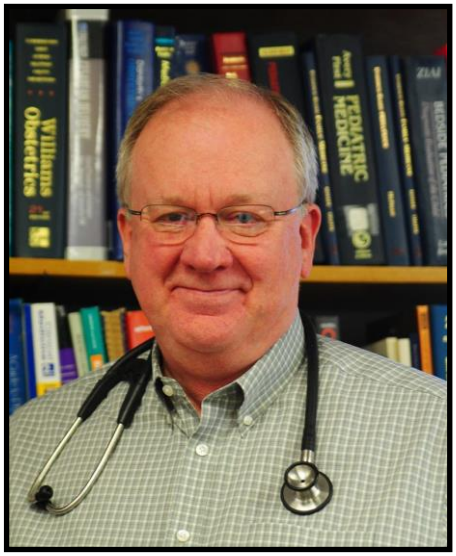
OKPRN News

Oklahoma Physicians Resource/Research Network (www.okprn.org) **Spring 2016**

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.



On the surface, the topic of the corporatization of Primary Care is not terribly interesting, as we deal with it day in and day out. But in the medical practice world this topic is becoming more and more of an issue... as we chart the waters of change. Ambulatory research has always been difficult, but with the changing of the "Masters" of Primary Care, the problem of voluntary participation in practice-based research has been intensified.

The focus of Primary Care has always been "The right care, at the right time, in the right place". I had anticipated that with the Accountable Care Act, there would be embedded the ability to improve care... as well as improve efficiency. I sense I have been naive once again with my hope that comes with a changing healthcare system.

I don't know how it is in your world... but that has not been the outcome of the changes in my world.

I can remember reading a paper co-authored by Jim Mold in which he struggled with the issue of the balance between research and quality improvement[1]. Those of us in the trench often resisted the label of research, whereas quality improvement or evidence-based practice has been more politically correct and socially acceptable in our practice-based worldview. Seems to me that the model of primary care, in which we work for a system or a corporation, add another layer to the difficulty

Making sure that the research was relevant to the practicing physician has always been one of the primary foci of practice-based research. Sometimes we get it right, other times we end up being the drones collecting the data. As for my personal interest I rarely learn much from collecting data. The part of the process that seems to pique my interest is the design and the clarification of the question at hand. I would assume that many of you are in a similar situation.

When I first started in practice-based research, the bulk of the practicing physicians who took on this task were private practitioners. There was a sense that we needed to improve the information that we utilized to provide primary care day in and day out. When this was left to the academics or to academic medical centers, the data was not always useful nor accurate for the populations for which we cared.

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[1] Mold JW, Peterson KA. Primary Care Practice-Based Research Networks: Working at the Interface Between Research and Quality Improvement. *Annals of Family Medicine*. 2005;3(Suppl 1):s12-s20. doi:10.1370/afm.303.

Fast-forward 30 some years and the bulk of us now are employed by corporations or groups that are providing primary care services. We continue to be interested in population-based health care (see the languages even changed). Many of the concepts in primary care have morphed or have been kidnapped as they make good marketing fodder for healthcare systems. You can tell from my language that I'm not terribly impressed with this motivation, although I will admit to you that it probably does serve to sustain the viability of the discipline. The difficulty is that the way we are employed and managed often comes between you and I as physicians and the decision-making we need to be accomplishing for our patients. I do know that is also interferes with the decision making freedom that we have in terms of participating in practice-based research.

Therein lies the conundrum...when a physician cannot make this decision to participate...who can...or will.

Each and every corporation, as well as academic institution, has rules and regulations about institutional review boards and their specific interpretation of the federal regulations. On one hand this serves as protection to patients... on the other hand it creates huge barriers for performing research or even quality improvement in the outpatient setting. I will leave it to our academic handlers to negotiate the specifics.

The corporatization of primary care also runs the risk of making the practice-based research endeavor untenable. In a healthcare system in which productivity is measured to the nth degree, there is rarely any value given to participating in a learning collaboratives such as the way we have set up OKPRN. The onus is for our organization to explain the value of this approach to both its members and to their corporate overseers.

I, for one, am not sure that we have accomplished this very well.

And maybe we need to add to the literature base about how to engage corporations and insurance companies into assisting with continuation of practice based research. My brief look at the literature base finds paltry data on the issue.

