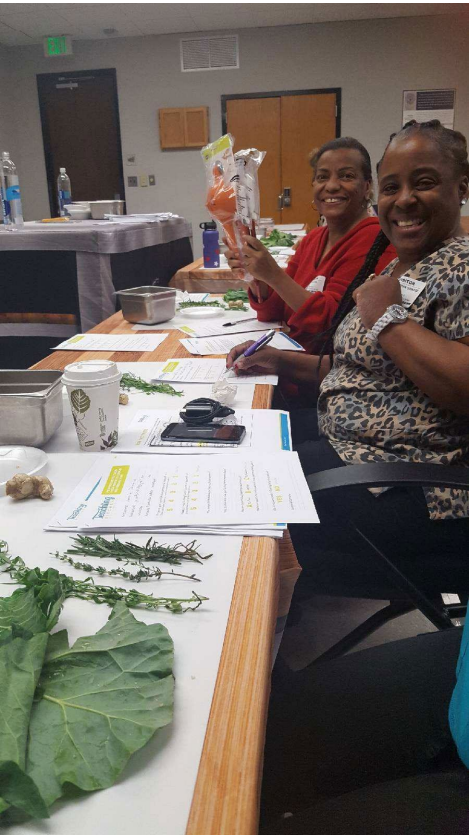
Curriculum updates and goals were also presented by faculty for the FHC on themes and trends in resident responses, sports medicine, women’s health, inpatient services, research, journal club, practicum, geriatrics, home visits, didactics, behavioral health, dermatology, prev med, obstetrics, patient safety, and pediatrics.

The curriculum work was followed by a spirited team building event at an escape room.

If you haven't tried an escape room, it is a great challenging team activity!

Museum Heist

CLINIC AND COMMUNITY HAPPENINGS…



On February 20, 2018 The Department of Family Medicine along with MedStar Franklin Square Medical Center's Chef Jim Fields offered a free hands-on cooking demonstration event for patients and staff.

The demonstration focused on cooking with low sodium and low sugar products / seasoning while making healthier meals with less carbs. The event also provided healthy cooking tips, food tasting and recipe cards for family meals. Participants learned how to use herbs in cooking and how they not only taste good, but have plentiful health benefits.

A free meal along with grocery items were given at the end of the cooking demonstration to participants.

FAMILY HEATLH CLINIC AND COMMUNITY FUN FACTS

1981:
The year Dr. Michael Niehoff was an intern at FHC

47:
Years the program has been around

12:
Number of workers that have left and come back to work for FHC

1650:
The number of visits residents need to graduate

2002:
The last year that Dr. Michael Dwyer had long hair

40:
The percentage of patients under the age of 15

2:
The number of pediatricians we have

FACULTY AND RESIDENT NEWS & IN THE NEWS…

➢Nancy Barr, MD and Kelly Ryan, MD both received the Michael Adams Award given out by Georgetown Internal Medicine Department for outstanding clinical preceptors. Recipients of the award are chosen by the 3rd and 4th year medical students of Georgetown. Award recipients are teaching faculty that meet and excide MedStar Georgetown University Hospital and Georgetown University School of Medicine mato, Cura Personalis, the care of the whole person.

➢Congratulations to our very own “Top Docs": Joyce King, MD, Family Medicine; Scott Krugman, MD, Pediatrics; Adrienne Suggs, MD, Pediatrics for being awarded Baltimore Magazine’s “Top Docs” in 2018. We are proud to announce that out of the 127 MedStar Health physicians recognized by Baltimore Magazine as "Top Docs", 65 are MedStar Franklin Square Medical Center physicians. Nearly 10,000 physicians in the region were surveyed for this year’s list and highly anticipated 30th annual edition.

➢Congratulations to the following Family Medicine faculty at MedStar Franklin Square Medical Center on their recent appointment to the academic rank of Assistant Professor of Clinical Family Medicine at Georgetown University: Uchenna Emeche, Britt Gayle, Martha Johnson

➢ Max Romano, MD, MPH has a research project published in the journal “Contraception”. The article is entitled "Continuation of long-acting reversible contraceptives among Medicaid patients" and was conducted with collaborators at MHRI, Washington Hospital Center, and MedStar Family Choice, which demonstrates some of the collaborative opportunity in our integrated health system. Max is the first author and Dr. Patryce Toye and Loral Patchen are coauthors. (the Y of Central Maryland received the donation in Dr. Rixey’s honor).

➢ Max Romano, MD, MPH was awarded “Best Preventive Medicine Poster” for the topic, *What is the Individual Survival Benefit of Population-based Clinical Preventive Services,* at the Preventive Medicine Conference in Chicago in May 2018.

➢ The MedStar Health Research Symposium Executive Planning Committee and Scientific Review Committee awarded Max Romano, MD, MPH, a tie for third place award in the PGY 1-3 Resident Category for the 2017 MedStar Health Research Symposium held in May. His poster “Continuation of long-acting reversible contraceptives among Medicaid patients” received one of the highest scores among over 180 abstract submissions and has qualified for an oral presentation at the Symposium.

FAMILY MEDICINE AND GLOBAL HEALTH

Dr. Kathy Stolarz was asked to help teach a Global Health- Women's Health SIM for Georgetown Internal and Pediatric residents in Washington, D.C. "Teaching OB Simulations for Georgetown Medicine's Global Health Track"

"The AAFP Global Health Workshop is my favorite conference of the year. Faculty, residents, and students share their experiences and ideas for developing future global health opportunities and curricula that are sustainable, ethical, high-impact, and meaningful. This conference re-energizes me every year and reminds me of why I became a Family Physician in the first place: to help those in need." Dr. Kathy Stolarz

FAMILY MEDICINE AND GLOBAL HEALTH

In February, Kai Chen, MD went on a winter public health expedition with Himalayan Health Exchange. Her team provided medical care in several villages located in the lower and outer Himalayas. Most clinic sites were improvised and held in schools, monasteries and tents. They provided care to over 2,800 patients during that month.

FAMILY MEDICINE AND GLOBAL HEALTH

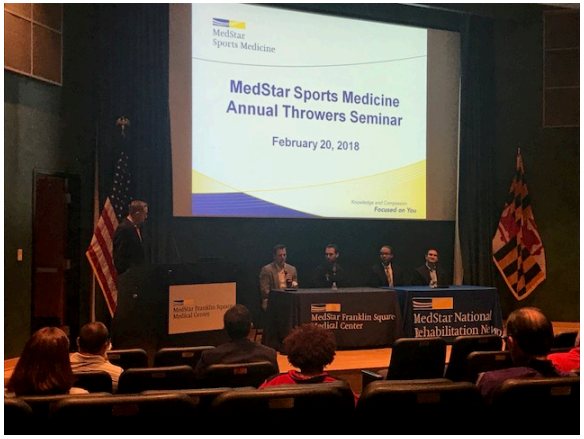
Dr. Hasan Shihab training research staff at ICDDR,B on using the Ages and Stages Quesionnaire from the Global Health trip to Bangladesh

A Field Research Assistant gathering data from a study participant during a home visit

SCHOLARS' CORNER AND CONFERENCES

Laura Long DPT, Kelly Ryan, DO, and Melissa Nicoletti, MD attend the 70th annual Maryland Academy of Family Physicians meeting

Kelly Ryan, DO attends the American Medical Society for Sports Medicine meeting



Family Medicine providers and residents attended the annual Sports Medicine Throwers Seminar to learn about recent advances in surgery, rehabilitation, and injury prevention.

