

# ARCHNET ADVISOR

YOUR NEWSLETTER FOR THE ARCHNET PRACTICE-BASED RESEARCH NETWORK



**Dr. Christine Jacobs**, ARCHNet President and Department of Family and Community Medicine Chair.

## What is ARCHNet up to now? PBRN Conference News 2017

Carissa van den Berk, PhD MSW, Outreach Director

Since our last meeting, ARCHNet has been working hard and keeping busy. ARCHNet Program Coordinator Adam Seehaver and I attended the 2017 NAPCRG PBRN conference in June, bringing back valuable lessons and ideas that we can use with ARCHNet:



More and more PBRNs are including medical residents and students as PBRN members. Due to PCORI funding incentives, some PBRNs have started to include a combination of patients and physicians in their PBRN networks.



The changing emphasis on value based payment systems have also encouraged many physicians to join PBRNs in order to develop solutions to treat challenging patients. Canadian PBRN results of the *Choosing Wisely* intervention studies showed innovative strategies to promote patient-physician conversations about medical tests and procedures to reduce wasteful use of costly medical services.



PBRN Director of Evidence Now used seven different regional PBRN networks to test the efficacy of heart disease prevention interventions called *ESCALTES*. The study included a total of 1800 small practices across the country.

**Our next ARCHNet dinner meeting is scheduled for February 12th at 6:00pm. See final page for more details.**

“PBRNs are both a place and a concept. As a place, they are a laboratory for surveillance and research. As a concept, they express the still unmet need for practicing primary care clinicians to accept responsibility to improve frontline clinical care by understanding what is happening in their practices.”

- L. Green & J. Hickner  
2006



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- Update on Multiple Allergies & Childhood Trauma and Patient Attitudes About Opioids studies
- Results of Trauma Screening Feasibility in Primary Care pilot
- Spotlight on Dr. Denise Hooks-Anderson

