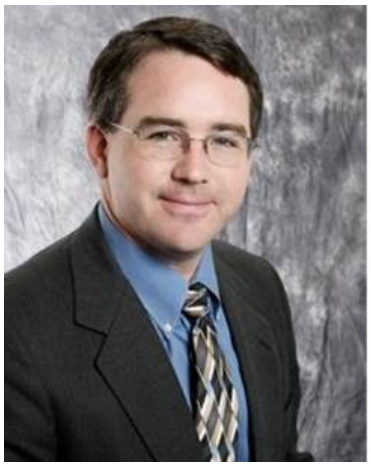
OKPRN News

Oklahoma Physicians Resource/Research Network (www.okprn.org) **Fall/Nov 2013**

Board of Directors

The mission of OKPRN is to support primary care clinicians through a professional network for peer learning, sharing of resources for best practices and practice-based research.

From The President's Desk



As we get ready to start another year, I want to take this opportunity to congratulate the members of OKPRN on receiving the Oklahoma Champion of Health Award. It's exciting to see the hard work and dedication of our members recognized! This award truly belongs to every member of our network. As a way to allow each of us to share in the award, the funds we received are going to fund a return of an OKPRN Annual Meeting. While we will continue to support and be involved with the OAFP Scientific Assembly, we will also have an additional opportunity for OKPRN members to share, learn and direct our organization's future.

As we move into 2014, the Network's TWENTIETH year of existence, we face an exciting and challenging future. I encourage each of you to consider your role in that future and to consider serving on the Board of Director's or a committee. Since the knowledge and power of OKPRN resides within our MEMBERS, we plan to increase the activity of our committees.

Help us make sure that we remain a member-driven organization by giving of small amounts of your time to help guide the next 20 years of OKPRN!

A Happy New Year to All,

Russell Kohl, MD, FAAFP

Announcements & Acknowledgements – Nagykaldi / Mold / Turner

Thank You For Participating in OKPRN Projects!

Poison Ivy Project	CKD Project	Adolescent Health	Spider-Tech Project	
Dr. Robert Stewart	Dr. Ray Long	OU FMC in OKC	Dr. Zack Bechtol	Dr. Greg Martens
Dr. Michael Woods	Dr. Michael Aaron	OU Ramona Residency	Dr. Misty Hsieh	Dr. Suben Naidu
Dr. Ronal Legako	Dr. Ray Huser	OU FMC in Lawton	Dr. Russell Kohl	Dr. James Mold
Dr. Ed Farrow	Dr. Terrill Hulson	OU Peds in OKC	Dr. Ronal Legako	Dr. Clinton Strong
Dr. Russell Kohl	Dr. Craig Evans	Durant FM Residency	Dr. Ray Long	Dr. Mickey Tyrrell
Dr. Zack Bechtol	Dr. Frank Davis		Dr. Greg Martens	Dr. Michael Woods
Dr. Frank Lawler	Dr. Suben Naidu		Dr. Suben Naidu	Bruna Claypool, PA-C
Dr. Brian Coleman	Dr. Gary Lawrence		OU FMC	
Dr. Ryan Aldrich	Dr. John Pittman		Dr. Clinton Strong	
Dr. Russell Click	Dr. Jeff Floyd		Dr. Mickey Tyrrell	
Dr. Robert Blakeburn	Dr. Louis Wall		Dr. Michael Woods	
Dr. John Brand	Dr. Kevin O'Brien		Kiamichi FMR - Idabel	
Dr. Greg Martens	Dr. Russell Kohl		Comm Health Conn	
Dr. Ray Long	Dr. Stephen Connery		Morton CHC - Tulsa	
Dr. Terrill Hulson	Dr. Greg Grant		Muskogee Pulmo	
Dr. Craig Evans	Dr. Misty Hsieh		Johanna Weir, PA	
Dr. Suben Naidu	Dr. Kristin Earley		Dr. Kalpna Kaul	
Dr. Greg Grant	Dr. Renee Balllard		Robin Avery, ARNP	
Dr. Jeff Floyd	Dr. Cinda Franklin		Dr. Gaurangi	
Dr. Kevin O'Brien	Dr. Cynthia Maloy		Anklesaria	
Dr. Brian Yeaman	Dr. Kelli Koons		Kenda Dean, ARNP	
Stacy Scroggins, PA-C	Nancy Dantzler, ARNP		Dr. Kevin O'Brien	
Bruna Claypool, PA-C	Joyce Inselman, ARNP		Dr. Brian Sharp	
Amanda Odom, PA-C	Kenda Dean, ARNP		Joyce Inselman, ARNP	
Dr. Kelley Humpherys	Dr. Marjorie Bennett		Nancy Dantzler, ARNP	
Dr. Kelli Koons	Mark Davis, PA		Cheryl Ross, ARNP	
Tammy Hartsell, ARNP	Chris Carpenter, ARNP		Dr. Misty Hsieh	
Dr. Jo Ann Carpenter	Dr. Titi Nguyen		Dr. Zack Bechtol	
Cynthia Sanford, APRN	Dr. Paul Wright		Dr. Russell Kohl	
Mark Davis, PA	Dr. Jeffrey Cruzan		Dr. Ronal Legako	
Dr. Chad Douglas	Dr. Stephen Lindsey		Dr. Ray Long	

