

AACP - Embracing the PBRN Model to Improve the Medication Use Process
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An Introduction to the PBRN Model and Interdisciplinary Panel Discussion

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Ken Miller: All right. I'm going to invite the speakers for this evening's program to come up to the front. All right. Does anybody want to start with a question? In the front here, is that Laura?

Q: Thank you all for a great presentation. I have two questions but I can't remember the second one at the moment, so I'm going to go to the first one. Dr. DeNucci, you mentioned that altruism was one reason dentists were led to join and also that curiosity was another reason. And maybe the two women can also comment. What are reasons that you are able to provide to convince people who've never done research in their life that this is a good idea?

Don DeNucci: That's a very good question. And I had the same question before I got started in this. There was altruism, there was curiosity, and there was also a desire to improve their patients' care. And I think all of us who are in a healthcare field have that particular desire. And those of us who are clinicians sometimes feel on a daily basis we're not really sure that what we're doing is actually based on evidence. So many of the practitioners were very interested in providing appropriate care and providing care that would be long—in dentistry we're looking at things like durability. And the patients pay a lot for the procedures that they get. And so those are the kinds of issues that I think—and then there's the other aspect that was alluded to I think by several of the other speakers and that's the opportunity to get together in a collegial spirit. That we found that when we would have breakout sessions we almost had to have bouncers come in and say, "It's over now." They wouldn't want to leave. So that's another, the collegial aspects were very, very important.

John Hickner: I agree. Beer(?).

Rebecca Chater: I was just going to add that I think the motivation in pharmacy is a bit different. I think we all recognize that there has been a real desire on the part of pharmacists to be recognized as healthcare providers and for the value that pharmacists bring to the healthcare table to be recognized. And I think that most pharmacists can identify with the fact that in order for that to be, to make that case compelling, the body of evidence needs to be rich and that contributing to that is something that will help to drive that forward.

Q: I'm Laura, by the way, from Colorado. And you'll probably all hear from me later--individually. I'm not sure exactly what this conference is going to result in. And I'm also agreeing that we're kind of on the start of something and some of us have done work in various

areas. I think my question's more of a global question, maybe this is a question for you, Ken. Are we looking to do a national research network or are we trying to help people here be individual networks within states and then we'll just see what happens? I mean, I think we're all doing—we're all here because we're at least interested in it if not already doing things. And I'm kind of wondering from maybe from Dr. Hickner's perspective how the national network helps because I've had some exposure to the national network with AAFP and I feel like it's such a great resource but how did that kind of come to be and would that be something we should be envisioning?

John Hickner: I think that the advantage of a national network tends to be the visibility and the ability to attract funders to support the work, national attention. So I think there is real value in a national network. On the other hand, they tend to be a bit unwieldy, more difficult to manage, more expensive, and there are many questions that have somewhat of a regional flavor to them at any rate. So I think if it's possible to do both that would be best.

Ken Miller: From AACP's point of view and from my understanding of PBRNs when I went to the first conference, I was aware of the national network, but I was really impressed with all the almost local PBRNs. Some of them were just inner city. They looked at very specific type of populations. Some of them were very rural and looked at the rural part of their state. And I think it would probably be—it's not going to be easy—but I think we should probably start at the local or regional level around a school or schools in a state or in a region that cooperates already in some sort of fashion. And if that takes off I think we could probably form, I'll call it, a PBRN of PBRNs for certain studies where we actually combine from time to time for national studies. But I think it would be probably easier for us to start, we don't have \$75 million from one of our National Institutes of Health so I think it's probably going to be easier if we start at a local or I would call it a regional level. And it may not start everywhere. I think one of the things that Kelly pointed out, you have to have people on your faculty or within a group of schools that may be cooperating that has—that brings different skills to this, not only practice, but also some of the research skills and most important to have a good practitioner base that you can work with.

Q: Well, first I want to tell Dr. Hickner that the study that he did in Michigan served as a model for several of my students in collaboration with a local community health center. The community health center saw the study and they wanted to do something similar and I said, "Well, I have students." So we did something similar.

A: Student power is great.

Q: My question is, is what kind of training do you provide to your community collaborators about research?