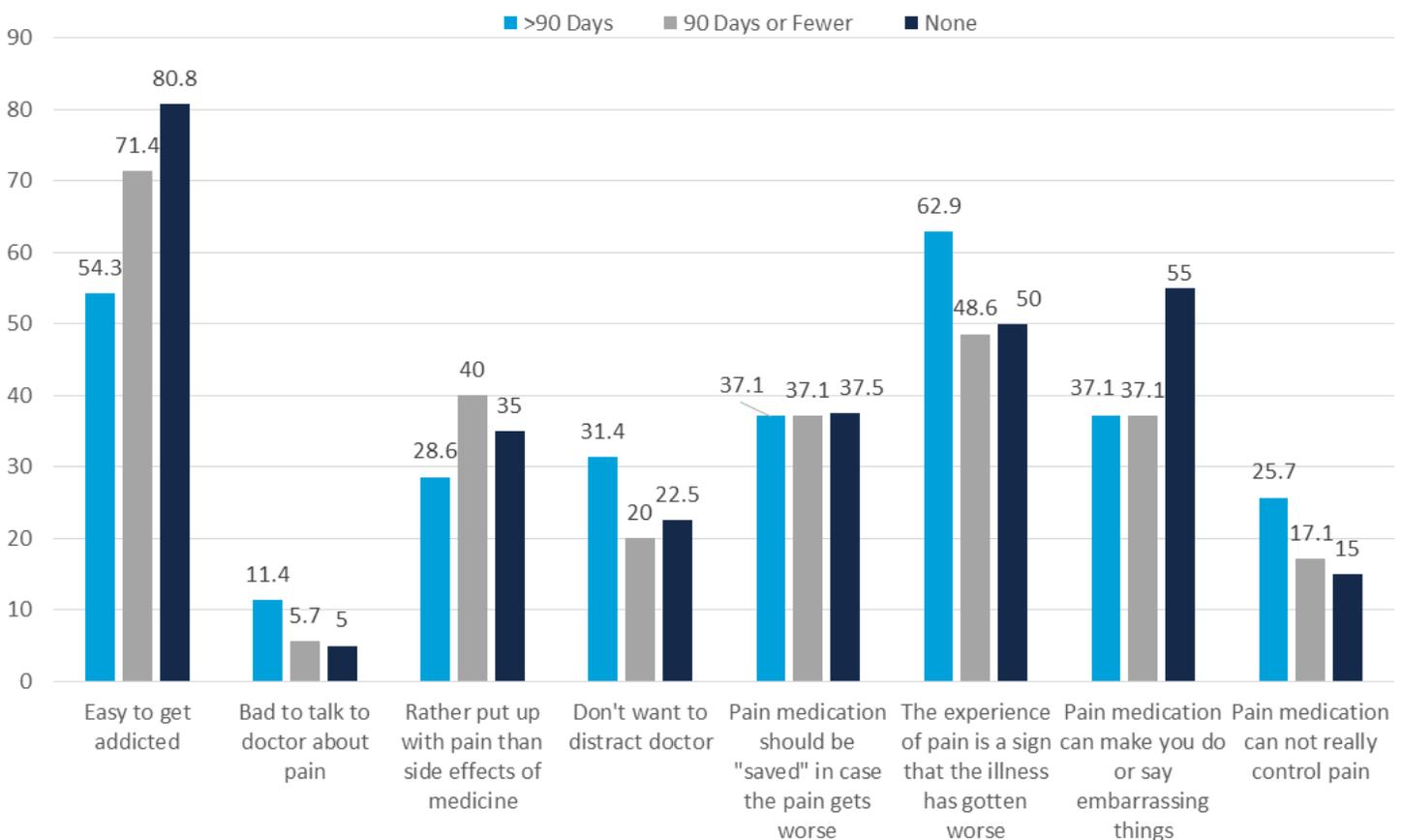
# Update: Patient Attitudes to Opioids

During the last PBRN meeting, ARCHNet members decided that it would be beneficial to measure patient beliefs about opioids to determine how opioid therapy is perceived by patients who either don't have chronic pain or who have never used opioids. ARCHNet site leader Dawn Davis and other member physicians were curious whether or not chronic opioid users perceived chronic pain and opioid use differently than patients who never experienced chronic pain or used opioids. ARCHNet research director, Jeff Scherrer worked with SLU Medical Family Therapy research fellows (Mayra Aragon-Prada, Jocelyn Fowler) to use a validated measure that measured patient pain experiences, past prescription opioid use and beliefs about prescription opioids. ARCHNet program coordinators (Adam Seehaver and now Catherine Hearing) have been distributing the survey to ARCHNet sites since May of 2017.

## Individuals with chronic pain who use opioids vs. those who do not

More patients who used opioids for longer periods of time (>90 days) reported that "good patients avoid talking about pain" and that "complaints of pain could distract the doctor from treating my underlying illness. Surprisingly, >90 day users were also most likely to report that pain medication does not really control pain. This latter finding might indicate these patients are experiencing hyperalgesia. As shown in the figure below, a much larger percentage of patients who never used opioids perceived opioid use as "addictive." The proportion who held this belief decreased with increasing opioid exposure.

