IRENE’s mission is to improve the health and well-being of Iowans through collaboration in practice-based research on questions important to primary care physicians and their patients. IRENE’s purpose is to create and foster a network of research collaboration between the academic medical center and primary care physicians throughout the state of Iowa with a particular focus on improving rural health.

In November of 2013, I was privileged to attend the 2013 North American Primary Care Research Group (NAPCRG) annual meeting in Ottawa, Ontario, Canada. I was invited, with one of my patients, to attend a pre-conference meeting about primary care advocacy. I really had very little idea about what to expect, but I must admit that being able to attend the general meeting with all of the wonderful ideas and research, and have my expenses paid, helped me overcome my initial fears and say yes to this pre-conference.

I am so very glad that I did! The pre-conference consisted of ten dyads, or physician/patient teams. We were assembled together with ten NAPCRG members and key players in primary care research in both the U.S. and Canada. Lectures were presented about the importance of primary care for better health in our countries and the need to continue primary care research.

The real meat of the meeting came with the discussions of what was really happening on the front lines of primary care in our own communities. Though the dyads were from different countries and different types of practice—rural/urban, small/large, profit/nonprofit, etc.—we were all experiencing the same struggles and asking the same questions. But, what was truly exciting is that we were heard by the NAPCRG members! After hearing our stories, they scrapped the original purpose for our meeting (NAPCRG giving us our marching orders for primary care research advocacy) and decided that they, as a group, needed to glean from us the direction that they should go in order to conduct primary care research that will be truly patient centered and “make a difference” to real world family medicine.

I believe we all left the meeting feeling energized and hopeful about the future of family medicine. Where are we going? No one is sure yet, but we are asking the right questions. We continue to meet by phone conference and I have no doubt that with the right people asking the right questions we will find the right answers.
Colon Polyp Model Use for Educating About Colorectal Cancer Screening in the Iowa Research Network

Acknowledgement: National Institutes of Health (NIH) and National Cancer Institute (NCI)

Using an anatomical model of a segment of the colon, that patients can see and touch, assists healthcare providers to present basic information about the structure of the colon and problems that can occur. The purpose of this study was to assess the use of a colon polyp model provided to family physicians or nurses in primary care offices in the Iowa Research Network. Colon polyp models were given or mailed to 117 healthcare providers who had attended statewide primary care training sessions, hosted office “Lunch and Learns” regarding colorectal cancer screening, or who had previous participated in Iowa Research Network colorectal cancer research. Through a mailed survey and follow-up telephone calls to non-responders, 81 questionnaires were completed. Descriptive statistics and chi-square tests were conducted. Thirty-six (44%) of the respondents reported they had used the model, 33 (41%) reported they demonstrated the model to a mean of 16% of their patients, 31 (38%) reported using the model to teach patients about the colon and polyps prior to a colonoscopy. Other model use described by respondents included educating staff to promote patient willingness for colonoscopies, demonstrating the need for colon cancer screening, and teaching patients about yearly fecal occult blood tests.

Respondents agreed that anatomical models were helpful for patient education, the design of the colon model was good, and that it facilitated demonstration of colon polyps. Providers who used the model educated their patients about CRC screening, felt confident in their ability to educate, and also felt the patient was more receptive to undergoing colonoscopy. Possible recommendations for office-wide adoption of an anatomical model include providing an inservice for all employees and storing the model in a standard location for ease of retrieval. Future studies might provide insights into the non-use of this model.

The colon polyp model was purchased from Health Edco (www.healthedco.com) for $89. It came in a 7 × 9 inch carrying bag. Six colorectal abnormalities, five polyps, and one invasive cancer are displayed on the 3 ½ inch long flexible colon model depicting both flat and stalk-like polyps (See Figure). The model is for educational purposes and can be cleaned with mild soap and water.

iPad Use in Iowa Primary Care Offices

Acknowledgement: National Institutes of Health (NIH) and National Cancer Institute (NCI)

Recent advances in mobile technology have ushered in a new era for family medicine practice settings. iPads are becoming common place and can be especially useful to support and improve the delivery of health services. The availability of medical knowledge online is growing and the availability to clinicians is evident with approximately 20,000 medical apps on the iTunes App Store and 8,000 on Google play.

Through a research infrastructure building grant, iPads were given to healthcare providers in primary care offices throughout Iowa. The purpose of this study was to determine the use of iPads in Iowa Research Network (IRENE), a practice-based research network, physician offices. Using an emailed Qualtrics survey, all 81 iPad recipients were invited to participate in the study. After follow-up, 48 (59%) participated.

Forty-one (85%) respondents reported they had used the iPad and 26 (54%) said any employee in the office could use it. The main reason for using the iPad was to browse the World Wide Web for healthcare information (See Table). Individual responses supported use of the iPad in the office; for example, to take photos of wounds to include in the electronic medical record and to increase clinic flow, as it is easier to put orders into the system. Those IRENE members who have an iPad are now positioned to participate in future research with the device.

