

NAPCRG 2008 MEMBERSHIP SURVEY

Summary

Total Respondents = 239

I. COMPONENTS

1. Please rate the value and effectiveness of the following:

Component	Mean	No value ←————→ Extremely valuable				
		1	2	3	4	5
Annual Meeting	4.58	0%	0%	6%	29%	65%
Newsletter	3.37	2%	12%	42%	36%	8%
Website	3.43	1%	13%	37%	39%	10%
Consultants Directory	2.70	8%	36%	37%	15%	4%
NAPCRG-L Listserv	2.67	11%	36%	34%	14%	5%
Special Interest Groups	3.33	3%	14%	38%	36%	9%
List Of Those Seeking Collaborators At Annual Meeting	3.21	4%	22%	33%	33%	8%
Membership Directory	3.67	1%	10%	30%	39%	20%

2. To what extent do you agree with the following changes in the newsletter:

Change	Mean	Strongly disagree ←————→ Strongly agree				
		1	2	3	4	5
Include More Research Information	3.80	1%	4%	29%	47%	20%
Include More Organizational Information	3.17	2%	15%	51%	28%	4%
Include More Features	3.11	2%	18%	52%	23%	5%
Include More Social News	2.50	17%	32%	36%	13%	2%
Publish More Often	2.33	24%	33%	32%	9%	2%

3. If you have used the Consultants Directory, please rate your experience (5% have used it):

Characteristic	Not satisfied ←→ Very satisfied					
	Mean	1	2	3	4	5
Access	4.08	0%	0%	17%	58%	25%
Ease Of Use	3.58	0%	8%	42%	33%	17%
Response Of Consultants	3.70	0%	0%	40%	50%	10%
Helpfulness Of Consultants	3.45	9%	9%	27%	36%	18%
Cost Of Consultation	3.67	0%	0%	56%	22%	22%

4. If you have not used the Consultants Directory, why have you not used it (95% have not used it):

Reason	% Yes
Didn't Know About It	41%
Don't Understand What It Is For	36%
Didn't Need It	23%
Difficulty Accessing It On Website	10%
Instructions For Its Use Are Confusing	11%
None Of The Topics Match What I Need	20%
No/Few Consultants Available For What I Need	21%
Consultant Never Responded To My Request	3%
I Tried But The Consultant Wasn't Helpful	2%
I Couldn't Afford The Cost	14%

II. COMMITMENT TO NAPCRG

1. What is the likelihood that you would attend an annual meeting if you were not presenting?

Likelihood	Current Survey	2005 Survey
Still Likely To Attend	52%	50%
Unlikely To Attend	36%	28%
Unsure	12%	22%

2. How important are the following factors in your decision to remain a NAPCRG member?

Factor	2005 Means	Current Survey					
		Mean	1	2	3	4	5
Attending Annual Meetings	4.10	4.55	0%	3%	9%	20%	69%
Research Skill-Building	3.77	3.70	3%	12%	22%	36%	27%
Networking And Peer Interaction	4.35	4.44	0%	1%	9%	35%	55%
International Flavor Of NAPCRG	3.45	3.96	3%	6%	16%	45%	31%
Departmental Expectation	2.35	2.53	28%	24%	23%	18%	8%
Part Of My Professional Role	3.52	3.52	8%	12%	21%	37%	22%
Information About Research Activities & Funding	3.70	3.53	2%	17%	28%	34%	20%
Participation In Groups And Task Forces	2.83	3.03	7%	23%	37%	26%	7%
Member's Benefits	---	2.74	15%	27%	34%	20%	5%

III. NAPCRG EXPERIENCE AND NEED

1. Through NAPCRG, have you ever:

Activity	% Yes
Found A Collaborator	54%
Received Methodological Assistance	50%
Learned About A New Paradigm	59%
Found A Mentor	27%
Received Critique Of A Study	60%
Received Critique Of A Grant Proposal	14%
Received Critique Of A Manuscript	30%

2. Please answer the following concerning mentorship and consultation.

Question	Current Study (% Yes)	2005 Study (% Yes)
Do you currently have a research mentor?	42%	36%
Do you currently need a research mentor?	19%	39%
Are you willing to serve as a mentor for new researchers?	55%	55%
Are you willing to serve as a mentor for more experienced researchers?	26%	22%
Are you willing to serve as a research consultant?	54%	56%

3. Have you ever been involved in a research project in which the following partners were significantly involved with the development of the research question and/or methods?

