

GUEST EDITORIAL

The Case for a National Health Social Work Practice-Based Research Network in Addressing Health Equity

Sarah Gehlert, Karina Walters, Edwina Uehara, and Edward Lawlor

Health social workers have been challenged historically by their inability to amass larger sample sizes of research participants, which severely limits the ability to rigorously test the interventions that they develop. This likely occurs because health social workers aim their practices at the needs of subpopulations, such as racial and ethnic minority groups, refugees and immigrants, and the homeless, rather than the population as a whole. Subpopulations, especially when considered in geographic context, are by definition limited in number. Although focusing on the needs of subpopulations fits well with the mission of social work, it puts social workers at a disadvantage compared with other professionals when it comes to testing their interventions and publishing the results for a wide audience of readers. A key benefit of a health social work practice-based research network (PBRN) would be the opportunity to collect high-quality data on interventions and populations of interest. The “rules of the road” in PBRNs establish standards of data collection, help solve consent and other compliance issues, and create timely access to data for researchers and practitioners.

Other health care professions, such as nursing and medicine, have addressed this challenge by developing successful formal and informal PBRNs, or coordinated groups of practitioners working with academic researchers to implement and test interventions across settings. Although this approach necessitates the standardization of designs and measures across practice sites, it has the advantage of allowing much larger samples to be accrued by pooling participants across sites and generating data that reflect health care in the community.

Although PBRNs have been defined in a variety of ways over the past 40 years of their existence, the

Agency for Healthcare Research and Quality (AHRQ) (<http://www.ahrq.gov/research/findings/factsheets/primary/pbrn/index.html>) offers what arguably is the best accepted definition of the phenomenon, namely groups of clinicians and ambulatory practices devoted principally to a set of primary care patients, who work together with academic researchers to answer community-based health care questions and translate research findings into practice.

The first PBRN in the United States was proposed during the 1979 meeting of the North American Primary Care Research Group (Green & Hickner, 2006), based on a legacy of community practice and research in primary care. An example is the pioneering work of practitioner Curtis G. Hames and academic John Cassel in the Evans County Cardiovascular Studies, in which they were able to engage 92 percent of adult residents of Evans County, Georgia, to understand the astonishingly high rates of cardiovascular and cerebrovascular disease among the county's black residents (Hames, 1971). By 1994, 28 PBRNs were active in North America (Green & Hickner, 2006).

PBRNs vary in scope and in the formality of their infrastructures. Some are national in scope (for example, a PBRN of the American Academy of Pediatrics); others are very local (that is, tied to smaller geographic areas); for example, the Washington University Pediatric and Adolescent Research Consortium includes 66 pediatricians and five nurse practitioners from 35 practices in the St. Louis area. Academic investigators work with this network of practitioners to foster clinical and translational research, which has resulted in a number of publications on topics such as treatment preferences in pediatric asthma (Garbutt, Yan, Highstein, & Strunk, 2014).

The most formal PBRNs, such as those qualifying for funding from AHRQ (for example, RFA-HS-05-011), must meet the following criteria:

- At least 15 practices and/or 15 clinicians
- A statement of purpose and mission, including an ongoing commitment to research
- A director who is responsible for administrative, financial, and planning functions
- A support staff of at least one person reporting to the director
- A mechanism such as a community advisory board to solicit advice and feedback from the communities of patients served by the PBRN clinicians
- An organizational structure independent of any single study
- Communication processes such as regular newsletters, e-mails or Listservs, conference calls, or face-to-face meetings

Formal PBRNs have strong infrastructures that foster communication among members, which requires support and resources. Although building and maintaining a formal PBRN is estimated to cost around \$60,000 annually (Green, White, Barry, Nease, & Hudson, 2005), this formal infrastructure establishes the enterprise and provides it with the flexibility needed to address complex population health problems such as health equity that can then be addressed at local levels. Nutting (1996) contrasted biomedical research, in which diseases are studied in highly selected patients out of context, with PBRN research, in which patients are studied in the communities in which health care is delivered. In the words of Green (as quoted in Werner & Stange, 2008), “practice-based research takes place where most of the people get most of their care most of the time.”

Although PBRNs have been around for over 40 years, health social workers have yet to make use of them. In a symposium at the 2013 Annual Conference of the Society for Social Work and Research, McMillen, Powell, and Proctor advocated for PBRNs, yet their symposium did not address health social work and they seem to have been advocating less formal collaborations than described by AHRQ (<http://secure.sswr.org/past-conferences/2013-annual-conference/>).

