



# FLORIDA STATE UNIVERSITY COLLEGE OF MEDICINE

*Research Workshop Series # 7*  
*Dissemination of Research Findings*





# Workshop Overview

- Importance of dissemination
- Understanding the audience
- Writing an abstract
- Poster and oral presentations
- Publications
- Defining the role of authors and contributors
- Developing a dissemination strategy



# Why is Research Dissemination Important?

- Promotes awareness of research and evidence-based practices
- Maximizes the impact of health outcomes
- Helps bridge gap between health research and action





# Dissemination of Research

## Examples include:

- **Poster Presentations**
  - Academic and Scientific Conferences
  - Research fairs (e.g. FSU CoM annual research fair)
- **Oral Presentations**
  - Academic and Scientific Conferences
  - Professional presentations (e.g. Grand Rounds)
- **Publications**
  - Peer-reviewed journals
  - Non-peer reviewed platforms (newspaper or magazine)





# Audiences for Research Dissemination

- Patients
- Community/ Consumers
- Health Care Providers
- Policymakers and Regulators
- Industry
- Investigators
- Funders





# Writing an Abstract

## Three types of abstracts:

### Descriptive:

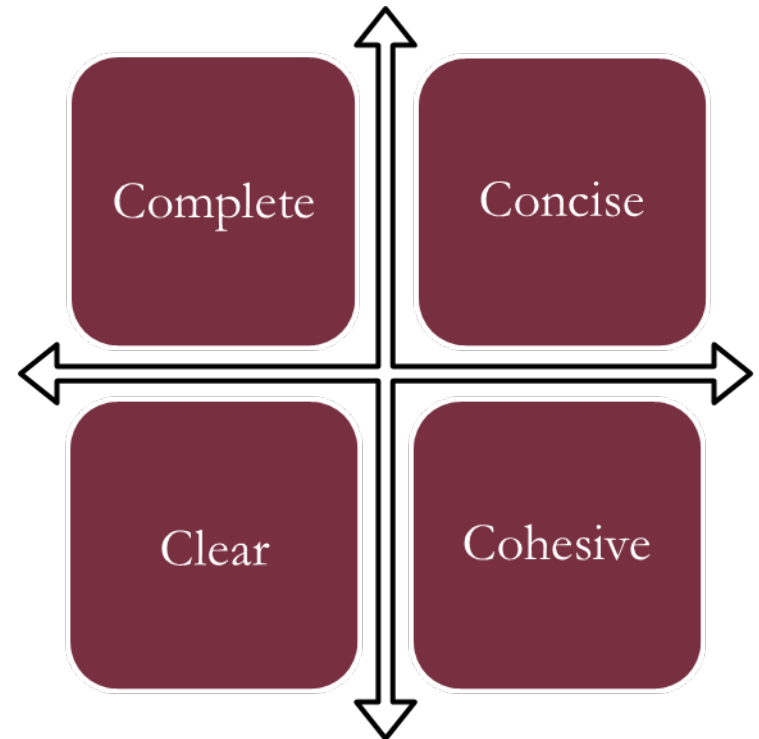
- Pre-research activities

### Informative:

- Post-research activities

### Critical:

- A comprehensive evaluation of study and comparison to similar work





# Writing an Abstract

## Qualities of a superior abstract:

- Brief: Usually 150-250 words
- Structured: Includes intro-body-conclusion format
- Includes purpose/objectives, methods, results, & conclusions
- Follows a logical flow
- Summarizes the paper or study



# Writing an Abstract

## Do Not:

- Repeat the title
- Refer to content beyond the study
- Include references, figures, or tables (included in paper)
- Use abbreviations or acronyms without first defining them





# Poster Presentations

## A professional poster will:

- Provide a visual, organized summary of research
- Include objectives, methods/design, & results
- Meet guidelines for the specific event
- Match the audience knowledge base and interests
- Focus your message clearly and logically
- Be readable from about 4 - 6 feet away



# Statins and the Elderly: Variation among experts in the absence of evidence.



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Supported by the Charles R. Mathews Geriatrics Education and Research Scholarship

## Background

In the United States, diseases of the heart are the most common cause of morbidity and mortality comprising 1 out of every 4 deaths. One of the major risk factors in the development of heart disease is high-cholesterol. "Statins" collectively describe a class of drugs that lower cholesterol through the inhibition of HMG-CoA reductase. The success of statins in the prevention of cardiovascular disease has led the United States Preventive Services Task Force (USPSTF) and the American College of Cardiology/American Heart Association (ACC/AHA) to create recommendations on their use in patients under 75, however, for those age 75 and older these organizations have no consensus recommendations. This leaves clinicians caring for adults 76 and older to determine for themselves whether or not they should prescribe or terminate statin therapy in this

## Research Aims

Determine clinical considerations that physicians use to evaluate when initiating, continuing, or terminating statin therapy in those over age 85 given this demographics unique challenges with polypharmacy, comorbid illness, and life expectancy.

Determine if there is a consensus among experts in the fields of geriatrics, family medicine, and cardiology on statin therapy.

## Methods

Experts in the field of geriatrics (7), cardiology (1), and family medicine (1) were selected based on their extensive scholarship and clinical expertise to receive a web-based questionnaire.

Physicians began by answering general questions on the use of statins in 85 year old patients. They then began evaluating four progressively complex medical cases to determine the effects of specific health modifiers on physician willingness to begin statin, continue, or halt statin therapy.

The questionnaire contained 66 questions addressing prescribing and terminating statins in 85-year-old patients. Physician's were asked to use a Likert scale to score the importance of factors related to treatment decisions including body mass index, diabetes, high cholesterol, life expectancy, cognitive status, polypharmacy, and previous cardiovascular



## Current Recommendations

Reason for Use	2013 ACC/AHA Guidelines	2013 ACC/AHA Treatment Recommendation	USPSTF Recommendations	USPSTF Treatment Recommendation
Primary Prevention (Age 40-75)	5 to <7.5% 10yr ASCVD Risk	Moderate-High Intensity Statins	7.5%-10% 10yr ASCVD Risk	"C" Low-Moderate Statins
	≥7.5% 10yr ASCVD Risk	Moderate-High Intensity Statins	>10% 10yr ASCVD Risk	"B" Low-Moderate Statins
			≥76yrs	"I" Insufficient Evidence
Secondary Prevention (≥75)		High Intensity Statin		
Secondary Prevention (>75)		Moderate Intensity Statin		

Conflicting recommendations from the American College of Cardiology/American Heart Association (ACC/AHA) and the U.S. Preventive Services Task Force (USPSTF) further obfuscate the use of statins in patients over the age of 75. Atherosclerotic Cardiovascular Disease (ASCVD).

