OKPRN News

Fall / Winter 2009

President's Message

Noble Ballard

For those of you who do not know me. I am a family practice physician from Altus, OK. In the first meeting of my OKPRN presidency, the Board transferred OKPRN's administrative contract from Rural Health Projects to the OUHSC Department of Family and Preventive Medicine. This will provide us with a smaller financial obligation and a little more flexibility. However, we need a minimum of $20,000 per year to keep the network running smoothly. Please consider a charitable contribution directly to OKPRN, Inc., or to the Family Health Foundation of Oklahoma with OKPRN designated as the beneficiary.

I hope that you all realize that OKPRN is one of the premiere regional practice-based research networks in the U.S. We now have more than 140 member practices and more than 250 member clinicians who care for more than 10% of the state's population. Through the years OKPRN has introduced a number of innovations that have spread to other networks and quality improvement organizations around the country. These have included separating the network from the University as a 501(c)(3) organization, research mini-fellowships for clinicians, practice enhancement assistants (PEAs), best practices research, local learning collaboratives, and blending quality improvement and research to bring additional resources into practices. The newest proposal for inter-practice site visits to spread local best practices seems equally promising. Please provide your feedback through the listserv regarding this concept.

It is a daily concern of all of us that the U.S. Congress is struggling with health care reform. The work we have done in OKPRN is featured in the Senate bill, which proposes an extension service for primary care that includes PEAs.

Influenza Surveillance

Zsolt Nagykaldi

OKPRN continues to be involved closely with the seasonal and H1N1 influenza sentinel surveillance initiative in Oklahoma. Our past arrangement with the Oklahoma State Department of Health (OSDH) that utilized the OKPRN Influenza-Like Illness (ILI) surveillance website was discontinued by the OSDH in 2008. The system continues to rely on a number of OKPRN clinicians to report, but reporting is now done through a specific OSDH website (also called the PHIDDO website): https://www.phin.state.ok.us/phiddo. This site is similar to the original OKPRN site, and the same parameters can be reported (number of ILI patients in each age category, total number of patients, number of type A and B positive tests, etc). Reports go directly to the OSDH and a weekly summary is distributed to the OKPRN listserv.

If you are interested in participating in the new ILI surveillance system, please contact Renee Powell, MPH at the OSDH via phone: (405) 271-4060 or via e-mail: reneejp@health.ok.gov

New Influenza Patient Self-Management Contract

Zsolt Nagykaldi

We recently received funding from the Agency for Healthcare Research and Quality (AHRQ) to improve a web-based influenza patient self-management tool that we developed two years ago. The tool is an interactive website that helps patients decide what to do when they think they might have influenza, when to seek help, and how to manage their symptoms. The purpose of the current project is to improve the self-management website (e.g. include an update feature), make it compliant with federal regulations, and develop an implementation guide that helps practices download

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the self-management web package from the AHRQ website and embed it into their own websites. In the course of the project, we will receive feedback from four primary care practices (two OKPRN and two STARNET practices in Texas) that will help us refine the implementation guide and the process of implementation. We will inform you when the new tool is available (probably early next year).

Stephens County Aspirin Initiative

Jim Mold

The Oklahoma State Department of Health (OSDH) funded OKPRN researchers and the Duncan Regional Hospital Foundation to undertake a community-based intervention designed to increase appropriate low-dose aspirin use for prevention of cardiovascular events. The project was conducted from January 2009 through June 2009 in Stephens County (pop 43,182). A local family physician, Kent King, M.D., directed the project at the community level, and one of his daughters, Katy King, a college student, did much of the groundwork.

Key community stakeholders and an Aspirin Task Force helped the OSDH design educational posters, bookmarks, and clinician educational handouts. The community developed sample church bulletin announcements, messages for the hospital electronic message board, newspaper articles, radio and TV spots, and billboard displays. Estimated numbers of people reached through the various advertising venues per week were as follows: churches 5460, billboards 4950, newspapers 10,000, TV and radio unknown. Eleven pharmacies and 13 physician practices displayed the posters and distributed bookmarks.

A survey administered to all 11 pharmacies and 7 of the 18 physicians at the end of the project indicated that most doctors and pharmacists believed that the project was effective in raising community awareness and that the educational materials used for the program were useful. They reported a 35.7% increase in the percentage of patients counseled about aspirin therapy, and a 66.2% increase in the percentage of patients who asked about low-dose aspirin therapy. Duncan Wal-Mart data showed that sales of aspirin, both low-dose (81mg) and standard dose (325mg) increased significantly (25% increase) during the project. Discharge data from the Duncan Regional Hospital indicated that rates of heart attacks, strokes, and GI bleeds did not change significantly, but the numbers were small.