John Hickner: It used to be very little back in the old days. Now the requirements are much higher, of course, with HIPAA and other things. And so it's in a state of flux right now. I think that most networks now are biting the bullet so to speak and recognizing that everybody who participates in a study needs a minimal level of training to comply with HIPAA and IRB regulations. Well, they have to do HIPAA already, but for IRB regulations. And there's a growing need to have different levels of IRB training because if you have a receptionist, for

example, who may simply be passing out surveys his or her level of training is probably different from the pharmacist's level of training or the researcher who's involved in the office. So it's being worked out, I would say.

I think the most important thing probably is that in each of the sites where you do research that there is a champion of some sort who does have enough training to understand what the research process is about, at least in a very basic form and is willing to supervise what happens in research in the office so that when Kelly goes around and visits the pharmacy she has somebody to talk to and knows that at least they understand what's going on and she doesn't have to talk to everybody in the pharmacy to get the study up and going. So in other words, there are the compliance issues. I haven't said much about the research methods issues. But probably the most important issue for the frontline people tends to be issues of bias and knowing that you need to have a non-biased sampling strategy of some sort. That's probably the most important lesson to get over.

Don DeNucci: In one of our recent meetings this very issue of bias came up from one of our coordinating centers. And we're going to discuss that next week actually. It's going to be on our agenda. But it had to do with practitioners that were so enthusiastic about the study that the results might not be generalizable to the patient population at large. I mean, it's kind of what Dr. Hickner was talking about in a sense, but coming from a little different perspective. So we're going to discuss that to see whether or not that's going to be an issue. It was brought up by a statistician who has a lot of experience with cancer trials. So we'll see. I'll stay tuned.

Q: Max Ray, from the University of Tennessee, My question is for Rebecca. Rebecca, I'm struck by the value proposition that you shared with us tonight, covered three slides and had a lot of interesting points on it. Who developed that and what I'm interested to know is this something that the top management of Carr Drugs would endorse? If they saw it, would they recognize it?

Rebecca Chater: You mean, if they saw my slides, would they recognize them?

Q: Well, sure. But what—

Rebecca Chater: A trick question. No, they would recognize them.

Q: Okay. Well, what's behind my question to me, is somewhat obvious point that it's difficult sometimes to bring the corporate goals of chain drugstores into alignment with our professional goals and our desire to create an innovative practice and then to do research on that practice. And I wanted to hear more about how you were able to pull this off within one chain.

Rebecca Chater: Well, you're right, I mean, it sure is a daunting prospect a lot of times to get cooperation and buy-in all the way to the top. But I can't claim credit for it in the case of my company. I think that if you have leadership within your company that believes that the future of the profession is something other than dispensing prescriptions, the battle is not all uphill to sell this. So I think my job was probably a lot easier than most would be. I will tell you though, commitment at the top is critical. You have to have a CEO who believes in what you're doing. And if your CEO believes in what you're doing, then somehow all the other pieces fall into place.

It's not quite that easy, but if you always know that you have that support then it's easier to work strategically with all the folks in the middle. And I guess communication. I can't—I think a lot of times we undervalue communication, but it's absolutely critical and I think that we probably err sometimes—we've had enough failures along the way to learn what happens when you don't communicate effectively. So sometimes I think that that's been the thing that's caused us to be able to accomplish what we've accomplished.

Q: And, Kelly, I assume that you've dealt with some of these same kinds of struggles with top management in some of the chains that you're working with in Virginia. Could you share with us some of your heartbreaks and headaches?

Kelly Goode: Well, a lot of it's very similar to Rebecca in that with the Ukrop supermarket chain the values were there and the director of pharmacy and they're willing to do innovative practice to support the future of the profession and what we wanted to do beyond dispensing. So that battle was very easy. The pharmacists were very professional. They're very enthusiastic. I don't have to do a lot of work to get them to help me do things. And a lot of it's too because I paid my dues with them as well and it helped them do things. But I'm not sure where the battle's going to be with if when we move into K-Mart and to CVS. Part of the battle though, I think, it's going to be fought a little bit at the local level and that we'll have a faculty member in their sites. And they're signing on to work with us with scholarship being a component of what that faculty member's supposed to do. So that's a piece of the affiliation agreement with their sites is that this will happen in their site. So I think that it's going to be easier now if we want to move that nationally I'm not sure what that's going to be. Most of my experience is in a chain similar to Rebecca and so I'm treading new water and trying to learn what it's going to be with the CVSes and the mass merchandisers of the world. The independents will be easy, but again in bringing them into a network that has other chains and things as well. And I don't really have the answer for that yet, but I think at the local level at least talking with them and initial contacts about trying to bring them into this practice-based research network. They're very excited about it and want to do that.

