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ARCHNET ADVISOR

KEEPING YOU UP-TO-DATE WITH THE LATEST NEWS IN FAMILY MEDICINE RESEARCH

ISSUE 4 / SEPTEMBER 2018

Why aren't our patients eating healthy? And what can we do about it?



JESSE KAO
SLU Medical Student

On average, Americans eat only 1.5 cup of vegetables and 1 cup of fruit per day, far from the recommended combined 5 servings.

Unhealthy diets have been a constant source of public health concern in America. People adhering to poor quality diets are more likely to live with chronic diseases such as cardiovascular disease, cancer, diabetes and respiratory disease. On the other hand, consuming healthy foods such as fruits, vegetables, nuts and whole grains are associated with weight loss,

which has a multitude of health benefits. Understanding the reasons why people adhere to unhealthy diets is crucial for the development of effective healthy eating interventions.

Barriers to healthy eating are multifactorial. Factors that impact people's diets include nutritional knowledge, lack of access to healthy foods, food insecurity and food attitudes. Individuals with nutritional knowledge are 25x more likely to consume adequate amounts of fruit and vegetables daily compared to individuals without nutritional knowledge. Women with nutrition knowledge also are more likely to consume low fat diets. This nutritional knowledge however, is not translatable if people cannot access supermarkets on a consistent basis. Low income areas have fewer supermarkets or chain stores per capita compared to advantaged areas. Greater access to supermarkets is

associated with reduced risk for obesity as well as increased fruit and vegetable consumption. Even if someone has nutritional knowledge and access to healthy foods, financial insecurity may impinge on the ability to adhere to a healthy diet. Interviews with food pantry clients reveal that many of them "have to stretch dollars" and are more concerned about paying other bills instead of buying healthy foods. Many of them also lack the time to purchase and prepare healthy foods. Even when all resources are available to purchase and consume healthy foods, preferences and attitudes may prohibit people from maintaining healthy diets.

ARCHNet proposes a study to elucidate reasons why patients from ARCHNet practices have difficulty eating a healthy diet. Data will be collected from a brief questionnaire made available in waiting rooms of ARCHNet clinics. An intervention will be established based on the results which will consider complex interaction of food access and preferences.

Patient's trust in their physician



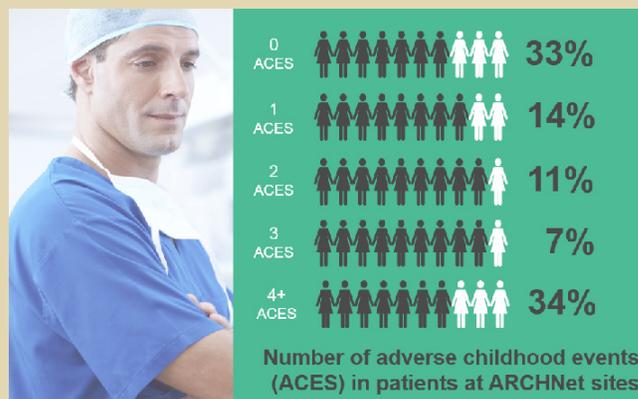
Dr. Carissa Clark
Assistant Professor

Does having more adverse childhood events make you less trusting toward your physician? Yes it does

Trusting your physician is really important. Studies have shown that patients who trust their physicians are more likely to adhere to medical advice, more likely to utilize more appropriate outpatient services, have greater satisfaction with care and better self-

reported health outcomes. For many individuals who have endured traumatic events during the childhood, trust can be difficult. Thus, we hypothesized that individuals who have been exposed to more childhood stressors, trust their physicians less. Using data from our ongoing study of adverse childhood events (ACES) and polyallergies, we found that patients with more adverse childhood events had significantly lower levels of trust in their providers.

Also, we found that patients who were low income (household income at or below \$30,000 per year) had higher trust, except when they had more adverse childhood events.



Beliefs about prescription opioids differ between patients who have and have not used prescription opioids

We studied patients attitudes about opioids to determine if patients without chronic pain or without prior exposure to prescription opioids held stigmatizing beliefs about patients who used opioids and to determine if prescription opioid users over-valued the benefits of opioids and under-estimated risks associated with opioids.



