From the North American Primary Care Research Group

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NAPCRG ANNUAL MEETING DISTINGUISHED PAPERS

NAPCRG's Annual Meeting is a forum for primary care researchers from across the globe to gather and present their research, collaborate for new research, and foster growth for up-and-coming researchers. The 2014 Annual Meeting will be held in New York, New York on November 21-25, 2014.

Two papers were selected and given the special designation of "distinguished paper" for excellence in research and contain the following factors: overall excellence, quality of research methods, quality of the writing, relevance to primary care clinical research, and overall impact of the research on primary care and/or clinical practice.

Below are brief summaries of this year's papers:

Implementation Intentions and Colorectal Cancer Screening: A Randomized Trial in Safety-Net Clinics

K. Allen Greiner; Christine M. Daley; Aaron G Epp; Aimee James; Hung-Wen Yeh; Mugur Geana; Wendi K. Born; Kimberly Engelman; Jeremy Shellhorn; Christina M. Hester; Joseph W. LeMaster; Daniel BucklesD; Edward Ellerbeck

Context: Low-income and racial/ethnic minority populations experience disproportionate colorectal cancer (CRC) burden and poorer survival. Novel behavioral strategies are needed to improve screening rates in these groups.

Objectives: This trial was designed to test a theoretically based "implementation intentions" intervention for improving CRC screening among unscreened adults in urban safety-net clinics.

Design: Randomized controlled trial

Setting: Urban safety-net primary care practices

Patients: Adults (N = 470) aged ≥50 years, due for CRC screening

Intervention: The intervention was delivered via touchscreen computers that tailored informational messages to decisional stage and screening barriers. The computer then randomized participants to generic health information on diet and exercise (comparison group) or "implementation intentions" questions and planning (experimental group) specific to the CRC screening test chosen (FIT or colonoscopy).

Main and Secondary Outcome Measures: The primary study outcome was completion of CRC screening at 26 weeks based on test reports (analysis conducted 2012-2013).

Results: The study population had a mean age of 57 years, and was 42% non-Hispanic African American, 28% non-Hispanic white, and 27% Hispanic. Those receiving the implementation intentions-based intervention had a higher odds (adjusted odds ratio, AOR: 1.83; 95%CI, 1.23-2.73) of completing CRC screening than the comparison group. Those with higher self-efficacy for screening (AOR: 1.57; 95%CI, 1.03-2.39), history of asthma (AOR: 2.20; 95%CI, 1.26-3.84), no history of diabetes (AOR: 1.86; 95%CI, 1.21-2.86), and reporting they had never heard that "cutting on cancer" makes it spread (AOR: 1.78; 95%CI, 1.16-2.72) were more likely to complete CRC screening.

Conclusions: The results of this study suggest that programs incorporating an implementation intentions approach can contribute to successful completion of CRC screening even among very low income and diverse primary care populations. Future initiatives to reduce CRC incidence and mortality disparities may be able to employ implementation intentions in large-scale efforts to encourage screening and prevention behaviors.

Who Gets Diagnosed With Depression in Hong Kong's Primary Care and What Happens to Them Over a Year?

Weng Yee Chin; Cindy Lam; Eric Wan

Context: Identifying and managing depression in primary care is challenging and factors affecting prognosis are not well understood, particularly in Asian settings.

Objective: To examine the naturalistic outcomes of primary care depression. Design Cross-sectional and 12-month cohort observational study using a practice-based primary care research network.

Setting: Public and private sector primary care clinics across Hong Kong

Participants: Adult patients were consecutively recruited from the waiting rooms of 59 primary care physicians to complete a questionnaire which included a depression screen. Blinded doctors recorded their diagnosis and management. Subjects (10,179) were recruited at baseline (response rate 81.0%); 4358 subjects (response rate 42.8%) agreed to follow-up by telephone at 3, 6, and 12 months. Instruments PHQ-9, SF-12v2, CESD-20, socio-demography and self-reported service use

Outcome Measures: Prevalence, incidence and remission rates for PHQ-9 screened-depression; health-related quality of life, and service utilization rates over 12 months.