Thank You For Supporting the Work of OKPRN!

We truly appreciate and value clinic staff (nurses, front- and back-office staff, office managers and all associates), who showed dedication and generosity in supporting OKPRN projects in 2013 and before! We are also indebted to our patients and study participants, who often enthusiastically contributed to the success of various OKPRN initiatives throughout the State. We can't thank you enough!

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Wisdom From The Listserv

Screening for High Blood Pressure in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement – Christine A. Sinsky, MD, FACP

The USPSTF found that good information was still lacking about the accuracy of blood pressure screening in children and adolescents, whether screening accurately identifies children and adolescents at high risk for heart disease and other complications of hypertension, and the benefits and harms of treating hypertension in children and adolescents.

The USPSTF concluded that there is not enough information to weigh the balance of benefits and harms of screening for hypertension in all children and adolescents. Until further information becomes available, the doctor and patient should make a decision to screen on the basis of the patient's specific situation, such as whether the child is overweight.

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Does This Patient Have Influenza? – Robert Gray, MD

In the case of abrupt onset, fever well above 100.4 and cough, plus the myalgias and malaise, the pre-test probability for rapid influenza tests skyrockets. This is somewhat the same as saying that the "prevalence" for that patient, has increased. Then the specificity of the test leads to post-test probability being quite high.

Knowing the result of a rapid test in the context of classic symptoms can be helpful in several ways. One, it helps to establish the pattern that can later be used to treat empirically. Two, before treating/prophylaxis for a family with an index case, it is persuasive (to the clinician AND family) that meds are indicated. Three, it helps when the differential diagnosis for that individual goes beyond influenza. It's reported from ED literature that fewer X-rays and labs are ordered when a rapid test is positive.

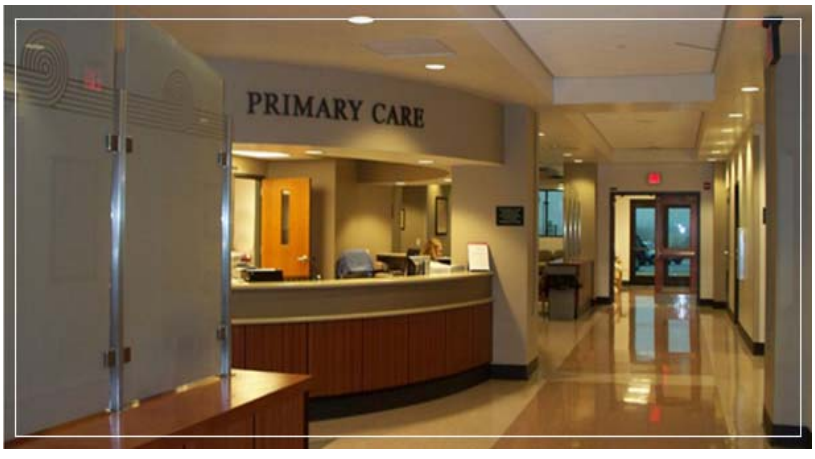
Thee is an article "Does this patient have influenza?" (www.okprn.org/Documents/Does_This_Patient_Have_Influenza.pdf) that details the odds ratios for various combinations of symptoms. I also have a poster that might help convey the message about universal flu vaccination (www.okprn.org/Documents/FluUniversalQuestion.pdf). For a previous OKPRN publication on influenza diagnosis from Dr. Hulson et al, see http://www.ncbi.nlm.nih.gov/pubmed/11742606.

Lastly, I would like to know of any best practices that actually succeed at neutralizing the common refrain by some patients that they don't want a flu shot because one time they got a shot and it gave them the flu. Emphasizing the facts about killed viruses doesn't seem to be all that helpful.