## Evaluating patients using ACC/AHA and USPSTF

Example Patients (Primary Prevention)	10yr ASCVD Risk	ACC/AHA Treatment Recommendation	USPSTF Treatment Recommendation
45yr Male	1.00%	No Treatment	No Treatment
55yr Male	3.30%	No Treatment	No Treatment
65yr Male	8.90%	Moderate-High Intensity Statins	Low-Moderate Statins
76yr Male	21.60%	No Treatment	No Treatment
45yr Male Smoker with T2DM	5.10%	Moderate-High Intensity Statins	No Treatment
55yr Male Smoker with T2DM	11.70%	Moderate-High Intensity Statins	Low-Moderate Statins
65yr Male Smoker with T2DM	22.50%	Moderate-High Intensity Statins	Low-Moderate Statins
76yr Male Smoker with T2DM	39.90%	Consider Treatment	Consider Treatment

*Those most likely to experience atherosclerotic cardiovascular disease within the next 10 years will not receive treatment based on the current ACC/AHA and USPSTF recommendations.*

## Results

Would you ever consider initiating statins for primary prevention in an 85yr old patient?

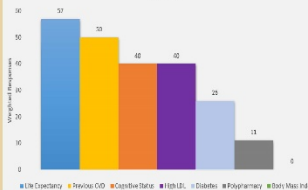


Would ever you consider initiating statins for secondary prevention in an 85yr old patient?

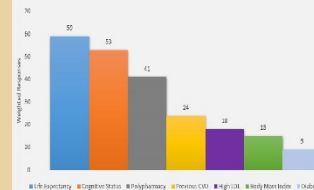


*Respondents are split on initiating statin therapy in 85 year old patients for primary or secondary prevention.*

Most Important Factors in Initiating Statin Therapy in the Elderly

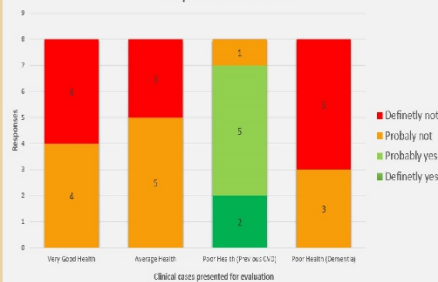


Most Important Factors in Terminating Statin Therapy in the Elderly



*Life expectancy was the most important factor when determining the initiation or termination of statin therapy.*

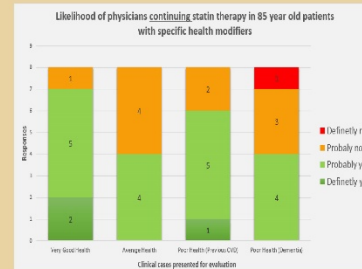
Likelihood of physicians initiating statin therapy in 85 year old patients with specific health modifiers



*When given four clinical cases with patients of varying health:*

*Respondents were unwilling to begin statin therapy (for primary prevention) in any patient over 85 years of age regardless of overall health status or cognitive function.*

*Respondents were willing to prescribe statins to an 85 year old for secondary prevention.*



*Respondents are unlikely to discontinue statins for any reason.*

## Discussion

Cardiovascular disease is the leading cause of death and patients age 85 and older are at a significantly increased risk.

Respondents reported that life expectancy was the most important variable when evaluating initiating and terminating statins in patients 85 years and older.

Given the average additional life expectancy of an 85 year old male and female, 6 and 7 years respectfully, there is a significant window in which cardiovascular disease may be reduced through statin therapy.

Yet, respondents overwhelmingly stated they would not initiate statins in patients 85 years or older when presented with four clinical scenarios.

Respondents identified cognitive status as the second most important considering when terminating statins. However, when presented with a clinical scenario involving a demented patients they were unlikely to terminate the medication.

This leads to a more general observation that regardless of health status respondents were unlikely to initiate or terminate statins in 85 year old patients.

The absence of any specific recommendations in this population may leave physicians without enough knowledge or confidence to manage these patients. This is evident through

## Future Directions

In the absence of USPSTF guidelines and recommendations from the ACC/AHA physicians have no current expert guidelines for the usage of statin drugs for primary prevention in the elderly.

As the number of people prescribed statins increases and the population ages; researchers must devise clear guidelines for the implementation and discontinuation of statins in the geriatric



# EXPLORING RELATIONSHIP SATISFACTION IN OLDER ADULTS WITH DIABETES USING DESCRIPTIVE EPIDEMIOLOGY

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*Table 1. Relationship Characteristics by Diabetes Status (n = 1,930)*

Diabetes Status	Married		Cohabiting		Dating	
Diabetes only	16	84.2%	2	10.5%	1	5.3%
Diabetes and other	333	89.8%	10	2.7%	28	7.5%
Other conditions only	1,152	89.2%	37	2.9%	103	8.0%
No chronic conditions	223	89.9%	8	3.2%	17	6.9%

*Table 2. Overall Relationship Happiness by Diabetes Status (n = 1,930)*

Diabetes Status	Not Happy		Somewhat Happy		Moderately Happy		Extremely Happy	
Diabetes only	2	10.6%	2	10.5%	5	26.3%	10	52.6%
Diabetes and other	38	10.3%	40	10.8%	71	19.1%	222	59.8%
Other conditions only	144	11.2%	141	10.9%	255	19.7%	752	58.2%
No chronic conditions	24	9.6%	30	12.1%	49	19.8%	147	59.3%

## OBJECTIVES & METHODS

This study describes epidemiological patterns in older Americans' experiences with diabetes, comorbid chronic conditions, and sexuality. We use data from the National Social, Health, and Life Project (NSHAP) to compute contingency tables of prevalence estimates illustrating variations in relationship satisfaction among older adults with and without diabetes.

## RESEARCH QUESTIONS

1. How does overall relationship satisfaction vary among older adults with and without diabetes?
2. How does relationship satisfaction vary across these groups in physical and emotional domains?
3. What role might interrelated socio-demographic characteristics play in these patterns?

