

Inter-Professional and International Collaboration in Integrative, Complementary, and Traditional Health Practice

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Abstract

Comprehensive integrative pain management in a federally qualified health center

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Background/Purpose: Communities of color and other marginalized groups often experience significant trauma due to racism, discrimination, poverty, and other structural factors. Not only do we know that this trauma leads to higher rates of chronic diseases, but also behavioral health conditions such as depression and anxiety, substance use disorders, as well as chronic pain. Compounding this, for underserved patients living with chronic pain, most do not have access to the resources that can effectively help manage their pain. In a state like Texas, which did not expand Medicaid and thus has the highest uninsured rate in the country, patients often cannot access imaging or specialists including orthopedists, rheumatologists, or pain management physicians, let alone other evidenced-based non-pharmacologic treatments that are safer and more effective than opioids. As a result, many patients don't have their pain adequately managed and go down the potentially dangerous road of opioid therapy.

Methods: People's Community Clinic, a Federally Qualified Health Center in Austin, TX, has developed an integrative pain management program that is aligned with current recommendations and guidelines from the US Department of Health and Human Services, the Centers for Disease Control and Prevention, American College of Physicians, and others. The goal is to improve pain, functioning, and quality of life while mitigating opioid prescribing. The program is based upon patients' preferences and integrates numerous evidence-based services offered at PCC including trauma-informed behavioral health counseling, nutrition, exercise, acupuncture, yoga therapy, substance use treatment, and our medical-legal partnership. Central to this program are group medical visits which focus on education, self-management, peer-to-peer connection, and community building. Additionally, complex cases are discussed in weekly inter-professional case conferences that include practitioners who provide the referenced services, which leads to improved patient care as well as an overall increase in practitioner satisfaction.

Results/Outcomes: This program has only been in existence for about two years, so we are still in the process of collating our data. We are evaluating the program using the Defense and Veterans Pain Rating Scale, behavioral health measures (PHQ-9 and GAD-7), physical health measures (BMI, HTN, and HbA1c), opioid usage, as well as the Flourishing Measures to assess overall quality of life. Additionally, we are collecting qualitative data including testimonials from patients in the program who have found it incredibly beneficial, especially the focus on nutrition and the group visits where patients often recognize that there are others going through something similar, thus often feel less alone and more supported.

Conclusions: A comprehensive integrative pain management program that aligns with best practices can be developed in an underserved setting, providing patients with individualized, culturally responsive care utilizing a wide variety of non-pharmacologic options. Further evaluation is ongoing to determine if the program improves pain, functioning, and quality of life, and reduces opioid usage.

Chronic disease management and prevention Clinical medicine applied in public health Implementation of health education strategies, interventions and programs

Provider perspectives on development of a mobile health application to improve dietary supplement tracking and reconciliation

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Background: In the United States, dietary supplement (DS) use is ubiquitous, especially among patients with acute and chronic illness. Concomitant use of DS with prescription medications is common, ranging from 34% in all age groups to 66% among older adults. Accurate monitoring of DS use is important to prevent supplement-drug interactions (SDI) and/or identify adverse events or DS overdosing. Unfortunately, DS information is often poorly documented in the medical record (known as reconciliation), impeding identification of important safety issues.

New methods are needed to support patient disclosure of supplements and reduce the burden of supplement reconciliation on providers. We propose a novel barcode-scanning mobile health application (mHealth app) to improve tracking and reconciliation of dietary supplements. Prior to app development, we assessed medical providers' views on facilitators and barriers to using a mHealth app to collect and share DS information, as well as collect provider input to inform the creation of the mHealth app.

Methods: We conducted qualitative interviews with providers from several departments at a large academic medical center. We asked providers to discuss patient use of DS, clinical DS discussions, DS reconciliation, risks and benefits of our proposed mHealth app, usability of the proposed app, and privacy concerns. Interviews were recorded via ZOOM teleconferencing and transcribed verbatim. The transcripts underwent thematic coding. We developed deductive codes based on the interview guide, and inductive codes based on salient topics identified during review and coding of the transcripts. We compared codes across all transcripts and condensed codes into meaningful categories. We used ATLAS.ti for qualitative data analysis.