<table>
<thead>
<tr>
<th>Use of iPads in Primary Care Settings</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Browse the web for healthcare information</td>
<td>37 (77)</td>
</tr>
<tr>
<td>Patient education</td>
<td>31 (65)</td>
</tr>
<tr>
<td>Personal leisure use</td>
<td>17 (35)</td>
</tr>
<tr>
<td>Email</td>
<td>15 (31)</td>
</tr>
<tr>
<td>Demonstrate a procedure</td>
<td>11 (23)</td>
</tr>
<tr>
<td>Take pictures</td>
<td>7 (15)</td>
</tr>
<tr>
<td>Show presentations</td>
<td>6 (13)</td>
</tr>
<tr>
<td>Social network (Facebook)</td>
<td>5 (10)</td>
</tr>
<tr>
<td>Conduct a health survey</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Keep children occupied</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Blog</td>
<td>0</td>
</tr>
</tbody>
</table>
RECENT IRENE PUBLICATIONS


If you are interested in receiving a copy of any of the above publications, please e-mail the request to IRENE@uiowa.edu.

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**41st Annual Refresher Course for the Family Physician**

April 1–4, 2014

Marriott Hotel & Conference Center ● Coralville, IA

**IRENE Dinner Meeting**

Free, all are welcome, please join us!

Wednesday, April 2, 2014 ● 5:30 pm–7:30 pm

Location: Vesta, 849 Quarry Road, Coralville, IA 52241

Presenters: Barcey Levy, PhD, MD and Jeanette Daly, RN, PhD

➢ To sign up for the dinner meeting, contact Jo Bowers: (319) 384-8994 or josephine-bowers@uiowa.edu.

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**We’re on the web!**

Joint National Committee (JNC-8) Releases Evidence-Based Guideline for the Management of High Blood Pressure in Adults

Paul James, MD, IRENE founder and Professor and Head of the Department of Family Medicine, served as co-chair for the Joint National Committee (JNC-8). Barry Carter, Pharm D, Professor of Family Medicine and Pharmacy was also on the panel. The panel members’ report, 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, was published February 5, 2014 in The Journal of the American Medical Association. These guidelines, the culmination of five years of work, are a departure from earlier guidelines and have thrust the committee and Dr. James into the media spotlight. In summary, their findings include “strong evidence to support treating hypertensive persons aged 60 years or older to a BP goal of less than 150/90 mmHg and hypertensive persons 30 through 59 years of age to a diastolic goal of less than 90 mmHg; however, there is insufficient evidence in hypertensive persons younger than 60 years for a systolic goal, or in those younger than 30 years for a diastolic goal, so the panel recommends a BP of less than 140/90 mmHg for those groups based on expert opinion. The same thresholds and goals are recommended for hypertensive adults with diabetes or nondiabetic chronic kidney disease (CKD) as for the general hypertensive population younger than 60 years. There is moderate evidence to support initiating drug treatment with an angiotensin-converting enzyme inhibitor, angiotensin receptor blocker, calcium channel blocker, or thiazide-type diuretic in the nonblack hypertensive population, including those with diabetes. In the black hypertensive population, including those with diabetes, a calcium channel blocker or thiazide-type diuretic is recommended as initial therapy. There is moderate evidence to support initial or add-on antihypertensive therapy with an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker in persons with CKD to improve kidney outcomes.”


Free Fecal Immunochemical Test Disbursement in Eight Family Physician Offices

Acknowledgement: National Institutes of Health (NIH) and National Cancer Institute (NCI)

Colorectal cancer screening campaigns have increased across the U.S. with financial support from the Centers for Disease Control and Prevention. Accompanying the promotion and provision of these campaigns are the difficult tasks of determining which fecal occult blood test to use and finding appropriate offices to offer the tests. The purpose of the study was to offer Iowa Research Network members in family physician offices the opportunity to provide a fecal occult blood test to patients who are unable to afford the test and then determine how many of the free fecal immunochemical tests (FITs) would be returned to the office. Eight Iowa Research Network offices participated in the study.

Beckman/Coulter provides a Hemoccult ICT patient mailer for one-day sample, two-day sample, or three-day sample. Based on the research literature that a one-day FIT often misses sporadically bleeding polyps that are a precursor to colon cancer, a two-day FIT was chosen. Each of the eight primary care offices were provided with all materials to develop 50 two-day patient FIT mailers and appropriate controls. The mailer housing the material for patients had instructions on how to obtain the stool sample, two collection cards, two collection tissues (rice paper), two applicator sticks, and a return biohazard mailer.

For each office, the total cost for kits, control solution, and mailers was $990.59. Detailed instructions were provided regarding the test devices needing refrigeration and the use of control solution. Prior to sending FITs to each office, site coordinators were educated about the project. An instruction sheet with a CRC screening log was emailed and paper copy sent to all coordinators. Upon receipt of the instructions, a research team member discussed with each coordinator the study procedures and use of the FITs and control solution.

After seven months of disbursing FITs, 180 (45%) of the 400 FITs had been handed out to patients. Of the 180 FITs handed out, 92 (51%) patients returned the first FIT card and 87 (48%) returned the second FIT card. Four offices had no positive results. For the other four offices, there were 13 patients with positive results either on the first card, second card, or both cards. Of those 13 patients with a positive result, 11 (85%) had a follow-up colonoscopy.

While this project was time-consuming, involved numerous personnel from each office, and caused a change in the office’s current FOBT testing, persons who may not have been screened were screened and followed-up appropriately with colonoscopy. The overall rate of FIT disbursement was less than hoped for.