## KEY STUDY FINDINGS

Older NSHAP participants with diabetes are very similar to those without diabetes with respect to relationship satisfaction. This pattern was consistent for overall happiness with relationships as well as physical and emotional satisfaction.

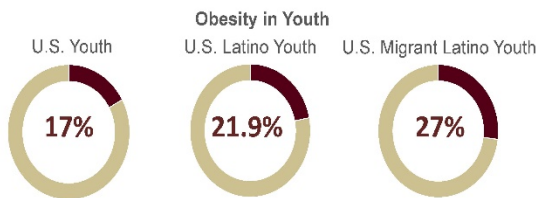
However, among people with diabetes we observed sex differences in overall happiness that were magnified for physical and emotional satisfaction. We also saw strong gender disparities that may intersect with race and education.





The Florida State University College of Medicine

The extent of the U.S. childhood obesity epidemic has been well documented. Overall, the prevalence of obesity among youth ages 2-19 is 17%; however, the prevalence among Latino youth is greater (21.9%) (Ogden et al., 2015). Latino children from migrant farm-working families are at even greater risk, with obesity percentages ranging as high as 27% (Rosado et al., 2013).

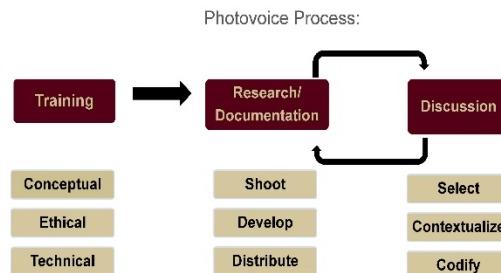


Many obesity programs have proven to be successful in helping to improve BMI and eating/exercise habits; however, many of these positive effects only last a short time. The lack of long-term success is due to multiple factors, including the social and built environment (Montesi et. al., 2016). Traditional obesity interventions focus on biological and behavioral factors; however, information on these other environmental factors is also important for informing obesity programs and policy, which may potentially improve long term outcomes.

## Purpose of Study

1. To identify social and environmental factors that contribute to childhood obesity from the perspective of a Latino migrant farm-working population residing in a rural area of Southwest Florida.
2. To identify potential solutions for the environmental factors that contribute to childhood obesity.

Photovoice methodology was used to collect information regarding the social and environmental obstacles that parents perceive contribute to childhood obesity. Photovoice is a process by which people can identify, represent and enhance their community through a specific photographic technique (Wang, 1997). Participants were given a camera to take pictures of their community and then attended a focus group to discuss photos taken.



## Sample

Participants were recruited during a 2 week period. Subjects were parents of children participating in a childhood obesity program facilitated at the pediatric department of a community health center serving a predominantly Spanish-speaking, migrant farm-working population located within a rural area of Southwest Florida. A total of 13 parents agreed to participate:

Parent Characteristic	n	% or M(SD)
Gender		
Male/father	2	15.4
Female/mother	11	85.0
Age (years)		
Parent		40.46 (6.96)
Employment		
Farm worker family	11	92.0
Migrant family	9	75.0
Ethnicity		
Hispanic	13	100

There were several emergent themes from the Photovoice data; they can be organized into three broad categories: social environment factors, built environment factors, and macrosystem factors. Here we focused on several examples and photos reported below for the built environment category:

### Environmental Safety Hazards



Environmental safety hazard: Perceived risk of reduced safety related to vacant migrant/seasonal housing units



k	Environmental safety hazard: Absence of barriers around water, dangers of stagnant water
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Presence of unwarranted animals/insects (stray dogs, alligators, mosquitoes)	
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	Lack of maintenance to public areas: Trash and unkept landscape
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## Recreational Facilities/Activities



Limited recreational facilities/amenities: Lack of awareness of facilities with public access



Lack of neighborhood planning: Absence of sidewalks
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# Barriers and Facilitators to Conducting Adolescent Health Risk Assessments in Primary Care



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## Background

- Most morbidity and mortality results from preventable risk factors. Unhealthy behaviors that begin in adolescence contribute to adult chronic disease, negatively impacting health and health care costs.
- Clinical guidelines recommend adolescents have annual preventive health visits that include health risk assessments (HRAs) to identify health risks and provide counseling and referrals.
- Despite the role HRAs and preventive services can play in adolescent health, the delivery of such services does not meet recommended clinical guidelines. This study used qualitative research methods to explore barriers and facilitators to the administration of adolescent health risk assessments in primary care to increase their administration, quality and effectiveness.

## Methods

Nine semi-structured focus groups were conducted with healthcare providers and staff from September 2011 to February 2012. All focus groups were moderated by researchers trained in qualitative methods, and were audio-recorded and transcribed verbatim. Inductive content analysis was assisted with qualitative analysis software (Atlas.ti) to uncover themes surrounding current and general barriers and facilitators to adolescent HRAs, counseling and referral. A purposeful sample of diverse primary care settings, as well as participants representing a variety of clinic personnel, were recruited to provide a broad view of the challenges to conducting adolescent HRAs.

## Results

RESPONDENTS (N=65)	RESEARCH SITES AND HEALTHCARE SETTINGS
<ul style="list-style-type: none"><li>Pediatric &amp; family medicine physicians</li><li>Pediatric residents</li><li>Nurses</li><li>Medical &amp; nursing assistants</li><li>Office/administrative staff</li></ul>	<ul style="list-style-type: none"><li><b>Four Florida cities:</b><ul style="list-style-type: none"><li>Gainesville</li><li>Jacksonville</li><li>Orlando</li><li>Tallahassee</li></ul></li><li>Pediatric residency programs</li><li>Federally qualified health centers</li><li>Private practices</li><li>Hospital-based adolescent clinics</li><li>School-based clinics</li></ul>

P R O V I D E R	Barriers	Time Constraints	<ul style="list-style-type: none"><li>• To conduct HRAs</li><li>• Engage in meaningful discussion/provide counseling</li><li>• Discuss multiple or critical issues</li><li>• Provide preventive care plus HRA</li></ul>
		Behavior	<ul style="list-style-type: none"><li>• Providers not comfortable discussing sensitive issues</li><li>• Displaying surprise or shock at patient responses</li></ul>
	Facilitators	Behavior	<ul style="list-style-type: none"><li>• Non-judgmental, non-threatening, non-confrontational, respectful communication</li><li>• Being comfortable discussing sensitive topics with teens</li><li>• Ability to put patients at ease</li><li>• Treat patients as mature individuals responsible for their own health care</li></ul>
		Knowledge	<ul style="list-style-type: none"><li>• Having knowledge of patient's family, home life, and community</li><li>• Cultural competence: understands and incorporates patient's cultural beliefs, values, and behaviors</li><li>• Instill patient "buy in" through education: explain links between behavior and health, and relay importance of preventive care</li></ul>
		Health Education	
		Relationships	<ul style="list-style-type: none"><li>• Open, honest, trusting patient-provider relationships</li><li>• Long-term, consistent patient-provider interaction with rapport built over time</li></ul>