Partner	% Yes
Full-Time Clinicians	66%
Care Delivery Leaders	34%
Clinic Patients	25%
Community Leaders	30%
Health Policy Leaders	33%

4. Please rate your level of need for the following:

Development/Opportunity	2005 Means	Current Survey					
		Mean	No need 1	2	3	4	Large need 5
Development Of Basic Research Skills	2.39	1.99	47%	26%	14%	9%	5%
Development Of Advanced Quantitative Methods	3.38	3.24	14%	10%	28%	36%	13%
Development Of Advanced Qualitative Methods	3.26	3.14	15%	12%	30%	29%	14%
Development Of PBRN Methods	2.92	2.84	22%	16%	27%	26%	9%
Development Of Writing Skills	2.73	2.49	27%	28%	21%	16%	8%
Development Of Grantwriting Skills	3.16	2.85	21%	22%	21%	23%	13%
Development Of Career Planning Skills	2.64	2.53	31%	22%	19%	20%	8%
Skills For Translating Research Into Policy	---	3.25	14%	14%	24%	30%	18%
Leadership Opportunities	2.98	2.93	18%	17%	29%	27%	10%
Opportunities For Critique Of Studies	3.01	2.92	16%	20%	30%	24%	10%
Opportunities For Critique Of Manuscripts	2.87	2.83	18%	25%	26%	23%	10%
Opportunities For Critique Of Grants	2.90	2.95	17%	21%	26%	24%	12%
Opportunities To Discuss New Ideas/Paradigms	4.03	3.60	6%	10%	22%	42%	20%
Find Collaborator(s)	3.77	3.21	10%	15%	30%	33%	12%

IV. ATTITUDES

1. How satisfied are you with the administrative structure and processes of NAPCRG?

Structure/Process	2005 Means	Current Survey					
		Mean	Not satisfied ←→ Very satisfied				
			1	2	3	4	5
Administrative Support By NAPCRG Staff	4.23	4.28	0%	1%	16%	36%	47%
Leadership Of Board Of Directors	3.91	4.09	0%	1%	24%	39%	36%
Openness Of Finances	3.84	4.02	0%	1%	31%	32%	36%
Openness Of Decisions	3.70	3.85	0%	4%	33%	36%	26%
Committee Structure	3.61	3.78	0%	4%	38%	33%	25%
Lack Of Bureaucracy	3.80	3.90	0%	1%	34%	39%	26%
Opportunity To Participate In SIGs	3.76	3.98	1%	5%	21%	40%	32%
Leadership Opportunities	3.44	3.57	1%	11%	41%	27%	21%
Nurturing Of New Researchers	3.88	4.08	0%	6%	17%	40%	37%
Nurturing Of Intermediate Researchers	---	3.84	1%	8%	28%	36%	28%
Nurturing Of Experienced Researchers	3.51	3.63	1%	12%	34%	32%	22%
Representation Of Research Issues Within Family Of FM Organizations	3.87	4.07	0%	4%	25%	33%	39%
Opportunities For Input From Membership	---	3.76	1%	6%	33%	38%	23%

2. Please rate the importance of the following in planning for the future of NAPCRG:

Issue	2005 Means	Current Survey					
		Mean	Not important ←→ Very important				
			1	2	3	4	5
Support For Research For Residency Programs	3.43	3.63	6%	13%	21%	32%	28%
Advancing Research Issues As Part Of FFM Initiative	4.15	4.15	1%	4%	15%	37%	43%
Advocacy For Primary Care Research With Funders	4.38	4.58	1%	1%	8%	23%	68%
Expand Offerings On The Website	3.06	3.16	5%	18%	45%	22%	11%
Continued Support For Annals Of Family Medicine	4.12	4.26	1%	5%	12%	32%	51%
Develop Advanced Research Methodology Meeting	3.46	3.76	1%	9%	27%	40%	24%
Develop Advanced Research Methodology Training Modules On The Web (CC)	3.58	3.67	3%	12%	25%	34%	26%
Develop Interactive Modules On The Website (CC)	---	3.16	8%	16%	41%	22%	13%