In The Spotlight – Three Rivers Health Center, Muskogee, Oklahoma

Our clinic began in 1993 in a small rented office in Muskogee. The Cherokee Nation Women Infant and Children's (WIC) Program and Public Health Nursing provided immunizations and well-child checks. More services were added and a building close to Muskogee Regional Hospital was leased in 1997.

In August, 2002, the clinic was moved to another location. At that time the staff included a full-time physician, a full-time Family Nurse Practitioner, a part-time pediatrician and supporting staff. In spite of slightly more available space the clinic's focus



remained limited to women and children's health care.

Sensing the need for a broader scope of services and to reduce the burden of outpatient services at the W.W. Hastings Hospital, the tribe entered into a Joint venture Program with the Indian Health Service to construct a facility with the appropriate size and scope of services for its service population. The Joint Venture Construction Program allowed the Cherokee Nation to receive dollars for staffing and operations. The Three Rivers Health Center is more than 100,000 sq. ft. and is the largest center in the Cherokee Nation system. During FY 2009 there were 70,764 outpatient visits.

Among others, the scope of service include pediatrics, dental care, optometry, physical therapy, pharmacy, nutritional services, public health nursing, WIC, health promotion, behavioral health and translation services in the Cherokee language. The clinic offers specialty clinics for diabetic and dermatology care. In addition, there are plans to add genetics services as well.

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OKPRN Members' Perspectives – Zsolt Nagykaldi, PhD

Realizing that this time of the year is exceptionally busy for clinicians, I took it upon myself to share some thoughts with you in this issue about my views of the direction health information technology (HIT) has taken in our land and some opportunities for bringing about change. It is said that those who are not at the table will be soon on the menu. This could not be more pertinent to American primary care in general, but also for primary care HIT.

Since the late '90s, vendors of "patient management" (billing) records have been expanding their basic billing systems with clinical content, calling it first "electronic medical record" (EMR), then later, when more clinical functionality was piled upon the billing system "electronic health record" (EHR) to evoke a connotation with broader health and wellness. To be fair, there were several other attempts, some by practicing clinicians, to design better systems, but most of these adhered to the prevailing paradigm for a variety of reasons. Unfortunately, the underlying architectural design and the paradigm remained the same with very few exceptions, that is, EHRs are overwhelmingly (and often hopelessly) disease and procedure-oriented, billing/coding-focused and episodic care-based documentation systems. Systems that sub-specialists tend to prefer, not primary care professionals.

We have been immersed into a cacophony of voices calling for patient-centered, person-focused, holistic, longitudinal and coordinated care, although we know that nothing is new about this kind of care. Some call it "family medicine". You are right when you ask: "How could the electronic record of the 20th century carry us to the medicine of the 21st century, which is clearly about personalized, patient-centered and behavior-focused care?" Not well at all.

I recently attended a national conference where many of us who design and study novel approaches to care and HIT implementation agreed that the best (or only?) chance we have in order to fix EHRs is to blow away the current framework and start building a new one from scratch. These were the "wish list" features and design approaches that emerged from our discussion and you may find them interesting:

1) There should be no more monolithic record systems! Vendors must be forced by a large number of users to stop selling their current, large, proprietary and all-exclusive packages.
2) Develop an open-source primary care EHR "operating system" (OS), using a large, national consensus process, utilizing the entire healthcare community. This would be available to all for a nominal fee. All developers would be expected to contribute to it openly and all would be required to develop their products in this framework for them to be certified.
3) The EHR-OS would include a nationally standardized clinical database structure with consensus application programming interfaces (APIs) for individual vendors to tap into.
4) A myriad of small and large companies could develop certified segments ("apps") for the EHR-OS in a fiercely competitive manner which would be priced accordingly, empowering users to build a highly tailored and value-added system for their practices or organizations and in an interoperable manner. For example, you could select from dozens of "patient registry applications" or various "clinical decision support modules" to cover your particular needs, or not use and pay for these, if you already have them or don't need them.
5) Since data are collected in a standardized fashion, improvement of the quality of care and sharing clinical data between entities at the practice level or population level would be significantly more attainable and efficacious. Data sharing would

be based on an "agnostic" (insurance and status-independent) national patient identifier (yes we finally need to make politicians do the right thing; all other civilized nations have this).

6) The EHR-OS and the entire framework would be whole-person-centered by allowing the clinician, office staff and patients to follow the regular narrative of the visit and making the system work hard to document relevant elements of the narrative, sort them and file them according to the latest laws and regulations and code them most appropriately for billing. As such, "disease templates" should be relegated to the attic and replaced by intelligent medical objects, natural text processing, sophisticated text and speech recognition and non-intrusive clinical algorithms to truly assist the users.
7) Patients should have direct access to and be able to contribute to their own data, not just through administrative information, but clinical records as well, using fully integrated patient portals, mobile platforms, comprehensive health risk assessment, patient-side decision support, effective media-based education and clinical integration of evidence-based social-media platforms.