Family Medicine Represented at the AAFP National Conference. Drs. , Kai Chen, Joseph Brodine, Farrah Siddiqui, and Britt Gayle.

Eli Moreno, MD poses with one of the posters from the Teaching Scholars Capstone ceremony.

THE SOCIETY OF TEACHERS OF FAMILY MEDICINE ANNUAL SPRING CONFERENCE COMES TO WASHIINGTON, D.C.

Faculty and residents attended STFM's Annual Spring Conference in Washington, D.C., May 4-10. The conference highlights family medicine past, present, and future and is the nation's most energized networking forum, with nearly 400 educational and interactive seminars, lecture-discussions, papers, and poster presentations.

"Integrating Ambulatory Patient Safety into the Family Medicine Residency Curriculum"
Melly Goodell; Hasan Shihab

"Should I be Collaborating with a Preventive Medicine Residency? Finding the Way Forward" Hasan Shihab; Joseph Brodine; Richard Bruno; Michael Dwyer; Nithin Paul; Sallie Rixey; Max Romano

"Teaching Home-based Primary Care in a Community Family Medicine Residency"
Elise Worely; Martha Johnson

"Starting and Sustaining a Successful Longitudinal Integrated Curriculum (LIC): Modeling Family Medicine as an Educational Hub for Third-year Medical Students"
Nancy Barr; Scott Krugman

"How to Practice and Teach High Value Care"
Lauren Drake; Steven Brown; Jacob Anderson; Joanna Campodonico; Shari Pressley

"Screening for Social Determinants of Health and Adverse Childhood Experiences: Why and How You Can Start!"
Scott Krugman; Michael Dwyer; Claudia Harding; Janelle Hinze; Farrah Siddiqui

"Structured Scholarly Activities at a Community-Based Family Medicine Program: Utilizing Community Resources to Help Residents Explore Their Passions"
Martha Johnson

"Menstrual Equity: Advocating for Our Patients"
Lauren Gordon; Helena Brijbasi; Richard Bruno; Hasan Shihab

"Incorporating Osteopathic Manipulative Therapy into an ACGME Accredited Residency Program:
Katherine Stolarz; Nikhil Desai

Netra Thakur, MD (former faculty) is now a member of the STFM Program Committee that helps to plan and run the annual conference.; Pictured with Claudia Harding, Nancy Barr, MD; Sallie Rixey, MD; Michael Dwyer, MD; Lauren Gordon, MD; and Melly Goodell, MD

Sallie Rixey, MD; Eli Moreno, MD; Martha Johnson, MD; Sarah Ramirez, MD (grad 2017); Melly Goodell, MD

Melanie Powell, MD,grad 2017, MedStar safety fellow 2018; Martha Johnson, MD; Melly Goodell, MD; Britt Gayle, MD; Michael Dwyer, MD; Nancy Barr, MD; Lauren Drake, MD; Hasan Shihab, MD, grad 2018; Kathy Whelan

Melly Goodell, MD and other STFM past presidents (and current president Stephen Wilson) gather near the U.S. Capitol during the Annual Meeting

STFM
SOCIETY OF TEACHERS OF FAMILY MEDICINE

FAMILY MEDICINE ADVOCACY & LEGISLATIVE

Some of our residents (Drs. Joseph Brodine, Samantha Kurzrok, Sadhika Jamisetti, and Max Romano) at an advocacy event for Federal Title X Funding where they met Baltimore Mayor Pugh, City Health Commissioner Wen, Congressman Sarbanes, Cummings, and Ruppersburger, and Senators Cardin and Van Hollen.

Our recent alumus Richard Bruno is Chair of the Public Health Committee for MedChi (Maryland State Medical Society). The Public Health Committee identifies public health issues of importance and works with MedChi to develop policies and activities that address these issues, in order to enhance the health status of our community.

LEADERSHIP:

As one of her final acts as STFM Immediate Past-President, Melly Goodell, MD (center) hosts the annual "Past Presidents' Breakfast at the STFM Annual Conference in D.C. in May 2018. The gathering is an opportunity for these past and current leaders to brainstorm about the future direction of Family Medicine education and of STFM, to share wisdom on shared challenges, and to reflect on progress and shared memories.

At the May STFM Conference, Dr. Melly Goodell completed her third year term as STFM President Elect and Past President. She considers the experience a professional and personal highlight of her career and strongly encourages faculty, residents, and students to seek leadership opportunities in our professional organizations.

Nancy Barr, MD- Georgetown LCME Review Committee; MAFP; Georgetown Faculty Advisor for Family Medicine intercost group Kaiser; Clinical advisor to Georgetown 3rd and 4th years; CCS Georgetown Committee Director of LIC; MD Academy of Family Physicians Vice President and Educational Committee; Georgetown C.O.M.E. Committee Voting Member

Michael Dwyer, MD- ABFM in-training Exam Committee; ABFM Item Writer

Britt Gayle, MD- MD HIV Planning Group; STFM HIV Steering Committee

Lauren Gordon, MD- Planned Parenthood

Eli Moreno, MD- Lead AAMC Program

Michael Niehoff, MD- Specialty Society Trustee Board member of MedChi

Katherine Stolarz, DO- US Clinician Network on Female Genital Mutilation/Cutting; Physicians for Human Rights Asylum Network; Vice President for the Board of Companion Community Development Alternatives

SCHOLARS' FORUM

Department of Family Medicine 13th Annual Scholar's Forum
Thursday, May 31, 2018

Congratulations to our presenters and faculty advisers.

Julian Barkan, DO, MPH
"SBIRT and Community Need: The Feasibility of a Drug/Alcohol Treatment Program at FHC"

Jasmeen Gill, MD
"Utilizing the DiSC Model in a Family Medicine Training Program"

Wm. Jordan Gottschalk, DO & Grace Wessling, MD
"Improving Pneumococcal Vaccination Rates in an Academic Clinical Setting"

Suchi Nagaraj, MD
"Elder Abuse Screening in the Family Health Center"

Melissa Nicoletti, MD
"Improving the Relationship between Primary Care & Physical Therapy"

Jamille Taylor, MD, MPH
"Caregiver Knowledge, Attitudes and Practices Regarding Medication Storage in the Home"

Hasan Shihab, MBChB, MPH
"Does providing fee data on lab tests impact physician ordering behavior?"

