ORPRN: 2002 to 2017
by LJ Fagnan, MD, ORPRN Network Director

2002 saw the birth of the Oregon Rural Practice-based Research Network. Our practice-based research network (PBRN) started small with just seven rural communities—Reedsport (Robbie Law, Janet Patin), Baker City (Jon Schott, Pat Hart), John Day (David Graham, Bob Holland), Lakeview (Scott Graham, Bob Bomengen, Steve Hussey), Union & Elgin (Jeanne Bowden, Muriel Schaul), Hood River (Steve Becker, Rick Starrett), Lincoln City (Karl Ordelheide), and Pacific City (Albert Thompson). Fifteen years later, in 2017, ORPRN partners include 189 primary care practices across the state, comprised of over 500 primary care clinicians caring for approximately 500,000 patients and working to transform and improve the quality of health care. Among these practices, ORPRN has worked to establish value with our history, relationships, expertise and “Boots on the Ground.” We have advanced primary care knowledge through practice-based research with 81 funded projects.

ORPRN’s research experience resulted in our selection in 2005 in AHRQ’s Master Contract Program (2005-2011). ORPRN became one of ten PBRNs vying for limited-competition primary care projects, and resulted in studying the business case for nurse-based care management and linkages between primary care and community resources in obesity management, populating the benchmark database for medical office patient safety, and evaluating the usefulness of a workflow toolkit for health information technology. Since 2012, ORPRN has led one of eight AHRQ-funded consortia designated as a Center of Excellence for Research and Learning, the Meta-network Learning And Research Center (Meta-LARC).

Meta-LARC has collaborated on projects studying self-management support and skin care practices in infancy to prevent development of atopic dermatitis.

In addition to ORPRN, the consortium includes the following partners:

<table>
<thead>
<tr>
<th>Partners</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duke Primary Care Research Consortium</td>
<td>Duke University</td>
</tr>
<tr>
<td>State Networks of Colorado Ambulatory Practices and Partners</td>
<td>University of Colorado</td>
</tr>
<tr>
<td>Quebec Practice-based Research Network</td>
<td>Université Laval</td>
</tr>
<tr>
<td>Wisconsin Research and Education Network</td>
<td>University of Wisconsin</td>
</tr>
<tr>
<td>University of Iowa Research Network</td>
<td>University of Iowa</td>
</tr>
</tbody>
</table>

ORPRN has built statewide relationships with primary care clinicians, practices, hospitals, community groups, health systems, payers, and Coordinated Care Organizations (CCOs). To conduct our research and practice improvement initiatives ORPRN has established an OHSU/ORPRN health extension workforce with nine Practice Enhancement Research Coordinators (PERCs) across the state having offices in La Grande, Ashland, Eugene, Bend, The Dalles, and Portland. ORPRN has an 11-member steering committee representing practices and communities across the state that meets monthly. Several of the founding committee shared their reflections of working with ORPRN on our 15th anniversary.

- “Those of us who have been involved since the early days have heard LJ use the ORPRN ontogeny, tracing its growth from infancy, to taking its first steps into toddlerhood, navigating adolescence, and moving toward organizational maturity. We no longer need to tell people what ORPRN does or who we are. They know us.”
  Robbie Law, MD
  Astoria, Oregon

- “My involvement with ORPRN began in 2002 with two primary care concerns: professional development and practice enhancement. Our network has grown and matured, and the impact of the network is widely recognized.”
  (Continued on Page 8)
PERCs as Cross-Pollinators: How the H2N Project has prompted practices to work together

Healthy Hearts Northwest (H2N) is part of EvidenceNOW, a national initiative funded by the Agency for Healthcare Research and Quality (AHRQ). H2N was established to help primary care practices improve the cardiovascular care they provide to patients. H2N focuses primarily on the “ABCS” measures of cardiovascular care: Aspirin use by high-risk individuals, Blood pressure control, Cholesterol management, and Smoking cessation.

Six of ORPRN’s nine Practice Enhancement Research Coordinators (PERCs) provide at-the-elbow H2N facilitation in 89 practices across Oregon. Each practice has developed an H2N team to focus on the ABCS measures and develop new strategies for improving the cardiovascular care provided to patients. A PERC’s role on these teams is to aggregate resources, disseminate evidence, and circulate new systems surrounding the ABCS measures with a particular view toward implementing quality improvement (QI) strategies. PERCs often act as cross-pollinators, taking innovative ideas from certain teams and suggesting these concepts to others. They act as sounding boards for ideas with the practice teams, thinking aloud about new ways of delivering best practices, with the understanding that the practice teams are experts on these care processes. In this way, the PERCs act as a bridge and span boundaries so that practices across Oregon share “best practices”. This article highlights specific ways PERCs act as cross-pollinators.

