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From the North American Primary Care Research Group

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PBRNS ENGAGING THE COMMUNITY TO INTEGRATE PRIMARY CARE AND PUBLIC HEALTH

The 2013 NAPCRG/AHRQ PBRN conference will be held June 18-19, 2013 in Bethesda, Maryland. It promises to provide opportunities to share strategies, methods and results, and learn more about funding opportunities.

Key takeaways from last year's conference were:

Practice-based research networks (PBRNs) are becoming a crucial link between primary care and public health. It has become apparent over the past decade that primary care and public health must work together much more closely than in the past if we are to truly tackle the serious health issues in our communities. The new Institute of Medicine Report, *Primary Care and Public Health: Exploring Integration to Improve Population Health,* provides a basic roadmap for collaborations between public health agencies, community-based organizations, and primary care practices.[1] The report, commissioned by the Health Resources and Services Administration and the Centers for Disease Control and Prevention, gives numerous examples of primary care and public health integration. This theme was emphasized at the NAPCRG PBRN meeting where attendees heard examples of practice-based research collaborate with primary care practices to improve patient and community health; attendees left the conference energized to build future partnerships with public health. Health care reform, whether in the form of the Affordable Care Act or local grassroots efforts to build communities of solution, drives the relationship-building efforts between primary care and public health.

Practice-based research networks have evolved over the past 40 years from a small group of curious family doctors to hundreds of rigorous, well-funded research laboratories. PBRNs have the infrastructure and capacity to bring primary care and public health together to improve the health of patients and community members. It is a testament to the diligent work of our providers and research that PBRNs are now in a position to think and work beyond the walls of their clinic. By collaborating with governmental public health agencies and non-governmental community-based organizations, PBRNs have potential to impact both routine clinical practice and the broader community. PBRNs already engage their providers and patients, and are perfectly poised to engage their communities. Thus, PBRNs can serve as the catalyst to integrate primary care and public health.

Three examples of ongoing PBRN and public health collaborations were presented. First, the early work in the Oklahoma PBRN included an advisory committee member from the state health department. Current work includes a robust primary care extension service that places extension agents into communities to directly work with primary care offices and public health programs. Second, the High Plains Research Network in Colorado developed an asthma toolkit that linked improved primary care practice capacity for diagnosis and treatment to community organizations and schools to increase awareness and self-management. Third, the Canadian Partnership Against Cancer provided an example of a large-scale national collaboration between numerous primary care practices, public health agencies, and consumer groups which lead to improved chronic disease prevention and screening. In addition, several posters and research presentations at the PBRN conference offered growing evidence for improved outcomes through primary care/public health collaborations. Finally, a workshop provided tangible steps for beginning a collaboration between a PBRN and public health and community-based organizations.

The emphasis in health care reform on health promotion and disease prevention brings everyone to the table. PBRNs can serve as the laboratory for testing, implementing, and disseminating locally relevant interventions in the primary care practice and the community setting. Interventions, innovations, and quality improvements in disease prevention and health promotion often require alignment of medical care, self-management, the built environment, and a community approach. Practice-based research networks will be a crucial tool for developing successful models that engage local and broader communities and create linkages between primary care and public health. PBRNs should think beyond the walls of their clinical practices and accept the challenge of expanding their capabilities to build new collaborations that benefit population health.

More information about the 2013 PBRN Conference can be found at http://www.napcrg.org.

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AAFP From the American Academy of Family Physicians

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AAFP RELEASES 2ND CHOOSING WISELY LIST OF QUESTIONABLE TESTS, PROCEDURES

As part of an ongoing effort to help physicians curtail the practice of ordering unnecessary tests and procedures, the American Academy of Family Physicians (AAFP) today released its second Choosing Wisely list of recommendations.

For this extension of the original American Board of Internal Medicine Foundation initiative, which launched in April 2012, the Academy joined 16 other medical specialty organizations in Washington, DC, to unveil the second wave of lists detailing various tests and treatments physicians should think twice about before performing, ordering, or prescribing. AAFP Board Chair Glen Stream, MD, MBI, of Spokane, Washington, represented the Academy at the February 21 press event.

The campaign underscores family physicians' long-term commitment to ensuring high-quality, cost-effective care for patients, Stream said in a prepared statement.

"The American Academy of Family Physicians is committed to the Choosing Wisely campaign and its mission of sharing evidence-based clinical information about tests and procedures to help family physicians and their patients make informed decisions. So much so that the AAFP has extended its involvement, developing a second list of 5 screenings and treatments that are frequently overused or misused," Stream said.

The Academy created its latest Choosing Wisely list of clinical recommendations via the AAFP Commission on Health of the Public and Science, which evaluated and approved each item using sources such as reviews from the Cochrane Collaboration and evidence reports from the Agency for Healthcare Research and Quality.

The AAFP collaborated with the American College of Obstetricians and Gynecologists in developing the final language of the first 2 items on the Academy's latest list, both of which concern elective, nonmedically indicated inductions of labor or Cesarean deliveries.

The AAFP's most recent list adds the following five recommendations to its initial 5 statements:

Don't schedule elective, nonmedically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age

Delivery prior to 39 weeks, 0 days, has been shown to be associated with an increased risk of learning disabilities and a potential increase in morbidity and mortality. There are clear medical indications for delivery prior to 39 weeks and 0 days based on maternal and/or fetal conditions. A mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery.

Avoid elective, nonmedically indicated inductions of labor between 39 weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable

Ideally, labor should start on its own initiative whenever possible. Higher Cesarean delivery rates result from inductions of labor when the cervix is unfavorable. Health care clinicians should discuss the risks and benefits with their patients before considering inductions of labor without medical indications.

Don't screen for carotid artery stenosis (CAS) in asymptomatic adult patients

There is good evidence that for adult patients with no symptoms of carotid artery stenosis, the harms of screening outweigh the benefits. Screening could lead to non-indicated surgeries that result in serious harms, including death, stroke and heart attack.

Don't screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer

There is adequate evidence that screening women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk provides little to no benefit.

Don't screen women younger than 30 years of age for cervical cancer with HPV (human papillomavirus) testing, alone or in combination with cytology

There is adequate evidence that the harms of HPV testing, alone or in combination with cytology, in