# OKPRN News

**Oklahoma Physicians Resource/Research Network** **Spring 2011**

## Board of Directors



## President's Message – *Noble Ballard*

Upon being accepted into medical school in 1960, I was ecstatic. I was sharing with Dr. Bill Ishmail, one of the doctors that had given me a recommendation, and he gave me some very good advice. He said once you get out and get busy, do not become a "stale doctor." By that he meant to keep up with the progress and innovations that medicine was to make and keep up with advances in medicine. Like you, I have seen a number of doctors who practice the same as they learned in school or post graduate work. But there are many who keep abreast of medicine and are ready to accept research and new developments in the art and science of medicine. They are the leaders of their community and practice the best medicine.

There is an organization in Oklahoma that has been quietly studying to advance the art and science of medicine. It is the OKPRN, a group of 200 plus private practitioners who work closely with researchers at the University of Oklahoma. The heart and soul of this organization is Dr. Jim Mold, professor and founder of OKPRN. He is a quiet, unassuming man who gets the most out of the research and makes it into good science. I became involved in 1997 when Jim gathered six practicing doctors and introduced us to the world of research. Over about five months, he guided us through the process of research and a paper on flu testing was produced.

Many papers have been presented at the summer convocations from practicing physicians just like you who have conceived and helped carry out the research, and then presented the papers. One of the most relevant and interesting of these do me was presented by a physician who treated returning solders who had post traumatic disorders. His conclusions were very beneficial to those of us who have had the sad experience of seeing these returning warriors. It is my opinion. he did a service to us and to the soldiers who have benefited from that research. An idea which would make a good and needed study can result from just a moment when you think of something while seeing a patient. Please don't let it go to waste. Be creative!

Now I am in the twilight of my career, but I will still be involved in OKPRN and will still be amazed at the creativeness of fellow physicians. We need more physicians to join OKPRN and be involved. It's exciting and rewarding. You will also meet some people that you would not have met any other way. ▲

# OKPRN Convocation at the OAFP Annual Scientific Assembly *Jim Mold*

For the third straight year, the OKPRN Convocation will be held in conjunction with the OAFP Annual Scientific Assembly, June 16-19, at the Renaissance Hotel and Conference Center in Tulsa. Student/resident/faculty posters will be displayed and judged on Thursday, June 16. The OKPRN Research and Development Track will begin at 8 AM on Friday and continue until 5 PM on Saturday. Our keynote speaker this year will be L.J. Fagnan, a family physician from Oregon who spent 26 years in private practice before taking a position at the University of Oregon to establish direct ORPRN, their statewide practice-based research network. The OKPRN Board of Directors will meet on Friday from 4:10 PM until 5:10 PM in the Strasbourg Board Room. ▲

# Funding OKPRN *Jim Mold*

OKPRN is a non-profit, charitable 501c3 organization. Its annual costs include a $12,000 per year administrative contract with the OU Department of Family and Preventive Medicine, which maintains the membership database, hosts the website and listserv, produces a biannual newsletter, proposes presentations and keynote speakers for annual convocations, handles the bank account, taxes, and other records, organizes Board of Directors and business meetings and elections, fields questions, concerns, and suggestions from members, and maintains affiliations with national organizations (e.g. AHRQ, Federation of PBRNs, AAFP National Research Network). Additional costs include printed materials such as brochures, stationary, envelopes, folders, food for Board of Directors meetings, and the costs of a keynote speaker for the annual convocation. The organization hopes to be able to sponsor students and residents who want to become more involved in primary care research to go to national research and quality improvement meetings. Thus, OKPRN can function on about $15,000 per year, assuming that the cost of the administrative contract doesn't increase.