Sharing Resources

Davies Clinic’s Blood Pressure Checklist
by Cullen Conway, MPH

A recent successful innovation occurred at the Davies Clinic, with the development of a Blood Pressure (BP) Checklist. The Davies Clinic has developed, implemented, and sustained a robust outreach and recall structure, but the clinical champion on this team was interested in finding an effective way of identifying and addressing elevated BP at the point of care. This team went through an iterative process of refining their BP Checklist to a point that worked optimally in their workflow. The finished checklist includes information on BP goals, the benefits of keeping BP down, as well as tips and advice on how to maintain a healthy BP. Additionally, this checklist includes a BP log for patients to monitor their BP between visits and focus on self-management. If a patient has an initial BP reading of 140/90 or above, an MA pulls out the checklist and places it next to the patient. When a clinician comes into the room and sees the checklist, they go straight to taking a second reading and providing counseling by walking through the checklist with the patient. The clinical champion has found this new process effective in helping to identify those patients in need of additional support around their BP. Additionally, patients have found this checklist to be extremely beneficial in understanding the importance of their BP, different strategies to maintain their BP, as well as an effective means of monitoring progress between visits. This form has been so effective that the clinic is in the process of developing a similar checklist to be used with their diabetic patients. Now that the BP checklist is functioning as desired, practice facilitators plan to share this document across other clinics and care teams to see if it would function similarly across these other teams.

Family Medical Group North East’s “Tobacco Free Readiness Assessment”
by Beth Sommers, MPH

As part of H2N, Family Medical Group North East (FMGNE) focused on identifying patients who use tobacco products and assessing their readiness to quit. The group developed a structured form, called the Tobacco Free Readiness Assessment (TFRA), to gather patient details around tobacco use and patients’ interest in becoming tobacco-free as a means to target cessation conversations and intervention activities based on patients’ self-identified stage of change readiness. The TFRA also gathers information from patients on their perceived barriers and motivations to becoming tobacco-free, gauges their awareness of resources available to help them quit, and asks whether patients are interested in receiving active support from their care team in becoming tobacco-free. The group codified into structured electronic medical record (EMR) data the stages of readiness in order to track individual and population changes over time. FMGNE developed the form and the associated workflow using the Plan-Do-Study-ACT (PDSA) method, an iterative process of testing changes, incorporating feedback, and testing some more. Over six months, the practice:

- Piloted use of the form with two clinicians on one care team. Findings: patients were open and interested in using the form. Information from the form led to deeper, tailored conversations between clinicians and patients.
- Reviewed the form with their patient and family-advisory council (PFAC) for feedback and suggestions. Findings: the PFAC confirmed the concept and liked that the form was a single page. They also liked the barriers section on the form – as it will give the clinicians insight into how to help patients.
- Held all-staff meetings to share progress and gain clinician and staff input. Findings: at a recent meeting the MAs reviewed the form and suggested the dummy codes associated with the stages of readiness be removed from the document. They felt it would make their patients afraid of “being tracked.”
18% of smokers marked they were ready to quit. The TFRA has been shared with several other practices who are interested in leveraging their health coaches to administer the form and follow up with patients.

\[Image 1\]

**Winding Waters Clinic’s “Your Heart Health Guide”**

by Angela Combe, MS

One of the most widely spread H2N resources has been the Winding Waters Clinic’s “Your Heart Health Guide.” This tool has been shared with over 10 H2N practices. In "Lasting Impact", an article on page 7, Winding Water Clinic’s Nurse Care Manager, Randi Movich, RN describes how the guide was created following a collaborative and iterative process during the Implementing Networks Self-Management Tools Through Engaging Patients and Practices (INSTTEPP) Boot Camp in 2014.

While enrolled in H2N, the clinic has undertaken many quality improvement activities. Specifically, focus has been to review, update and test the inclusion of “Your Heart Health Guide” into hypertension workflows using the PDSA method and incorporating patient feedback. The clinic plans to continue monitoring their performance rates and is hopeful that “Your Heart Health Guide” will help improve cardiovascular outcomes. Across Oregon, the tool has been well received and tested for use in hypertension workflows and other quality improvement strategies. One of Cullen Conway’s practices has been effectively using “Your Heart Health Guide” as a guiding document for their visits with patients not meeting the blood pressure measure. The front desk does outreach noting the patient’s name and appointment on the tool for the Medical Assistant (MA) to fill in the information from the prior visit. The clinician then reviews and updates the tool with the patient extending the conversation for more complete understanding. The patient then leaves with the tool and schedules a follow-up if necessary. The spread of this tool statewide has been incredible, supporting peer-to-peer learning, highlighting innovations and use of best practices.