P A T I E N T	Barriers	Literacy and Language	<ul style="list-style-type: none"><li>•Low literacy</li><li>•Low health literacy</li><li>•Non-English speakers</li></ul>
		Confidentiality and Communication	<ul style="list-style-type: none"><li>•Privacy/confidentiality concerns</li><li>•Discomfort/apprehension to discuss private and sensitive issues</li><li>•Socially acceptable responses, rather than honest disclosure</li><li>•First time patients (not comfortable, no history/relationship with provider)</li><li>•Parents present during administration</li></ul>
		Time Constraints	<ul style="list-style-type: none"><li>•Constraints of busy parents/families</li><li>•Healthcare conflicts with school schedules and responsibilities</li><li>•Teens' general apathy towards health issues and preventive care</li></ul>
		Health Issues	<ul style="list-style-type: none"><li>•Cognitive disability</li></ul>
	Access	<ul style="list-style-type: none"><li>•Lack of transportation</li><li>•Paying for services</li></ul>	
Facilitators	Disclosure	<ul style="list-style-type: none"><li>•Teens' desire to discuss health behaviors with knowledgeable, trusted adults</li><li>•Patients' comfort with provider</li></ul>	

P R A C T I C E	Barriers	Clinic Layout	<ul style="list-style-type: none"><li>• Small clinic size or physical layouts that hinder privacy</li></ul>
		Staffing	<ul style="list-style-type: none"><li>• Sole or small number of clinicians</li><li>• Not having personnel or resources to deal with issues that are uncovered</li></ul>
		Communities	<ul style="list-style-type: none"><li>• Small communities where anonymity is lacking</li></ul>
		Culture	<ul style="list-style-type: none"><li>• Lack of culturally appropriate resources (e.g., interpreters, multilingual educational materials)</li></ul>
		Environment	<ul style="list-style-type: none"><li>• For school-based clinics, pressure to return patients to class</li><li>• For school-based clinics, lack of privacy because clinic is on campus</li></ul>
	Facilitators	Staffing	<ul style="list-style-type: none"><li>• Staff that enjoy working with teens</li><li>• Staff who are experienced in adolescent health</li><li>• Healthcare teams (e.g., physicians, health educators, social workers) bring different areas of expertise, interact differently with patients and debriefing across team provides better understanding of patient</li></ul>
		Communities	<ul style="list-style-type: none"><li>• Small communities where providers have known patients for many years</li></ul>
		Finances	<ul style="list-style-type: none"><li>• Billing systems to recoup costs</li></ul>
		Scheduling	<ul style="list-style-type: none"><li>• Longer appointment times for adolescent patients</li></ul>
Environment		<ul style="list-style-type: none"><li>• "Adolescent friendly" environment (reading materials, educational materials, etc. are teen-oriented)</li></ul>	

R E F E R R A L	Barriers	Lack of Resources	<ul style="list-style-type: none"><li>Adolescent-specific</li><li>Mental health</li><li>Nutrition</li><li>Primary care, especially in rural communities</li><li>Resources and programs disappear when funding ends/budgets reduced</li></ul>
		Staffing	<ul style="list-style-type: none"><li>High turn over rate of counselors/behavioral specialists</li><li>Uninsured</li><li>Low income patients</li><li>Lack of transportation</li></ul>
		Access	<ul style="list-style-type: none"><li>Up-to-date knowledge/lists of available resources and programs</li><li>In-clinic presence or linkages with social workers/community-based personnel</li></ul>
	Facilitators	Linkages	<ul style="list-style-type: none"><li>Linkages with academic institutions that provide services</li><li>Establishing referral networks in advance via contact from providers</li></ul>

## Results

H R A T O O L S	Barriers	Language	<ul style="list-style-type: none"><li>Language not appropriate for younger teens</li><li>Vocabulary that is too technical, formal, or outdated</li><li>Medical terminology</li><li>Family members acting as interpreters (all or correct information may not be relayed)</li><li>If too long, teens lose interest and takes too much time to administer</li></ul>
		Length	<ul style="list-style-type: none"><li>Domains not appropriate or comprehensive</li></ul>
		Content	<ul style="list-style-type: none"><li>Paper instruments: gives teens time to consider answering honestly; reduces confidentiality; teens lose, forget, or throw away paperwork</li><li>Looks like a test</li></ul>
		Format	<ul style="list-style-type: none"><li>Move from less to more sensitive issues</li><li>Questions that are short, straightforward, explanatory and inclusive</li><li>Responses that trigger needed discussion are easily located</li></ul>
Facilitators	Facilitators	Content	<ul style="list-style-type: none"><li>Domain screening questions that guide administration or non-administration of subsequent questions; use of skip logic if IT-based</li><li>Current/missing teen health issues, e.g., bullying, cyberbullying, sex and social media, high caffeine products, occupational health risks, gender identity issues, self-injurious behavior</li><li>Ability to clarify responses or ask for more discussion</li><li>Consent/privacy issues presented at beginning and end of survey</li></ul>
		Format	<ul style="list-style-type: none"><li>Brief, streamlined instruments</li><li>Electronic/IT-based</li><li>Easy to read fonts</li><li>Easy and quick to respond</li><li>Visually attractive</li></ul>

