IHL Internship

January-December 2016

Tom Waddell Urban Health Clinic

Integrative Pain Management Program Pilot

Julie Viellieu
California Institute of Integral Studies

1. Tom Waddell Urban Health Center Pain Management Program Pilot

   230 Golden Gate Ave. San Francisco CA

   Site Supervisor: Dr. Barb Wismer

2. History of Organization

The Tom Waddell Urban Health Center is part of the San Francisco Department of Public Health (DPH). Named after Dr. Tom Waddell, it provides health care to mostly poor, disadvantaged, and homeless people. California was the second state in the nation (after Massachusetts) to establish a Board of Health, in 1870. San Francisco wrestled with an outbreak of bubonic plague in 1900 and a re-outbreak of the plague after the 1906 San Francisco earthquake. These experiences solidified the vital role of a public health system in government. By the mid-1900s, the state had built a world-class science-based operation with significant funding and regulatory power. Throughout the century, the agency dealt with a series of health issues, including air pollution, sanitation, water purity, and disease. It also took on chronic ailments, infectious disease, and smoking.

Eventually, the emphasis shifted nationally to allocating resources toward specific disease programs (such as HIV/AIDS) and acute care for the poor. The State Board of Health was eventually dissolved, and the network of connections between the states and localities diminished. In time, the Department of Health Services, which had dual responsibilities for serving the poor and needy, as well as the general health concerns of the state, became the leading agency for health care.

In 1991, the state enacted a major realignment that shifted responsibility for a range of public health programs from the state to local health jurisdictions (LHJs) with dedicated state

tax revenues and federal funds to pay for them. Local health authorities were administering more than 30 categorical programs by 2008, many of them targeting specific populations' needs. Although LHJs are required to meet certain reporting functions, much of their spending has been unmonitored by the state leading to fragmentation of the state's public health effort.

After September 11, 2001, attacks, California formed a terrorism response team representing 22 state government agencies, including the Department of Health Services. As early as 2002, a steady movement began to establish a separate health department not burdened with ever-growing responsibilities for poor citizens. As a result, in 2007 the Department of Public Health was created as an offshoot of its former parent agency and renamed the Department of Health Care Services (DHCS).

The creation of a separate Department of Public Health was intended to elevate the visibility and importance of public health issues. It was also expected to result in increased accountability and effectiveness of the CDPH and DHCS programs by allowing each department to administer a narrower range of activities and focus only on their core missions. The CDPH has two divisions: The Community Health Network (CHN) and the Population Health and Prevention Division. The CHN is the city's health system and has locations throughout the San Francisco, including San Francisco General Hospital Medical Center, Laguna Honda Hospital, and Rehabilitation Center, and over 15 primary care health centers, including Tom Waddell Urban Health Center.

3. Mission, Vision, and Goals

The mission of the Tom Waddell Urban Health Center is to provide health care to the poor, disadvantaged, and homeless persons of San Francisco.

The vision and goals of the Tom Waddell Urban Health Center are to encourage patients to be active participants in the decision-making process of the health care they receive. Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions.

My experience at the Tom Waddell Urban Health Center aligned with both the vision and mission stated. The care is highly patient-centered, all aspects of healing are considered by both the health care provider, as well as the patient.

4. Program Description

I was a part of an Integrative Pain Management Program (IPMP) Pilot. The pilot is a comprehensive, sustainable, integrative pain management program that serves patients with chronic pain within the San Francisco Health Network (SFHN) that includes non-pharmacologic treatment (physical, behavioral, and integrative services) and education that will improve patient outcomes and staff experience. The pilot includes primary care patients with chronic pain being treated with opioids.

5. Output

The IPMP is a multimodal approach to chronic pain management. This includes medications, procedures, psychological and physical treatments, and integrative modalities. The IPMP program offers the psychological, physical and integrative therapies, with the primary care provider and team managing the medications and medical procedures. The

program also provides drug education to promote safer and more efficient use of medicines. All services will be offered in groups whenever feasible. Groups offer more efficiency and more patients to be served, as well as social support, community building, reduced loneliness, and improved self-care and satisfaction. Many patients in the safety net are isolated, without meaningful connections or contact with family or friends. The program promotes active self-care whenever possible, given the importance of the patient's role in their healing. Active self-care allows for ongoing treatment beyond the walls and timeframe of the program and promotes a healthy and healing lifestyle. The program provides health coaches that can skillfully facilitate patients making necessary behavior changes. A neuroscience education framework is used.