3. What areas of research are important to primary care and need more exploration?

1. Impact of redesign; impact of consortia; impact of primary care
2. primary care mental health value of primary care health care reform
3. Health Policy as affects primary care Social Scientific factors that affect patient care and outcomes Workforce development, esp. rural, poor urban, international, and primary care
4. Inter-pregnancy maternal care Maternal depression
5. Prevention, healthy lifestyles and chronic disease, the role of inflammation and oxidative stress in the prevention of cancer and cardiovascular disease, treatment of diabetes, treatment of obesity, treatment of hypertension, nutrition in disease, exercise
6. quality of care including interventions that improve it, preventive services, providing mental health care to our patients, cost benefit of interventions, elements of medical home improve outcomes, value added of having a primary care doctor
7. Interprofessional care models; attracting students to family medicine
8. practice transformation health outcomes from medical education interventions
9. Developing and implementing sustainable models of: primary healthcare in the developing world; family medicine education in the developing world; medical education in the developing world.
10. pharmacogenomics & research methodology
NAPCRG has been stangely silent on the CTSAs, which is the best funding opportunity for FM/primary care groups in decades.
11. As a result, a new cross-disciplinary infrastructure is being developed with little or no NAPCRG involvement. The HMO research networks and some of the larger academic-affiliated PBRNs are quite well connected, in contrast.
12. cost-effectiveness of integrated care (behavioral health with medical providers); comparative models of chronic care management
13. how cost effective primary care is compared to other specialties; how outcomes are the same or differ; How effective are our training programs for training the FPs of today /the future; women's health from a true PCP perspective
14. health delivery... on PCMH prevention into practice genomics to ambulatory care
15. development of the primary care team
16. Practice bAESD RESEAERCH NETWORKS
17. improving quality of care attracting more primary care docs
18. What are the best methods for studying clinical care improvement among heterogeneous populations and sites?
19. Interface between research and information technology, e.g., EMRs
20. medical home, team function, EMR, patient web services, processes of care and antiquity of current visit based billing structures, before and after visit care, topic areas chronic disease that are most relevent to FP
21. effective models of care mental health the social aspects of health and the role of primary care in this
22. health disparities; generic interventions (e.g. not health condition-specific); health behavior change interventions
23. health system reform; re-organization of health care around primary care provision, primary care reimbursement

- How to improve integration of primary care with community services/organizations to address issues of mental health and
24. motivating behavior change in patients to improve a myriad of outcomes. Best ways to communicate between providers both within the same organization and between organizations and different disciplines.
 25. physician patient interaction non-narcotic management of chronic pain barriers to application of findings/recommendations in actual practice ways to manage and reduce the administrative (paper work) burden of practice
 26. Stronger evaluation methods, particularly in educational research. Stronger health services research on populations that are widespread, not so localized.
 27. economics interface with public health
 28. application of science to patients in primary care settings that don't meet study criteria
 29. Practical clinical trials, partnership research, and scientific observational studies and case studies
 30. health seeking behavior, practice change management and interdisciplinary team development
 31. what works in practice as opposed to tertiary care centers
 32. interactions mental and physical health
 33. Value of primary care providers to the community. Successful ways of attracting primary care practitioners to areas of need.
 34. Knowledge translation and implementation CPD and practice change
 35. palliative care, MUS
 36. cross cultural aspects of health/illness; communication between pts and providers, and among providers; gender issues
 37. QUalitative and narrative methods, promoting legitimacy for the non-quantitative aspects of research.
 38. doctor-patients relations, Dementia and the family
 39. provision of care in continuity model in rural areas understanding role of hospital care in life cycle and illness cycle when Primary care providers hardly provide this care
 40. Clinical research - research about/with/for caring for patients and about the natural history of health and illness.
 41. 1. Community involvement and impact on community health. 2. Patient/Physician interaction and health outcomes
 42. how to incorporate residents and students into primary care projects as co-investigators, helpers, and PIs
 43. Organization of care; collaboration between primary care providers and specialists
 44. impact of enhancing electronic access to clinical information on practice
 45. mental health information technology
 46. Areas of chronic disease management, access to care, health care disparity
 47. Different payment models in the US, paying for care coordination, outcomes while paying for care coordination.
 48. Connection between clinician-patient relationships and health outcomes
 49. Community and Public Health. How can primary care researchers help inform and perform public health research.
 50. How to get more outpatient docs involved in research
 51. Statistical research methods
 52. use of knowledge in practice; impact of managed health care systems and deprofessionalisation on care