Obstructive Sleep Apnea

Jim Mold

OSA is diagnosed and managed in primary care settings. Four other networks (South Florida, Alabama, ProHealth in Connecticut, and Los Angeles) are also providing data. The study will be completed on December 31, 2009. So far, we can release the following tentative results.

OSA is managed fairly similarly in the five states. Almost two-thirds of patients surveyed in primary care waiting rooms are at high risk for OSA based upon a validated screening tool (Berlin Questionnaire). Most of these patients have never been tested, diagnosed, or treated. Very few primary care practices routinely screen for OSA. Nearly all patients referred for diagnostic testing receive a polysomnogram (PSG), usually with split night testing. Almost none are offered home sleep testing. More than three-fourths of the PSGs are positive. Most patients do not receive a consultation from a sleep consultant. Treatment is almost always some form of positive airway pressure device (e.g. CPAP). A large proportion of patients discontinue use of the device after a few months. Ongoing care and documentation of use and improvement in symptoms are inconsistent. Coordination of care between primary care clinician, sleep lab consultant, and durable medical equipment company could be improved. The assistance provided to patients by the durable medical equipment companies is often inadequate.

If anyone has suggestions for ways to improve the recognition and management of OSA patients that we can relay to AHRQ and Medicare, please contact me (james-mold@ouhsc.edu).

Primary Care Extension and Health Access Networks

Jim Mold

Based in large measure on the studies conducted in OKPRN over the last 10 years, departments of the federal and state governments are considering, along with payment reforms and other primary care support initiatives, the development of a primary care extension service. The concept is that local quality improvement efforts, based upon local knowledge and local relationships, are likely to be more effective and efficient than centralized ones. This is similar in concept to Cooperative Extension for agriculture. The goal would be to create local coalitions of primary care clinicians, public health departments, mental health providers, and key community organizations that would work together off of a common budget to improve the health of their local population and reduce health care costs.

Key functions of these local coalitions would include practice facilitation, care management, health information exchange, and outcome measurement. Basic funding would come from health insurance companies including Medicaid, Medicare, and private insurance companies and possibly the Health Resources and Services Administration (HRSA) or AHRQ. Project-specific funding would come from multiple sources (payers, NIH, AHRQ, CDC, foundations, local industries, etc.). For additional information about this idea, see "A health care cooperative extension service: Transforming primary care and community health" by Kevin Grumbach and James Mold, published in JAMA, June 24, 2009, volume 301(24), pages 2589-2591, which can be accessed through the OKPRN website under "Publications" OKPRN is prominently featured in the article.

Diabetes Quality Indicators Study

Jim Mold

An application for funding was submitted in October to the Agency Healthcare Research and Quality (AHRQ) to study the degree to which diabetes quality indicators are associated with patient-oriented outcomes. We will also examine reasons why clinicians and patients choose to follow or not follow standard diabetes guidelines. If funded, the project would include 10 OKPRN clinicians and 150 patients who would provide data annually over a period of 5 years. An equal number of clinicians and patients from Los Angeles would be enrolled. Outcomes would be both monitored over time and also projected, using a risk prediction tool. We should hear about funding in late Spring or early Summer.

Two-year grant from the National Heart, Lung, and Blood Institute

Asthma Guidelines Implementation Project

Jim Mold

OKPRN researchers have received a two-year grant from the National Heart, Lung, and Blood Institute to study the comparative impacts of practice enhancement assistants (PEAs) and local learning collaboratives (monthly lunch meetings involving geographically clustered practices) on implementation of asthma guidelines. The project will include 24 OKPRN practices and 24 practices from Western New York (Rochester and Buffalo). Additional information is provided in the enclosed flyer. Please let me know if your practice is interested in participating (james-mold@ouhsc.edu).

Clinical and Translational Science Institute

Jim Mold

In response to feedback from individuals, communities, and their legislators, the National Institutes of Health (NIH) under its previous director launched a major initiative designed to transform health research. The goal of the Clinical and Translational Science Awards (CTSA) program is to align health researchers in ways that will increase the probability that their discoveries will actually improve the health of the public. The NIH has announced that it intends to fund 60 academic medical centers who agree to completely transform their research enterprises, including putting a greater emphasis on clinical research and on getting the results of research into practice. Forty-six centers have been funded so far.