P R O C E S S	Barriers	Time Constraints	<ul style="list-style-type: none"><li>Time constraints in busy primary care practices limits administration and counseling</li><li>Slowed workflow because of time needed for administration and counseling</li><li>Time needed for verbal administration to low-literacy patients</li><li>Inability or difficulty recouping costs associated with the time spent conducting HRAs</li></ul>
		Finances	<ul style="list-style-type: none"><li>Conducting non-English HRAs</li></ul>
		Language and Culture	<ul style="list-style-type: none"><li>Guarding against theft, damaged devices</li></ul>
		IT	<ul style="list-style-type: none"><li>Providing written educational materials instead of verbal discussion (literacy issues, teen may discard to preserve confidentiality)</li></ul>
Facilitators	Facilitators	Educational Materials	<ul style="list-style-type: none"><li>Annual visits: long time frame between visits may cause opportunities to intervene to be missed</li></ul>
		Scheduling	<ul style="list-style-type: none"><li>Assurance to patients that providers are available to discuss sensitive topics at any time</li><li>Describe HRA content and explain why the HRA is being administered</li><li>Addressing teens directly, rather than talking to parents or parents responding for teens</li><li>Start with general discussions, "small talk" to put patient at ease</li><li>"Normalize" behaviors, e.g., "many people your age have issues with..."</li><li>Discuss topics at every visit; primes patient and promotes discussion and disclosure</li><li>Providers available who are trained to deal with critical issues or triggered emotional responses</li><li>Prime parents in advance about HRA administration, patient privacy and teens taking charge of their healthcare</li></ul>
		Confidentiality and Communication	<ul style="list-style-type: none"><li>Use of wait time or staff time to assist to complete HRAs</li><li>Gender-matching patients and providers</li></ul>
		Administration	<ul style="list-style-type: none"><li>Culturally competent, meaningful and appropriate tools</li></ul>
Facilitators	Facilitators	Language and Culture	<ul style="list-style-type: none"><li>Engages patients by capitalizing on teens' interest in IT, more appealing, enjoyable and less tedious</li><li>Saves time</li><li>Increases privacy</li><li>Reduces provider paperwork</li><li>Can be linked to electronic health records for billing and continuity of care</li><li>Can provide immediate access to educational materials/instructional videos</li></ul>
		Information Technology	

## Conclusions

- Barriers and facilitators to conducting adolescent health risk assessments are multidimensional and multifactorial.
- The use of HRAs in primary care can be expanded and enhanced by addressing barriers and the means to facilitate HRA improvement, administration and application.
- Qualitative research with healthcare providers and staff can inform researchers on techniques to conduct effective intervention studies in community-based clinical settings.



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# Health IMPACTS for Florida: Utilizing Community-Based Participatory Research Principles to Strengthen a PBRN

Maryum Khan, MPH<sup>1</sup>, Jessica De Leon, PhD<sup>2</sup>, Katie Eddleton, MPH<sup>1</sup>, Elizabeth Shenkman, PhD<sup>1</sup>, and the Health IMPACTS for Florida Research Collaborative

<sup>1</sup>University of Florida Clinical and Translational Science Institute and <sup>2</sup>Florida State University College of Medicine



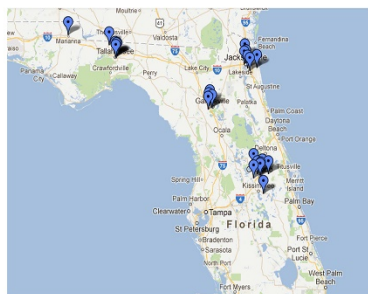
## Background

- Community-based participatory research (CBPR) is an applied collaborative approach that enables community members to participate in all stages of the research process with a goal of influencing change in community health, systems, programs or policies
- Academic and community partners join to develop models and approaches to building communication, trust and capacity, with the final goal of increasing community participation in the research process
- CBPR's perspective to research equitably involves all partners in the research process and recognizes the unique strengths that each brings
- CBPR principles were employed to create richer and more productive relationships across the state of Florida to increase and strengthen Health IMPACTS for Florida's recruitment of primary care practices in its practice-based research network (PBRN)

## Description

- Health IMPACTS utilized CBPR principles to recruit practices for study participation, adapt protocols and facilitate implementation
- Affiliated medical school sites for UF and FSU network with local practices across north and central Florida
- Community Research Associates (CRAs) acted as liaisons between the PBRN, clinical practices and community and academic stakeholders, providing training, facilitating study implementation and supplying ongoing technical support
- Once recruited to participate in the PBRN, some sites self-selected to participate in one or both Health IMPACTS pilot studies

## Setting and Participants



Health IMPACTS statewide PBRN based on the partnership of University of Florida (UF) and the Florida State University (FSU).

- 22 clinics: Community health centers, private practices, academic clinics, hospitals, school-based clinics, residency programs and federally qualified health centers
- 137 providers: specialties include pediatrics, family medicine, adolescent medicine and sports medicine
- Cities represented in Health IMPACTS are Gainesville, Jacksonville, Orlando and Tallahassee. Community stakeholders include academic faculty, community organization leaders and practice directors



## CBPR Components

- The program identity of Health IMPACTS is reflected in its logo, which cites community-based approach to its collaboration

**health IMPACTS** FOR FLORIDA

A UF-FSU Collaboration Integrating Medical Practice and Community-based Translational Science

- Key community and academic stakeholders helped identify and then facilitate relationships for Health IMPACTS to successfully partner with respective practices
- Creation and implementation of research protocols for Health IMPACTS studies were shaped with practice involvement
- Specific study implementation logistics varied across each practice to coincide with the site's characteristics, resources and workflow
- Results of the study were disseminated back to practices, with special emphasis on desired outcomes of focus
- In one practice, the final study protocol was specifically catered to the needs of the practice and its patients

## Evaluation

- Health IMPACTS successfully recruited 41 practices that were involved in at least one study
- Each practice reported weekly feedback of their participation experiences via in-person CRA visits
- These were recorded as fidelity monitoring for all sites, and used for collaborative quality improvement
- A research summit was held to disseminate findings and lessons learned, and to gather information from providers on their research experiences, topic areas/research questions for future studies, provider incentives to promote continued and expanded participation, and feedback from subjects and parents
- Final study summaries were disseminated to all participating practices after study completion
- Practices that completed at least one study expressed interest in participating in future Health IMPACTS research opportunities

## Discussion

- CBPR principles are crucial to the vitality of the Health IMPACTS PBRN
- Successful recruitment of practices and study participation to completion varied on several factors, such as interest in the research topics, perceived benefits of study involvement, staff support, clinic needs and characteristics, information technology capabilities, study fit with patient populations and disruption of work flow
- Health IMPACTS will continue to draw upon CBPR tenets to enrich its network, stakeholder relationships and synergistic collaborative model