The list continues, but you may see my point. The current Meaningful Use (MU) process could be the only alternative for clinicians to stand up and say loudly and clearly: "We can't use 'meaningless' products in a meaningful manner! Give us meaningful HIT (allow us to design systems for primary care) and then we can use them meaningfully!"

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NEWSROOM

OKPRN was especially proud to receive the 2013 Champion of Community Health Award on October 8, in the Tulsa Cox Business Center. OKPRN President Dr. Kohl received the Award on our behalf, followed by a personal address from Regis Philbin. Please watch the short promotional video clip made by BCBSOK which was posted on the OKPRN website recently: http://www.okprn.org/aboutus.html (see the first clip).

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Network Renewal Continues – Nagykaldi / Walsh

Let's give a warm OKPRN welcome to our new Network Coordinator: Margaret (Meg) Walsh! Meg was hired recently by the Oklahoma Shared Clinical and Translational Resources Institute and has been dedicated to work with three Oklahoma-based PBRNs (OKPRN, the child health research network, and the pharmacy PBRN). Before coming to OKPRN, Meg held several positions at the U.S. Department of Defense as a human resources specialist and trainee. She holds a Bachelor of Arts degree in Germanic Studies, Criminal and International Studies, and Psychology. She is currently working toward a Master of Science in Management and Leadership. Since she arrived, Meg has already jumped into the middle of OKPRN activities with a high level of enthusiasm and helped us improve our operations substantially. We are excited to work with her and take OKPRN to the next level!

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OKPRN Project Updates – Mold / Nagykaldi / Aspy / Welborn / McCarthy

Name of the Project	Clin-IQ: Resident Scholarly Activity
Funding Source/Amount/Period	None.
PI/Director Contact Information	Toney Welborn MD (toney-welborn@ouhsc.edu)
Purpose of the Project	The Residency Review Committee (RRC) requires that residents and faculty collaborate on research. The purpose of Clint-IQ is to fulfill the RRC requirement by answering a clinically relevant question in publishable format.
Participant Enrollment Status	The 2012-13 Clin-IQ enrollment has been completed.
Key Findings To-Date	University of Oklahoma, Oklahoma City Residency Program

1. In women over 18 years of age with breast cancer in a 1st degree relative, at what age should screening for breast cancer begin, and with what imaging modality?

Tentative Answer: Routine Mammography screening for women with a positive family history of breast cancer should start earlier than 40 but not before age 25 or 10 years younger than the youngest family member diagnosed with breast cancer, whichever is later. Contrast-Enhanced MRI + Mammography should be utilized in screening women with known BRCA 1 or 2 mutations or how have 1st degree relatives with these mutations and this screening should start at age 30. Women treated with Mantel Radiation should undergo Contrast-Enhanced MRI + Mammography screening 8 years after completion of radiation therapy. Level of Evidence for the Answer: A

2. In adults with osteoarthritis, what therapies have been shown to slow progression of disease compared to weight bearing exercise alone?

Tentative Answer: Yes. Level of Evidence: A

3. In adult smokers unwilling to quit, does changing from tobacco cigarettes to "electronic cigarettes" decrease the negative health effects associated with smoking tobacco?

Tentative Answer: Yes. Level of Evidence: A

4. In patients with type 2 diabetes mellitus on oral hypoglycemics does self-monitoring blood sugars influence control and consequences of diabetes?

Tentative Answer: N/A

5. In adults with chronic constipation, are stool softeners like docusate more effective at reducing constipation when used alone compared with combination use with other laxatives/bowel stimulants?

Tentative Answer: No. Level of Evidence: A

6. In adolescent athletes, does single sport specialization lead to increased injury rate compared to multi-sport athletes?

Tentative Answer: No clear evidence that single sport specialization leads to an increase in injury rate. However, amount of time spent doing a sport specific activities and intensity can increase the injury

rate. Level of Evidence: B, limited quality patient oriented evidence.

7. In adult strength trainers, are over-the-counter protein supplements effective at increasing muscle bulk and strength compared with weight training alone?

Tentative Answer: Yes. Level of Evidence: B

8. In adult males with low testosterone, does supplementation with testosterone increase their risk of prostate cancer compared with no supplementation?