The University of Oklahoma Health Sciences Center (OUHSC) applied for and received a one-year planning grant three years ago and received a good score (but not quite good enough to be funded) on its first application for a CTSA grant last year. A second, improved application was submitted in October. Included in the OUHSC proposal are funds to support OKPRN and two new networks currently under construction, in Pediatrics and Pharmacy. It also includes funding to expand and enhance the ClinIQ Program, establish some translational think tanks that could include some OKPRN clinicians, and link OKPRN practices to software that would make quality improvement and research participation easier for them and for academic researchers. We should hear about funding in late Spring or early summer of 2010.

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The Future Delivery of Preventive Services

Zsolt Nagykaldi

In the past year, we have been working on a novel, sophisticated electronic Health Risk Appraisal (HRA) tool to capture personalized risk information from patients in the course of their regular care. Health information is entered securely by the patient online before or between visits and then processed real-time by a comprehensive risk engine that takes over 230 individual risk factors into account. The result is a highly personalized and prioritized list of recommendations for preventive actions that can be printed by the patient, electronically transmitted to any healthcare location, or reviewed online by the practice. The report also provides a life expectancy estimate, a translation of the life expectancy estimate into a "real-age" parameter, and the ranked effects of behavioral and care improvements on life expectancy. In the future, the report will also include resources that can help patients achieve their personalized goals. The HRA tool can become the engine of a more ambitious and comprehensive care delivery model that focuses on individualized, prospective Wellness Plans developed and managed by prepared, proactive patient-practice teams, within the framework of the Patient Centered Medical Home (PCMH).

Health Information Exchange

Jim Mold

The OU Department of Family and Preventive Medicine has received a contract from the Agency for Healthcare Research and Quality (AHRQ) to study the impact of health information exchange on primary care practices. We have chosen to focus on Cleveland County because of the progress they have already made. The involved primary care clinicians are all members of OKPRN.

The Norman Physician Hospital Organization (NPHO) was formed in 1994 to provide cost effective, quality health care to the residents of the counties served by the health care providers that comprise the NPHO. In an effort to further enhance continuity and

quality of care provided by network members, the NPHO has developed a Clinical Integration Plan which utilizes electronic medical records in conjunction with an electronic information interface to facilitate the collection and sharing of clinical information. Currently, 32 primary care providers are using eClinicalWorks. Thirty specialists in orthopedics, neurology, endocrinology, general surgery, gastroenterology, pulmonology, OB/GYN, urology, and cardiology are also participating in the network, using eClinicalWorks™ Electronic Health eXchange (eEHX) to create a local network hub to coordinate the transfer of data. This allows providers to better monitor and manage care for patients, promote patient safety while reducing costs, and improve patient health by improving continuity and coordination of patient care.

In addition, the NPHO plans to connect the HIE hub to SMRTNET, an Oklahoma developed Regional Health Information Organization (RHIO), allowing providers to access 37 million records from across the state for patients receiving care beyond the NPHO network. The planned connection of this local HIE to a RHIO provides the opportunity to study how such connections improve health care delivery and benefit patients. The contract will also allow us to connect NPHO practices to the Preventive Services Reminder System through SMRTNET.

Three Counties Participate in EPSDT Enhancement Project

Cheryl Aspy

For the past several years, OKPRN has been collaborating with the Oklahoma Health Care Authority and the OU Child Study Center to develop a more efficient way to increase the rate and improve the quality of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examinations. We used methods that had been successful in other quality improvement initiatives such as academic detailing, performance feedback, practice facilitation, and case management.

Research assistants audited charts (n=25) for each of the five age groups (<1, 1, 2-5, 6-14, and 15-20 years) and determined the number of visits that should have occurred and noted the number that actually occurred. The quality of each most recent visit was rated 0, 1, 2, 3, or 4 (0, 25%, 50%, 75%, or 100% respectively) in each of the following categories: Vital Signs, Health History, Assessment of Development and Behavior, Physical Exam, and Anticipatory Guidance. This data was collected both at baseline and at the end of the project. Practice Enhancement Assistants worked with each clinic to help them identify specific activities they could use to improve their rates of EPSDT visits as well as enhance the delivery of quality care. Principles summarized from those practices that were most effective in improving their visit rates included the following:

1. Call patients in the evenings and on weekends to remind them of their appointments and need to schedule appointments.
2. Make sure that no opportunity is missed by converting illness visits to EPSDT visits when possible.
3. Have older kids come in for their EPSDTs on their birthday or shortly thereafter.
4. Nurses do much of the visit.
5. Split the bonus payments among staff

When these specific techniques were implemented, the visit rates improved significantly. Table 1 contains the baseline and follow-up percents for both quantity and quality of visits for all three counties.