Because OKPRN has chosen not to charge member dues, the costs of running the organization must be captured through voluntary contributions and subcontracts on grants. Over the past three years, charitable contributions have totaled about $5,500 per year, while subcontracts have ranged from $5,000 to $22,500 per year depending upon how successful OKPRN-affiliated researchers have been with grant applications. The OKPRN bank account is currently in the black. However, financial stability of OKPRN will continue to depend upon your support. Thank you to those who have contributed in the past and those of you who plan to do so in the future! ▲

# OKPRN Website Utilization Report – Zsolt Nagykaldi

In the first part of this year, our website (www.okprn.org) continued to attract a considerable number of visitors and delivered value to the healthcare community in Oklahoma and beyond. In February of 2011, the OKPRN website was visited in 2,957 individual sessions and over 6,600 hits were registered from personal computers. Requests came from a wide geographical area beyond Oklahoma, including Canada, several European countries, Asia, and Australia. Our most popular resources include best practices documents, conference presentations, PEA Questions of the Week, clinical care guidelines and toolkits, and publications. Most notably, our website facilitated a unique trans-Atlantic collaboration with the Department of Family and Community Medicine at the University of Maastricht, the Netherlands in the person of Viola Voncken-Brewster, a primary care researcher and PhD candidate who will be working with us here in Oklahoma in the next three years as she studies how computer technology can improve patient self-management in COPD. ▲

## The Potential Value of Health Risk Appraisal (HRA) in Primary Care – *Zsolt Nagykaldi*

A current, federally funded OKPRN research project led by Dr. Nagykaldi is aimed at the development and testing of a novel, web-based HRA tool in primary care settings. The HRA tool is being deployed via the existing patient Wellness Portal website. Recent health care reform legislation mandated that the Centers for Medicare and Medicaid Services (CMS) must pay for annual wellness visits (AWVs) and the periodic completion of an HRA by Medicare beneficiaries. Clinicians, patients, and the healthcare community generally support this initiative as a step in the right direction to transform and improve primary care. However, it is not clear what type of HRA would be most helpful in primary care and the most efficacious way to implement it.

Although HRAs have been used widely since the early 70's in various wellness programs, very few studies looked at the systematic implementation of HRAs in primary care. The HRA study attempts to synthesize the knowledge base of several decades, lessons learned in HRA design and adoption, and best practices for practice enhancement in order to achieve a new synergy between clinical evidence, advances in "intelligent" heath IT, and our constant aspiration to personalize care in order to help our patients take ownership of their health. We expect that this approach could truly empower patients and clinicians to focus on the most effective and personalized care options that can achieve the two ultimate goals of medicine: helping patients live a longer and better life.▲

## The OKLAHOMA Studies 12 Years Later

In 1999, the Presbyterian Health Foundation gave the OU Department of Family and Preventive Medicine $200,000 to conduct a longitudinal study of older primary care patients to see, among other things, if the quality of primary care results in better patient outcomes (quality of life, physical and emotional functioning, and longevity). The project was called the OKLAHOMA Studies (OKlahoma Longitudinal Assessment of the Health Outcomes of Mature Adults). Eight hundred and fifty-four (854) patients of 26 OKPRN clinicians' completed questionnaires and were examined by two research nurses (vital signs, hearing, vision, cognition, balance, walking speed, and cognition) at baseline and annually for four consecutive years. The data from this study has resulted in 26 peer-reviewed publications, with 6 additional manuscripts in press or in the review process.

A recent analysis examined the original question, "Does the quality of primary care (as perceived by patients) predict longevity and/or future trends in quality of life?" The answer, which will be published in the Journal of the American Board of Family Medicine later this year, is fairly interesting. We are now looking at the impact of pets on quality of life and survival.▲

Save the Date, June 16 – 18, 2011 – OAFP Annual Scientific Assembly

## RESEARCH PROJECTS

# Obstructive Sleep Apnea: How concerned should we be, and can we do better? – *Jim Mold*

The evidence that obstructive sleep apnea (OSA) contributes to risk of serious adverse health outcomes is perhaps as strong as it is going to be, given that randomized controlled trials could be ethically and practically difficult. What we know is that the cost of care for those with OSA is reduced by 50% in the year following treatment. We also know that individuals with moderate to severe OSA have a 15 times higher rate of motor vehicle accidents and that OSA is associated with diabetes, hypertension, stroke, ischemic heart disease, congestive heart failure, impaired cognition, and mood disorders.

Based upon a study conducted in OKPRN and four other regional PBRNs, primary care practices are magnets for people with OSA. Because we see people with obesity, diabetes, hypertension, heart failure, stroke, and pulmonary hypertension approximately one in five (20%) of the adult patients being seen in our offices on any given day have undiagnosed OSA. Most of us are doing a poor job of detecting and treating these patients according to sleep experts. However, it isn't so easy to improve our performance.