## Beliefs about opioids by exposure level

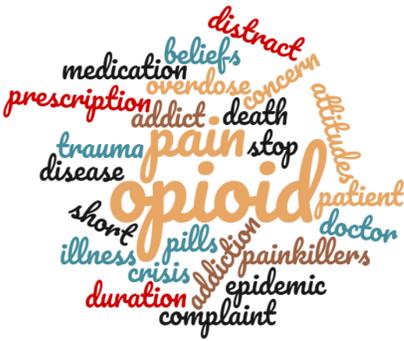


## Patients with 6 or more months of chronic pain vs. those with less than 6 months

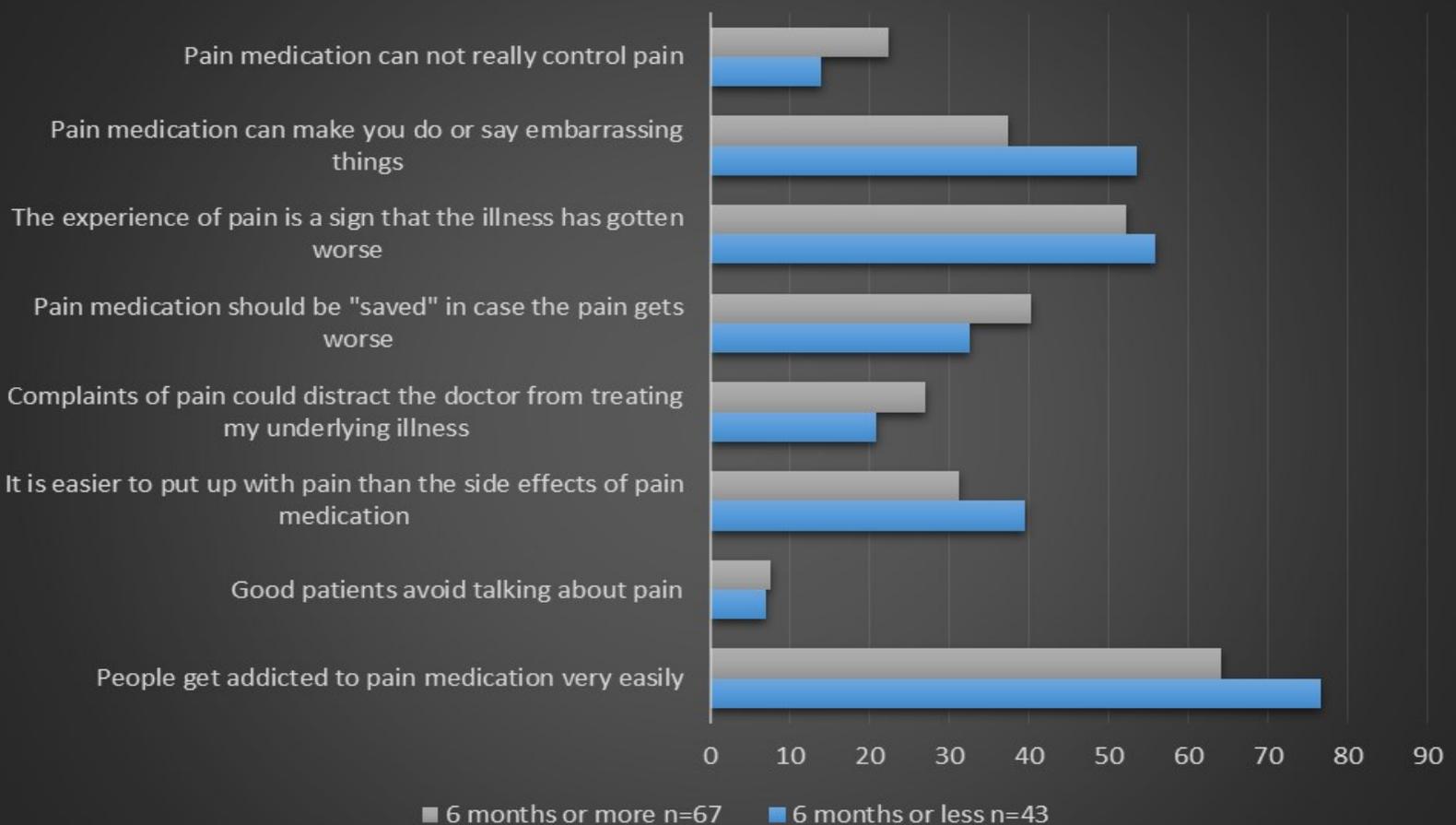
When comparing beliefs about opioids by duration of pain (<6 months vs. > 6 months) we observed that patients with less than 6 months of lifetime chronic pain, were more likely to express concern about opioid addiction. That is, they appeared to prefer to put up with pain, instead of enduring either opioid side effects or withdrawal. This group was also more likely to report that pain medication can lead to saying or doing embarrassing things.

### The Takeaway

These preliminary results of 110 patients suggest that patients with no opioid exposure hold different beliefs about opioids than patients with longer duration opioid use and short term pain patients appear to have more concerns about opioids than long term pain patients. As the sample grows we will be able to determine the combined effect of pain duration and opioid use duration on beliefs about opioids.



## Beliefs about pain by pain duration



# A Chat with ARCHNet Medical Director, Dr. Denise Hooks-Anderson

“One time when I was working at a Community Health Center the staff said they were ordering tripe sandwiches. I thought they said trout, so I requested one. It was disgusting.”