Tentative Answer: The current evidence suggests that exogenous testosterone does not increase the risk of prostate cancer. Level of Evidence: B.

9. In patients on warfarin, does home self-testing of PT/INR provide the same outcomes compared to testing by a home health nurse or in a clinical setting?

Tentative Answer: Yes. Level of Evidence: A

10. In overweight or obese adolescents, is a calorie-controlled diet alone more effective at decreasing BMI than exercise alone?

Tentative Answer: Behavioral modification, including a calorie controlled diet contributes to weight loss in the pediatric and adolescent population, at greater levels than exercise alone. Level of Evidence: B

11. Are at home sleep studies as effective at diagnosing obstructive sleep apnea in adults as poly-somnography

Tentative Answer: N/A

12. In adults with a diagnosis of tinnitus, what treatment modalities (OTC, naturopathic, prescription drugs, psychological counseling) have been shown effective at relieving symptoms and/or improving quality of life?

Tentative Answer: N/A

St Anthony Residency Program

1In adults with chronic insomnia, is melatonin as effective as other sleep medications with fewer side effects?

Tentative Answer: N/A

2. In patients with concussions, is total number of concussions more predictive of permanent neurologic deficit compared to severity and duration of symptoms from any one concussion? In adults with chronic pain does long term treatment with SSRI/SSNI (alone or in conjunction with other medications) control pain more effectively?

Tentative Answer: N/A

3. What are the appropriate treatments of proctalgia fugax and chronic proctalgia and are these treatment modalities founded on solid evidence?

Tentative Answer: N/A

4. In adults with heart failure with preserved ejection fraction (HFPEF), are ACE inhibitors equal to ARBs or beta-blockers in decreasing mortality and hospital admissions for heart failure?

Tentative Answer: N/A

Requests to OKPRN Members

You can send us researchable clinical questions of interest to you in your practice via the OKPRN website: http://www.okprn.org/OKPRN_members/ProjectIdea.asp.

Name of the Project

Using Health Risk Appraisal to Prioritize Primary Care Interventions (K08)

Funding Source/Amount/Period

Agency for Healthcare Research and Quality (AHRQ)
Funding: $425,122; 07/01/2008 - 06/30/2013

PI/Director Contact Information

Zsolt Nagykaldi, PhD (znagykal@ouhsc.edu)

Purpose of the Project

1) Conduct a systematic review of the existing literature in order to refine a novel implementation model of a clinically integrated Health Risk Appraisal (HRA) implementation that will help clinicians prioritize evidence-based interventions;
2) Refine and pilot test the integrated HRA technology within a primary care practice-based research network to determine the feasibility of implementation and the efficacy of the instrument;
3) Conduct a randomized clinical trial to examine the impact of this integrated HRA approach on important patient outcomes, including estimated life expectancy, patient centeredness of care, and provider and patient satisfaction in primary care practices.

Participant Enrollment Status

Completed.

Key Findings To-Date

Objectives: Health Risk Appraisals (HRAs) have been implemented in a variety of settings, however few studies have examined the impact of computerized HRAs systematically in primary care. The study aimed at the development and pilot testing of a novel, comprehensive HRA tool in primary care practices.

Methods: We designed, implemented and pilot tested a novel, web-based HRA tool in four pair-matched intervention and control primary care practices (N=200). Outcomes were measured before and 12 months after the intervention using the HRA, patient surveys, and qualitative feedback. Intervention patients received detailed feedback from the HRA and they were encouraged to discuss the HRA report at their next wellness visit in order to develop a personalized wellness plan.

Results: Estimated life expectancy and its derivatives, including Real Age and Wellness Score were significantly impacted by the HRA implementation (P<0.001). The overall rate of 10 preventive maneuvers improved by 4.2% in the intervention group vs. control (P=0.001). The HRA improved the patient-centeredness of care, measured by the CAHPS PCC-10 survey (P=0.05). HRA use was strongly associated with better self-rated overall health (OR = 4.94; 95% CI, 3.85-6.36) and improved up-to-dateness for preventive services (OR = 1.22; 95% CI, 1.12-1.32). A generalized linear model suggested that increase in Wellness Score was associated with improvements in patient-centeredness of care, up-to-dateness for preventive services and being in the intervention group (all P<0.03). Patients were satisfied with their HRA-experience, found the HRA report relevant and motivating and thought that it increased their health awareness. Clinicians emphasized that the HRA tool helped them and their patients converge on high-impact, evidence-based preventive measures.