Most OSA patients do not spontaneously mention their symptoms to us, probably because they hate to think of the cost of testing and the inconvenience of treatment and because they don't understand the health consequences of OSA. A good screening tool is available (the Berlin Questionnaire) and another tool is available for assessing the severity of symptoms before and during treatment (the Epworth Sleepiness Scale), but they are probably too long to administer to everyone at every visit. Guidelines are vague.

Management of OSA involves coordination among the various parties (patient and family, primary care clinician, sleep lab, sleep consultant, durable medical equipment vender, and insurance company). Treatment with CPAP is somewhat difficult and often requires a great deal of patient support and education particularly during the first three months. Patients with OSA should probably be seen on a periodic basis longitudinally to be sure that they continue to do well and that appropriate adjustments are made as required. Positive developments have included the availability of reliable home sleep tests and auto-PAP. In the future, more primary care physicians need to obtain the training needed to provide and interpret these newer sleep tests and to better manage patients with this common and serious sleep disorder. ▲

# Leveraging PBRNs to Accelerate Implementation and Diffusion of Chronic Kidney Disease Guidelines in Primary Care Practices – *Cheryl Aspy*

This AHRQ funded project involves 96 primary care practices in Oklahoma, Wisconsin, Minnesota, and Los Angeles with the goal of improving care for patients with chronic kidney disease (CKD). It involves two phases. Phase I uses a multi-component intervention (Academic detailing, Feedback, Practice Facilitation, and IT support) to help 32 practices (8 in each PBRN) improve their care of CKD patients by implementing current guidelines. During Phase II, each Phase I practice will teach two other practices how to implement the CKD guidelines using the knowledge and skills they have gained during Phase I. Currently we are collecting initial data to provide feedback to each practice about their current status in caring for CKD patients. This information will guide their intervention decisions to improve care. Each practice will work with a PEA for 6 months using Plan, Do, Study, Act cycles to find the best approach to insure guideline implementation. Phase II will begin in April 2012 with project conclusion scheduled for September 2013. ▲

## Improving Implementation of Asthma Guidelines- *Cheryl Aspy*

The purpose of this National Heart, Lung and Blood Institute funded project is to study ways to help primary care practices implement the most recent Asthma Guidelines. This is a joint project with OKPRN and two Western NY practice based research networks and involves 24 practices in each network. Practices were randomly assigned to one of 4 intervention groups: a) the information only group; b) the information plus PEA group; c) the information plus LLC group (Local Learning Collaborative); and d) the information plus PEA plus LLC group. We are now in Phase VII of the project and our current focus is collecting post surveys from all participants. All practices are encouraged to continue implementing asthma guidelines. Chart audits to test the effectiveness of each intervention group will begin in January 2012. Results from the pre-intervention data will be presented at the Convocation in June.▲

## Poison Ivy: T'is the Season – *Jim Mold*

Poison ivy is treated with topical and systemic agents with the intent of reducing the pruritis either by reducing the perception of pruritis or by reducing the inflammation that is causing it. A survey of OKPRN clinicians identified 27 different ways poison ivy is currently being treated in Oklahoma. There have been only three placebo controlled clinical trials reported in the English language literature since 1966. All have involved agents not in common use, none of which proved to be more effective than placebo.

We are now one year into a prospective study funded by the American Academy of Family Physicians Foundation of patients of all ages with poison ivy. Interested patients are enrolled over the phone by a research assistant. Enrolled patients agree to allow the research team to view their medical records related to the poison ivy episode and to complete a sign/symptom diary. Patients who complete the diary receive a $20 gift card.

The research questions are:
1) What are the characteristics of poison ivy and the patients who present with it in primary care practices?
2) What treatments are used most commonly by primary care clinicians in Oklahoma?
3) What treatments are associated with better outcomes after controlling for a variety of other variables?

The outcomes of interest are:
1. Time to resolution of pruritis, vesicles, raised lesions, and erythema
2. Reoccurrence of signs/symptoms following initial resolution

Potential modifying variables include: Patient age, gender, race, diagnosis of diabetes mellitus, ongoing use of systemic corticosteroids or other anti-inflammatory medications, and severity, parts of body affected, and percentage of surface involved.