Patients' attitudes about opioids are important-because they can tell us whether patients will use opioids for acute and chronic pain and whether

patients will have trouble tapering opioid medications. ARCHNet has partnered with University of Texas Southwestern RRNet (UTSW) to survey patients while they wait to meet with their provider from June 2017 to July 2018. The survey contained questions about duration and severity of low back pain, pain interference and treatments used by patients including prescription opioids, use of physical therapy and psychological counselling for pain. In addition to brief demographic questions, patients were asked to complete a Barriers Questionnaire. The Barriers Questionnaire contains eight items about pain and prescription opioid use which are scored on a five point scale ranging from strongly agree to strongly disagree. Questionnaires were placed in waiting rooms next to a lock box for returning

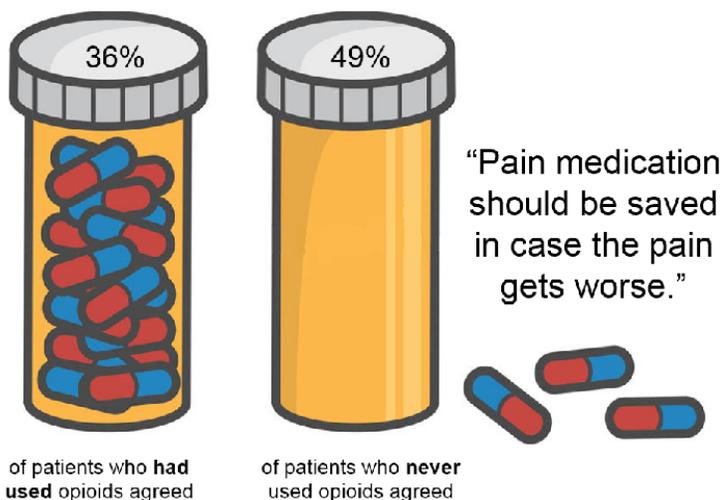
completed surveys.

Combined data from ARCHNet practices and UTSW included 38.7% white, 28.4% black, 23.5% Hispanic, 5.7% Asian and the remaining were multi-racial participants. Of all respondents, 68.6% were female and 37.3% reported attaining at least bachelors degree or higher. The mean age of respondents was 49.1 years

(SD±15.38).

Overall, 52.9% of respondents reported having had chronic low back pain and 56.1% rated their worst pain score > 7.0. Substantial pain interference was endorsed by 60.3%. Prescription opioids for pain were tried by 63.3%, 31.0% tried injections, 48.7% physical therapy and 14.9% counselling.

Continues on page 5



This Years Annual NAPCRG PBRN Conference

Craissa van den Berk-Clark

Catherine Hearing and I made our way to the annual NAPCRG PBRN conference in Bethesda, Maryland this year. This is a wonderful and intimate conference which involves PBRN directors and coordinators from across the US and Canada. Both Catherine and I appreciate the opportunity to attend this conference on behalf of ARCHNet because we get to bring home ideas from other PBRNs about how to better respond to the needs of PBRN members and to improve community understanding of PBRNs.

- PBRNs are making more efforts to involve medical students and residents by incorporating PBRN education into already existing research training programs. PBRN education includes lectures on the role of PBRNs in research, well-known PBRN studies, survey Methods and research involving medical registries.
- PBRNs have begun developing practice facilitation programs which provide a liaison to PBRN member clinics involved in studies, helping to facilitate research and quality improvement at their practice. For some studies, practice facilitators are employed full time to coordinate between specific practices and the research team. Depending on grant budgets, they can also have time to help individual clinics build research and quality improvement capacity.
- Some larger PBRNs like DARTNet and OCHIN, have recruited enough members to cover whole regional areas. This has allowed them to negotiate with state and local governments to implement demonstration and prevention programs through their PBRN members.
- Many PBRNs across the country are providing their doctors access to Project ECHO. Project ECHO uses technology to link specialists at academic centers with primary care clinicians practicing in the community. Weekly teleECHO clinics are held, at which time primary care physicians present patient cases and the collective group of physicians work to determine best treatment. This model allows primary care physicians to better treat patients with complex health conditions, while providing whole-body care in the community. Missouri proudly hosts a Superhub (Show-Me ECHO).



AAFP AFFILIATION



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

ARCHNet is now part of the AAFP National Research Network!

The AAFP National Research Network affiliates local Primary Care PBRNs (like ARCHNet) in order to represent the entire US to help AAFP develop, conduct, promote and disseminate primary care research.