Q: Yes. A question for our colleagues in medicine and dentistry. I'm sorry, Cindy Raehl from Texas Tech. We have in pharmacy curricula now a requirement for introductory pharmacy practice experiences which are our early students, all of our students in all colleges must do that and it must be direct patient care. And so my question is, have you seen examples in your professions where because of that early clinical experience now that has led to some PBRN type activity or has created enthusiasm on the part of preceptors who become researchers? And thus we could even have national agenda for a research topic buried within all of our IPP courses that of course our deans are very excited about.

John Hickner: Well, that's a terrific idea. And it's something I've toyed with but never really been able to pull off at least in the clerkships and schools I've worked in. I do know, however, that the University of Illinois did that at one point. They required the students out in a first year summer family medicine experience to gather data, say each of them review the charts of five patients with diabetes and bring back data, that kind of thing. But I could easily see similar projects in pharmacy schools, especially if the students are required to have contact with patients that they have a very simple survey I suppose and each student does a survey with five patients,

and then you have a thousand students involved in the project; you could do some really interesting survey work at least that would be of real value. So that's a terrific idea. And then perhaps those students catch the bug a bit, at least some of them do, and carry that on into their residency training into practice. So that's a great place to start. I really endorse that idea.

Q: Brian Isetts from the University of Minnesota. I have an announcement and a comment. Kelly Goode let the cat out of the bag a little bit here, whereas the last five years our profession's been working on obtaining CPT billing codes, and we received temporary status two years ago. And I can't take credit for this, Kelly, thank you very much anyway. But the three of us went to the CPT editorial panel meeting three weeks, excuse me, three weeks ago in San Diego. We just received notification that we now have category one, permanent CPT billing codes. This isn't being recorded is it? The reason I asked though is because you can tell your mother but it's not official until the AMA publishes it.

And the comment really relates to the fact that, you know, is Dr. Hickner and Rebecca talked about this injection of intellectual inquiry into a busy patient care schedule. We have a large number of practitioners in pharmacy who are doing so many great things caring for patients and we just—they have oodles of time. And here we have this opportunity to capitalize upon that energy if you will, of caring for patients and have this inquiry. And I think this is what we have to identify, those practitioners are out there they're caring for patients; to capitalize upon what we want to get accomplished here today is to get a national PBRN. Thank you.

Q: Hi, I'm Gayle Brazeau from the University at Buffalo. And we listened to both Kelly and Rebecca talk about the workflow issues in pharmacy. I wanted to ask our colleagues in medicine and dentistry, as you've looked at your networks, have you been sort of analyzing what is the maximum time that practitioners can spend on this so it's still productive, they still feel like they're, you know, they're able to do it, but still do it in the context of their other responsibilities because I think that's going to be an issue that we're really going to have to wrestle with. So what lessons have you learned in your networks?

John Hickner: We've learned that the physicians are willing to donate time if they feel it's worthwhile, but that they're not willing to donate a lot of time in general. It's hard to quantitate because it varies from patient to patient and it varies from study to study. An easy way to look at it is that most studies can be successfully deployed and completed in a practice-based setting if the duration is only two or three months max, you can get it done. As the duration gets longer and there's need for more permanent or quasi-permanent infrastructure basically now you're talking about money. So that's point one.

The second point is that you can buy time of office staff though. Most PBRNs have successfully bought office staff time whether it's a receptionist, a nurse coordinator, somebody to run the study. And I think most PBRNs have recognized that they must at least allow practices to break even financially by participating in the study. There can't be any cost to the practice in other words other than the professional who works in the practice who often is willing to donate time just as they do for teaching medical students, but that time donation then has to be a small chunk.