52. practice change and incorporation of new findings into practice
53. Mixed methods research; interdisciplinary research; interprofessional collaboration
54. more methods stuff
55. teaching basic skills and integrating those skills with technology (ie, survey design fundamentals and electronic surveys; basic stats with stat packages)
56. efficacy of primary care clinical methods
57. Practice-based research methods
 1. Over-reliance on biomedical treatments at the expense of lifestyle/behavior change. 2. Erosion of the original practice domain of Family Physicians. 3. Barriers to patient ownership and continuity of care. 4. Establishing motivational interviewing as a basic skill of Primary Care Physicians.
58. 1) Research on surveillance 2) Qualitative methodology 2) Seniors Health issues
59. I think insuring high quality research methodologies is EXTREMELY important. I felt several of the abstracts I reviewed for annual meeting this year were weak in that respect. Ideally we should nurture better use of methodology in these cases
60. see below
61. more on PBRNs

Natural history of important illnesses seen in PC. Clinical trials of unproven interventions in PC. Study of acute conditions (as well as chronic). Impact of system changes (New Model) on fundamental processes of primary care: communication, continuity, relationship.
62. Medical Informatics
63. prevention risk assessment lifestyle

Demonstrating the value of sufficient time in office visits to attend better to the problems and patient needs...how does time spent correlate with outcomes, including patient satisfaction, patient sense of competence/confidence; specific and broad clinical outcome measures, including costs.
64. youth and adolescent mental health
65. chronic disease management; practice innovations to meet challenges of changing health care system
66. translation of treatments/prevention/etc into underserved communities.
67. Type 2 Diabetes

Understanding the processes by which primary care and Family Medicine are defined. Gaps in knowledge with regard to preventive services (I recommendations of USPSTF) How to prioritize of patient care recommendations/interventions for individual patients. Microeconomic issues in primary care. Development of novel methods for studying symptoms and their evaluation. Measurement of quality of care.
68. Men health
69. Health Services research
70. Patient perspectives

- patient-centered medical home physician-centric are to patient/practice-centric care Enabling patients to take ownership of their health Communication b/t doctor & patient Opportunity to treat/prevent obesity in primary care settings Financial implications of implementing medical home model
75. health Communication b/t doctor & patient Opportunity to treat/prevent obesity in primary care settings Financial implications of implementing medical home model
 76. Impact of ACGME competencies on residency education -- both process and outcomes; evaluation of alternative residency structures (ala P4 programs) but with more emphasis on outcome evaluations
 77. Interprofessional collaboration
 78. Self-management Primary care renewal
 79. Implementation
 80. Environmental Medicine
 81. interdisciplinary research
 82. continuity, comprehensiveness, clinical research on 'real'patients
 83. Inter-relationship between social, cultural, demographic, health, and morbidity factors
 84. probably comorbidity workforce
 85. international research. We need to develop and use more robust science in family medicine research.
 86. Quality improvement, report cards, score cards
 87. T3 translation methods, better understanding of RCTs in PBRNs.
 88. statistics
 89. How to create interoperable medical information systems. How to address health conditions across multiple institutions and programs.
 1. Translational research around chronic disease management in primary care--particularly optimal organization of practices and teams.
 2. Follow up studies to the NDP regarding 'Medical Homes'
 3. Advance studies regarding Clinical IT in quality and safety, particularly in primary care.
 4. Impact of alternative financing strategies on access, quality, and safety.
 90. Team building System change Motivating patient self management creating policy change to embrace prevention and primary care
 91. care
 92. Longitudinal research; the benefits and cost of values-based practice
 93. translation research, behavioral change research
 94. Research on affectiveness of primary care for illness and disease better focussed to contextual issues (personal care, continuity, generalist approach, integrated, holistic approach)
 95. Improving family functioning
 96. Integration of disciplines with and apart from medicine.
 97. Health services research in general
 98. Interprofessional education and practice
 99. Use of IT in primary care Best EHR systems in primary care Decision support in primary care
 100. More effective delivery of primary care in the context of improving cost effectiveness of health care. Impact of use of more