AAFP's National Research Network (NRN) has conducted over 70 research studies since its establishment in 1999. Their research has spanned many topics from ADHD to sleep problems. The NRN spans: Oklahoma, Kentucky, Colorado, Texas, California, New York, Virginia, New Jersey, Connecticut, Alabama, Florida, Arkansas and now Missouri!

What does this mean for ARCHNet?

- Quicker access to AAFP resources
- Recognition as a national partner
- Ability to participate in national, multisite research studies

GUIDELINES



PROSTATE CANCER SCREENING

USPSTF recommends men ages 55-69 could benefit from PSA-based prostate screening. Together with their doctor, those men should make an individual decision regarding a PSA screening. Men age 70+ should not be routinely screened for prostate cancer.



CARDIOVASCULAR DISEASE SCREENING

USPSTF recommends against screening for CVD using ECG in people at low risk. "Assessing CVD risk is traditionally based on factors such as age, race/ethnicity, sex, obesity, diabetes, smoking status, cholesterol levels, and blood pressure." Incorporating ECG will likely not result in any benefit to the patient.



OSTEOPOROSIS SCREENING

USPSTF recommends screening for osteoporosis in women 65 years and older, to prevent fractures, as well as women who have been through menopause and are at increased risk for osteoporosis.

NEW RESEARCH



Dr. Jeff Scherrer
Research Director

ARCHNet recently began a new study to characterize the beliefs patients have about opioid analgesic use (OAU), their experiences with cessation, their perceived barriers to cessation and their needs to successfully stop OAU by conducting open-ended interviews and using qualitative methods to analyze them.

While the overall rate of very long term OAU is low (6% of all patients who received an opioid); among patients whose first opioid prescription is for 8 or more days, 13.5% remain users at 1 year and among those who initiate OAU for >30 days, nearly 30% are still using 1 year later. Because physiological dependence is a normal consequence of chronic, daily OAU, it is not surprising that long term users are also high dose users and iatrogenic physiological dependence plays a large part in explaining the 2 million opioid users in the U.S. thought to be opioid dependent.

To understand the beliefs and perceived barriers to cessation held by very long term opioid users with non-cancer pain, we are recruiting patients to structured interviews. Currently, 7 patients have participated in the 20 minute interview and we are looking for 13 more. The interviews will provide pilot data to support an NIH grant submission designed to understand patient's reasons for persistent use and identify potential false beliefs about the benefits and safety of prescription opioids. The NIH grant will expand the interview locations to Baylor Scott and White HealthCare, Henry Ford Health System and across the nation. This broad sample of interviews will be used to create survey questions that measure factors associated with OAU persistence vs cessation. Ultimately, this survey will be distributed to about 1,000 patients across the nation, and results will be used to develop and implement an intervention to encourage OAU cessation.

Thank you to the doctors handing out flyers to help us recruit!

Primary Care Research Symposium

Scott Secrest

Each year since 2011, the Saint Louis University departments of Family and Community Medicine, General Internal Medicine, and General Academic Pediatrics have co-hosted the SLU Primary Care Research Symposium. Each symposium consists of an hour-long keynote presentation by a career primary care researcher, research presentations by SLU faculty in each department, and a poster session featuring projects undertaken by SLU School of Medicine students and residents. The goal of the symposium is to promote awareness of research in primary care medicine and encourage students to choose a path in primary care.



Dr. Kurt Kroenke

In recent years, researchers from Case Western Reserve University, Oregon Health & Science University, University of Texas Southwestern Medical Center, and the University of Missouri School of Medicine presented. In 2018, Dr. Richelle Koopman of University of Missouri presented on enhanced EHR design that makes it easy for patients and physicians to make good clinical decisions to improve health. She seeks to leverage improved data visualization, electronic support for decision making and patient-physician information-sharing to enable people with chronic conditions and their physicians to make well-informed shared decisions that lead to better health outcomes.

The 2019 Symposium, our 8th iteration, is scheduled for Wednesday, April 17, beginning at 12:00 PM. Our keynote presentation will be given by Dr. Kurt Kroenke of the Indiana University School of Medicine. Dr. Kroenke developed the PHQ-9 depression scale, GAD-7 anxiety scale, P4 suicidality screener and many more outcome measures. The event is open to the public and lunch is provided for those that RSVP. We are typically able to offer between 2.0 and 2.5 CME Credits for attendees. For more information the symposium coordinator, Scott Secrest, can be reached at scott.secrest@health.slu.edu.