	Conclusions: Despite study limitations, results suggest that a comprehensive, web-based, and goal-directed HRA tool can improve the receipt of preventive services, patient-centeredness of care, behavioral health outcomes, and various wellness indicators in primary care settings.
Requests to OKPRN Members	We are interested in disseminating the Wellness Portal - HRA to more OKPRN practices who need a free evidence-based tool to meet the Medicare Annual Wellness Visit (AWV) health assessment requirement. Please contact the PI at znagykal@ouhsc.edu for more information, if you are interested.

Name of the Project	CoCONet2 – The Coordinated Coalition of Networks -2 (P30)
Funding Source/Amount/Period	Agency for Healthcare Research and Quality (AHRQ) Funding: $476,125 ; 07/1/2012 - 06/30/2017
PI/Director Contact Information	James W. Mold, MD (james-mold@ouhsc.edu)
Purpose of the Project	The purpose of this project is to develop a network of networks to improve the quality and effectiveness of primary care by engaging frontline clinicians in the conduct and dissemination of relevant practice-based research, and by acquiring, developing, and sharing new knowledge through networks of clinicians and practices. In addition to OKPRN, we will collaborate with UNYNET from upstate New York, LANet from Los Angeles, WREN from Wisconsin, MAPFRN from Minnesota, and the OCHRN – Oklahoma Pediatric Network. Westat, Inc (Rockville, Maryland) will be the coordinating Center for this project to develop communication processes among the individual networks and to facilitate development of a data repository for future projects. This "meta-network" has already submitted applications for several multi-network projects. Funding is for 5 years with funds dedicated each year to building infrastructure in each of the networks to facilitate collaboration and development of future researchers.
Participant Enrollment Status	Not applicable.
Key Findings To-Date	CoCoNet2 is a meta-network made up of 6 regional PBRNs including OKPRN, the Upstate New York Network (UNYNET), the Wisconsin Research and Education Network (WREN), the Minnesota Academy of Family Physicians Research Network (MAFPRN), the Los Angeles Network (LANet), and the Oklahoma Child Health Practice Based Research Network (OCHPBRN).
Requests to OKPRN Members	Please consider participating when the call for participation in a specific project goes out.

Name of the Project	Leveraging Practice Based Research Networks to Accelerate Implementation and Diffusion of CKD Guidelines (R18)
Funding Source/Amount/Period	Agency for Healthcare Research and Quality (AHRQ) Funding: $3,199,548 (multi-network project); 09/01/2010 - 08/31/2013
PI/Director Contact Information	James W. Mold, MD (james-mold@ouhsc.edu)
Purpose of the Project	The purpose of this project was to help 96 primary care practices in 4 states implement CKD guidelines (KDOQI) by giving intensive assistance to 32 early adopter practices (performance feedback, academic detailing, and weekly facilitation) and then helping them to assist 2 additional practices each through performance feedback, local learning collaboratives, and monthly facilitation. We also anticipate that

	participation in this project will prepare these practices and the four participating PBRNs to conduct future QI initiatives.
Participant Enrollment Status	All participants have been enrolled.
Key Findings To-Date	Key findings to date include: Analysis of data from this project suggests that both the early adopter practices and their trainee practices were able to improve their care of CKD patients. One interesting finding, however, was that use of ACE inhibitors and ARBs remained MUCH lower in Oklahoma than in any of the other states. CKD Guidelines say that we should be prescribing ACEIs or ARBs in patients with all stages of CKD unless or until they begin to have difficulty with hyperkalemia or have other adverse effects of these medications.
Requests to OKPRN Members	Nothing at this time

Name of the Project	Infrastructure for Maintaining Primary Care Transformation (IMPaCT – U18)
Funding Source/Amount/Period	Agency for Healthcare Research and Quality (AHRQ) Funding: $999,015; 09/30/2011 - 09/29/2013
PI/Director Contact Information	James W. Mold, MD (james-mold@ouhsc.edu)
Purpose of the Project	To develop a Primary Care Extension Program (PCEP) throughout Oklahoma and to assist Arkansas, Missouri, and Colorado as they try to develop similar systems. Three other states, North Carolina, Pennsylvania, and New Mexico also received IMPaCT grants. The PCEP idea came directly from the quality improvement research done in OKPRN. Oklahoma's PCEP will connect primary care practices more closely with the Area Health Education Centers, the three academic health centers, and local Turning Point Partnerships, providing practices with no or low-cost performance assessment and feedback, academic detailing, practice facilitation, and a set of shared community resources, including care managers, social workers, preventive services registry managers, community health workers, IT consultants, and pharmacy consultants. County Health Improvement Organizations (CHIOs) will serve as neutral conveners, bring together representatives from primary care, public health, mental health, and community organizations to solve local health problems like inactivity, obesity, tobacco use, and alcohol and drug abuse.
Participant Enrollment Status	Clinician champions interested in either primary care extension or primary care-community partnerships are being sought.
Key Findings To-Date	There are now 15 certified county health improvement organizations (CHIOs) including 17 counties, with at least 5 more applications in progress.
Requests to OKPRN Members	Those interested should contact Jim Mold (james-mold@ouhsc.edu) or their regional AHEC or Turning Point Partnership.