Neuroscience education aims to shift how patients, providers, and staff understand and talk about pain from a tissue oriented biomedical point of view to a nervous system oriented biopsychosocial point of view. Patient education can have positive effects on pain, function, disability, and catastrophizing. Using education as therapy is becoming a foundation of good clinical care. Many of the patients have a history of trauma, so a trauma-informed approach will be utilized.

6. Internship involvement

I was brought on as a Health Coach for this pilot. There is evidence that health coaching can improve outcomes of patients with chronic pain. I was required to come to the group once a week and participate in the group process, as well as participate in coaching sessions weekly with my designated clients by phone. Most of the patients were very receptive to being coached, although it was a very different process in this high pain situation. The additional support we provided was apparent and welcomed by both patients and staff.

7. Organizational Structure

The structure of the IPMP project has many components including referrals from providers, patient self-referrals, and DPH referrals. The provider discusses all initial referrals by e-referral. The Tom Waddell team conducts all behavior health input. Orientation and home groups are supported by all staff and volunteer personnel. Appropriate staff will oversee all modalities.

See Appendix A for the flowchart.

8. Organizational Politics and Structure

Kris Leonoudakis-Watts is the IPMP pilot lead manager. She ensured all the resources were available and understood by both staff and patients. There were monthly staff meetings to discuss things that needed updating, removal, or other changes. The team actively listened in both meetings and during groups. There was a deep understanding of the challenges of chronic pain and opioid use. Respect and compassion for the patient journey were very high. The patients felt safe and secure with the competent and engaged staff. There was transparency and commitment to help this population flourish on their terms.

9. Funding

Grants funded the IPMP pilot. The DPH secured the grants, and the future of funding is unknown. The government will need to contribute more involvement to the availability of funding to continue to support the IPMP program. At the end of the pilot, there was enough funding to extend it until more financing is secured.

10. External Competition

The IPMP is a pilot program, and it is the first of its kind in the country. Chronic pain and addiction to pain medications is a growing national problem. Hopefully, there will be more of the integrative mind-body approaches to pain in the future. This IPMP pilot is a new frontier and a much-needed one for the health of the country.

11. Interview with Key Stakeholder

I interviewed Dr. Barb Wismer, one of the members of the steering committee of the IPMP program. This initiative has been in development since 2005 with a steering committee of 20 people of the DPH who all had a hand in its creation. IPMP was born out of the suffering of patients with chronic pain and the stress this puts on the staff responsible for treating them. Something had to change in response to the crisis. The goal is to make IPMP available in other DPH clinics to deal with a greater number of patients suffering from chronic pain. The DPH is aiming to have another clinic site by the end of 2017. The DPH seeks to flourish in the sense that if someone needs help, providers will know about the IPMP and be able to make appropriate referrals.

12. Stage of Program Development

After the initial IPMP pilots had ended, there were surveys and interviews conducted with patients and staff, as well as attendance logs and other markers to evaluate the program. The qualitative responses revealed that patients were taking a variety of strategies with them into everyday life, including movement, meditation, and social connection. They liked the group setting, which provided a safe place and the ability to make connections. They also had suggestions about what they wanted from the program moving forward. More education about sleep, nutrition and more guest speakers were some of the patient suggestions for improvement.

13. Program Situation Statement

Activities that were received well by everyone were massage, meditation, and the group process. Acupuncture had the lowest approval score.

14. Target Population Description

This program is set up for Tom Waddell Urban Health Center patients and the DPH referral clinics patients who are suffering from chronic pain and addicted to opioids long term. Primary Care Providers refer patients to the IPMP program. The Program Lead will review medical records of eligible patients.

15. SWOT Analysis

Internal		External	
Strengths	Weaknesses	Opportunities	Threats
• Program inception and creation by DPH steering committee of 20 over ten years • Collaborative team of researchers, clinicians, and staff all helped develop IPMP • Use of facility provided by DPH • Eastern and Western Practitioners communication and navigation for full integration of services for IPMP program. • Support of clinic staff at Tom Waddell	• Grant Funding from government is always a challenge • Finding a way to build funding into long-term regular funding • Ability to expand IPMP program into all of the DPH clinics and hospitals in an efficient time frame. • Future of integrated IPMP program determined by Public Health leaders.	• Community Outreach to educate public about chronic pain. • Building understanding of integrative modalities within the current medical system. • Understanding healing and patient-centered self-care practices • Continued communication between Eastern and Western practitioners.	• Finding grants appropriate for the IPMP program • The government will continue to decrease funding.

Appendix A. IPMP Services Flowchart