I would also assume that at the board level we need to be thinking outside the box a bit and asking some of the more innovative insurance companies and healthcare corporations to participate at a board member level. It will be important in this setting to make sure that control of the network remains with the practicing physician. It seems we have the same risk of "stealing the agenda"... as we have had over the years with our academic colleagues.

As OKPRN enters the era of the corporatization of primary care, it is important to look for broader support and at the same time sharpen our ability to tell the story of the importance of practice-based research. We have to always remember that this is a volunteer organization that has as its focus the improvement of primary care and healthcare of Oklahomans.

I, for one, thank you for your help in this endeavor.

Announcements & Acknowledgements

Thank You For Participating in OKPRN Projects!

Healthy Hearts for Oklahoma (H2O)
Michael Aaron, MD
Pam Ahearn, MD
James Baker, MD
Kristy Baker, APRN
Zachary Bechtol, MD
James Brand, MD
Cary Carpenter, DO
Jo Ann Carpenter, MD
Bella Carroll, MD
Jere Claunch, PA
Neal Clemenson, MD
Brian Coleman, MD
Audra Cook, MD
Mitch Coppedge, MD
Steve Crawford, MD
Frank Davis, MD
Chad Douglas, MD
Shadi Edalati, MD
Craig Evans, MD
Cinda Franklin, MD
Janet Garvin, DO
Jeff Gastorf, DO
Michael Goddard, MD
Philicia Groves, APRN
Wesley Hinz, DO
Jamie Hokett, MD
Misty Hsieh, MD
Terrill Hulson, MD
Stacey Knapp, DO
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Tomas Owens, MD
Philip Palmer, MD
John Pittman, MD
Kaly Ramakrishnan, MD
Kathryn Reilly, MD
Laurence Rubenstein, MD
Renee Russell, MD
Robert Salinas, MD
Kyle Schauf, MD
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Mary Schreck, APRN
Peter Schwiebert, MD
Eunice Simon, APRN
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Pamela Tietze, MD
Terrence Truong, MD
Mickey Tyrrell, MD
Elizabeth Wickersham, MD
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Michael Woods, MD
Amanda Wright, MD
Paul Wright, MD
Brian Yeaman, MD
John Zubialde, MD

Spider-Tech Project
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Cheryl Ross, ARNP
Community Health Conn
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Dr. Clinton Strong
Dr. Chad Douglas
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Dr. Greg Martens
Dr. James Mold
Dr. Janet Garvin
Dr. Jo Ann Carpenter
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Dr. Kevin O'Brien
Dr. Michael Woods
Dr. Mickey Tyrrell
Dr. Misty Hsieh
Dr. Ray Long
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Dr. Russell Kohl
Dr. Suben Naidu
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Johanna Weir, PA
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Kenda Dean, ARNP
Kiamichi FMR - Idabel
Morton CHC - Tulsa
Muskogee Pulmo
Nancy Dantzler, ARNP
OU FMC
Robin Avery, ARNP

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 2014 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

OK, here it goes. There has always been a degree of controversy on the effectiveness of flu vaccine on reducing mortality, hospitalizations, etc. On the other hand it's an inexpensive, safe intervention, so I go along with the recs but if a patient doesn't want it, I don't push it. We probably do oversell it, but we oversell much (most?) of medicine.... Hey [ ] --comments? [ ] MD

Rather interesting article. Makes me wonder if we often "over sell" the things we do and then end up with a loss of credibility. One only has to think about how HRT was going to save lives, or, our rethinking the efficacy of breast and prostate cancer screening. [ ] DO

I agree. However, I would take one step further and say that we need to decide how hard to "sell" a particular intervention based upon each person's risk factors. Some people stand to benefit more from flu vaccine than others. Also, patients tend to over-appreciate quality of life and under-appreciate length of life. Therefore I believe it is our responsibility to sell things like colonoscopy, which don't generally sell themselves. [ ] MD

If we're too forthcoming on how little we know about how to treat most illnesses we might lose what little credibility we still have... [ ] MD

I had a very intense discussion with my mother's internist, who looked at her (age 86, failing health, very unfit) and told her to quit smoking, eat a proper diet to lose weight and get more exercise. Clearly, he wasn't seeing the woman who was sitting in the room. I "kinda" lost it and asked him if he was looking at this woman. Probably not the best way to endear myself to him (not that I cared). It is hard to make decisions about our own health and healthcare. We are afraid we'll be wrong. That's why most of us want to believe you know the answers. When you don't, it's all about who is sitting in the exam room. That is the only way to gauge how you will go about empowering us to participate in our healthcare. For me, the focus was always on prioritizing and trying to move things forward a little bit at a time. Some of the questions I used to ask either myself or my patients included:

1. Are you still interested in staying alive?
2. Under what circumstances would you no longer want to be kept alive? (no antibiotics for pneumonia).
3. What are the most likely reasons this person might die prematurely? Is there anything I can do about them?
4. What does a typical day look like for you?
5. What would you like to be able to do that you can't do now?
6. What are the things that make life worthwhile for you, without which you wouldn't want to go on living?
7. How can I help this person become more resilient, better able to handle the next challenge? [ ] MD

Let me just say that as a new physician, I am learning a great deal from this thread. Thank you to all contributors. [ ] MD

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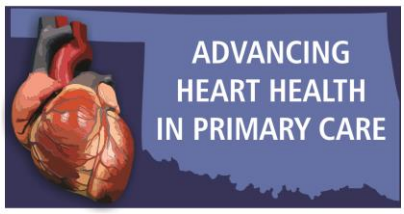
In The Spotlight – YourCare Clinic – Yukon, Oklahoma

YourCare Clinic is a friendly clinic for all ages, providing primary care and acting as a convenient after-hours alternative to primary family providers. Located inside the Yukon Homeland Supermarket, providers are available at the patient's convenience Monday through Saturday and during extended hours. Offering services such as immunizations, allergy testing, sports physicals, well-child and well-woman checks, acute sick care and routine tests, YourCare provides quality care in a comfortable setting with compassion and empathy for patients of all ages.▲

Healthy Hearts for Oklahoma (H2O)

The Oklahoma Cooperative for AHRQ's

EvidenceNOW



Healthy Hearts for Oklahoma (H2O) – The Missing Link

– Dan Duffy, MD, MACP & Principal Investigator

As readers of this newsletter know, the James W. Mold Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) of the Oklahoma Clinical and Translational Research Institute (OSCTRI) was awarded a $15 million grant to study the impact of a multidimensional primary care practice enhancement process. Many of the OKPRN members have contributed to the background research and development that led to this great accomplishment.

In a nutshell, the H2O or Healthy Hearts for Oklahoma project, assembles the pieces of the OPHIC or the "Cooperative." A home and a staff have been assembled. Steve Crawford and I are tasked with leadership of the cooperative. We have a staff led by Meg Walsh and the project is managed by Chuck Tryon. Zsolt Nagykaldi developed our primary care database, an electronic practice record and the facilitation training program.

The works of the project's intervention are 19 Practice Enhancement Facilitators (PEAs), five coordinators (PFCs), five technical practice advisors (PAs) to help practices get performance measures and maximize the efficiency and effectiveness of their electronic medical records. Thirty-six clinicians across the state, two-thirds of whom are clinicians, provide academic detailing (AD) support to practices through two face-to-face visits with the practice clinicians.

The partners and contractors for the cooperative are the Oklahoma Foundation for Quality Improvement, the Community Services Council, MyHealth Access Network, the Oklahoma Center for Healthcare Improvement, and the I.H.S., tribes, and other health systems across Oklahoma.

The College of Public Health, the College of Medicine Department of Family and Community Medicine, the School of Community Medicine Department of Medical Informatics, and the OSCTI are working seamlessly to create the cooperative. That is no simple task!

Over 250 small practices with 1 to 10 clinicians have agreed to engage with an academic detailer, PEA, and PA for a year. They will use their electronic medical record and MyHealth Access Network, when possible to measure the quality of their care using four measures of heart disease prevention. These are the use of low dose aspirin for secondary prevention of heart disease, control of BP to less than 140/90 for patients with hypertension, counseling tobacco users to quit, and using statins to lower risk of heart disease for patients at high risk because of cholesterol, diabetes, or existing heart disease. The OPHIC model provides so much more than outcomes-based measurement of the implementation of evidence-based guidelines for preventing heart disease. OPHIC offers practices assistance in achieving four goals of a vibrant primary care practice:

1) ***Quality of Care*** for preventing heart disease or whatever else the practice chooses as a focus;