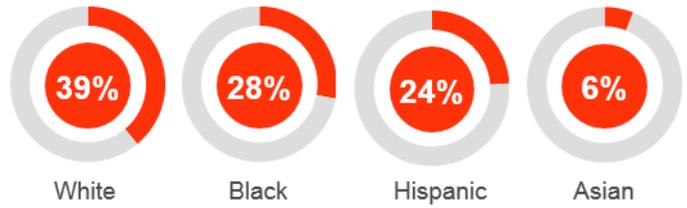
For Dr. Richelle Koopman presents at 2018 Research Symposium

Patients Beliefs about Opioids

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Patients with chronic pain who ever received an opioid were significantly (p=0.027) less likely to agree with the belief "it is easier to put up with pain than deal with side effects of pain medication"

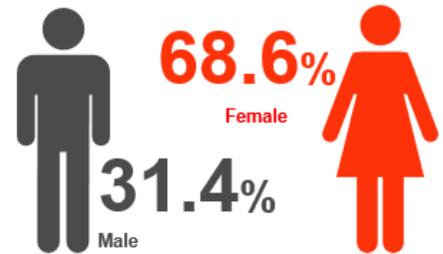
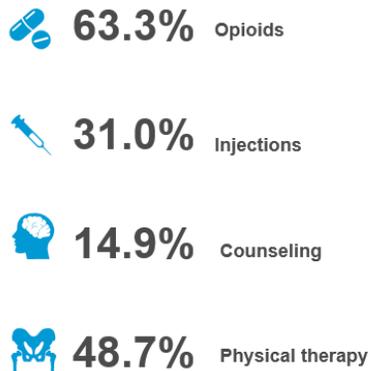
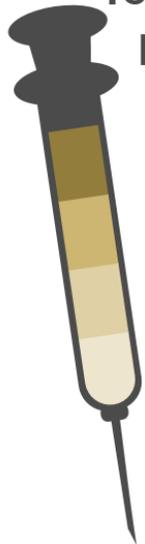
(32.4% vs. 45.8%, respectively) than chronic pain patients who never used an opioid



Patients who had used opioids were significantly less likely than those who never received opioids to agree with the statement: "pain medication should be saved in case the pain gets worse", 36.0% vs. 49.4%, p=0.031. Patients who received an opioid vs. those who did not were significantly less likely to agree with the statement: "pain medication can make you do or say embarrassing things", 28.6% vs. 42.7%, p=0.018. Agreement with the remaining opioid beliefs statements did not differ between pain patients with

and without prescription opioid use. Among patients without a history of chronic low back pain, receipt of an opioid was not significantly associated with any of the opioid beliefs.

To deal with the pain, patients have tried:



Low Physician trust among Patients with Multiple Medication Allergies



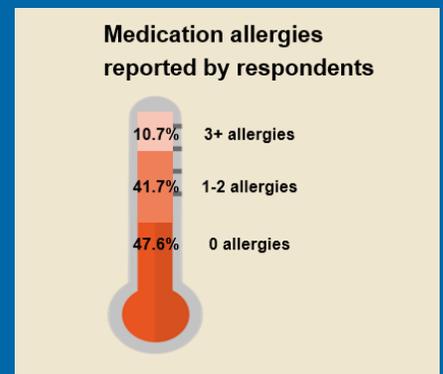
Scott Secrest
Senior Research Assistant

ARCHNet members have had concerns about patients incorrectly reporting multiple drug allergies. Many of these patients may be detecting adverse symptoms to medication and therefore are not taking medications they need to take. Studies have shown that psychiatric issues increase the likelihood of having more drug allergies. There are also studies showing that psychiatric issues are associated with lower trust in physicians. Given the importance of

trust in the providers, and given that patients who trust their physicians are more likely to be adherent- I thought it would be interesting to see whether trust impacted drug intolerance. If so, then it would be more clear that medication allergies also are the result of physiological issues- and can be controlled by the environment.

We used a sample of 271 ARCHNet patients who were prescribed a medication and split them into 3 groups: (1) no allergy, (2) 1-2 allergies and (3) 3 or more allergies. We found that even after adjusting for race, gender, depression, anxiety and smoking status, that patients with 3 or more drug allergies were more likely to agree with the statements "I doubt that my health care provider really

cares about me," and "I sometimes distrust my health care provider's opinion and would like a second one." Further research will still need to be done to confirm mechanisms leading to polymedication allergies but this ARCHNet study paves the way to better understanding of how patient relationships with doctors affect outcomes.





