ARPA-H and Primary Care Research

The Council of Academic Family Medicine (CAFM) is responding to a question included in the materials attached to the CURES 2.0 proposal regarding how a new Advanced Research Projects Agency for Health (ARPA-H) can have the biggest possible impact on the public. CAFM believes that the best way to provide the high-risk/high-reward breakthroughs that ARPA-H seeks to accelerate is by including and prioritizing primary care research within its portfolio.

The Council of Academic Family Medicine (CAFM) collectively includes family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, research scientists, and others involved in family medicine education.

The questionnaire[1] released about ARPA-H asks how Cures 2.0 can ensure that the agency has the biggest possible impact and also how its mission, culture and organizational leadership should be different than the status quo. The answer: prioritize primary care research. The breakthroughs discovered through ARPA-H will have little impact if ARPA-H does not also include emphasis on primary care research. For example, detection of and care for cancer, diabetes, Alzheimer’s, and ALS — the four priorities of ARPA-H — often occur in primary care settings. Primary care physicians will have to be an essential point of care, and each of the priorities undertaken by ARPA-H should have a component of primary care research and funding prioritized to investigate the best ways to deliver care and new scientific breakthroughs to patients. More, and updated, technology is a good first step, but incorporating primary care is necessary to have a fundamental impact (and equity) in treatment of cancer, Alzheimer's, diabetes, and ALS.” To aid in this effort, in addition to including primary care research, the organizational leadership of the new Agency should include primary care researchers to help increase the impact of the work.

Primary care touches the lives of all Americans – according to the National Center for Health Statistics, more than half of all physician office visits (54.5%) were made to primary care physicians[2]. Studies from specialty settings are often the only research available with limited value in the primary care setting. Primary care patients often present with undifferentiated symptoms like “fatigue” and “aching all over”, and they may differ in their social contexts, care-seeking behavior, whether they live in rural areas, co-morbidities, disease progression, and what care modalities they have tried before. Therefore, studies of patients from specialty clinics will produce results that generally are not applicable to a primary care setting. For example, one study found that 1 in 6 patients presenting to oncologists with enlarged lymph nodes had cancer, compared with only 1 in 100 in primary care.[3] [4]

Basic science and disease-specific research is the historic and current focus of the NIH. Primary care research in contrast has been underfunded within this framework when compared to all other health disciplines especially specialty care. For example, less than 0.5% of NIH funding goes to family medicine researchers, and it is concentrated among a limited number of departments with little funding for new investigators.

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[1] https://www.aau.edu/sites/default/files/AAU-Files/Key-Issues/Cures-2.0-ARPA-H-RFI-FINAL-(002).pdf

[2] https://www.cdc.gov/nchs/fastats/physician-visits.htm (accessed July 23, 2021)

[3] Pangalis GA et al. Clinical approach to lymphadenopathy. Semin Oncol. 1993; 20: 570.

[4] Williamson HA. Lymphadenopathy in a family practice: A descriptive study of 240 cases. J Fam Pract. 1985; 20: 449.

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AHRQ currently serves as the principal source of funding for primary care practice research in the Department of Health and Human Services. Unfortunately, reduced funding levels of AHRQ have exacerbated the disparities in primary care research. Therefore, AHRQ has reluctantly reduced its investment in primary care over time, cutting significant programs such as the multiple chronic disease project and reducing the statutorily authorized Center for Primary Care Research to a virtual clearinghouse under the auspices of the Center for Evidence and Practice Improvement. As such, it provides access to information and resources but has no dedicated funding.

Family medicine organizations support our national health care research enterprise. Our comments in this letter are directed at identifying some areas within that enterprise that we feel are important to emphasize as you further develop the draft legislation. Given that the purpose of health-related research is to improve the lives of our patients, we recommend more emphasis on addressing best practices on how to deliver scientific breakthroughs into the practice of medicine. Understanding how to better organize health care to meet patient and population needs, recognizing the impact of social determinants of health, evaluating innovations to provide the best health care to patients, and engaging patients, their families, communities, and practices to improve health is critically important, and research in these areas must keep pace.

As the Committee looks to developing CURES 2.0 and ARPA-H, we urge you to include primary care research within the portfolio of work.

The Council for Academic Family Medicine looks forward to working with you to achieve this goal; please contact Hope Wittenberg with questions or comments at hwittenberg@stfm.org

Sincerely,

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