Results: Interviewees (N=15) included 8 men and 7 women. Their professions were physician (n=5), pharmacist (n=4), physician assistant (n=4), and dietitian (n=2). The median and range of estimated patient DS use was 45% (12.5%-100%), and the median and range of estimated patient visits including a DS discussion was 10% (4%-100%). Interviewees recognized the potential of unsafe supplement use, with the majority providing specific examples of DS adverse events.

Providers acknowledged the importance of accurate DS reconciliation, but also several challenges to DS reconciliation. These include lack of accurate database entries in the medication section of the electronic medical record (EMR), wide variations in supplement ingredients and dosing, lack of patient disclosure, and time requirements for manually entering DS information.

Our proposed app received strong positive reviews from interviewees, with the majority stating they would personally use or suggest the app to their patients. Benefits identified include a quicker reconciliation process, more accurate DS ingredient and dosing information, and identification of SDIs. Concerns expressed include lack of smart phone use among older adults, frequency of reminder prompts to update supplement information, and communication challenges between the app and a patient's EMR. There was low concern among interviewees regarding patient privacy.

Conclusion: Overall, providers believe DS reconciliation is important but inaccurately represented in the EMR. Strong support was expressed for our proposed barcode-scanning DS mHealth app, and provider input identified several key design aspects to support increased usability.

Chronic disease management and prevention Clinical medicine applied in public health Planning of health education strategies, interventions, and programs Provision of health care to the public Public health or related research

Abstract

A model of multidisciplinary integrative medicine training and care at a federally qualified health center

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Low income patients served by Federally Qualified Health Centers (FQHCs) desire integrative medical services but often lack the financial means to seek care outside of the safety-net medical setting. At Family Health Centers of San Diego (FHCS), a large FQHC system, a team of 8 integrative medicine practitioners including physicians in family medicine, obstetrics and gynecology, a nurse practitioner, a psychologist, a physical therapist, and a chiropractor, formed a multidisciplinary group to provide team-based integrative care. Cross referrals are conducted via a hub-and-spokes model, with the integrative physician as the hub, and the multidisciplinary team as spokes. Primary care providers within FHCS or any multidisciplinary team member can refer patients who desire an integrative approach for a consult with the integrative physician. The integrative physician provides patients with recommendations on mind-body approaches, supplements, complementary and alternative practices, and physical activity tailored to the patient's medical and mental health diagnoses as well as belief system. Referrals are generated to the specific team member who has expertise in the patient's area of need. Case-based discussions through web-based conferences are scheduled monthly, and integrative retreats are scheduled quarterly for team check-ins and wellness-building activities. All members of the team are in various phases of training at an integrative medicine fellowship program. Team member report: "My patients open up more, and my job has been more rewarding because I take care of patients more holistically." Patients report higher satisfaction and feeling "heard and helped."

Chronic disease management and prevention Planning of health education strategies, interventions, and programs Provision of health care to the public

Abstract

Coaching a wellbeing leadership culture: Bringing a pediatrician wellbeing program into practice

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Background: Lack of wellbeing among physicians is well documented, negatively affecting patient outcomes and even resulting in self-directed violence - physician suicide. Programs taking an organizational integrative approach to supporting individual behavior change by physicians may provide a critical element of sustaining wellbeing and preventing burnout.

Methods: We are implementing an observational pre/post wellbeing intervention of 30 Assistant and Associate Professors in the Department of Pediatrics at the University of North Carolina, Chapel Hill. This comprehensive Pediatrician Wellbeing Program is being integrated into existing infrastructure for departmental faculty development and mentorship, between June 2020 and 2021. Work and program satisfaction measures, and the World Health Organization validated Well-being Index (WHO-5), will be assessed pre and 6-months post intervention. National Board of Medical Examiners-certified, National Board for Health & Wellness Coaches will provide consultation to faculty and their mentoring teams for constructing a Wellbeing-Individual Development Plan (IDP) and explore how the power of coaching and mindfulness can potentially improve mentor-mentee interaction and communication. This Wellbeing-IDP leads the user in developing their vision, skills and activities, timeline, and method of accountability (e.g., social/peer, coach, therapist) for wellbeing. In addition, up to 6, 30-minute follow-up individualized coaching sessions with the mentee are provided. All coaching sessions use principles for health coaching, including brief motivational

interviewing, self-empowerment and determination, transtheoretical model of stages of change, mindset, sense making, and making SMART goals (Specific, Measurable, Achievable, Relevant, Timely). The Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) evaluation framework is being used to guide intervention development and evaluation, and the Consolidated Framework for Implementation Research (CFIR) to assess constructs effecting implementation and subsequent routinization.