RESIDENT RESEARCH POSTERS

Julian Barkan,
DO, MPH

SBIRT and Community Need: Feasibility of Drug/Alcohol Treatment at FHC

Julian Barkan, DO, MPH
MedStar Franklin Square Medical Center, Baltimore, Maryland
Department of Family Medicine

MedStar Franklin Square Medical Center

Abstract

Purpose: MedStar Franklin Square has the busiest emergency department in the state of Maryland and as a result sees a large number of patients that screen positive on SBIRT (Screening, Brief Intervention, and Referral to Treatment) which is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was invited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. SBIRT analysis at Franklin Square shows that since 8/15/2016 there have been 41,919 completed screenings, of which 4,847 (12%) were positive either for alcohol or opioid use. Of those 1,917 (40%) had a brief intervention with an SBIRT counselor and 908 (47%) were given referrals. However, only 195 individuals (4% of total positive screens) were linked to treatment when they desired it. This means there is a large need in terms of linking to treatment. With medicines like Vivitrol, which works for both opioid abuse and alcohol abuse, treatment can be simplified and performed in more locations than just stand-alone clinics that specialize in either alcohol or opioid use. We would like to analyze the SBIRT data to perform a feasibility study to see what the patient experience is like in trying to link to treatment in order to see if the Family Health Center can be a location where treatment can be offered.
Methods: Using de-identified SBIRT data, I will review the patient conversations with those that screen positive in terms of their desires, challenges, etc. I will also talk to key informants including directors and staff at FHC. I will use direct observation for patients screening with SBIRT through a rotation with the SBIRT team.
Results:
Conclusions: There is a need and a desire for patients with substance abuse to obtain treatment. Since options are limited, the Family Health Center may be a place where a treatment program can be set up to serve the needs of our community.

Background

- Alcohol leads to ~88,000 deaths and 2.5 million years of potential life lost (YPLL) each year in the United States from 2006 – 2010 (CDC)
- Opioid use causes ~116 deaths per day
  - In 2016 42,249 died from OD
- In a city of 645,000, the Baltimore Department of Health estimates there are 60,000 drug addicts, with as many as 48,000 of them hooked on heroin.
- 2089 overdoses in MD in 2016
- Screening, Brief Intervention, and Referral to Treatment
- Screening
  - Quickly assess severity of substance use
  - Identify the appropriate level of treatment.
- Brief intervention
  - Increasing insight and awareness regarding substance use
  - Motivation toward behavioral change.
- Referral to treatment
- At Franklin Square all SBIRT counselors are previous drug/alcohol users

Objectives

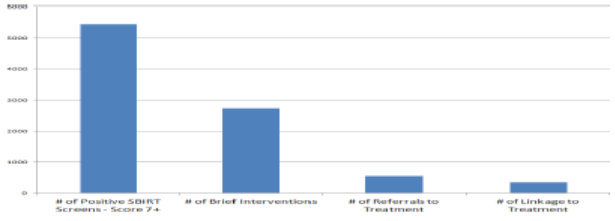
- Objective: To conduct a feasibility analysis of a program that links users, identified by SBIRT or current FHC patients, to services for drug or alcohol treatment at FHC
- Hypothesis: FHC will be able to treat patients with Vivitriol for both alcohol and ETOH abuse

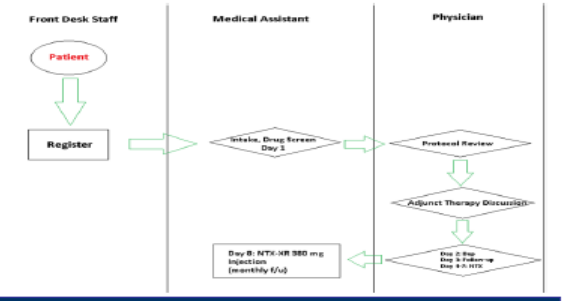
Methods

- To evaluate demand, quantitative data was used that is collected through FirstNet by nurses
- Mosaic runs the data collection
- To evaluate practicality, the ER process was directly observed by the study investigator
- To evaluate acceptability , key informants interviewed about their perception about a treatment program at FHC
  - Answers were evaluated for themes.
- Spoke to MedStar Family Choice regarding cost/reimbursement
- All patients in the ED are screened for drug use/substance use
- AUDIT C score

Results

# of Unique Patients Seen	48982
# of Encounters	75539
# of SBIRT Screens completed	58632
# of Positive SBIRT Screens - Score 7+	5453
# of Brief Interventions	2739
# of Referrals to Treatment	546
# of Linkage to Treatment	342





Discussion

- Co-morbidity
  - "Managing chronic pain/substance use has to be coupled in the setting of primary care"
  - Major effect on co-morbid conditions if using drugs/alcohol
  - "Behavioral component must be addressed simultaneously"
- Lack of incentive
  - Insurance companies do not pay much
  - Vivitrol paid $1239 by MedStar and office can get it for $1214
- Burden on Staff
  - Difficult to manage these patients
  - "People have a fear of addicts"
  - Organizing follow up
  - New program, starting from the beginning
- Training MAs, doctors
- Nunes et al found no specific characteristic that one patient will do better than another
  - Extended-Release Naltrexone promotes abstinence across range of demographic and severity characteristics
- Saxon et al found that better mental health, higher education and lower recent drug use at baseline associated with greater treatment duration
  - lower relapse rates and improved outcomes
- More than 2/3 of patients can be detoxified with long acting Naltrexone (Vivitrol) in outpatient setting (Mannelli 2015)
  - Using Naltrexone or Buprenorphine

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RESIDENT RESEARCH POSTERS

Jasmeen Gill, MD

Utilizing the DiSC Model in a Family Medicine Training Program

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Abstract

Personality plays a significant role in academic and professional performances. There has been a recent interest in the development and assessment of professionalism in medicine. This descriptive study will encourage family medicine residents to identify their own personal work behavioral tendencies and develop an understanding of how these styles may affect team members. The reflective questions will also help us explore how improving communication can enhance effectiveness in accomplishing tasks by improving your relationships with others. There are few studies that investigate the relationship between personality type and team-oriented outcomes in the setting of medical training. A study done among 3,122 hospital leaders shows that they fall into the dominant and conscientiousness profile, a majority of the time.

Participants included 23 of 26 family medicine residents (8 PGY1, 6 PGY2, 9 PGY3) at a family medicine residency training program in a community hospital setting. Participants were surveyed using an online version of the validated DiSC personal profile system. Residents' personality traits were given as a percentage of each of the four categories. The descriptive data is reported as means of percentages.

The results of the survey showed that 34.3% of residents (39.6% PGY1, 32.8% PGY2, 30.7% PGY3) are of the steadiness profile and 23.6% of residents (20.9% PGY1, 27% PGY2, 23.8% PGY3) are of the influence profile.