CURRENT PROJECTS

Barriers to cessation of very long term opioid users

Nutritional needs assessment

Chronic Pain, trauma and social networks

Trauma and decision making

Behavioural economic approaches to smoking cessation in primary care

Together We Can Make It – figuring out how to ease transitions for individuals with severe mental illness after inpatient admissions...

Carissa van den Berk-Clark

Modern medical practice has progressed from a paternalistic model of doctor-directed care, towards shared decision making. The shift to community based care when it comes to mental illness, however, did not come with adequate funding, and from the 1980s onward, resources to build a stable and empowering mental health infrastructure became increasingly scarce.

An immediate consequence of the reduction in funding has been financial pressure on inpatient psychiatric facilities and outpatient mental health providers. Given increased demand for limited acute services, hospitals with psychiatric inpatient beds have reduced the length of hospital stay. Around 30 years ago, patients would stay in care for about a month, while today, most patients stay for only a few days. Financial pressures have also led to an overemphasis on biological aspects of care (i.e., psychopharmacology) and safety.

Often, patients leave the hospital not fully stabilized, with there being little time to involve the patient's family or other caretakers to figure out how to manage patients' symptoms, and to encourage patients to attend more intensive outpatient treatment (when available) or adhere to medication regimen.

With funding from a Patients Centers Outcomes Research Institute (PCORI) grant, I have been working with Southern Illinois

Health Foundation and a group of dedicated patients who had either been admitted for inpatient psychiatric treatment or intensive outpatient psychiatric treatment. We have been meeting once a month for the past 2 years to talk about research and to determine the best approaches to improving transitions to the community after inpatient stays. I have learned that patients need enormous amount of support and structure during this sensitive period and they want more programming that involves interactions with peers who have similar challenges with mental illness. We have developed a proposal to incorporate new evidence based interventions like Critical Time Intervention and Wellness Recovery Action Plans into inpatient care and have just submitted them to PCORI and SAMSHA.

GUIDELINES



SHINGLES VACCINE

Use new herpes zoster subunit (HZ/su; Shingrix) vaccine over the currently available herpes zoster live (Zostavax) vaccine for adults 50 and older.



OBESITY SCREENING

Patients ages 6-18 should be screened for obesity. "Those who are diagnosed with obesity should be offered or referred to comprehensive, intensive behavioural interventions to promote improved weight status"



OVARIAN CANCER SCREENING

USPSTF recommends against screening women for ovarian cancer due to its difficult nature to detect and unreliable screening tests. Current evidence suggests that regular screening does not prevent women from dying of ovarian cancer.

A moment with Dr. Sarah Gebauer



DR. SARAH GEBAUER
ARCHNet Medical Director

Dr. Gebauer, the co-medical director of ARCHNet, had the worst roommate ever during her freshman year at Bradley University. To put it mildly, the roommate had some eclectic tastes. There was – positioned prominently in the room – a fake marijuana plant that had fiber optic lights, and a mannequin head that would give Sarah a heart attack every time she opened the door. This is just the beginning of the list of their differences: One was an English major, the other a bio major, one liked to study while the other liked to party. Sarah reflects on this roommate with enormous amounts of humour and affection, such amicability and empathy is necessary and vital in being a physician researcher.



Dr. Gebauer's patients are lucky to have her-literally. Spending two days a week conducting research, and an afternoon teaching at SLU leaves her with less than 3 days a week to see patients at the St. Louis County Department of Health and SLU medical

residents at St. Mary's Hospital. At the County Health Department, she provides a lot of preventive services, including well women visits. She also has a medication-assisted treatment (MAT) waiver, so she can prescribe buprenorphine to help patients with opioid use disorder right in her clinic, rather than sending them to an Addiction Clinic Program. Since starting at the Health Department, Dr.

Gebauer has developed a special interest in PTSD and trauma care, given the large immigrant and lower SES populations she sees.

As a social epidemiologist, Dr. Gebauer is building her expertise in social determinants of health. Social determinants of health are composed of factors in the environment in which people live, work and engage in leisure activities which effect health functioning.