That's what you get with Dr. Hooks-Anderson; candid, concise, and compelling. That discussion took place right after wrapping up a more serious discussion about her career. To Dr. Hooks-Anderson, her patients come first. Most of them have hypertension, diabetes, or are

overweight, so she spends a lot of time on preventive care. Her research helps her clinical practice. As Dr. Anderson puts it, “I think about what I can do to improve my patient's health. The daily problems I see translate into research. I engage in research to help my patients understand their role and how it will help solve their chronic health problems.” Many of her patients are African American, and many of her African American patients don't trust the medical profession or researchers because of historic exploitive relationships and memories of a time when hospitals only treated African American patients in their basements. Since her involvement in research, Dr. Hooks-Anderson feels she has the opportunity to help build their trust with the medical and research professions and show African American patients what's in it for them.



This is tripe, aka: cow stomach .



She became involved with ARCHNet because “research is part of your job here, but I see how patients care improves as a result of researcher involvement.” Denise was instrumental in developing one of our current ARCHNet research



projects. She noticed that her “patients with 3 or

more drug allergies tend to have severe anxiety, depression and some kind of psychosis. My colleagues tend to see the same thing, but there isn't a lot of information about the association.” Through collaboration with clinicians and the research team, we are now working on answering her question. Research and clinicians complement each other well.

*“I engage in research to help my patients understand their role and how it will help solve their chronic health problems”*

We'll leave you with one last chuckle from Dr. Hooks-Anderson: “When I was six years old, some friends and I found a pack of cigarettes afterschool. We went behind the house and tried to smoke them but our neighbor caught us and told my mom. That was still during the time of corporal punishment. I haven't smoked since.”

# What do patients and primary care providers think of trauma screening in primary care?



Carissa van den Berk, PhD MSW

Trauma is an emotional response to a terrible event such as an accident, rape, natural disaster, combat or domestic violence. This response is often so severe that it exceeds one's ability to cope. About 6-33% of individuals who had been exposed to a traumatic event develop acute stress disorders and a large proportion of these (around 80%) go on to develop PTSD. PTSD symptoms include hyperarousal (resetting of the way central nervous system responds to minor stressors), re-experiencing (flashbacks, memory problems), emotional numbness and avoidance. Individuals exposed to trauma are also 6 times more likely to develop a psychiatric disorder, 2-3 times more likely to have a substance use disorder, often are high utilizers of health care and have more chronic health problems. As a result of significant stigma associated with mental health treatment, only around 7% of people with PTSD seek help. Primary Care providers are in an excellent position to facilitate treatment because they provide a majority of mental health care for mood and anxiety disorders. Thus, ARCHNet received PBRN seed funding from the American Association of Family Physicians to determine the feasibility of trauma screening in the primary care setting. We screened 21 ARCHNet patients for trauma screening and then performed a debriefing session to assess their reaction to screening. We then interviewed 10 ARCHNet member physicians and 8 trauma exposed ARCHNet patients to better understand constraints and opportunities to screen for trauma in primary care. The majority of patients (62%) were exposed to trauma and the average number of symptom clusters (0-4 range) was 3.1. About 27% of patients had received some type of trauma screening from a primary care provider in the past and about 19% felt comfortable answering questions about trauma from their primary care providers. Patients often felt that discussing trauma with their primary care provider would trigger memories and these patients were often going through significant stressors at the time which made planning and help seeking challenging. Physicians were also hesitant to screen, citing a number of issues, including time, complexity, lack of mental health training and stigma.



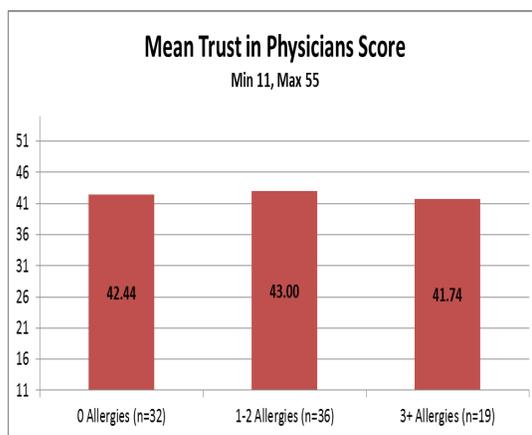
PBRN Coordinator  
Catherine Hearing

## The Cat Hearing Update

In October, SLU FCM brought a new research assistant on board to replace Adam. She will be the point-person on this team and continue the efforts to expand the ARCHNet PBRN. Prior to SLU FCM, she was an instructor at the University of Central Florida, teaching preventive healthcare to undergraduate pre-med students. Before moving to the university, she oversaw a state-wide network of health literacy educators—a group dedicated to improving the English skills of patients, resulting in improved patient-provider communication. She is excited to be in St. Louis!