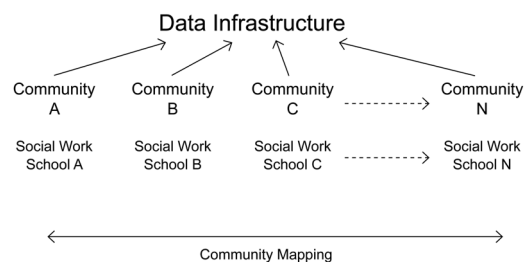
A major reason why health social worker researchers have tended to work individually or in less formal collaborations rather than PBRNs may be the lack of

a national health social work organization over which a PBRN might map its efforts. Although the Society for Social Work Leadership in Health Care is national, its membership is largely confined to hospital social work practitioners and administrators. Smaller organizations within health social work, such as the Association of Oncology Social Work, the Council of Nephrology Social Work, and the National Association of Perinatal Social Workers have launched some cross-site research projects but do not have ongoing formal structures analogous to PBRNs.

Aside from the advantage of conducting research in context, a PBRN is ongoing and operates between projects, thus minimizing the time it takes to mount a study. This conservation of time and other resources would make funding health social work more attractive to foundations and federal agencies such as the National Institutes of Health and the Department of Defense. A criticism of community health research has been the time that it takes to establish relationships with practitioners and other stakeholders.

Developing a national PBRN for health social work would involve expenditure of money and the time and effort needed to assemble a group of like-minded practice–research partnerships in a broad area of research such as health equity. This seems to us to be a reasonable task. The payoff would be an ongoing network of health social work researchers with a director and staff to coordinate communication. Figure 1 provides an overview of a proposed structure for such a PBRN. In this model, a number of health social work academic researchers with their community partners would communicate via a Listserv and newsletters with a centrally located director working with at least one staff member. Community and academic relationships might either be formal, as in community-based participatory research, or less formal, such as ongoing relationships with advocacy

Figure 1: Health Equity Social Work Practice-Based Research Network



organizations (for example, the American Cancer Society, the American Heart Association, the American Lung Association, or the American Diabetes Association), community health clinics or federally qualified health centers, or local or state departments of health. The director and staff member might assist the academic researcher and community members to develop research projects; standardize protocols and instruments; and store, clean, and analyze data. They might also help with preparing summaries of data or progress reports for individual, cross-site projects.

A national health social work PBRN would benefit health social work by increasing communication among social work researchers in health care and among practitioners and researchers. A well-designed and national PBRN would close the gap between those who have been advocating adoption of evidence-based practices and those advocating practice-based evidence. Practitioners would be aligned with investigators in generating the most compelling questions to study, gathering good and appropriate data, and considering early the challenges of implementation in practice and policy.

A national health social work PBRN would benefit the profession by illuminating health social work's unique contribution at this pivotal time in U.S. health care. Few would argue that social work has received sufficient attention as a health profession under the Patient Protection and Affordable Care Act (Allen, 2012; Andrews, Darnell, McBride, & Gehlert, 2013). Highlighting health social work interventions by increasing sample sizes of participants from the subpopulations disproportionately experiencing problems would allow the research results to be published in more widely read peer-reviewed journals in addition to the social work journals that are read by practitioners in the field. Smaller sample sizes and less rigorous methods have severely limited the visibility of social work intervention research. This has limited the recognition of the contributions of social work health care research. As has been stated earlier in this editorial, the streamlining of the research process afforded by PBRN infrastructure would make health social work research more attractive to foundation and federal funders.

In summary, we strongly advocate for the development of a health social work PBRN that could facilitate joint projects among researchers and practitioners across a wide geographic area. This would allow interventions developed by health social workers to be tested with more rigorous methods, pro-

viding the attention they deserve. This has the potential to decrease health inequities in the United States. Indeed, a national health social work PBRN seems a worthy target for a Grand Challenge. **HSW**

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Sarah Gehlert, PhD, MSW, MA, is E. Desmond Lee Professor of Racial and Ethnic Diversity, George Warren Brown School of Social Work, and professor, Department of Surgery, Washington University in St. Louis, One Brookings Drive, Box 1196, St. Louis, MO; e-mail: sgehlert@wustl.edu. **Karina Walters, PhD**, is William P. and Ruth Gerberding Endowed University Professor, and **Edwina Uehara, PhD**, is professor and Ballmer Endowed Dean in Social Work, School of Social Work, University of Washington, Seattle. **Edward Lawlor, PhD**, is dean and William E. Gordon Distinguished Professor, George Warren Brown School of Social Work, Washington University in St. Louis. The authors wish to acknowledge the support of NIH/NCATS 5 UL1 TR000448-07.