2) ***Financial Security*** through preparation for the value-based payment models contained in MACRA and MIPS. Our expertise has been demonstrated by the Comprehensive Primary Care program. H2O participants will be ready to apply for and succeed in the CPC plus program to be launched over the coming year. The additional funding of thousands of dollars, more efficiency and better outcomes will be one of the strongest assets for financial security bringing thousands of new dollars into the practice.
3) ***Joy in Practice*** is the secret sauce in a vibrant practice. Patients heal when the practice is a place to thrive and grow. Teamwork and working at the top of everyone's license contribute to joy in practice as does belonging to a larger group of like-minded professionals.
4) ***Healthy Community*** contribution not only adds to joy in practice, but recognizes that the primary care clinician practice is not solely responsible or resourced to provide the healthy environment and life choices needed by our patients. We can do this together as a community aiming our collective efforts at health. H2O practices learn how to incorporate community resources into practice and how to influence the policies and programs of community and county health organizations.

We are one year into the H2O project. Recruitment and enrollment is done. We are now working to achieve the four goals of a vibrant practice for the participating practices and clinicians, many of whom are OKPRN members. None of this would have happened if it had not been for the years of work OKPRN members put into testing and proving the effectiveness of the multiple interventions for enhancing the quality of practice.

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Meg's Memo – Meg Walsh, OKPRN Network Coordinator

Last year OKPRN members completed a priority survey where you told us the topics you were interested in learning more about. **Advance Directives** were at the top of that list. We heard you and now we're able to do something about it! Clinician/Researcher Elizabeth Wickersham, MD and MPH candidate Munim Deen (who presented at the OKPRN convocation last year) have been awarded grant funding to focus on Advance Directives: to determine the current barriers to implementation of AD's with patients and clinicians, and to best address these barriers to improve implementation of AD's within the community setting.

This project will lay the foundation for subsequent projects that will help Dr. Wickersham and Mr. Deen develop an evidence-based Practice Toolkit for implementing advance directives, available to healthcare professionals throughout the state and nationally in order to assist their patients with end-of-life care planning. And all this because you asked for it!

The voice of the clinician has always been of vital importance to the success of OKPRN. We don't want to be doing research that isn't of interest to you or relevance to your practice. Keep the good ideas coming! If there is something you'd like us to focus on, or something that makes you think, "hmmmm," let us know.

Please do not hesitate to drop me a line to share your thoughts with me – Margaret-Walsh@ouhsc.edu or 405-271-3451.

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OKPRN Project Updates – Mold / Nagykaldi / McCarthy

Name of the Project	**Healthy Hearts for Oklahoma (H2O)**
Funding Source/Amount/Period	Agency for Healthcare Research and Quality (AHRQ) Funding: $15,000,000; 2015 - 2018
PI/Director Contact Information	Daniel F. Duffy, MD (Daniel-Duffy@ouhsc.edu) Steven Crawford, MD (Steven-Crawford@ouhsc.edu)
Purpose of the Project	1) Construct an effective and sustainable Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) to disseminate and implement the results of patient-centered outcomes research 2) Help 300 small to medium-sized primary care practices improve management of four cardiovascular disease risk factors: smoking, blood pressure, cholesterol, and use of low-dose aspirin; and 3) Carefully evaluate the effectiveness of the implementation strategies.
Participant Enrollment Status	We are actively recruiting 250 practices across the state of Oklahoma. To be eligible practices must: 1) Have 10 or fewer clinicians. 2) Have an EMR/ER. 3) Be connected to, or be willing to be connected to, the Health Information Exchange (HIEO)
Key Findings To-Date	None yet.
Requests to OKPRN Members	We need **MANY** OKPRN practices to participate in this study. Contact the PIs for more information or complete the practice interest survey to determine eligibility http://healthyhearts.ouhsc.edu

Name of the Project	**Implementing a Community-Based Model for Delivering Preventive Services in Rural Counties**
Funding Source/Amount/Period	Agency for Healthcare Research and Quality (AHRQ) Funding: $1,400,000; 07/01/2014 - 06/30/2018
PI/Director Contact Information	Zsolt Nagykaldi, PhD (znagykal@ouhsc.edu)
Purpose of the Project	1) Substantially increase the rates of delivery and receipt of evidence-based primary, secondary, and tertiary preventive services to approximately 70,000 individuals, cared for by 59 primary care clinicians in 20 PCPs in 3 rural counties; 2) Increase average estimated life expectancies of those patients; and 3) Calculate the financial impact of the model on participating hospitals, primary care practices, and county health departments. 4) Prepare a Guidebook that can be used by other rural counties wishing to implement similar models
Participant Enrollment Status	In progress.
Key Findings To-Date	None yet. The project is in the 6-month run-in period including relationship building, recruitment, and administrative work.
Requests to OKPRN Members	None at this time.