By studying the neighborhood characteristics (structural, built and social attributes) through new technologies like Geographic Information System software, she is helping us learn about what interventions need to be done locally to improve health outcomes. "We need to understand the social aspect so we can provide training to healthcare professionals"

Her research career wasn't predestined. It started off quite shaky in college when she

was assigned to a basic science research lab. She was a disaster, and I quote: "I was really bad at bench work, like I screwed up and broke a lot of expensive things, but I was good at background literature and understanding why we were doing what we were doing. I was so bad I almost got kicked out, thank goodness I could do the literature searches."

"The beauty of ARCHNet is that it's where rubber meets the road, where research becomes real, not just theoretical anymore. We're able to connect the science we're doing with the bedside."

Luckily, she now works with people! Being an ARCHNet member, "is really inspiring because I get to meet with

community physicians who are seeing similar problems in their clinics and we are finding solutions. It's exciting to see that the group seems very interested in social determinants and if we can get many types of practices together, we can get more information about the community." Dr. Gebauer is hopeful that we can assess the individual needs of our patients and the ways in which to respond to those needs - to arm the community members with facts to bring to our local government so they can develop informed policies around actionable items.

"It is really inspiring because I get to meet with community physicians who are seeing similar problems in their clinics and we are finding solutions."

Ready to earn free CME through SLU?

It's easy! Just attend our free events throughout the year.

If you've received CME from Saint Louis University before, all you need to do is sign in at the event. If you have never received CME from SLU, please go to the following website and fill out the form.

<https://tinyurl.com/y9bby5we>

If you have any trouble accessing the form or questions about the content, please contact Cat at 314 977 8487

We will have paper versions of the registration at the event if you prefer to register that way.

ARHCNetDinner
Meetings are now
worth 1 CME credit.



A Growing Community

We are excited to welcome new members, some of whom are already involved with SLU through the Family and Community Medicine preceptor program!

We are pleased to welcome our newest members: Dr. Reynal Caldwell, Dr. Alex Labounty, Dr. Alex Macdonald, Dr. Chandra Shekar, Dr. Peggy Taylor, and Dr. Valerie Walker

Thank you to all of our existing members for your participation in advancing Family Medicine research and practice:

Dr. Michael Barron, Dr. Denise Buck, Dr. Stephen Cagle, Dr. Sarah Cole, Dr. Dawn Davis, Dr. Sarah Gebauer, Dr. Melissa Hollie, Dr. Denise Hooks-Anderson, Dr. Christine Jacobs, Dr. Elizabeth Keegan-Garrett, Dr. Bill Manard, Dr. Daniel Meshoto, Dr. Lowell Sesintaffar, Dr. Michael Spezia, Dr. Jane Tucker, Dr. Christian Verry, Dr. Mattie White.

Enjoy working with students and teaching? Well, precepting may be the perfect thing for you. Benefits of being a SLU preceptor are: adjunct faculty appointment to Saint Louis University School of Medicine, access to SLU library resources, 20 CME credits at no cost, and \$1000 payment per six-week rotation. Join some of your fellow ARCHNet members such as Drs. Denise Buck, Dawn Davis, Denise Hooks-Anderson, Sarah Gebauer, Peggy Taylor-Boyd, and Christian Verry in this very rewarding opportunity. Dr. Denise Hooks-Anderson is an outstanding preceptor, highlighted in the last Preceptor Newsletter for receiving the Medical Student Clinical Teacher Award. If you have any questions, please contact Ashley Lewis (Preceptor Program Coordinator), at 314-977-8492.



Drs. Denise Hooks-Anderson, Sarah Gebauer and Christine Jacobs

“We see the stunning complexity of primary care and the meagerness of the infrastructures to discover and support it. The resilience, adaptability, and continued expansion of PBRNs is on display This is good news for those seeking transformation of health care such that it actually matches patients’ goals and needs and improves both individual and population health”
- L. Green & J. Hickner 2015

GUIDELINES

HYPERTENSION SCREENING

AAFP does not endorse the 2017 AHA/ACC hypertension guideline. Continue to use the 2014 guideline of treating hypertension starting at 140/90 mm Hg.

HYPERTENSION TREATMENT

Start treatment in patients 60+ y/o who have persistent systolic blood pressure (SBP) of at least 150 mm Hg to reduce the risk of mortality, stroke and cardiac events

HEPATITIS B VIRUS SCREENING

Screen for hepatitis B virus (HBV) infection in patients at high risk. “In the United States, persons considered at high risk for HBV infection include those from countries with a high prevalence of HBV infection, HIV-positive persons, injection drug users, household contacts of persons with HBV infection, and men who have sex with men” and pregnant women.

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