Results: Interim analysis will be reported, including baseline measures for wellbeing and work satisfaction, and study implementation (eg, number initial coaching and follow-up coaching sessions; sessions rescheduled, missed, and length; use of existing institutional resources). In addition, we will report identified themes (eg, stressors, barriers, and challenges common to participants) emerging from the coaching sessions, which can then shape departmental mentor and leadership strategic planning. The existing organizational process for faculty mentorship will be evaluated for the ability to expand beyond career development as an isolated endeavor, including the ability to build awareness around available resources and skills they can develop to promote wellbeing. Challenges to implementation, and corresponding study adjustments to overcome them, will also be reported.

Discussion: A wellbeing intervention that incorporates an innovative health coaching model to cultivate individual behavior change supportive of one's own and others' wellbeing can be integrated into existing infrastructure for departmental faculty development and mentorship. By disrupting the focus of mentoring from one directed solely on career development, the structure of the mentorship program will evolve so that career and wellbeing planning go hand-in-hand, using coaches to navigate the planning process between faculty and mentors. Career aspirations will no longer be planned singularly apart from, but instead can be integrated with, wellbeing. This interim analysis of implementation and baseline measures provides information to guide our developing program for promoting wellbeing and preventing physician burnout.

Administer health education strategies, interventions and programs
Administration, management, leadership
Assessment of individual and community needs for health education
Implementation of health education strategies, interventions and programs
Other professions or practice related to public health
Program planning

Abstract

Examining professional stakeholder perceptions of community-based interventions to explore potential intervention adoption.

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Introduction: Complex trauma is defined as long-term physical, sexual, and emotional abuse and neglect, and/or domestic violence. Without effective and timely intervention, trauma-associated outcomes lead to an increased risk for alcoholism and drug use and abuse, depression and suicide ideation, and liver and heart disease across the lifespan. Cognitive-behavioral therapy, the standard treatment for trauma-associated outcomes, is not always effective or practical as a treatment approach, due to youth stress that makes information processing challenging and difficulty accessing services. Community-based interventions (CBI) are increasingly being used as a type of treatment for trauma-associated outcomes in youth. CBI are more accessible, are able to cater to multiple youth simultaneously, and are less stigmatizing than traditional clinic-based therapy. Additionally, CBI incorporate Bruce Perry's Neurosequential Model of Therapeutics, which states that trauma-focused interventions should be relevant, relational, repetitious, rewarding, rhythmic, and respectful. CBI that incorporate these principles are sports participation, art practice, and animal interaction.

Purpose: To assess stakeholders' perceptions of acceptability, appropriateness, and feasibility of three types of CBI for youth aged 6–18 with a history of complex trauma.

Theoretical Framework: Successful implementation of CBI is needed to decrease trauma-associated outcomes. The exploration, preparation, implementation, and sustainment (EPIS) model is used to guide the implementation of effective interventions. During exploration, values of individual adopter characteristics are

facilitators and barriers to the adoption of effective interventions. Before a decision is made to adopt a CBI, stakeholders' values must represent a positive perception of the intervention's acceptability, appropriateness, and feasibility.

Methods: A self-report survey will be used to elicit information at one time point about stakeholders' perceptions of acceptability, appropriateness, and feasibility of three types of CBI: sports participation, art practice, and animal interaction. Public health, school mental health, and child welfare professionals in Wisconsin who work with youth involved in Child Protective Services will be recruited to participate in an online survey.

Measures: Three implementation measures will be used to determine stakeholders' perceptions, specifically: Acceptability of Intervention Measure, Intervention Appropriateness Measure, and Feasibility of Intervention Measure.

Results: Results are expected in Spring 2020. Internal consistency reliability and construct validity of the instruments will be analyzed. ANOVA will be used to compare perceptions of interventions within and between stakeholder groups.

Conclusion: By determining which CBI for youth who have experienced complex trauma are perceived as positive by stakeholders who work with this population, the process of implementing these types of interventions can commence.

Conduct evaluation related to programs, research, and other areas of practice Implementation of health education strategies, interventions and programs Public health or related nursing