Based on our survey results, family medicine residents, fit into the steadiness and influence profile. The relationship between personality and performance becomes increasingly significant as learners advance through medical training. Implementation of programs to promote education about how personality traits can affect various aspects of working in a team environment may allow for positive reflection and enhanced productivity. This can further be applied to help residents understand personality traits that underlie positive health and resilience. Instilling this awareness may not only benefit them as a team member, but help them understand how to promote the their own health and that of their patients. After all, personality is a strong predictor of well being.

Background

- Three basic elements: medical knowledge, procedural/technical skills, and personality
- Personality plays a significant role in academic and professional performances
- APA defines personality as: configuration of characteristics and behavioral tendencies that comprise an individual's unique features
- Most physicians do not have an understanding of their own personality traits and work behavioral tendencies
- Recent interest in the development and assessment of professionalism in medicine (ACGME milestones)
- Relationship between personality type and team-oriented outcomes
- Predict academic performance, career interest, as well as patient outcomes
- As the number of physicians increases, non-clinical roles also increases
- Data gathered from 3,122 IM/Hospitalist physician leaders over 10 years

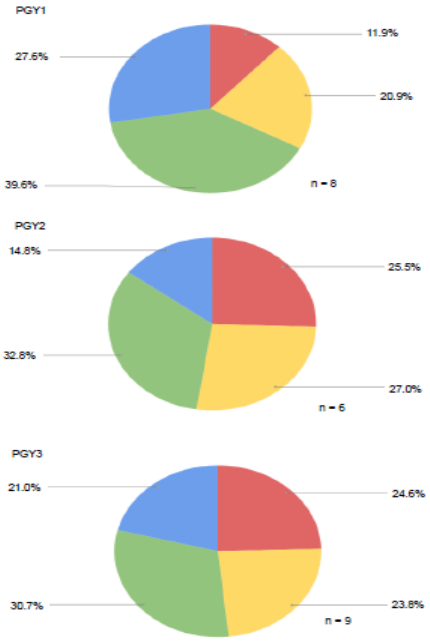
Objectives

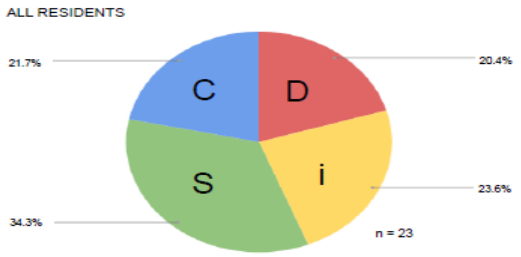
- Identify your own personal work behavioral tendencies
- Develop an understanding of how these styles may affect others
- Understand, respect, appreciate and value individual differences
- Understanding the existing style preferences of residents can help programs to more effectively design their programs

Methods

Participants included 23 of 26 family medicine residents (8 PGY1, 6 PGY2, 9 PGY3) at a family medicine residency training program in a community hospital setting. Participants were surveyed using an online version of the validated DiSC personal profile system. Residents' personality traits were given as a percentage of each of the four categories. The descriptive data is reported as means of percentages.

Results





Discussion

- 34.3% of residents have steadiness as their primary personality trait
- 23.6% of residents have influence as their secondary personality trait
- Our residents: 6/23 (26%) have the same style preference
- Similar styles tend to be compatible socially
- Work task effectiveness is strengthened by mixing different styles
- Mixing different styles may result in interpersonal conflicts
- The more one tends to overuse a single style, the less one tends to "flex" to the styles of others
- We can effectively work together with all styles
- Limitations:
  - Small n
  - Not all residents responded to the survey (88%)
  - Used one kind of personality test
  - Answers may be tailored to "meet the needs of the study" or as socially desired
  - Research findings have not been consistent
  - Limited research in the medical training group

Next Steps

- Develop and practice strategies for working together to increase productivity in the work environment, despite personality variances
- Team building (FMI, FHC, Advisor-Advisee, Provider-MA)
- Correlation between burnout/resilience
- Longitudinal study to trace the development or change in personality attributes from 1st to 3rd year residents

References

RESIDENT RESEARCH POSTERS

Suchi Nagaraj, MD

Screening for Elder Abuse in the Family Health Center

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Abstract

Purpose: As family medicine physicians we are caring for the well being of a multitude of age demographics, including the elderly. Commonly upon geriatric visits with patients we focus on chronic ailments and any acute exacerbations of them. Present for most visits with the geriatric population include their caretakers—whether that be a spouse, child, other family member, paid caregiver, etc. Many of the patients in the geriatric population have succumbed to the care of someone else because they have deteriorated secondary to their disease processes or age in and of itself. The strain that caregiving can place on a relationship between those parties can lead to frustrations, anger management issues, caregiver fatigue and ultimately abuse of those being cared for. While most abuse is identified in health care settings, studies have shown that rates of abuse identification by health care providers remain low.
Currently there is no "gold standard" for screening for elder abuse. There are methods that have been devised to assist, however. So why do this? Studies have shown that elderly individuals, on average, make 13.9 visits per year to a physician. Among the multiple visits that patients make to providers should we at some point screen for abuse?

Background

Many of the patients in the geriatric population have succumbed to the care of someone else. The strain that caregiving can place on a relationship between those parties can lead to –Frustration ,Anger management, Caregiver fatigue And ultimately abuse of those being cared for.
~1 in 10 Americans experience some form of elder abuse and as high as 5 million elders are abused each year
While most abuse is identified in health care settings, studies have shown that rates of abuse identification by health care providers remain low
Research suggests that only 1.4% of cases of Elder Abuse reported to Adult Protective Services come from physicians
Currently the Family Health Center does not have a standard protocol/tool for screening for elder abuse or reporting.

Objectives

Hypothesis: At the Family Health Center we are currently not routinely screening for elder abuse. With the application of screens available for its use more providers will screen and increase awareness.

-How often the FHC is screening for elder abuse
-How many patients have a positive screen in our patient population
-Measure how comfortable providers are with screening and what barriers are perceived that may limit screening routinely

Methods

A tool that has been validated to be used to screen in competent patients is the Elder Abuse Suspicion Index.
5-question survey for our patients to take whilst awaiting their meeting with their provider
A 6th question at the end of the survey for the provider to answer – Circle physical exam findings:
If the patient answered yes to any of the questions 2-4, the intent was for providers to investigate further about the situation and could be considered abuse findings.

If the provider's exam findings were not probable based off discussion with the patient, these could be considered abuse findings.
A post screen survey of 10 questions was also done to evaluate providers use of the screen, comfort level of its use among other factors associated with abuse and screening in the FHC.
3 PDSA cycles took place to ultimately obtain data

Results

Total number of geriatric age visits from 4/2 -5/23 = 486
5/1-5/23 total geriatric visits (Active Phase) = 235
Average patients per day seen in the last 2 months 12.7

Median Age of those screened for elder abuse in clinic = 69 y.o.
Mean Age= 71.5 y.o.