Name of the Project	Epidemiology and Management of Poison Ivy in Primary Care
Funding	AAFP Foundation

Source/Amount/Period	Funding: $41,539; 3/1/2010 – 2/28/2014
PI/Director Contact Information	James W. Mold, MD (james-mold@ouhsc.edu)
Purpose of the Project	The purpose of this project is to learn more about the characteristics and treatments of poison ivy in the primary care setting.
Participant Enrollment Status	About 400 people will take part in the project. To date we have enrolled 153 patients, of whom 76 have completed their diaries.

Descriptive Statistics on Data Collected to Date

Age:	Mean 46; S.D. 18; Range 5-80
Gender:	61% female
Race:	85% white
Vesicles When Seen:	51%
Duration of Pruritis:	Mean 11 days; Range 1-43 days
Duration of Rash:	Mean 14 days; Range 1-42 days

Average number of treatments used per patient: 2.3
Numbers of Different Categories of Treatments Used by at Least One Person: 11
Number of Different Individual Treatments Used by at Least One Person: 44
Most Frequent Categories of Self Treatments: oral antihistamine (39%); topical antipruritic (32%)
Most Frequent Categories of Prescribed Treatments: oral corticosteroid (47%); parenteral corticosteroid (38%)

Key Findings To-Date	We are having difficulty recruiting a sufficient number of patients for the poison ivy study. We have very little trouble enrolling them once they have been recruited. We need all clinicians on deck so that we can meet our enrollment target.
Requests to OKPRN Members	We request your participation in the poison ivy project. It's really easy!! Your responsibilities would be to fax a contact sheet of the patient with poison ivy to our office and to fill out a simple progress note on the patient with poison ivy. The patient would then be contacted by a PEA for consent and directions on their part in the project. Patients are reimbursed $20 for completing a symptom diary. If you would like more information please contact Cara Vaught via email at cara-vaught@ouhsc.edu.

Name of the Project	Specificity and Sensitivity of ELISA Test For Detection of Loxosceles Reclusa (Brown Recluse) Spider Venom
Funding Source/Amount/Period	Spider Tek Funding: $12,000; 7/1/2010 – 6/30/2013
PI/Director Contact Information	James W. Mold, MD (james-mold@ouhsc.edu)
Purpose of the Project	The purpose of this project is to find a faster, simpler way to determine if a patient has been bitten by a brown recluse spider, so the bite can be treated appropriately.
Participant Enrollment Status	We have enrolled 25 patients and need more.
Key Findings To-Date	The spider bite assay development/validation study continues and good progress is being made.

	Our contract has been extended, and we are still enrolling patients with suspected spider bites.
Requests to OKPRN Members	If you would like to participate in the spider bite project please contact Cara Vaught at cara-vaught@ouhsc.edu. You would be reimbursed $180 for your time. You would be asked to fill out a progress note on the patient, swab the spider bite site, and take pictures of the bite. The patient would be reimbursed $25 for their time.

Name of the Project	Clinical and Translational Science Award (CTSA) and the IDEA Grant
Funding Source/Amount/Period	National Institutes of Health (NIH) Funding: no funding yet
PI/Director Contact Information	James W. Mold, MD (james-mold@ouhsc.edu)
Purpose of the Project	Approximately 7 years ago, in response to concerns from Congress that funding for the National Institutes of Health (NIH) did not always seem to be producing tangible benefits for population health, the then Director of the NIH pulled some money from each Institute and began awarding multi-million dollar grants to academic health centers to support clinical and "translational" research. The term, translational, refers to the notion that there are several translational steps required to move findings from basic research into clinical trials and then eventually into practice. The OUHSC applied several times unsuccessfully for a CTSA through the usual mechanism, coming very close each time (but no cigar). When a new competition opened up for states with less overall NIH funding, it again applied and received the second highest score. However, at this point it appears likely that only one award will be made this year. That simply means reapplication for the next funding cycle, and that process is underway and ought to be successful. The application includes funding for OKPRN to contract for a 75% time network coordinator. It would also establish a program called "translational think tanks" that would bring together small groups of researchers and community clinicians to develop innovative ideas into research and development projects, and it would help to expand the ClinIQ program to more residency programs.
Participant Enrollment Status	We got the grant. Activities will begin September 1, 2013. Funding for a 75% OKPRN Network Coordinator is included.
Key Findings To-Date	No findings yet.
Requests to OKPRN Members	For additional information, contact Jim Mold (james-mold@ouhsc.edu).