## References

Community-based participatory research. (2014) Retrieved June 20, 2014 from [http://obssr.od.nih.gov/scientific\\_areas/methodology/community\\_based\\_participatory\\_research/](http://obssr.od.nih.gov/scientific_areas/methodology/community_based_participatory_research/)

## Funding

This study was supported in part by NIH awards UL1 RR029890, KL2 RR029888 and TL1 RR029889





# Implementation of an iPad-based Concussion Assessment Tool within a Practice-based Research Network (PBRN): Preliminary Results, Challenges, and Strategies for Success

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<sup>1</sup>Florida State University College of Medicine, <sup>2</sup>University of Florida College of Public Health and Health Professions, <sup>3</sup>University of Florida Clinical and Translational Science Institute

## Background

- Traumatic brain injury is one of the most significant public health problems in the United States, and it is the leading cause of death among young people
- Approximately 1.7 million brain injuries occur each year.
- Estimated costs of mild traumatic brain injury approach \$17 billion annually.
- Increased understanding of the effects and consequences of concussion and mild traumatic brain injury (mTBI) has led to the development of position papers, systematic assessment tools and protocols for evaluating the neurological, behavioral, and cognitive effects of these injuries, focused mostly on adult populations.
- Although organized surveillance and management protocols are routinely in place within professional and intercollegiate sports, they are not widely used in youth sports, and none of the recent international symposia on concussion in sports has focused specifically on pediatric concussions.
- Several other states have ratified concussion legislation that is designed to protect child and adolescent health by requiring that concussed kids be medically cleared before returning to play.
- These laws create a practice gap, as many medical and healthcare practitioners who will be called upon to evaluate concussions in young patients are not trained in recognizing or managing the signs and symptoms of concussion.
- This study served as a pilot study for the Health IMPACTS Research Collaborative, including research sites in Gainesville, Orlando, Jacksonville, and Tallahassee.

## Study Aims

1. To develop a viable community-based network that fosters basic and clinical research in head injury prevention and management for underserved Florida children and youth.
2. To provide an evidence-based concussion assessment/management program to assess the relationship between health risk factors and injury susceptibility, severity, and recovery for children/youth participating in organized sports activities in Florida communities.
3. To teach community physicians, residents and medical students about concussion risk/management, and to apply evidence-based principles and procedures for recognition, assessment, and management of concussion/mTBI risk in children and youth. To measure the effects of training by using knowledge-based pre- and posttests for all participating practitioners.
4. To provide education modules for parents, coaches, physicians/healthcare professionals and the general public that are designed to reduce long-term consequences of mTBI.

**health IMPACTS FOR FLORIDA**  
A UF-FSU Collaboration Integrating Medical Practice and Community-based Translational Science

## Methods

### PROVIDER TRAINING PROTOCOL

- 1) 20-item pretest: assessed initial provider concussion knowledge
- 2) Webinar on Concussion Management (ACSM): focused on concussion education, evaluation, and medical management
- 3) McCrory, P., Meeuwisse, W., Johnston, K., et al. (2009). **Consensus Statement on Concussion in Sport: The 3rd International Conference on Concussion in Sport** held in Zurich, November 2009. *Br J Sports Med* 2009 43: 176-184.
- 4) **Sport Concussion Assessment Tool 2 (SCAT2) and Balance Error Scoring System (BESS) Demonstration Videos:** produced by the Matthew A. Gfeller, Sport-Related Traumatic Brain Injury Research Center
- 5) 20-item posttest to assess efficacy; 80% required to administer SCAT2

### INCLUSION CRITERIA

Children and teens ages 9-18, who participate in sports programs and present for a non-acute medical visit

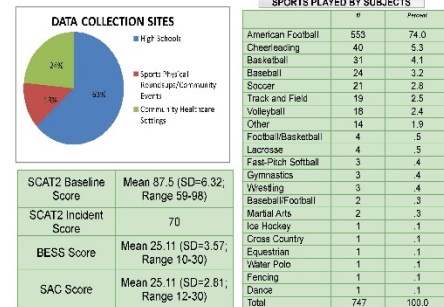
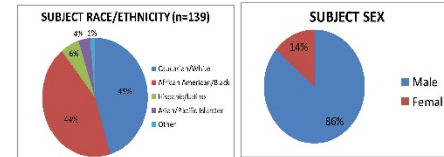
### EXCLUSION CRITERIA

Concussion diagnosis in the past 3 months

### SCAT2 data collected via iPad app at baseline and post-incident

## Preliminary Results

PROVIDER TRAINING: 69 providers completed concussion training protocol  
SCAT2 SUBJECTS: N=766 baseline assessments, N=1 Incident assessment



## Challenges

- **Time constraints and practice workflow concerns**  
Who will consent subjects?  
How to fit a 10-15 minute assessment within patient visit?
- **Multiple study-related education requirements for providers**  
CITI training on human subjects in research  
Provide training protocol
- **Variance among practices regarding information technology**  
Knowledge, resources, equipment, wireless access  
iPad theft risk  
Password forgetfulness
- **Protocol adherence and quality control**  
How to assure protocol adherence when coordinators are not present?  
Enrollment targets  
Availability of quick reference materials
- **Multiple IRB submissions**  
Diverse systems, policies, procedures, and deadlines  
Revision "Ripple Effect": every revision must be approved by all IRBs
- **Provider Recruitment and Retention**
- **Adapting study to different practice settings**  
Hospital-based Pediatric and Family Medicine Residency Programs  
School-based Clinics  
Community-based Private Practices  
Federally-qualified Health Centers

## Strategies for Success

- **Consent forms modified to reflect multiple IRB contact information**  
Eliminates the need for two consent forms
- **FSU Human Subjects Training Requirements modified**  
Community-based faculty truncated from full-time faculty requirements  
Reduced number of courses for community site support staff
- **Central IRB concept for future studies**  
Strengthens collaborative ties and study cohesion across multiple research sites  
One set of deadlines, ICFs, and regulations
- **Incentives for Providers**  
Continuing Medical Education credits (CME for physicians, ARNPs, PAs)  
iPads for data collection became part of the practices' resources
- **Quality Control**  
Intensive one-on-one training  
Initial enrollment assistance on-site  
Frequent site visits  
Continuous process improvement  
Protocol/methods "cheat sheets"  
Reference manuals  
Realistic patient enrollment targets
- **Information Technology**  
Streamlines data collection  
One-on-one training helpful  
Practice time with device prior to study initiation  
Password hints  
4G iPads provided when needed
- **Provider Retention**  
Be flexible and motivational
- **Funding**  
Maximize opportunities  
Think broadly about how network research can fit into sponsors' funding preferences  
Collaborations in health  
Improved health outcomes