So far 53 patients of 18 clinicians have enrolled in the study; and 38 patients have completed and returned diaries. Ten different categories of treatment have been used. Factors associated with slower resolution include involvement of arms and hands and presence of raised lesions at presentation. Treatment with oral corticosteroids appears to reduce time to resolution. Many treatment categories had too few instances to be evaluated. Our goal is to enroll 500 patients.▲

## PSRS / Wellness Portal Report – *Zsolt Nagykaldi*

We recently completed a three-year study funded by the Agency for Healthcare Research and Quality (AHRQ) that measured the impact of a novel, web-based patient Wellness Portal on patient-centered preventive care by examining the behavior and experiences of both patients and primary care clinicians and the degree to which recommended prevention services were provided. The prototype of the Wellness Portal was developed with the help of ten OKPRN practices and their patients between 2008 and 2010 and now it also incorporates a comprehensive health risk assessment tool that is being tested in another study. The Portal study included a 6-month feasibility and acceptability pilot in two primary care practices, followed by a 12-month cluster randomized controlled trial (c-RCT) in eight practices. The study design and data analyses accounted for clustering of patients

within practices. The majority of pilot study participants were satisfied with the Portal. Ninety percent found it easy to use, 83% found it to be a valuable resource, and 80% said that it facilitated their participation in their own care.

The c-RCT included 422 adults 40 to 75 years of age and the parents of 116 children 2 to 5 years of age. Seventy three percent of patients used the Portal during the study. Both patient activation and participants' perception of patient-centeredness of care increased significantly in the Portal group compared to control ($p=0.0014$ and $p=0.037$ respectively). A greater proportion of Portal users adhered to recommendations about aspirin use (78.6% intervention v. 52.3% control; $p<0.0001$), received pneumovax because of chronic health conditions (82.5% v. 53.9%; $p<0.0001$) and age (86.3% v. 44.6%; $p<0.0001$). Adult intervention group participants received 84% of all recommended preventive services, while in the control group, participants received only 67% of recommended services during the study period ($p<0.0001$). Children in the intervention group received 95% of all recommended immunizations compared to 87% in the control group ($p=0.044$).

Results of the Wellness Portal study suggest that a comprehensive patient portal integrated into the regular process of care delivery can increase the patient-centeredness of care, enhance the delivery of both age and personal risk factor -dependent preventive services, improve patient activation, promote the utilization of web-based personal health records, and increase the knowledge of clinicians about their patients' medical history in primary care settings. The Portal implementation demonstrated the importance of developing a more sophisticated understanding of patient-computer interactions and technology-related human behavior in primary care. ▲

## Linking Oklahoma Primary Care Practices and Cooperative Extension Community Nutrition Education Programs to Manage Obesity – *Toney Welborn*

The purpose of this project is to link primary care practices (PCPs) throughout Oklahoma with community-based nutrition education programs (CNEPs) offered by the Oklahoma Cooperative Extension Service Family and Consumer Sciences (OCES-FCS) Division to manage obesity. There are a total 24 PCPs participating in the project during this first year.

The CNEPs are available at no cost to low income clients and families and have been shown to effect healthy behavior changes. OCES-FCS has both an interest in and capacity for reaching more clients through primary care practice referrals. We proposed to use our well-tested quality improvement strategies to help PCPs improve recognition and referrals of overweight and obese patients and to help OCES-FCS learn to respond to these referrals.

We will track the success of referral initiation, patient enrollment in the nutrition programs, and patient, physician, and nutrition educator satisfaction using de-identified data already being collected through OCES-FCS's current enrollment and evaluation forms. Feedback to the practices will be tracked by review of medical records. Based upon lessons learned, we will develop a guidebook. This guide will provide other clinicians and county extension offices with the tools needed to create similar linkages.

Baseline audits were completed in the 24 practices. De-identified data included, weight, height, BMI, BMI percentile, age, gender, diagnosis of overweight/obesity, referrals for overweight/obesity. Below is baseline data about BMI percentile in children and BMI in adults. Among children being seen in these community health centers and residency program practices, 10% were overweight and 40% were obese (BMI > 95%). Among adults, 30% were overweight and 49% were obese (BMI > 30). Fewer than 10% of these patients had been referred for weight loss assistance. ▲