- midlevel practitioners in primary care, especially with increases in independent privileges in NP's.
101. e-health, health communications, osteoarthritis, patient empowerment, personalized medicine
 102. How to integrate QI efforts with research to make QI efforts and findings more applicable to other systems.
 103. Medical home constructs: separately as well as together; processes and consequences with varying SES and other patient characteristics; regardless of link to pay for performance as well as in context of pay for performance
 104. Chronic disease - more RCTs
 105. Prevention putting prevention in practice new models of delivery
 106. Health Services Research
 107. Interdisciplinary collaboration, impact of PC organization on quality of care
 108. New models of practice involving patient-centered team care with a physician leader
 109. Health Literacy is really important to primary care.
 110. group randomized trials
 111. Cancer screening Patient-centered care
 112. feasibility/utilization of medical home model - outcomes - disease and patient oriented, physician income/satisfaction.
 113. health care disparities (racial/ethnic, socioeconomic, and age disparities)
 114. Women's health and preventive health. Women's health needs to take a determinants of health perspective and be separate from obgyn issues.
 115. Health equity
 116. management of chronic illnesses. management of behavioral disorders. type 1 and type 2 research. more health disparities research
 - 1) characteristics and rigor in choice of a good outcome measure, both instrument and questionnaire.
 - 2) assessment of protocol driven health care delivery...when the MD is not even in the protocol
 - 3) Data capture and display in EMR's. Who decides what the screen should look like?
 - 4) EMR interference in medical logic
 - 5) interpretation of electronic BP measures. Calibration of monitors.
 - 6) Software to determine continuity of care measures in EMR driven teaching programs
 117. 1. research that explores outcomes (economic and health) related to investments/innovations in primary care 2. research that explores methods for patient activation/shared decision making
 118. Family Violence
 119. Patient experiences
 120. genomics
 121. health services - PC primary care practices as complex organizations cost effectiveness of PC decision making for patients and clinicians in PC
 122. symptom oriented research Cost effective care
 123. longitudinal practice based research. clearer delineation of common syndromes in family practice. multimorbidity.
 - 124.

4. What new paradigms may be important to primary care and need to be more fully explored?

1. network analyses; cost-benefit analyses
2. complexity science information theory
3. Biopsychosocial model has been around for a while, but new ways to study, to implement, and to educate for it are needed, esp. as basic sciences, subspecialties, and pharma team up to reduce health care. NAPCRG researchers are on the frontlines to reverse this.
4. Life course approaches to epidemiology
5. What will be the impact of universal health care? What are the implications of the baby boomers reaching retirement and illness age? What are the implications of the growing of America (obesity) on future prevalence of chronic disease?
6. how to organize our offices to provide best possible care, better funding models
7. paradigms for chronic care
8. complexity theory transformational science
9. Minimizing the use of diagnostic and invasive technology to improve morbidity and mortality; appropriate rationing of health care resources to improve morbidity and mortality
10. NETWORKED RAPID CYCLE CQI TO ADDRESS SYSTEMS CHANGE TO IMPROVE QUALITY OF CARE
11. single payer health care
12. We need new ways to categorize episodes of illness (ICPC?), We need to harness the power of EMR and understand the limits of its use. We need better networking among ourselves to use the power of our numbers to answer important questions.
13. medical home, team function, processes of care and antiquity of current visit based billing structures, chronic care model, electronic medical records,
14. more collaborative approach to proposing policy solutions
15. How to use aspects of the CCM and systems changes to address some of the issues in 12.
practical ways to insure care for rural and underserved populations electronic support for the logistics of chronic care practical
16. ways to free physicians to focus on care rather than the logistics of information gathering and scheduling routine interventions, e.g., immunizations, scheduling mammograms practical ways of interacting with payers in terms of "allowable"; medications, tests, consultants
17. Having people/patients set the research agenda collaboratively with funders.
18. Delivery of health care with limited resources
19. research modules that allow the quick assessment of implementation of a process or guideline
20. Partnership research
21. community based primary care and community generated participatory action research on the social determinants of health
22. xx
23. expanding conceptual horizons beyond medical diagnoses
24. Impact of technologies (local=EMR and global=internet)

