Hybrids, Chimeras, or New Species? Emerging Models of PBRNs

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Overview

- Historical structure and function of PBRNs
- PBRN leaders describe 3 ‘newer generation’ networks
- Large group formulation
- Small group discussions and application
- Small groups report
- Summary of take home messages
1980’s: Foundations

• Regional and national PBRNs were developed to conduct primary care research
  – Family Medicine and Pediatrics
    • ASPN, PROS, WReN, UPPR-Net
  – Sought to become ‘laboratories’ that build the science base of primary care
  – Sustained by academic departments & foundation grants
1980’s continued

- PBRNs were research collaboratives of practicing primary care physicians and academics
- Revolutionary and counter to mainstream medical culture
- Focused on diagnosis and management of common medical conditions
  - Observational card studies, natural experiments
- Emphasis on clinical phenomena and clinician behavior
- Limited engagement of community members
1990’s: Increasing Rigor

• Marked increases in rigor and complexity of studies
  – Qualitative and multimethod designs, intervention studies, group randomized trials

• Direct Observation of Primary Care; Acute Otitis Media; STEP-UP; Improving the Care of Children with Asthma; Depression Management in Primary Care
1990’s continued

– Federation of PBRNs started in 1997
– Departmental & foundation grant core funding models continued
– Experimentation with not-for-profit models
– Sporadic engagement of community stakeholders
  • Unfamiliar skill set; uncertain benefits
2000’s: Proliferation and Expansion

- AHRQ provided infrastructure development funding to 45 networks; more than $8 million
- Quality Improvement & Best Practices networks began
- Evolution from clinical laboratories to collaborative learning communities
- AHRQ-funded PBRN Resource Center initiated
- 17 RWJ-funded Prescription for Health Projects conducted in PBRNs
2000’s continued

• Recognition of slow translation of research into practice
  – First CTSAs funded in 2006
    • PBRNs part of community partnership cores
• Direct engagement of community members by PBRNs described in the literature: CBR, CES, & CBPR
  – Interest and openness to community engagement
• Direct academic affiliation the predominant organizational model
  – CTSA core support
2010’s
Shifting toward PCOR and Public Health

• IOM report: Integrating Primary Care and Public Health
• Folsom Report Revisited: Communities of Solution
• Affordable Care Act
• Accountable Care Organizations: Population health
• Community engagement expertise available through CTSAs
• Patient Centered Outcomes Research Institute (PCORI)
  – Patient engagement is required
## Trajectory of PBRNs

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<td>Quality Improvement/ Best Practices Learning Communities</td>
<td>ACA &amp; ACOs: population health focus</td>
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<td>Dependence on academic departments</td>
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<td>CTSA funding</td>
<td>PCORI: Emphasis on community engaged networks and studies</td>
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<td>Direct engagement of patients driven by studies</td>
<td>Attention to community engaged research</td>
<td>CER partnerships through CTSAs</td>
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