Family Medicine Updates

From the North American Primary Care Research Group

PRACTICE-BASED RESEARCH NETWORKING FOR GROWING THE EVIDENCE TO SUBSTANTIATE PRIMARY CARE MEDICINE

Outpatient general practices, the level at which most people interact with the US health care system, represent a genuine conundrum to researchers. These practices provide a potential gold mine of data for examining the structure, processes, and outcomes of primary medical care. Evidence acquired from outpatient general practices could address important health care issues that cause serious morbidity, such as asthma, diabetes, back pain, headache, and the common cold. In this outpatient arena, research could translate into practice, bridge the performance gap, answer real-world research questions, and benefit health care in our academic communities. We definitely can improve the quality of health care in general practices and prevent avoidable hospitalizations. Researchers in general practices, however, have less control over confounding variables, they are less able to standardize patients, and they are less able to acquire statistically rigorous sample sizes in reasonable timeframes.

The untapped potential of general outpatient practices has been recognized by the giants in our field: Will Pickles, John Fry, Curtis Hames, Paul Nutting, and Larry Green. The dilemma in primary care medicine has always been how to harvest the available data while overcoming the difficulties of pursuing scientific endeavors. In the 1980s, Green, Nutting, and others became vocal advocates of practice networks, a concept long applied in Europe. General, community-based primary care practices formed *de facto* national or regional networks by using their information infrastructure. For example, the British have a rich history of examining large health care data sets describing patients from numerous primary care practices. Based on this model, the Ambulatory Sentinel Practice Network (ASPN) was established to bring together primary care physicians, mostly practicing family physicians, from the United States and Canada. Their common bond was their commitment to discern proactively the answers to questions that could help them provide better medical care to their patients.

In recent years, the practice-based research networking has grown considerably, propelled by the Committee on the Future of Primary Care, which was convened by the Institute of Medicine. The 1996 Committee report is considered seminal because of its updated definition of primary care and its endorsement of practice-based research networks. The Committee described such networks as "the most promising infrastructural development that [the Committee] could find to support better science in primary care." Many academic primary care departments have successfully developed regional or statewide practice-based research networks as platforms upon which to build a research infrastructure. Today, regional and national practice-based research networks are offering important contributions to the evidence base of family practice, general pediatrics, and general medicine.

In 1995, a core group of network directors affiliated themselves as the Federation of Practice-Based Research Networks (FPBRN) with a mission to expand the number of practice-based research networks in the United States, provide technical assistance to new networks, promote network-to-network collaboration, and foster a greater appreciation of the unique capabilities and infrastructure needs of networks among government and private funding agencies.

The seeds planted through the advocacy efforts of primary care researchers, organizations representing primary care physicians, and the FPBRN appear to be bearing fruit. In early 2000, the Agency for Healthcare Research and Quality (AHRQ) provided competitive funding to support the infrastructure needs of 19 practice-based research networks. AHRQ released a second request for applications in 2001 for competitive funding to supplement AHRQ-supported networks to pursue bioterrorism research. More recently, other sponsors, including the National Cancer Institute and the Robert Woods Johnson Foundation, have endorsed practice-based research networks.

More information about the resource needs for developing and managing a regional practice-based research network may be obtained from the Federation of Practice-Based Research Networks Web site at http://www.aafp.org/research/fpbrn/ or from the author (johngryan@miami.edu). Interested readers are encouraged to attend the annual Convocation of Practice-Based Research Networks, sponsored by the National Network of the American Academy of Family Physicians. The Federation of Practice-Based Research Networks also sponsors preconference workshops at

annual meetings of the North American Primary Care Research Group (NAPCRG).

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From the American Academy of Family Physicians

AAFP FINDS COLLABORATIONS KEY TO DEVELOPING GUIDELINES

It's an oft-repeated phrase: Two heads are better than one. Likewise, the AAFP has found that when developing clinical practice guidelines, 2 organizations are often better than one. In fact, of the last 9 AAFP clinical practice guidelines, 8 involved other organizations. What does this trend toward collaboration mean?

"We're leaders," states AAFP Scientific Activities Division Director Herbert Young, MD. "Other organizations recognize this and want to work with us."

While bringing organizations together results in a larger team and thus a lengthier approval process, says Young, the benefits abound. According to Young, collaborating on guidelines serves 2 purposes. First, it brings together 2 or more organizations, each having a perspective specific to its membership. Second, the collaboration usually guarantees more impact and wider dissemination than would occur if just 1 organization worked on a guideline.

"The Academy is making a conscious effort not to have guidelines that duplicate those of other organizations," says Richard Clover, MD, of Louisville, Ky, chair of the Commission on Clinical Policies and Research. "It's more efficient to work together." If 2 organizations developed separate guidelines on the same topic, confusion could ensue, Clover said.

"Management of Newly Detected Atrial Fibrillation," the result of work by the Joint Panel of the AAFP and the American College of Physicians on Atrial Fibrillation, premiered in the December 16, 2003, *Annals of Internal Medicine*, reaching 115,000 internists and medical students. News of the guidelines also appeared in AAFP communications vehicles, reaching its 93,700 members.

The joint panel reviewed almost 200 studies to devise its recommendations and determined that the literature did not support the conventional treatment to try to achieve sinus rhythm in patients with newly detected atrial fibrillation, says panel Co-chair Michael LeFevre, MD, a professor of family medicine at the University of Missouri–Columbia School of Medicine. "This guideline asserts that the best approach for most patients with atrial fibrillation is to focus on control of heart rate and stroke prevention, rather than attempt to restore sinus rhythm."

ACP and AAFP first collaborated as partners in the Headache Consortium, which comprised more than 20 medical societies. AAFP and ACP worked further to develop the Headache Consortium guidelines into a set that focused more on primary care. That set was published in the November 19, 2002, *Annals of Internal Medicine*. Two more clinical practice guidelines—on deep venous thrombosis and pulmonary embolism—are in the works between the 2 organizations.

Picking a Partner

Young maintains that the AAFP was one of the first organizations to embrace evidence-based medicine, and early on had to walk away from collaborations in which other partners did not embrace the methodology.

The Academy has found it easiest to work with other primary care organizations such as ACP and the American Academy of Pediatrics, Young says, but AAFP has also worked with subspecialty organizations such as American Academy of Neurology and American College of Cardiology.

The decision by the AAFP to collaborate on a clinical practice guideline rests on 2 factors, says Young: the methodology and the relevance to family medicine.

For some guidelines, the AAFP goes it alone. The updating of AAFP policy on vaginal birth after cesarean section is one such example. The American College of Obstetricians and Gynecologists declined to participate.

Level of Involvement

The Academy participates with other organizations on a number of levels.

Level 1 involvement requires a major investment of resources in development of the clinical practice guidelines. This level of involvement usually entails having several AAFP representatives participate in the panel with an equal number of members from other organizations. The atrial fibrillation guidelines are the product of level 1 involvement. Another level 1 endeavor, an AAFP collaboration with the American Academy of Pediatrics to develop guidelines on otitis media and otitis media with effusion, due to be released this year, will address the issue of watchful waiting and antibiotic use.

Level 2 involvement typically involves sending an AAFP liaison to participate as panel members on discussions of clinical practice guidelines. At the end of the