# Update: Polyallergy and Adverse Childhood Events

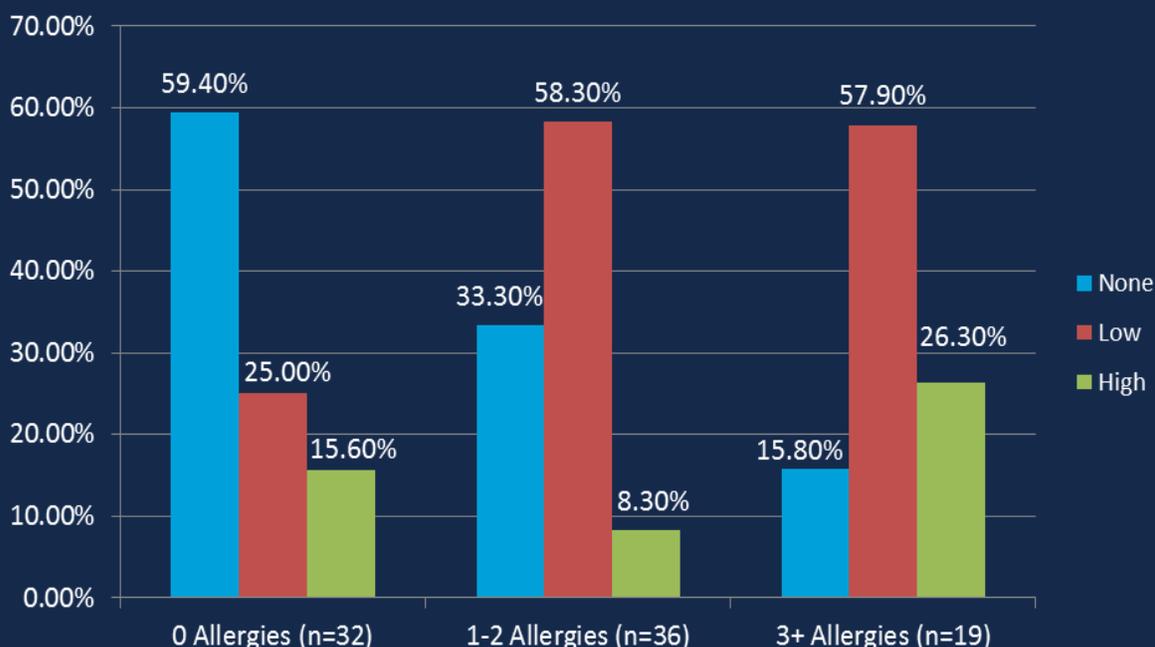
The PBRN launched a study to determine if patients with multiple medication allergies are more likely to have been exposed to high levels of adverse childhood events (ACEs), a measure of potentially traumatic events occurring in childhood. Dr. Hooks Anderson was instrumental in coming up with the idea for this study because of ARCHNet physicians mutual interest in determine strategies to deal with patients who had been exposed to traumatic events and whose perceived allergies which prevent them from receiving more common therapeutic medications. ACE measures include evaluations of childhood exposure to verbal, physical and sexual abuse as well as other negative events, and have long been known to contribute to adult health.



Patients are being recruited in two ways: (1) SLUCare Family Medicine patients are recruited through EPIC rosters (n=600), and (2) private practice patients are recruited via signs in participating clinics. Identification of patients via EPIC rosters with multiple allergies (half with 3 or more allergies) was used for recruitment purposes and is not recorded in study data. The rest had 0 or 2 allergies to a medication. Number of allergies presented in the study is patient reported. Patients who wish to participate are given a code number and a link to a web based survey. To date, eighty seven patients have complete data on all measures which include ACEs, trust in physician, neuroticism, depression, anxiety, self-reported allergy and

allergy symptoms and demographic variables. We explored whether polyallergy was associated with trust, depression and ACEs. As shown, degree of trust in physicians was not associated with number of medication allergies.