Number of those screened in total in clinic: 38
screened yes (by patient response): 0
screened yes (by provider assessment): 0
screened no (by patient response): 38
screened no (by provider assessment): 38

Since April 2 to April 30, email introducing screen to FHC
0/251 screens completed =0% participation

May 2 to May 21, implementation of active encouragement for usage of screen by office champion regarding elder abuse
38/235 = 16% participation

Patient screens:
5 patients noting that they rely on caregivers for bathing, dressing, shopping, banking or meals.
Provider assessment:
2 patients that had physical exam findings
One patient with healing bruise s/p fall
Another pt with med compliance issues

Discussion

Elder Abuse is certainly an issue that primary care providers should be aware of and screening for routinely as this is a reportable issue, but at the present time, it is happening infrequently.
The goal of this study was to not only analyze how often we are screening at the FHC but also to bring more awareness to this issue and identify barriers for routinely screening
2 PDSA cycles to obtain clinical data regarding usage of screens and their findings as well as a post screening analysis of providers
In conclusion we can see that since the implementation of these screens in the clinic there has been a multitude of opportunity to screen and it has been done 38/235 times = 16% of the time
---

FHC's screening is comparable to nationwide rates of screening. This is nationwide issue and not only just of our clinic.

We have not had a positive screen in our clinic.

Those who did use the screen were comfortable using it and how to report in the event a screen was positive.

Limitations of this study included duration of the study, lack of knowledge that this tool was available, no preevaluation for comparison after implementing the tool.

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Administration for Community Living
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National Adult Protective Services Association
http://www.napsa-now.org/cases/

World Health Organization
http://www.who.int/ageing/projects/elder_abuse/en/

RESIDENT RESEARCH POSTERS

Grace Cho Wessling, MD

Improving Pneumococcal Vaccination Rates in an Academic Clinical Setting

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Abstract

Background:
Pneumonia is the 8th leading cause of death in the US and creates a significant financial burden on the healthcare system.[1] Fortunately, there has been an overall decrease in mortality rates with increased administration of the pneumonia vaccines.[1,2] Studies have shown that physician reminders, patient letters, and nurse-driven models are all effective interventions for improving rates at at residency programs, residency-driven QI projects have been found to improve rates as well, though this has been mostly studied with pediatric vaccinations[3,4,5].
Methods:
At a residency clinic, the precepting room is a unique place where physician reminders can be given with the added benefit of improving education in physicians who will practice for many years to come. A standardized precepting culture that requires residents and/or attendings to always discuss vaccinations at the end of every visit is currently not in place at the Family Health Center at Franklin Square Hospital in Baltimore, Maryland. This was implemented during a 2 week test period with resident reminders and through various PDSA cycles.
Results:
A 1 week pre-intervention observation of precepting sessions revealed that pneumococcal vaccination need and status was discussed just 24% of patient visits. Of those times vaccination was not discussed, 75% had an indication for the pneumococcal vaccine and had not yet received it indicating numerous missed opportunities. Also noted was that 75% of all visits were follow up or acute visits during which vaccination status was not routinely mentioned. 57% of all missed vaccination opportunities were during these follow up or acute visits. For patients with an indication for vaccination it was mentioned 48% of visits. Over the succeeding 3 weeks, while direct intervention was made during the precepting process, vaccination status was mentioned during 63% of all patient visits. For patients with an indication for pneumococcal vaccine, it was mentioned 68% of visits.
Pre and post intervention surveys given to residents measuring resident reported comfort levels pneumococcal vaccination indications indicated no improvement in comfort levels.
Conclusion:
Pneumonia is a potentially preventable cause of death in adult Americans. We identified the precepting process as an avenue through which we could improve our pneumococcal vaccination rates and thus improve the morbidity and mortality in our patients and decrease the financial strain on our health system. Our data indicates that we have many underutilized patient encounters with acute and follow up visits through which we have been able to increase our pneumococcal vaccination rates. By implementing this in the residency setting, the training of new physicians with high competency in pneumococcal vaccinations should continue to reduce illness and death due to pneumonia.

Background

According to the CDC, pneumonia is the 8th leading cause of death in the United States, with 85% of all deaths due to pneumonia and influenza occurring in those over the age of 65. The financial burden of this disease is heavy with an estimated $16.2 billion spent to fight pneumonia and influenza in 2013.[1]

From 1999 to 2013 there has been a 35% decline in the mortality rate from pneumonia while concurrently an increase of 28% in the overall pneumonia vaccination rate adults over the age of 65.[1,2] As of 2016, 66.9% of adults over the age of 65 have received at least one pneumonia vaccine during their lifetime. However, at the Medstar Family Health Center at Franklin Square Hospital in Baltimore, Maryland, pneumonia vaccination rates remain at 20.41% (2017).

Studies have shown that physician reminders, patient letters, and nurse-driven models are all effective interventions for improving vaccination rates in adults.[3] At residency programs, resident-driven QI and educational curricular changes have made improvements in vaccination rates but this was studied in either the inpatient setting or with pediatric vaccinations.[4,5] There have not been studies done using interventions on the precepting process.

Objectives

Do resident physician reminders to discuss vaccinations in all precepting sessions help increase rates of pneumoooccal vaccinations at the Family Health Center?

Methods

At a residency clinic, the precepting room is a unique place where physician reminders can be given with the added benefit of improving education in physicians who will practice for many years to come. A standardized precepting culture that requires residents and/or attendings to always discuss vaccinations at the end of every visit is currently not in place at the Family Health Center at Franklin Square Hospital in Baltimore, Maryland. This was studied using 5 PDSA cycles.

PDSA Cycle 1 was used to evaluate the extent of the problem. Charts were reviewed for 56 patients that were admitted to the Family Medicine inpatient service in 2016 to determine whether these often elderly and chronically ill patients had had pneumonia vaccines. This data was then presented at a clinic Practice Improvement meeting to raise awareness of the problem.

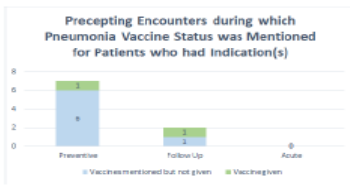
PDSA Cycle 2 was performed by a Georgetown medical student, who created easy-to-use flow charts to help providers determine whether their patients had appropriate indications for pneumococcal vaccine administration. An incentivized contest was used to encourage use of these flow charts.

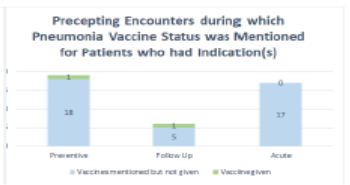
PDSA Cycles 3 and 4 were performed over a period of several weeks during peak flu vaccine season. Resident precepting sessions were directly observed to identify opportunities for pneumonia vaccination. Inclusion criteria included adults 19 and older and all preventive, office follow up, and acute visits. Exclusion criteria included children 18 and younger, pregnant patients, and Flexcare patients.