Don DeNucci: Dentistry is a little bit different because each dental office is like a miniature surgical suite. You can probably imagine when you go to see your dentist, your dentist spends time talking with you but he's also spending time doing something. And so we have to weigh that against the burden of the research. Now one study that's going to be published soon in the *Journal of the Academy of General Dentistry* and this may seem like a rather mundane topic, but to dentists it's kind of a significant one, and that is how deep do you drill into a tooth before you stop? And you think—do you go right to the nerve or do you back off? And that was one of the studies. Now and so that really didn't involve a lot of practitioner extra time other than to fill out a form explaining exactly what they did. And so I think as the studies become a little more complex we'll have to balance these things. One of the other practitioners has kind of a team approach. She rewards her staff members for participating and so forth. But that can only go so far. So I think eventually there'll have to be some compensation issues. There are some minor compensation issues, incentives that we use, but they're very nominal.

Ken Miller: We're going to take one more question because we've already run past our time. So, one more.

Q: I'm Bill Doucette from the University of Iowa. The last few years or so I've done a fair amount of practice-based research without an official PBRN. And so it seems like every time we get a study funded and we try to put it together, we kind of reconstitute a network. So we don't have much infrastructure behind it. And I was wondering how, if you have any ideas, how we could make that jump into having the infrastructure for kind of an ongoing network? Obviously, AHRQ, maybe we have to start lobbying AHRQ or something, but any other ideas, I'd appreciate that.

Don DeNucci: Become a dentist.

John Hickner: A number of things come to mind. A departmental sponsor is the first one. That is, the department itself agrees that this endeavor is so important that we're willing to spend some of our infrastructure money to support it. The second mechanism is the traditional mechanism of indirect costs and grants. And getting indirect costs back directly to the department is another way to do it. A third way is to go to bed with the devil I suppose. There are lots of pharmaceutical companies out there with money and you can do some for-profit studies to provide funding for your sort of not-for-profit, more research-oriented development activities. And there are other clever ways to do it too, local foundations, professional foundations. It's a matter of looking for money.

Don DeNucci: I just have one slightly serious comment. And actually we're looking at this very same issue with the VA. Now the VA's a little different in that it's a federally-funded agency and it doesn't have some of the dynamics that an academic institution would. But what we hope to do is show that dentistry can become more cost effective and efficient if we do research to find out what we really should be doing.

John Hickner: Yeah, I should clarify my comment too about pharmaceutical companies. I've done collaborative studies with pharmaceutical companies and it's actually been wonderful. They've been really good partners to work with and at least the studies that I've worked on

they've given us full editorial policy in doing the study. So I don't mean to disparage pharmaceutical companies by any means. But that is—tends to be more for-profit approach to things, especially when you're doing their studies that they designed. So I think you need a combination of helping them with their work and then they help you with your work. It can be a very good partnership.

Ken Miller: Well, let's thank our panel for a wonderful evening. And I have one other group that I'd like to thank. And that's all of you out there. I know we asked you to do an awful lot of reading. And I know you ask your students to do that and they oftentimes don't do that, and we even gave you a test and most of you filled it out. You actually sent in comments about what you wanted to get out of this particular program. So we know that you actually looked at many of the things that we asked you to look at and familiarize yourself with practice-based research networks before you came to the conference for the next several days. So we really appreciate that because I think we start in a much higher plane than we would if we just walked in here not knowing anything about the whole idea of practice-based research networks.

Now I've been asked to just make one or two housekeeping announcements. Embassy Suites serves a breakfast that's part of your room bill, so you have to take advantage of that. We are not going to set up a special breakfast so you go down to the breakfast room. I believe it opens at 6:30 or maybe even 6:00 for you runners that'll probably be out there early. And then tomorrow evening we have what's called Dine Around. Now I should tell you we're not paying for your Dine Around. We will help you find a restaurant to go to, but when the bill comes don't send it to AACP because your registration fee did not cover that. We got this idea actually from AHRQ who sponsored a Dine Around and they didn't pay for it either. But I understand Earlene went to the Dine Around last year and met a lot of interesting people and made some wonderful contacts. And so we want you to do that here too. It's obvious that there needs to be a lot of sharing amongst all of you. Some of you have done a lot of practice-based research and are looking for ideas and others of you are looking for ideas, so please sign up with a group. You don't have to go with your best friend and just talk to them. We're hoping that these Dine-Arounds are just an opportunity for you to go out in a social setting and talk to one another and pay for your own meal. So we'll take care of lunch tomorrow and the hotel will take care of breakfast. So we'll see you here promptly at 8:00 in this room tomorrow morning. Thank you very much.

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