## Conclusions

- Establishing a multi-city, community-based research network is a complex undertaking
- Challenges are many, yet unique to each specific site
- PBRNs can reach diverse patient populations in underserved areas that do not typically have the opportunity to be involved in research
- Motivated, research-minded providers are key
- Researchers must be sensitive to the needs of busy community practices
- Protocols must add value and limit additional burden to providers and staff
- Ongoing assistance and troubleshooting by site coordinators is required for project success
- Research community needs to further explore collaborative IRBs to streamline and enhance the community-based clinical research process

## Future Research

- A revised consensus statement on concussion in sport has been issued, summarizing the proceedings of the 4th International Conference on Concussion in Sport, held in Zurich, November 2012.
- Revised assessment tools were supported, now known as the SCAT3 and Child SCAT3 (ages 5-12). Selected based on age at assessment, these new instruments will replace the SCAT2 in this protocol.
- Data collection will move forward to ascertain normative data for these new tools in children and teens.

## Funding

This study was supported in part by a State of Florida New Florida Initiative Award and by NCATS UL1 RR02990-03S3.





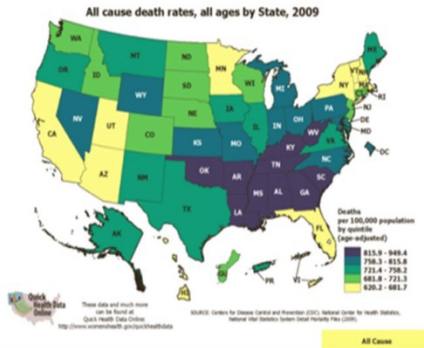
# THE POPULATION HEALTH MODEL AND COUNTY HEALTH RANKINGS: USING THE COUNTY HEALTH RANKINGS TO EVALUATE THE EXPLANATORY POWER OF THE POPULATION HEALTH MODEL

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## Background of the Study

- Southern states have historically ranked as the unhealthiest states in the United States.
- The lowest health ranking states are primarily among southern U.S. states, including: Mississippi (No. 50), Louisiana (No. 49), Alabama (No. 48), and Arkansas (No. 47) (America Health Rankings, 2012).



## Study Objectives

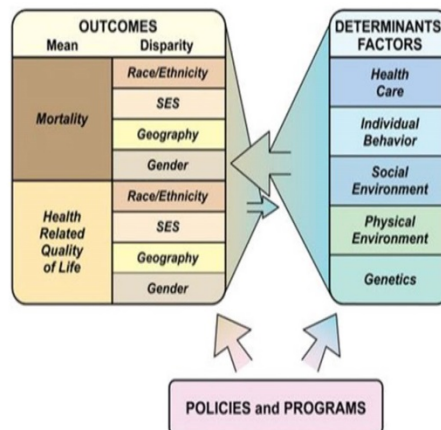
This study seeks to:

- (1) test the explanatory power of the domains (health behavior, clinical care, social and economic environment, and physical environment) of the population health model
- (2) to determine which of the domains has significant impact on health status.

## Methods

- Grounded on the theoretical framework of the population health model
- County health data were obtained from the County Health Rankings and Roadmaps website
- 875 counties in ten southern U.S. states. States included: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee.
- Counties were evaluated for a three-year period, 2010, 2011, and 2012.
- Premature death, which is Years of Potential Life Lost (YPLL) before the age of 75, serves as the output variable.
- The input variables are 4 health factors (health behavior, socioeconomic status, physical environment, and clinical care).

## Population Health Model



## Results

- N=2615
- Explanatory variables in the population health model serve as unbiased estimators of the health status of a population, with the exception of the physical environment domain.
- Three of the four domains in the population health model were shown to have a significant impact on county premature death rates.
- The physical environment domain was not a significant determinant of premature death rates.
- The social and economic environment domain was shown to have had the most influence on premature death rates.

Table 1: MLR Summary Model

Model	R-Square Value	Change Statistics	Durbin-Watson
1	.531	F Change 739.890	P-Value .000
			1.398

Table 2: Coefficients Table (MLR)

MLR Model	Regression Coefficients B**	Sig.	Tolerance
1 (constant)	-.001	.909	
Health Behaviors	.659	.000	.625
Clinical Care	.139	.029	.815
Social Economic	1.041	.000	.630
Physical Environment	-.121	.376	.997

## Conclusion

- Results suggest that the social and economic environment domain had the most influence mortality thus it is considered the most significant predictor of county health status
- The impact of contributing health factors, such as social and economic factors, should be carefully studied on a continuum to identify which factors contribute the most and which are modifiable.
- Prompts for further investigation into regional disparities within the United States. More exploration is needed of the demographic make-up of these southern counties, such as race/ethnicity, age, and gender.
- Identifying health disparities among these groups can provide pathways for public health professionals to develop and implement health programs and policies that cater to population sub-groups.
- Public health funding and resource allocation should be directed towards regions with lower health status, such as in the south.

## Policy Implications

- Population health policies aimed at reducing mortality require an understanding of the socioeconomic context within which modifiable variables exist.
- Policies can be strengthened by accounting for regional variations and emphasizing the importance of creating a focus on region-specific preventive care.
- Measures within the physical environment domain on the County Health Rankings website have been modified to adequately show the role it plays in population health status.