Pre-Post Rates:

	Canadian	Garfield	Delaware
	Rate/Quality	Rate/Quality	Rate/Quality
Baseline	67%/71%	59%/58%	56%/82%
6 Mo	76%/85%	59%/67%	61%/83%
12 Mo	73%/94%	NA/NA	NA/NA

Publications

Duff K, Mold JW, Gidron Y. Cognitive functioning predicts survival in the elderly. J Clinical and Exp Neuropsychol 2009;31(1):90-5.

Fox A, Gandhi S, Aspy CB, Mold JW. Which Adults Should be Tested or Treated for Vitamin D Deficiency? JOSMA 2009; 297-298.

Shah N, DeLeon D, Schwiebert P, Mold JW. Does anticoagulation benefit patients with congestive heart failure (CHF) who have reduced left ventricular ejection fraction (LVEF) and are in normal sinus rhythm? JOSMA 2009; 102(4):126-127.

Smith KD, Merchen E, Turner CD, Vaught C, Nagykaldi Z, Aspy CB, Mold JW. Patient-Physician E-mail Communication Revisited A Decade Later: An OKPRN Study. JOSMA 2009 (Sept);291-293.

Terrell DR, Beebe LA, George JN, Vesely SK, Mold JW. Referral of patients with thrombocytopenia from primary care clinicians to hematologists. Blood 2009 Apr 23;113(17):4126-7.

Solberg LI, Elward KS, Phillips WR, Gill JM, Swanson G, Main DS, Yawn BP, Mold JW, Phillips RL Jr. How can primary care cross the quality chasm? Ann Fam Med. 2009 Mar-Apr;7(2):164-9.

Grumbach K and Mold JW. A health care cooperative extension service. JAMA 2009; 301(24): 2589-2591.

Presentations

James Mold

Practice-based research. University of North Carolina Family Medicine Faculty Development Fellowship Seminar. Chapel Hill, NC. 8/13/09.

A primary care extension services. DHHS Health Resources and Services Administration (HRSA) Annual healthcare Workforce Summit, Washington DC, 8/11/09.

Recognition, diagnosis, and management of obstructive sleep apnea in primary care. Annual AHRQ PBRN meeting, Bethesda, MD, 6/25/09.

Workshop: Identifying practices most likely to benefit from QI interventions. Annual AHRQ PBRN Meeting, 6/24/09.

Implementation research. University of California, San Francisco researchers, 5/18-19/09.

Implementation research. University of Wisconsin, Department of Family Medicine Grand Rounds, 5/7/09.

Zsolt Nagykaldi

Evaluating innovation: Measuring the benefits of health IT interventions. 42nd STFM Annual Spring conference, Denver, CO, 4/30/09.

Pandemic influenza preparedness: Surge capacity and triage to encourage influenza self-care at home. 42nd STFM Annual Spring conference, Denver, CO, 5/2/09.

Wellness portal and health risk appraisal projects. Annual OKPRN-OAFP Joint Convocation, Tulsa, OK 6/18/09.

Pandemic influenza preparedness in primary care. Annual OKPRN-OAFP Joint Convocation, Tulsa, OK 6/19/09.

Using health risk appraisal to personalize and prioritize prospective care in primary care practices. Annual AHRQ PBRN meeting, Bethesda, MD, 6/24/09.

Translational research and health information exchange (HIE). Oklahoma's Health Information Technology for Economic and Clinical Health Summit – OKHITECH, 8/14/09.

Integrating primary care providers into community pandemic influenza preparedness. CDC Planning Stakeholder meeting, Atlanta, GA, 8/24/09.

Medical home in practice: Harnessing technology to provide patient-centered prospective care. STFM Annual Conference on Practice Improvement, Kansas City, MO, 11/5/2009.

Highly personalized life-expectancy calculations and prioritization of services using e-health risk appraisal and the Cox proportional hazards model in primary care settings. 37th NAPCRG Annual Meeting, Montreal, Canada, 11/14/0

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Upcoming Events

June 17th – 20th, 2010

OAFP Annual Scientific Assembly and OKPRN Convocation at the Renaissance Hotel & Conference Center, Tulsa, Oklahoma

ADDENDUM

Improving care for asthma patients:
Helping practices implement asthma guidelines

OKPRN has received a 2-year grant from the National Heart, Lung, and Blood Institute (NHLBI) to study ways to help practices implement the most recent Asthma Guidelines.

