NR7-14

The Development and Implementation of a Psychiatric Practice-Based Research Network: Initial Results

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Introduction

As part of its efforts to promote translational medical research, the National Institute of Health (NIH) has undertaken a program, the Clinical Translational Science Award (CTSA), whose overall objectives are to integrate clinical and translational research and research career development.

To date, there have been 40 programs funded at Academic Health Centers with their diverse public and private partners (1). The CTSA at the University of Texas Health Science Center San Antonio (UTHSCSA), named the Institute for Integration of Medicine and Science (IIMS), proposed developing specialty Practice-Based Research Networks (PBRNs) as part of its community engagement component. (Figure 1)

PBRNs have been recognized as excellent tools for conducting a variety of research activities in primary care (2,3). They can be designed to attempt to answer practice-based questions and interests such as types of patient symptomotology, clinician use of different treatment measures, practice characteristics (demographics, insurance status, etc), treatment compliance and others.

In psychiatry, PBRNs have also been proposed as potential platforms for mental health services research (4). There are already several PBRNs in mental health including the American Psychiatric Association's Research Network, a national PBRN which has conducted a number of "top down" studies, i.e., research studies initiated by the national office and then carried out by network members with results compiled centrally (5).

Based on these and other reports, we set out to design and develop a psychiatric PBRN that would work in conjunction with the IIMS-UTHSCSA in carrying out its missions. In this poster we describe the formation and implementation of the South Texas Psychiatric Practice-Based Research Network and the results of its initial efforts with the hope that this will encourage others to consider forming similar networks that can prove useful in moving our profession's scientific work forward further enhancing the clinical care we provide our patients.

Figure 1. South Texas/Northeast Mexico Border Region

Materials and Methods

Meetings with key psychiatric leaders were held, including officers of the county psychiatric society, psychiatric directors of community mental health centers, directors of public and private hospitals, academicians and others.

At the first Network meeting the eight psychiatrists present decided on a simple card study to examine the occurrence of a "negative reaction" to patients in daily practice in order to gauge network member commitment and network functionality.

For four consecutive weeks, 11 Psychiatrists chose one day a week to fill out a study card that documented setting, primary diagnosis and if they had a negative reaction to their patient. Cards were filled out immediately following the visit and cards were filled out regardless of negative reaction to the patient (figure 2).

Results

Data on 501 patients at the eleven sites was collected. The sites turned in an average of 46 cards per site, with a range of 13 to 89. **Table 1** illustrates the most frequent primary diagnosis reported was depression (40.9%), followed by the "other" category (19.8%). The most frequently reported diagnoses in the "other" category were ADD/ADHD (30%), alcohol drug dependence/abuse (19.2%), dementia/cognitive disorder (16.7%), schizoaffective disorder (12.5%), and post traumatic stress disorder (5.8%).

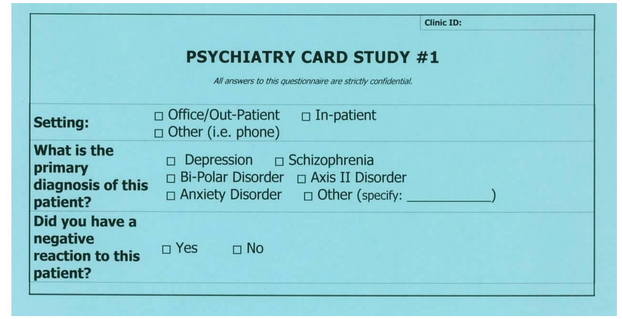
Table 2 illustrates of the 501 cards collected, 48 (9.5%) reported a "negative reaction" to a patient. Among the patients eliciting a negative reaction, the most common primary diagnosis was bipolar disorder (35.4%); depression (22.9%) was second. The most common diagnosis from the "other" category that elicited a negative reaction was alcohol and drug problems (28.6%).

Table 1. Primary diagnoses

Primary Diagnosis	Patients (N=501)	
	N	%
Depression	205	40.9
Other	99	19.8
Bipolar	93	18.6
Schizophrenia	53	10.6
Anxiety Disorder	46	9.2
Axis II Disorder	5	1

Table 2. Negative Reaction by Diagnosis

Primary Diagnosis	Negative reaction (N=48)	
	N	%
Bipolar	17	35.4
Depression	11	22.9
Other	10	0.2
Axis II Disorder	4	0.1
Schizophrenia	3	0.1
Anxiety Disorder	3	0.1



Clinic ID:

PSYCHIATRY CARD STUDY #1

All answers to this questionnaire are strictly confidential.

Setting: ☐ Office/Out-Patient ☐ In-patient ☐ Other (i.e. phone)

What is the primary diagnosis of this patient? ☐ Depression ☐ Schizophrenia ☐ Bi-Polar Disorder ☐ Axis II Disorder ☐ Anxiety Disorder ☐ Other (specify: _____)

Did you have a negative reaction to this patient? ☐ Yes ☐ No

Figure 2. Negative Reaction Card Study

Conclusions

- **This initial small study was conducted to determine if a volunteer network of busy clinicians, all psychiatrists, working in different clinical sites could successfully carry out a planned and coordinated study, to assess "functionality" of the network. The results indicate that it was successful. Eleven participants completed the study the data card was simple and had very few complaints about undue burden, albeit and gathered a small amount of data.**

- **The study reported here is the first to determine a rate of negative reactions in a variety of diagnostic groups in real life practices. Even though neither the card used to gather data nor the accompanying instructions spelled out what was specifically meant by negative reaction, the participants understood that this was an attempt to tap into many types of negative or non-therapeutic reactions (counter-transference) experienced by the members in response to their patients.**

- **The second outcome of this project was the quantification of the rate of "negative reactions" to some of their patients by a group of psychiatrists. This is the first time, to our knowledge, that such a rate (9.5%) has been reported.**

- **In conclusion, the results of this project demonstrate the feasibility of using PBRNs in psychiatric practice to study clinical problems of interest to network members and to our field.**

References

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Funding Source: NIH/NCRR Grant#U54 RR024387-01A1