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Academic Accomplishments – Nagykaldi

2012-13 Publications From Research Linked to OKPRN

- Nagykaldi ZJ, Yeaman B, Jones M, Mold JW, Scheid DC. HIE-i: Health Information Exchange With Intelligence. J Ambul Care Manage. 2014 Jan-Mar;37(1):20-31.
- Scheid DC, Hamm RM, Ramakrishnan K, McCarthy LH, Mold JW; Oklahoma Physicians Resource/Research Network. Improving colorectal cancer screening in family medicine: an Oklahoma Physicians Resource/Research Network (OKPRN) study. J Am Board Fam Med. 2013 Sep-Oct;26(5):498-507
- Nagykaldi Z, Voncken-Brewster V, Aspy CB, Mold JW. Novel Computerized Health Risk Appraisal May Improve Longitudinal Health and Wellness in Primary Care: A Pilot Study. Applied Clinical Informatics 2013; 4: 75–87.
- The Primary Care Extension Program: A Catalyst for Change. Phillips RL Jr, Kaufman A, Mold JW, Grumbach K, Vetter-Smith M, Berry A, Burke BT. Ann Fam Med. 2013 Mar;11(2):173-8.
- Nagykaldi Z, Aspy CB, Chou A, Mold JW. Impact of a Wellness Portal on the delivery of patient-centered preventive care. J Am Board Fam Med. 2012 Mar;25(2):158-67.
- Lawler FH, Mold JW and McCarthy LH. Do Older People Benefit from Having a Confidant? An Oklahoma Physicians Resource/Research Network (OKPRN) Study JABFM 2013;26:9–15.
- Mold JW. Primary Care Research Conducted in Networks: Getting Down to Business. J Am Board Fam Med. 2012 Sep;25(5):553-6.
- Mold JW, Lipman PD, Durako SJ. Coordinating Centers and Multi–Practice-Based Research Network (PBRN) Research. J Am Board Fam Med. 2012 Sep;25(5):577-81.
- Mold JW, Lawler F, Schauf KJ, Aspy CB. Does Patient Assessment of the Quality of the Primary Care They Receive Predict Subsequent Outcomes? An Oklahoma Physicians Resource/Research Network (OKPRN) Study. J Am Board Fam Med. 2012 Jul;25(4):e1-e12.
- Aspy CB, Hamm RM, Schauf KJ, Mold JW, Flocke S. Interpreting the psychometric properties of the components of primary care instrument in an elderly population. J Fam Comm Med. 2012 August;19(2):119-124.
- Thompson, DM, Fernald, DH, Mold JW. Intraclass Correlation Coefficients Typical of Cluster-Randomized Studies: Estimates From the Robert Wood Johnson Prescription for Health Projects. Ann Fam Med. 2012 May/June;10(3):235-240.
- O'Mahar KM, Duff K, Scott JG, Linck JF, Adams RL, Mold JW. Brief report: the temporal stability of the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) Effort Index in geriatric samples. Arch Clin Neuropsychol 2012 Jan;27(1):114-8.
- Mold JW, Holtzclaw BJ, McCarthy L. Night sweats: a systematic review of the literature. JABFM 2012 Nov-Dec;25(6):878-93.

OKPRN By The Numbers	
MEMBERS	
Total membership	261
By member status	Active members: 196; Affiliate members: 55; Inactive members: 10
By discipline	MDs: 144; DOs: 66; NPs: 22; PAs: 20; Other: 9
By specialty	Family & General Medicine: 218; Internal Medicine: 9; Pediatrics: 13; OBGYN: 5; Other: 16
By demographics	Gender: 38% female; Mean age: 40-49 years; Mean years in practice: 10.5 years; Mean years in OKPRN: 6.5 years
PRACTICES	
Number of practices	137
By location	Urban: 40; Sub-urban: 31; Rural: 66
By OK quadrant	SW: 34; SE: 36; NE: 34; NW: 33; +1 former member now in Texas
By ownership	Hospital: 15; Physician or group: 43; Other corporate or system: 9; Other: 70
Average practice size	~2.2 OKPRN clinicians per practice (counting OKPRN members only)

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