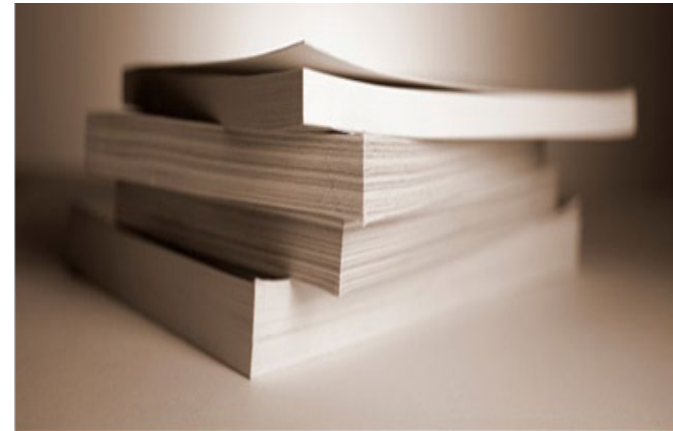
# Oral Presentations

- Allows for a more in-depth discussion of your research
- Follow protocol format
- Enable the audience to ask questions and provide feedback
- Can use PowerPoint or Prezi as a visual guide
- Keep presentation clear and concise
- Allow time for Q&A
- Engage audience
- Typically competitive selection only



# Types of Publications

- Short communications
  - Research letters, brief reports
  - Perspective, opinion, and commentary
- Reviews
  - Narrative review, meta-analysis
- Traditional manuscript
  - Original Research
  - Full articles with complete details
  - Peer-reviewed
  - Clinical Case Studies
- White papers
  - Not research specific
  - Discussion of a complex issue or problem





# Publication Considerations

- Research possible journals
- Be mindful of audience
- Follow submission guidelines
- Discuss authorship early in research process
  - Authorship guidelines determined by journals
- Can't submit same article/manuscript to more than one journal at a time
- May be required to provide documentation of IRB approval or QI determination



# Article/Journal Impact

## Impact Factor

- Measure of a journal's impact on the body of scholarly literature
- Derived from the average number of times a published article was cited during the course of 2 years

## Article Impact

- Assess an article's impact and popularity in social media and the web





# Journal Audience and Mission

Journal	Audience	Mission
<i>JAMA Internal Medicine</i>	Practicing internist and subspecialties	Promote art & science of medicine
<i>Annals of Internal Medicine</i>	Physicians, health care professionals, & researchers worldwide	Medical education, research methodology
<i>Journal of Internal Medicine</i>	Broad field of general and IM & subspecialties	Clinical work, features original articles & reviews
<i>Internal Medicine Alert</i>	IM	New findings in diagnosis and treatments, theoretical and clinical

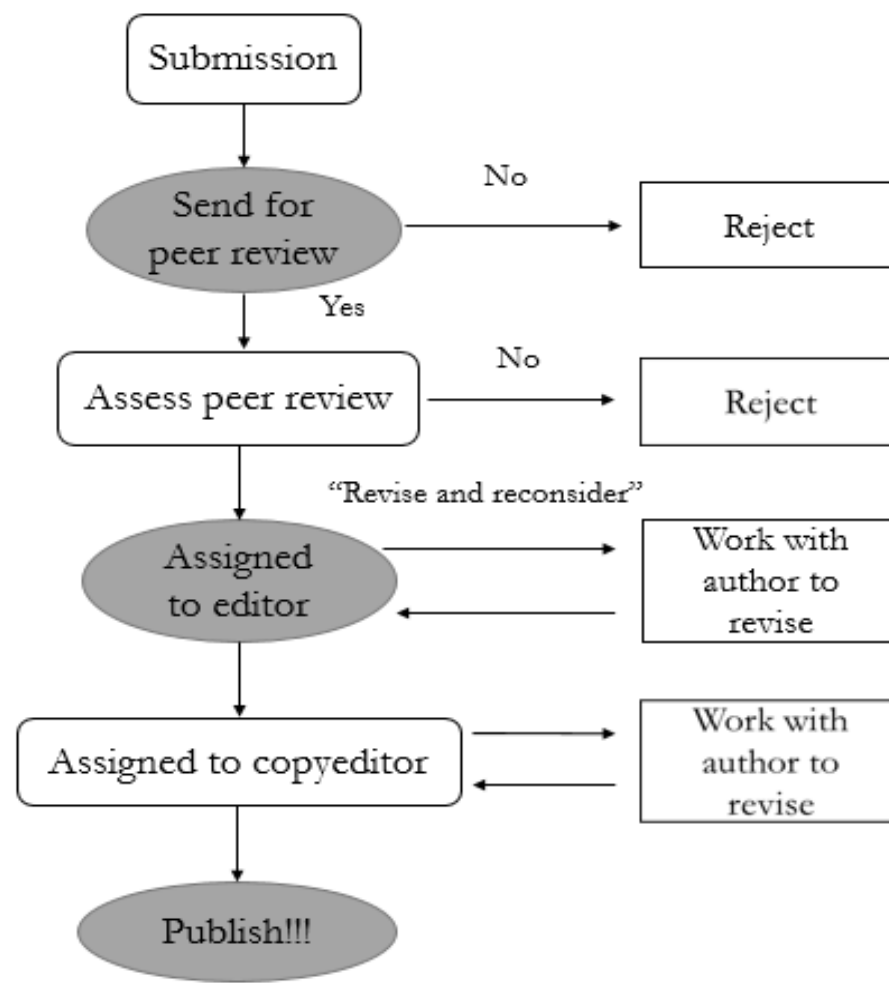


# Understanding the Culture of Publishing

- Don't take reviewer comments personally
- Publishing acceptance rates vary
  - Could be as low as 3%
- Do not get discouraged
- Revise and resubmit is the norm
- Reviewer comments provided
- Usually 3 reviewers will evaluate your article



# Manuscript Submission Process





# Defining Authorship

## 4 criteria (ICMJE):

1) Author must have contributed significantly to concept/design OR acquisition, analysis, or interpretation of data

**AND**

2) Actively participate in drafting the manuscript or engaged in critical review

**AND**

3) Approve final version of manuscript that is published

**AND**

4) Take accountability for all aspects of the work

*\*\*Those who do not meet full criteria can be acknowledged*



# Defining Contributors

- Non-author activities:
  - Acquisition of funding
  - General supervision of a research group or general administrative support
  - Writing assistance (i.e. editing)
- Contributors can be acknowledged



# Steps in Developing a Dissemination Strategy

1. Review past dissemination efforts
2. Devise dissemination objectives
3. Determine audiences
4. Develop messages
5. Decide on dissemination approaches
6. Determine dissemination channels
7. Review available resources
8. Consider timing
9. Evaluate efforts







# Citation Management

## Advantages:

- Useful for managing & organizing several literature sources
- Allows you to build your own library for your research topic
- Simplifies creating a bibliography (auto-generate)
- Allows sharing references with peers
- Provides recommendations for sources
- Ability to change citation formats to fit journal submission requirements



# Citation Management

## Endnote

- Reference Management Tool supported by FSU College of Medicine
- Keep track of & organize articles, books, and other references for your publication
- Format references by style required by the publisher
- [Set up an EndNote account](#)



# *Questions & Discussion*