Name of the Project	**Clin-IQ: Resident Scholarly Activity**
Funding Source/Amount/Period	None.
PI/Director Contact Information	Elizabeth Wickersham MD (elizabeth-wickersham@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	**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	Zsolt Nagykaldi, PhD (zsolt-nagykaldi@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	**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	Elizabeth Wickersham, MD (elizabeth-wickersham@ouhsc.edu)
Purpose of the Project	The purpose of this project is to find a faster, simpler way to determine if a patient has actually been bitten by a brown recluse spider, so the bite can be managed 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	We request your participation in the brown recluse project. 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: $20,000,000; 2013-2018
PI/Director Contact Information	Mark Doescher, MD (mark-doescher@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 produce 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. In 2013, the OUHSC received a 5-year grant, which established the Oklahoma Clinical and Translational Science Institute (OCTSI) and the Oklahoma Shared Clinical and Translational Science Resource (OSCTR). One of the "key component activities (KCA)" is called "Community Engagement." Funding for this activity is going toward a network coordinator (Meg), support for spread of the ClinIQ process to other programs and institutions, and development of a "translational think tank" process that helps move research along the pipeline more quickly. Continued development of the Oklahoma Primary Healthcare Extension System is also included within the Community Engagement KCA.
Participant Enrollment Status	The OUHSC was awarded the grant. Activities began September 1, 2013. Funding for a 60% FTE 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

2013-15 Publications From Research Linked to OKPRN

- Mold JM, Aspy CB, Smith PD, Zink T, Knox L, Darby Lipman P, Krauss M, Harris DR, Fox C, Solberg LI, Cohen R. Leveraging Practice-based Research Networks to Accelerate Implementation and Diffusion of **Chronic Kidney Disease Guidelines** in Primary Care Practices: a Prospective Cohort Study. Implementation Science. 2014, 9:169
- Nagykaldi Z. Practice-based Research Networks at the **Crossroads of Research** Translation. J Am Board Fam Med. 2014 Nov-Dec;27(6):725-729
- Krist AH, Beasley JW, Crosson JC, Kibbe DC, Klinkman MS, Lehmann CU, Fox CH, Mitchell JM, Mold JW, Pace WD, Peterson KA, Phillips RL, Post R, Puro J, Raddock M, Simkus R, Waldren SE. **Electronic health record functionality** needed to better support primary care. J Am Med Inform Assoc. 2014 Sep-Oct;21(5):764-71.
- Mold JW. How **primary care produces better outcomes** - a logic model. Ann Fam Med. 2014 Sep;12(5):483-4.
- Mold JW, Fox C, Wisniewski A, Lipman PD, Krauss MR, Harris DR, Aspy C, Cohen RA, Elward K, Frame P, Yawn BP, Solberg LI, Gonin R. **Implementing asthma guidelines** using practice facilitation and local learning collaboratives: a randomized controlled trial. Ann Fam Med. 2014 May-Jun;12(3):233-40.

- Nagykaldi ZJ, Jordan M, Quitoriano J, Ciro CA, Mold JW. User-centered design and usability testing of **an innovative health-related quality of life module.** Applied Clinical Informatics 2014; 5:958–970.
- Nagykaldi Z, 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.

OKPRN By The Numbers	
MEMBERS	
Total membership	281
By member status	Active members: 213; Affiliate members: 49; Inactive members: 19
By discipline	MDs: 166; DOs: 56; NPs: 25; PAs: 21; Other: 13
By specialty	Family & General Medicine: 231; Internal Medicine: 11; Pediatrics: 16; OBGYN: 5; Other: 18
By demographics	Gender: 39% female; Mean age: 40-49 years; Mean years in practice: 10.5 years; Mean years in OKPRN: 6.5 years
PRACTICES	
Number of practices	149
By location	Urban: 47; Sub-urban: 30; Rural: 72
By OK quadrant	SW: 35; SE: 45; NE: 32; NW: 34; +1 former member now in Texas
By ownership	Hospital: 42; Physician or group: 55; Other corporate or system: 16; HMO: 1; Government: 2; FQHC: 11; Indian Clinic: 15; University: 16.
Average practice size	~2.2 OKPRN clinicians per practice (counting OKPRN members only)

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