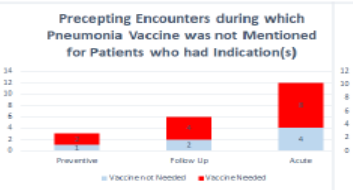
For week 1, 37 unique encounters were recorded as either having mentioned flu and pneumonia vaccinations or not. Each encounter was also categorized as an acute visit, preventive visit, or follow up visit for a chronic problem. Weeks 2-4 involved directly intervening during precepting sessions by reminding attending physicians to mention vaccinations during every precepting encounter and by educating residents on correct indications for pneumococcal vaccination as they pertained to their patients.

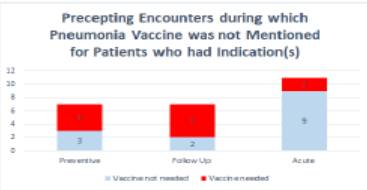
Finally, PDSA Cycle 5 involved doing a survey of all residents at this program prior to these interventions and then months after these interventions to determine whether these educational measures worked to retain good precepting habits.

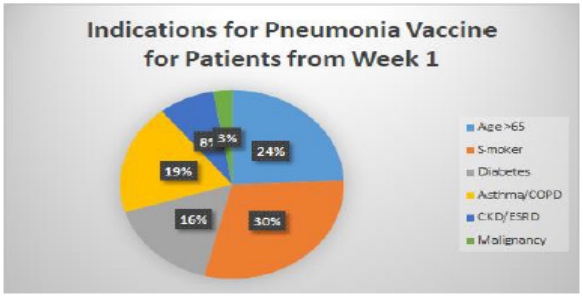
Results











Discussion

Pneumonia, the 8th leading cause of death in the United States, is a potentially preventable disease. However this requires following what can be confusing recommendations for pneumococcal vaccinations. Unfortunately at the MedStar Franklin Square Family Health Center, our vaccination rates of eligible patients, particularly patients >65 years old, was well behind the national average.

A multi-cycle process was utilized involving chart review, physician education including distributing easy-to-use flow charts in physician and staff work spaces, and staff incentivization. Furthermore the precepting process was identified as an area for direct intervention

From these interventions the most significant findings included noting that there are significantly more opportunities to discuss pneumococcal vaccinations outside of preventive medicine visits where vaccination status is routinely discussed. Furthermore, based on the data collected, it was apparent that an intervention in the precepting process significantly increased the discussion of vaccination status during patient visits. The combination of these two findings dramatically increases the opportunities to improve vaccination rates improve attempts at preventing pneumonia.

While this study was carried out in a residency clinic there are many aspects that can be employed in any primary care setting. Staff education to help MA's identify patients with indications for pneumococcal vaccine would be applicable in general practice clinics. Additionally, every clinic will have workspaces for staff and physicians that can be supplied with easy-to-read flow sheets for pneumococcal vaccine indications. Utilizing non-preventive medicine visits is an easy way to increase pneumococcal vaccination opportunities at any primary care clinic.

This study was limited by the short time period of precepting interventions. It was also limited by the lack of long term follow up on frequency of discussion of vaccination status during patient visits.

Recommendations resulting from this study include the continued use of visual reminders in the work spaces, utilization of non-preventive medicine visits for vaccinations, and utilization of the precepting process as a safety net to ensure vaccinations are discussed during all visits.

In future studies would consider using hospital discharge process and discharge follow up process to further improve the identification of patients in need of vaccinations and ensure these patients receive appropriate vaccines.

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RESIDENT RESEARCH POSTERS

Melissa Nicoletti, MD

Improving the Relationship Between Primary Care & Physical Therapy

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Abstract

Physical therapy (PT) is an essential component of first-line treatment for many musculoskeletal conditions.

Do primary care physicians (PCP's) have an understanding of physical therapists role in the evaluation and treatment of various disease processes? Although PCP's refer patients to physical therapy, it is unclear of their knowledge in the role that physical therapists play in treatment plans and interventions.

Background

Primary Care Physicians are typically the first point of contact for individuals seeking care for musculoskeletal conditions.

In the US, more than ⅛ of adults and ¾ of those 65 years and older are affected by these conditions, making them more common than hypertension, diabetes and cardiovascular disease.

In the advent of new healthcare models & value-based payment, there is a considerable burden for PCP's to provide coordinated, integrated, team-based care to achieve improved population health.

There is limited data as to the barriers for primary care referral to physical therapy, although insurance status has been found to be a vast predictor in whether or not to refer to PT.

Objectives

1. To understand the barriers of primary care providers in referring their patients to physical therapy.

2. Encourage discussion and collaboration of primary care providers and physical therapists.

3. Broaden the knowledge base for primary care providers to easily refer their patients to physical therapy for specific pathologies

Methods

A 17 question anonymous survey was administered to residents and faculty in the departments of Family Medicine & Internal Medicine at MedStar Franklin Square.

30 Family Medicine (FM) Resident & Faculty responses were received via a paper survey.18 Internal Medicine (IM) Resident responses were received via survey monkey. These results were then analyzed and compared due to the varied training in each residency program. The analysis included comparison of charts, graphs and data of the IM and FM programs responses.
This data was then collected and analyzed to assess for improved understanding of the role of physical therapists in primary care. The data reported in results are the percentages & averages of the responses to the surveys.
Interventions will then be applied including the development of an algorithm for ease of referring to physical therapy for residents and faculty.

Results

Likert Scale

Confidence in their MSK exam: Both FM & IM responses averaged 3.2 which is somewhat confident.

Confidence in explaining physical therapy to patients: FM averaged 3.7 – somewhat confident. IM averaged 4.5 – More confident.

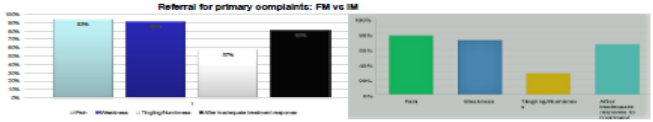
	FM	IM
Refer to PT:	96.67%	88.89%
Receive feedback from PT:	76.67%	35.29%

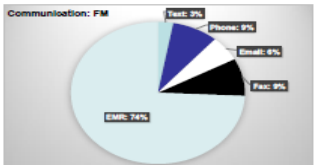
2 additional barriers to referral:
1. Cost of PT
2. Time constraints

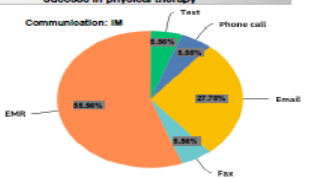
Average Costs of PT:

Insurance	FM	IM
With	$91	$37.5
Without	$337	$555

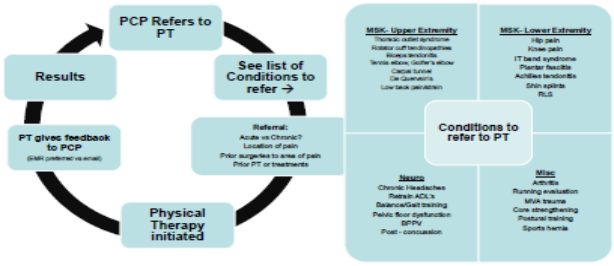
	FM	IM
Familiarity with PT locations & specialties	76.67%	35.29%







Referral Algorithm



Discussion

Musculoskeletal pathologies constitute a majority of primary care visits which has caused increasing pressure on PCP's to acutely improve the quality of life of these patients. As the population ages there continues to be an escalating demand for care for these pathologies but there are various barriers in the referral process.
There is limited data regarding PCP's referral to PT although two barriers that seemed to be a trend independently added by those responders is the cost of physical therapy and time constraints on our patients. The cost of outpatient PT is more a burden then an alleviating factor to our patient population. The average cost of PT with insurance $20-30/session & without insurance is $400 for an initial evaluation with $200-250 for follow-up, respectively.
Another barrier is the PCP's confidence in their musculoskeletal exam which can be a deterrent when sending our patient's to PT. There were similarities in referral rates to PT by family medicine & internal medicine physicians although IM physicians did not feel they received appropriate feedback once referred. This difference could account for increased accessibility of PT's in FM clinics.

One way we can remove these barriers in referral is by increasing the accessibility of PT's to PCP's by scheduling shadowing days for the PT to shadow PCPs and vice versa. We can also educate residents & attendings on the fundamentals of PT, scope of practice as well as specific treatment modalities.
Educating patients is of utmost importance as well where physical therapy handouts can be provided which explain the role of physical therapy and various modalities utilized. This will also assist those providers in improving their knowledge of physical therapy and in their explanation for referral.

Overall, our providers are aware of physical therapy for minor MSK injuries but there is a knowledge gap in the extent of what they do and the modalities they use.

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RESIDENT RESEARCH POSTERS

Jamille Taylor,
MD, MPH

Caregiver Knowledge, Attitudes and Practices (KAP) of Medications in the Home Environment

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Abstract

Purpose: Medication ingestion contributes to significant morbidity within several vulnerable populations, including children. Eighty percent of unintentional ingestions occur among unsupervised children in the home setting. The purpose of this study is to 1) assess caregiver KAP with respect to medication storage 2) Estimate the prevalence of unintentional medication ingestion among FHC pediatric patients 3) Estimate medical care sought for FHC pediatric patients due to medicine ingestion.
Methods: A 12 item questionnaire was offered to caregivers at all pediatric visits during a 3 day period in May 2018. Questions assessed caregiver knowledge, attitudes and practices on medication storage in the home. Questions also elicited information regarding medical care sought for children following unintentional medication ingestion. Statistical analysis was performed using Microsoft Excel.
Results: 40 caregiver respondents completed the questionnaire during well child checks and pediatric acute visits at the FHC. Respondents provide care/housing to children of all ages. 39% of respondents have homes with >2 adults. 81% of respondents agree that medications should be stored "up and away" after use. 87% of caregivers report exclusive storage of medications above counter height. A majority of respondents feel that medications should be stored in original containers. Caregivers generally disagreed that medications can be stored anywhere in the home.
Conclusions: Primary care providers, particularly family medicine physicians, have a unique opportunity to educate caregivers and positively impact safety in the home environment for multiple household members. Based on cross-sectional survey data, caregivers of pediatric patients in our clinic have excellent knowledge about medication safety practices. Medication storage practices seem to align with caregiver knowledge, and attitudes concerning medication safety. Increased numbers of adults in the home may serve as a risk factor for unintentional medication ingestion due to increased potential for medications in the home. Multiple factors have a role in unintentional medication ingestion among pediatric patients. Education campaigns to reduce the amount of unused or expired home medications are a potential intervention strategy to help reduce unintentional ingestion events. Further research could further examine these risks and identify other modifiable factors to reduce morbidity from medication ingestion among pediatric patients.

Background

- 80% of accidental ingestions occur when children are unsupervised and at home
- 1/180 2-year-olds is brought to ED for suspected ingestion
- 10% of ED visits for overdose in kids are in teens who self-administer medications
- 42% of calls to MD poison control were concerning suspected ingestions for children <5 years old

Objectives

The purpose of this study is to :

1) Assess caregiver KAPs with respect to medication storage in homes where pediatrics patients of the FHC are cared for
2) Estimate the prevalence of unintentional medication ingestion among FHC pediatric patients
3) Estimate medical care sought for FHC pediatric patients due to medicine ingestion

Methods

A 12 item questionnaire was offered to caregivers at all pediatric visits during a 3 day period in May 2018. Questions assessed caregiver knowledge, attitudes and practices on medication storage in the home. Questions also elicited information regarding medical care sought for children following unintentional medication ingestion. Statistical analysis was performed using Microsoft Excel.

Results

Figure 1. Household Demographics

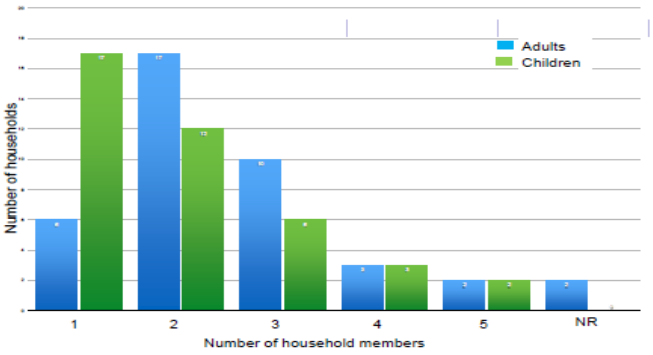

Figure 2. Composition of households

Number of adults in household	Number of children in household					
5	1	1	-	-	-	
4	2	-	-	1	-	
3	5	1	3	-	1	
2	6	8	1	2	-	
1	3	1	-	1	1	
	1	2	3	4	5	

Results

- **Caregiver Knowledge**
  - 14/40 (35%) of respondents disagree that pills are more dangerous than other types of medications
- **Caregiver Attitudes**
  - 37/40 (92.5%) Strongly agree/agree that medicines should be stored in original containers
- **Caregiver Practices**
  - 34/39 (87%) of respondents exclusively store medicines above counter height
- Two (5%) respondents have taken a child to the ER for suspected ingestion and 1 caregiver has called poison control in the past

Discussion

Primary care providers, particularly family medicine physicians, have a unique opportunity to educate caregivers and positively impact safety in the home environment for multiple household members. Based on cross-sectional survey data, caregivers of pediatric patients in our clinic have excellent knowledge about medication safety practices. Medication storage practices seem to align with caregiver knowledge, and attitudes concerning medication safety. Increased numbers of adults in the home may serve as a risk factor for unintentional medication ingestion due to increased potential for medications in the home. Multiple factors have a role in unintentional medication ingestion among pediatric patients. Education campaigns to reduce the amount of unused or expired home medications are a potential intervention strategy to help reduce unintentional ingestion events. Further research could further examine these risks and identify other modifiable factors to reduce morbidity from medication ingestion among pediatric patients.

