DD1 Guidelines are dangerous beasts requiring proof of value before being released

David Hahn, MD MS

SUMMARY/DESCRIPTION OF IDEA: Most "evidence-based" guidelines are complicated sets of clinical recommendations stitched together from limited efficacy studies of varying quality. Administrators then create guideline-based "clinical quality indicators" by which clinicians are judged, ranked and paid. Maximization of "quality indicators" precludes shared decision-making that is ethically required particularly for chronic disease management. Almost every month JAMA seems to publish another critical analysis of a (usually) hospital-based "quality indicator" finding that it has no value. The purpose of comparative effectiveness research (CER) is to test the relative value of two clinical approaches, one of which can be usual care. Primary care researchers should recognize guidelines for what they are: dangerous beasts in need of CER before being released into the wilds of primary care.

DD2 Quality improvement, research, and ethical oversight-a call for new approaches

Jennifer Carroll MD, MPH; Kevin Fiscella MD, MPH; Jonathan Tobin PhD; Hua He PhD; Gbenga Ogedegbe, MD, MS, MPH

SUMMARY/DESCRIPTION OF IDEA: This Daring/Dangerous idea addresses the issue of the need to develop and apply new ethical principles under the Common Rule to address the increasingly blurred lines between quality improvement and research. With increasing national attention on both learning healthcare systems and patient centered outcomes research, there is a need to confront challenging issues related to human subjects protections such as the Institutional Review Board (IRB) review process, the need for informed consent around the use of particular data sources (e.g., electronic clinical data), and the ethics of randomization of standard clinical interventions. IRBs distinguish health care quality improvement (QI) and health care quality improvement research (QIR) based primarily on the rigor of the methods used and the purported generalizability of the knowledge gained. Neither of these criteria holds up upon scrutiny. Rather, this apparently false dichotomy may foster under-protection of participants in QI projects and over-protection of participants within QIR. Ethical oversight should not hinge solely on methods nor on potentially specious arguments regarding generalizability of knowledge. Instead, the level of oversight, including requirements for informed consent of participants, should match the risk posed to participants and balance the ethical imperative to improve care. Minimal risk projects should entail a lower level of oversight including waivers for informed consent for both QI and QIR projects. Minimizing the burdens of conducting QIR while ensuring appropriate safeguards for QI projects is needed to restore this imbalance in oversight. Potentially, such ethical oversight could be provided by the integration of Institutional Review Boards and Clinical Ethical Committees, using a more integrated and streamlined approach such as a two-step process involving a screening review, followed by a review by committee trained in QIR. Standards for such ethical review and training in these standards, coupled with rapid review cycles, could facilitate an appropriate level of oversight within the context of creating and sustaining learning health care systems.

DD3 Unmasking Burnout

Mark Stephens, MD; Melissa Walker, APT; Lananh Nguyen;

SUMMARY/DESCRIPTION OF IDEA: Burnout is pervasive in medicine. We use the creation of expressive masks as a means of self-exploration to uncover themes relating to professional burnout. An accompanying narrative allows further self-reflection and promotes strategies to promote wellness and healing in physicians, medical students and other health professionals.

DD4 The Medical Care of "Permanently Hospitalized" Undocumented Immigrants

Patrick McColloster MD FAAFP;

SUMMARY/DESCRIPTION OF IDEA: In Houston over 200 severely disabled undocumented immigrants per year have prolonged or indefinite hospital stays due to a lack of funding for nursing home placement. Many are abandoned by their families or lack sufficient resources for home care.   Some area hospitals repatriate these patients to reduce costs – a controversial practice residing in an ethical grey area. Others utilize charitable organizations for placement.   Casa Juan Diego, a Houston Catholic Worker House, currently provides financial and medical assistance to 110 families with disabled members. An additional 45 patients are housed in "personal care homes," usually at a cost of $800 per month for room and board. These personal care homes are poorly regulated facilities that offer a low cost alternative to nursing home placement – which in Houston averages $5,250 per month. Both alternatives are much less expensive than the average cost of $60,000 per month for hospitalization. In order to cut costs and provide humane care, a consortium of area hospitals can be formed that would develop policies and placement protocols for these "permanently hospitalized" immigrants. This presentation will describe the scope of the problem, work at Casa Juan Diego and a brief proposal for the development of the placement consortium.

DD5 Physician Assistants as Researchers: Daring to Transform the Traditional Supervising Physician-PA Relationship

Lindsay Kuhn, MHS, PA-C; Lindsay Kuhn, MHS, PA-C;

SUMMARY/DESCRIPTION OF IDEA: Physician Assistants (PAs) are nationally certified and state-licensed medical professionals who work in physician-PA teams and are educated in a collaborative approach to healthcare. PAs are trained generally in the medical model, preparing them to practice in any number of primary care or sub-specialty areas. They take medical histories, conduct physical exams, diagnosis and treat illnesses, order and interpret tests, counsel on preventive care, assist in surgery, and write prescriptions. There are currently over 95,000 PAs practicing medicine in all 50 of the United States. According to the US News and World Report, PAs ranked among the top ten of the 100 Best Jobs of 2015 and in 2014, Forbes magazine ranked the Master's Degree in Physician Assistant Studies as the number one degree for jobs, citing a 20% growth rate in the profession. It is expected that the number of PA educational programs will grow from 180 today to 250 by 2018.   The collaborative approach to healthcare has been shown to improve coordination of care and can improve outcomes. PAs work interdependently to extend the care that their supervising physicians provide and cost-effectively increase access to care, which is of utmost importance as healthcare reforms.   The physician-PA relationship lends itself nicely to other partnerships such as that between a Principal Investigator (PI) and Sub-Investigator in practice based research networks (PBRN). However there is little in the current literature to describe the role of PAs as research team members and < 1% of PAs are employed in this capacity. As a Physician Assistant myself, it has been my personal experience attending previous PBRN Conferences and various national and international research meetings that few PAs attend and even fewer present.   For this Daring Ideas presentation I will my share my unique perspective as a Physician Assistant researcher from the Mecklenburg Area Partnership for Primary Care Research PBRN in Charlotte, NC. I will describe how opportunities aligned for me professionally to expand my clinical expertise into various arenas from clinical trials to community-based participatory research interventions, focusing on how my addition to the team enhanced our projects and balanced the PIs' workloads. From safety monitoring to practice facilitation to first author publication, my career has evolved over the past 5 years within my department. The overarching goal of the presentation will be to advocate for more PAs to take on this complimentary role.   By the end of the session, participants will better understand the value of PA researchers and consider expanding their own teams to include one themselves.