Results: Prevalence of PHQ-9 screened-depression was 10.69%. Patients with a self-reported prior history of depression, higher PHQ-9 scores, lower SF-12v2 scores, and who were non-Chinese were most likely to

be diagnosed with depression. Twelve-month remission rate was 60.31%. Detection status and baseline PHQ-9 severity were not predictive of remission, however doctor identification was associated with better improvements in mental health-related quality of life. Twelve-month incidence of PHQ-9 screened-depression was 5.25%. Screened-negative patients who received a diagnosis of depression at baseline were the most likely to become PHQ-9 positive over 1 year. Over 1 year, 19.7% of screened-positive subjects had consulted a psychiatrist, 8.9% other psychological services, and 37.5% had used psychotropic medications.

Conclusions: Around 1 in 10 primary care patients screen positive for depression. Most have mild, self-limiting symptoms, poor mental health-related quality of life, and increased use of primary and secondary care services. Doctor detection does not affect 12-month remission but enhances health-related quality of life.

From the Agency for Healthcare Research and Quality

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AHRQ UPDATES ON PRIMARY CARE RESEARCH: THE AHRQ PATIENT-CENTERED MEDICAL HOME RESOURCE CENTER

Developed as an evidence-based primary care approach to improve the quality, efficiency, and experience of care,[1] the Patient-centered medical home (PCMH) model is designed to provide primary care that is: (1) patient-centered, (2) comprehensive, (3) coordinated, (4) accessible, and (5) focused on quality and safety.[2] The PCMH model affords new opportunities for providers, clinical teams, and health care systems to provide coordinated, patient-centered care to improve the overall health of the growing number of Americans living with multiple chronic conditions.

To support PCMH research, evaluation, and implementation, AHRQ developed the Web-based Patient-Centered Medical Home Resource Center. The PCMH Resource Center provides tools and resources to aid researchers, clinicians, and policy makers interested in learning about the patient-centered medical home and adapting the model to transform and strengthen the organization and delivery of primary care services. Resources that can be found at http://www.pcmh.ahrq.gov include: explanatory and definitional materials and research; evidence and evaluation tools and resources; implementation manuals for practice facilitation in primary care; a catalog of Federal PCMH activities; and a citations database.

Resources to Improve Care for People Living with Multiple Chronic Conditions

These white papers available on the PCMH Resource Center site examine important issues in designing and delivering appropriate care for people living with multiple chronic conditions:

Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms

"Neighbors" in the medical neighborhood include the medical home, specialists, hospitals, health plans, and other stakeholders. This paper describes how these neighbors could work together better, thus allowing the medical home to reach its full potential to address patients' needs and improve outcomes.

Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions

Patients who have complex health needs typically require both medical and social services and support from a wide variety of providers and care givers. This paper discusses strategies to help primary care practices perform as effective medical homes to coordinate such services for patients with complex care needs.

Enhancing the Primary Care Team to Provide Redesigned Care: The Roles of Practice Facilitators and Care Managers

Efforts to redesign primary care require multiple supports. Two potential members of the primary care team—practice facilitator and care manager—can play important but distinct roles in redesigning and improving care delivery.

PCMH Citations Collection

For individuals interested in learning more about the PCMH model of health care delivery, the PCMH Resource Center also features a searchable citations database with more than 1,100 PCMH- related citations of journal articles, reports, policy briefs, and newsletters.

Visit the AHRQ Patient Centered Medical Home Resource Center to learn more: http://www.pcmh.ahrq.gov.

References

1. Patient Centered Medical Home Resource Center. 2011. Agency for Healthcare Research and Quality. Rockville, MD. http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483.
2. Patient-centered Primary Care Collaborative. Defining the medical home. http://www.pcpcc.net/about/medical-home.