Next Steps

- Increased provider awareness of topic
- Parent-Caregiver focus groups
- Information sheet for distribution during well child checks and back to school visits
- Signage from poison control center

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RESIDENT GRADUATION & FUTURE PLANS
CONGRATULATIONS TO THE CLASS OF 2018

Hasan Shihab, MBChB, MPH
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Jamille Taylor, M.D., MPH
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Julian Barkan, D.O., MPH
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2018 FAMILY MEDICINE GRADUATION & AWARDS CEREMONY

Faculty Excellence Award: Nancy Beth Barr, M.D.
Faculty Teaching Award: Kathy Stolarz, D.O.
Outstanding Resident Teacher Award: Jasmeen Gill, M.D.
Pediatric Teaching Award: Scott Krugman, M.D.
Reichel Award for Geriatrics: Suchi Smitha Nagaraj, M.D.
Reichel Award for Outstanding Teaching: Marcos A. Wolff, M.D.
Scholarship Award: Hasan Muhammad Shihab, MBChB, MPH
Global Health Scholar: Hasan Muhammad Shihab, MBChB, MPH
Thomas M. Holcomb Award: Joseph Brodine, M.D.
Lee Rome Memorial Award: William Jordan Gottschalk, D.O.

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 accept students from various LCGME accredited institutions in the United States and Canada for elective rotation. In addition to medical students, we also host students in other related fields such as pharmacy and social work.

Rotations are four weeks in length in an outpatient setting. Priority is given to those students pursuing a career in family medicine. Only those students attending an LCGME accredited school in the US or Canada may apply.

Our Family Health Center is a NCQA Level III PCMH (patient centered medical home), a model of healthcare delivery aimed at improving the quality and efficiency of care by using evidence-based, patient-centered processes that focus on highly-coordinated care and long-term participative relationships. With more than 10,000 patients and 30,000 visits per year, our Family Health Center exposes medical students to a very diverse patient population and a large percentage of pediatric patients. This allows students to participate in the management of chronic diseases, preventive care, developmental assessment, acute patient issues, project based learning quality improvement, patient registry data and other PCMH projects.

During their rotation, medical students work 1:1 with senior residents and faculty in a welcoming teaching environment and are exposed to a wide variety of clinical experiences, including adult medicine, pediatrics, geriatrics, orthopedics, gynecology, obstetrics, office procedures and behavioral health. Our students go on home visits and participate in didactics alongside the residents and also participate in specialty clinics within our health center such as sports medicine and procedures. Students also have the opportunity to work at Health Care for the Homeless (HCH) and visit a variety of community based facilities that collaborate with the Family Health Center in an effort to provide better care for our patients. In addition, our core faculty is augmented by pediatricians and a PharmD who have regular clinical and teaching roles that add to the elective rotation. Pharmacy educational sessions cover multiple areas of pharmacology including hypertension, antibiotic selection, smoking cessation, patient education and adverse drug reactions.

The Family Health Center also houses the Longitudinal Integrated Clerkship (LIC) for the Georgetown School of Medicine. In this program, students learn internal medicine, family medicine, pediatrics and obstetrics / gynecology simultaneously while caring for a panel of their own patients over the course of six months. Now in its third year, the LIC has become a very sought after clinical experience; last year, there were triple the number of applications as there were spots available. It continues to receive excellent reviews from the students and faculty alike.

YEAR 3 OF THE GEORGETOWN LONGITUDINAL INTEGRATED CURRICULUM A HUGE SUCCESS!

We have now had 30 Georgetown students go through the program longitudinal integrated curriculum in the 2017-2018 academic year! The students spent one semester (6 months) of their third year of medical school with us learning about primary care in family medicine, internal medicine, pediatrics and obstetrics/gynecology in an innovative, patient-centered way. Unlike traditional blocks, the students experienced primary care simultaneously in these areas during the six months.

Congratulations to these students on their successful completion of the LIC semester!

Monica Gupta, Alena Hoover, and Anne Yeung reflect on their LIC experience:

"Participating in the Longitudinal Integrated Curriculum (LIC) has been one of the most rewarding experiences of medical school.

The longitudinal aspect of the program allowed us to develop relationships with patients over six months of working with them. We could follow our patients' medical conditions and experiences as they traveled from Family Health Center, to specialist clinics, to the Operating Room. This facilitated some of the most educational experiences and meaningful relationships of our third year of medical school.

Similarly, we were able to create lasting relationships with the physicians and staff with whom we worked at FHC. There is no learning community that could have been more supportive in ushering us into our clinical years than FHC. Residents and attendings alike were kind, excited to teach, and invested in mentoring us in our personal development as future physicians.

We may have left Baltimore at the conclusion of our clerkships, but we will always carry with us the relationships that helped us take our first steps into becoming the physicians we have always aspired to be."

SPORTS MEDICINE IN THE COMMUNITY

Health fair at Laurel Racetrack with Andrea Gauld, residents, and pharm students. Providing care to uninsured backstretch employees

The Sports Medicine team providing race coverage as the medical director for Rice Valley Ranch Half Marathon trail run

Participation physicals with our athletic training team and sports medicine team at Franklin Square

Demonstrating the new antigravity treadmill at the grand opening of the new physical therapy and orthopedic office

Dr. Kelly Ryan and Dr. Melissa Nicoletti attend the IIRM Sports Medicine Conference Series in Washington, D.C.

The Sports Medicine team providing race coverage as the medical director for Rice Valley Ranch Half Marathon trail run

Dr. Kelly Ryan providing physicals for Union Memorial employees and staff

Speaking to athletic trainers on proper management of suspected exertional heat stroke in athletes and importance of early recognition

MEDSTAR MEDICAL COVERAGE

Dr. Kelly Ryan traveled to Dubai for the International Conference for the Health, Safety, and Welfare of Jockeys on our concussion protocol

Our very own, family medicine physician, Dr. Kelly Ryan, provides medical coverage to the Maryland Thoroughbred Horsemen's Association at Laurel and Pimlico racetracks.

MedStar Health's Horsemen's Health program continues to make headlines. Dr. Kelly Ryan was featured in the Baltimore Sun article "With help from Maryland doctors, horse racing industry takes on concussions". She has developed, along with others, protocols to sustain the long-term health of jockeys. Visit http://www.baltimoresun.com/health/bs-hs-horsemens-health-20180418-story.html to listen to the video and read the whole article.

Dr. Ryan was also featured in Mid-Atlantic Thoroughbred magazine for concussion protocol as well. Visit http://www.midatlantictb.com/cms/flipbooks/jan2018/mobile/index.html#p=76 for the full article.

Photography by Dottie Miller and Caris Photography.

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