- 25.comorbidities, promoting selfefficacy in patients with chronic disease,
- 26.not sure what you mean
- 27.Staff work, involvement of nurses and social workers in primary care
- 28.Making the generation of new knowledge part of the fabric of family practices.
- 29.Community leadership and interaction beyond the office building
- 30.community based-participatory research
- 31.interprofessional work
- 32.the linkage of public health and primary care
- 33.Imapct of medical home concept with quality indicators especially in chronic disease models
- 34.sociology of knowledge
- 35.multi-method, coordinating and working with non-MD based disciplines (education, business, psychology, engineering, etc.)
- 36.the need for physicians to know how to surveil their own practices
37. community-clinic interface. How community factors relate to primary care. In essence, I believe we need to expand our focus beyond clinic processes.
- 38.clinical research methodology within outpatient setting
- 39.Greater success in translating research findings into practice
- 40.Whole Person (not just biomedical) Care
- 41.Use of EMR and ethics
- 42.Participatory research T-2 (translational) access to funding presentations?
- 43.participatory research in habit changes , compliance prevention
- 44.the new generation of researchers vs the older generations - how they approach studies and the electronic world
45. What are the roles and the mix of skills needed for efficient and effective care in the evolving health care systems and new model of PC.
- 46.Complexity Science
- 47.pay for performance
48. Re-emphasis on the "old" paradigm...spec., that adequate time with Primary Clinician...and the relationship...make a difference
- 49.environmental model for us
- 50.Goal-directed health care.
- 51.The effect of chronic stress on the poor with regards to health
52. Moving from acute, reactive, episodic care to proactive population management Making the patient a partner in their disease managment
- 53.More rigorous research
- 54.Revising from translational research to connecting research and practice in a 2-way dialogue

- 55. implications of research in the social sciences
- 56. role of narrative in medicine alternatives to the scientific model
- 57. the importance of priority setting practice management (ie the running of a safe efficient and quality practice)
- 58. team work - seeing family medicine as a multidisciplinary activity
- 59. use of film, video
- 60. New research methodologies that will get the attention of NIH type funders
- 61. screening of healthy people individualized treatment modalities
- 62. The most important research paradigm would be action research. The most important patient care model is the extended chronic care model.
- 63. Advanced 'self care'--how much can actually be done by an engaged patient with structured Web resources and an asynchronous physician coach.
we should no longer looking at diagnosis alone. We should be looking at diagnosis and severity. Mild to moderate disease should be handled by Primary Care. Severe disease by subspecialists. A lot of research is needed to create efficient interfaces and team building between PCP and sub-specialists. Research on the delineation of roles and responsibilities when a patient has multiple doctors is sorely needed. Making a business case for better primary care
- 64. complexity science; would like to see it addressed head on in a plenary rather than just as special interest group.
- 65. Medical home
- 66. complexity theory
- 67. chronic care models of service delivery;
We need a new method. Maybe something like large, simple trials that have minimal data-collection requirements, but involve 100s or 1000s of primary care clinicians, each collecting data on a few patients. We need a new approach so that we can answer the questions of importance to us; instead of a very few, complex, and expensive projects, we need many, simple (but large), and relatively cheap projects. We also need to billionize AHRQ.
- 68. Interprofessional education and practice
- 69. Open access scheduling Medical home concept Team care group visitsw
- 70. Use of alternate communication (eg internet) in interactions with patients.
concrete application of complexity theory to chronic care model of care- community, health system, patient care team, patient, family, peers for optimal managment of chronic disease such as diabetes,cancer, arthritis, congestive heart failure, COPD.
- 71. Genetic basis of disease
- 72. Survivorship Care in Primary Care (cancer)
- 73. as above
- 74. Patient-centered care
- 75. Employing health educator for one's practice (chronic disease management, health psychology counseling) - financial feasibility; health literacy applied to primary care settings; cultural competency measures related to outcomes for primary care settings

79. Public health and determinants of health perspective.

80. Virtual teams

81. the impact of letting go of inpatient and ob care

82. 1) Effect of interdisciplinary health care paradigms: pros/cons. 2) Effect of controlled access to drugs 3) Risks/benefits when multiple health care providers can prescribe the same medication

83. rethinking the quality discussion

84. complexity and chaos theory and math

85. Use of EMR in research

86. complexity science