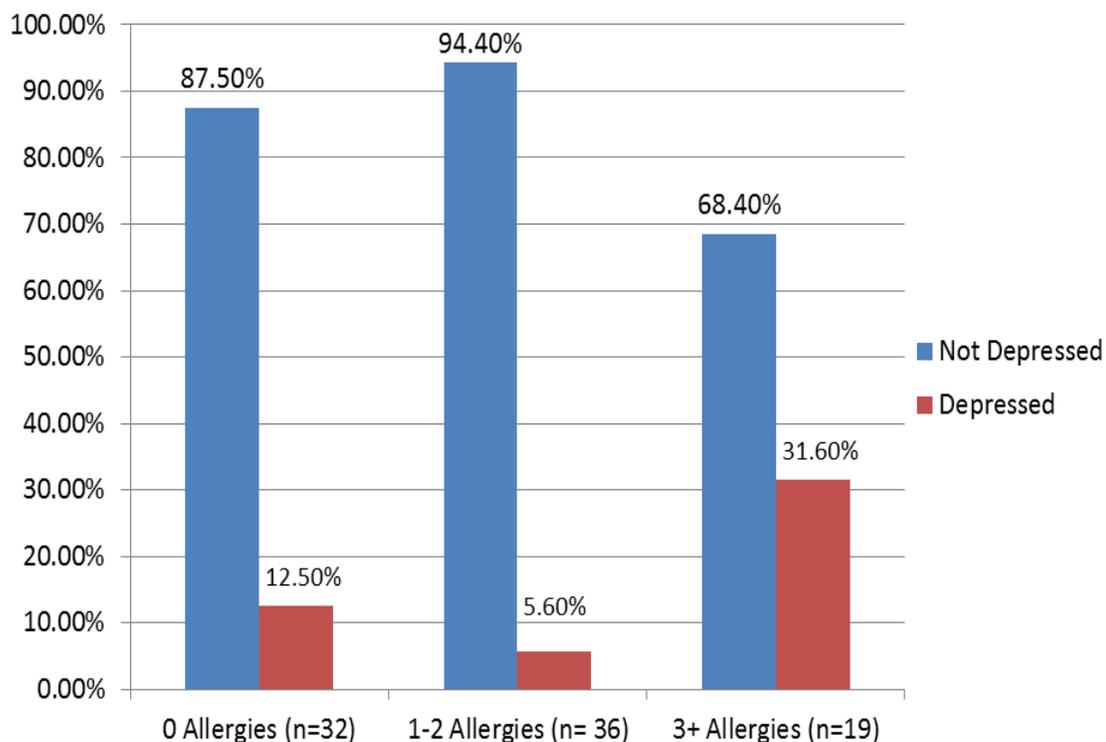
## ACEs Risk Category by Medication Allergy Count



As expected, patients with 3 or more medication allergies were more likely to report 4 or more ACEs compared to patients with no allergies and with 1-2 allergies (see figure to left). Interestingly, patients with 3 or more allergies or 1-2 allergies reported similar prevalence of low ACE exposure (1-3 ACES). Patients without any allergies were also most likely to have no ACEs.

Depression was measured by the PHQ-8 and was strongly correlated with ACEs. Those with 3 or more allergies had the highest prevalence of depression. However, depression was more common in patients with no allergies compared to those with 1-2 allergies. This is very preliminary evidence that having 1 or 2 allergies is normative and may be associated with less childhood trauma exposure.

## Depression Rate by Medication Allergy Count



## ONGOING PROJECTS

- . Multiple Allergies and Childhood Trauma
  - . Data collection continues until we reach goal of 600 patients
- . Trauma and Discounting Among Smokers
  - . NIH Grant has been submitted
- . Patient attitudes about opioids
  - . Data collection continues until we reach goal of 300 patients

# ARCHNet

# Dinner Meeting

February 12th, 6:00-7:30pm

O'Donnell Hall

Saint Louis University School of Medicine

1402 S. Grand Blvd.

*Parking is available in the Hickory East:*

To get there, go East on Chouteau from Grand and then turn south onto Theresa Ave. You'll go through two stop signs and be right between two parking garages. Hickory East will be the one on your left. Go ahead and take a ticket from the mechanical gate, and bring it with you to the meeting. We will give you a voucher to use when you leave the garage.

If you have any trouble with parking or directions, you can reach Catherine Hearing at 561-846-1784 (cell). Please RSVP to the calendar invite.