Who can participate? We are looking for practices that have seen at least 50 asthma patients between 6 and 65 years of age in the past 2 years, and are interested in improving their processes of care for these patients. Once your practice is enrolled in the study, it will be randomly assigned to **one** of the following four study groups:

1. An ***information only*** group that will receive the NHLBI asthma guideline, a two-page summary of the guideline, and an asthma care toolkit based upon the guideline
2. A group that receives information and assistance from a practice enhancement assistant
3. A group that receives information and participates in six monthly one-hour lunchtime discussions of asthma care strategies (local learning collaboratives)
4. A group that receives information, assistance from a practice enhancement assistant, and participates in six monthly lunchtime discussions of asthma care strategies

In addition to the above assistance, participating practices will also receive:

- $2,000 per practice ($500 after enrollment and $1500 after completion)

If your practice is randomly assigned to group 2 or 4, you will also receive:

- Part IV Maintenance of Certification credit (quality improvement module)
- AAFP Prescribed CME credits (20 hours)

What are the requirements for participation in the study? All practices will be expected to implement the NHLBI asthma guidelines. Specific approaches can be individualized.

- Practices with PEAs will meet with their PEA for approximately 1/2 hour per week to look at performance data and plan implementation strategies
- Practices involved in the lunchtime discussions will meet with two other practices over lunch for one hour once a month to review performance data and discuss strategies

What data will be collected? We will work with you and your staff to collect the following information required for the study:

- Written consent from all members of the practice (clinicians, staff, and administrators)
- A list of all patients 6 – 65 years of age with asthma who made at least one visit to the practice within the past year (collected winter 2009/10 and again in March 2011)
    - A medical records auditor will arrange to visit your office to abstract information from randomly selected medical records

The following will be collected both before and after study participation:

- A survey about your practice and the processes that you use
- A survey on asthma care that will be completed by each staff member
- A phone interview to clarify the information provided in the surveys

What Constitutes a "Practice" for Purposes of this Project

For this project, a "practice" is defined as a group of clinicians, nurses, medical assistants, and other office staff who have the authority and ability to make substantive changes in the processes used to care for asthma patients. In some cases this could include as few as one clinician and one medical assistant, even though their may be many more clinicians and staff working in that clinic. In other cases, all members of a clinic or health care organization may need to be involved. In all cases, all members of the "practice" as defined above will be required to commit to this project, sign an informed consent document, complete the required survey instruments, and be at risk for being interviewed by phone.

What is a Practice Enhancement Assistant (PEA)?

Practice enhancement assistants (PEAs) are professionals trained to help primary care practices improve their patient care processes. They ordinarily operate under Business Associate Agreements with the practices, or under HIPAA waivers for approved research projects like this one. They help practices by showing them better ways to do things (based upon research and the successful methods used in other practices), by organizing quality improvement cycles (Plan-Do-Study-Act), by helping them to identify and overcome obstacles, and by providing periodic performance feedback. PEAs become temporary members of the practice, acting as "change agents" and facilitating individualized solutions. Both OKPRN and UNINET now have extensive experience with PEAS, and have found that practices generally find them very helpful and non-intrusive. In this project, we expect that the PEAs will spend approximately one half-day per week in each practice. Much of this time will be spent observing and reviewing charts. We are asking that at least 30 minutes (ideally an hour) be spent meeting with key clinicians and staff to review progress and next steps.

What is a Local Learning Collaborative (LLC)?

Collaborative learning groups (CLGs), also called learning collaboratives generally involve fairly large numbers of distinct practices that receive education, perform periodic medical record reviews, implement registries, and work individually and collaboratively to implement evidence-based practices over time. Bringing the practices together is thought to create urgency and competition, resulting in a greater desire for improvement. However, CLGs require participating practices to commit additional staff time to developing and maintaining registries and performing weekly abstracts, and several members of the practices are required to attend several all-day meetings. Thus, they seem to be best suited to larger practices or health systems with sufficient staff and other resources. There is also a tendency for practices involved in CLGs to rediscover ineffective strategies before moving forward.

Our experience suggests that the same urgency and competition and sharing of successful approaches can be achieved by small groups of practices meeting more often for shorter periods of time. In these settings, because of the relationships that exist or form, the practices are more likely to be willing to build on the effective strategies identified within the groups. These "local learning collaboratives" (LLCs) are small groups of practices, usually within the same geographic area, who work together to improve the quality of their work. The LLC concept assumes that those involved in a particular type of work are best qualified to identify problems and suggest improvements. In this study, groups of three practices will meet either in person or via televideo to share performance reports and learn from each other what seems to work and what doesn't work as well for providing optimal asthma care. The six monthly meetings will take one hour each. They will be facilitated by a member of the research team.