**Collaborative Learning Sessions**

**Clinics on eCW: sharing, then planting, a seed**

by Kristin Chatfield, MPP

When a small practice in Central Oregon joined H2N, not only had they never worked with OHSU or ORPRN, they have never before looked at their data. In fact, they decided it was more cost effective to pay penalties than report to the clinician Quality Report System (PQRS) or Meaningful Use. Still, they knew they were providing great care and were ready to learn how to prove it, starting with the ABCS measures.

The solo clinician diligently and effectively documents visits in eClinicalWorks, but how to make the EMR work for them at the panel level? The Health Information Technology (HIT) facilitator and H2N PERC met with the MA and office manager, the clinician’s spouse, who also happens to have an IT background. After plenty of clicking and head scratching, the HIT facilitator suggested we reach out to a practice in the Healthy Hearts New York City (NYC) Cooperative to see if they might share some instructions. NYC sent back some basics for navigating the reporting system eClinicalWorks, which the office manager implemented for their clinic in Central Oregon. The office manager then developed clean, stream-lined instructions which we have distributed to multiple eClinicalWorks practices across the H2N cooperative! These instructions are easy to read and replicate, proving that with a little technical assistance primary care clinics are poised to learn from one another.

If you are wondering, yes, the ABCS data did show that this provider provides great care, surpassing the Million Hearts clinical targets! They got so good at using data, their first PDSA cycle involved cross referencing those who did not meet the ABCS measures with those who have high Body Mass Indexes (BMIs) and flagging them for special care.

**Choosing an EMR: Dr. Walker’s Clinic & Deschutes Rim**

by Emily Chirnside, BS

With data extraction and ease of electronic documentation being on the forefront of primary care practices, big and small, I offered a small rural primary care clinic an opportunity of connection to aid them in a very big decision.

Deschutes Rim Health Clinic in Maupin, OR began entertaining the idea of transitioning to a new EMR system in the summer of 2016. Within a month they were narrowing in on their top two vendors. They had been “courted” by each vendor and had hosted demonstrations on how each system would work, for providers, for billing, etc. Both sounding too good to be true, I encouraged this clinic to think about speaking with other clinics that were already using the particular systems “in real life” to assist in a tie breaker.

With the substantial financial commitment tied to making a switch like this, the clinic enthusiastically entertained the idea of being connected with another H2N clinic to speak with. The H2N HIT facilitators and I worked quickly to identify the clinics of being connected with another H2N clinic to speak with. The clinic enthusiastically entertained the idea of transitioning to a new EMR system in the summer of 2016. Within a month they were narrowing in on their top two vendors. They had been “courted” by each vendor and had hosted demonstrations on how each system would work, for providers, for billing, etc. Both sounding too good to be true, I encouraged this clinic to think about speaking with other clinics that were already using the particular systems “in real life” to assist in a tie breaker.

The TFRA has been shared with several other practices who are interested in leveraging their health coaches to administer the form and follow up with patients.

**Primary care clinics are poised to learn from one another.**

**Choosing an EMR: Dr. Walker’s Clinic & Deschutes Rim**

by Emily Chirnside, BS

With data extraction and ease of electronic documentation being on the forefront of primary care practices, big and small, I offered a small rural primary care clinic an opportunity of connection to aid them in a very big decision.

Deschutes Rim Health Clinic in Maupin, OR began entertaining the idea of transitioning to a new EMR system in the summer of 2016. Within a month they were narrowing in on their top two vendors. They had been “courted” by each vendor and had hosted demonstrations on how each system would work, for providers, for billing, etc. Both sounding too good to be true, I encouraged this clinic to think about speaking with other clinics that were already using the particular systems “in real life” to assist in a tie breaker.

With the substantial financial commitment tied to making a switch like this, the clinic enthusiastically entertained the idea of being connected with another H2N clinic to speak with. The H2N HIT facilitators and I worked quickly to identify the clinics using the Athena Health EMR system (the EMR Deschutes Rim was most interested in). We then narrowed it down by finding a clinic in relative distance from Maupin and by size of the practice. We connected with Dr. Kent Walker’s clinic, which is the exact same panel size. Myself and co-PERC Angela Combe facilitated and primed the virtual introduction and connection between the two sites and within days the two clinics had worked out a date in late September for a half day visit. On this day, the entire Deschutes Rim staff visited with Dr. Kent Walker’s office manager Darla Linker. Darla ran with this opportunity and created a valuable experience for the entire group. She walked everyone through the functions of the EMR, adding her tips and tricks along the way. The visit was so successful that Deschutes Rim immediately selected and enrolled in Athena Health, rolling it out in their clinic in early November. I foresee this facilitated connection lasting and growing as Deschutes Rim becomes more familiar with their new EMR. I could see the two clinics using one another in the future to exchange workflows, ideas, timely IT support and beyond.
Project ECHO:
An innovative approach to support rural and urban, under-served communities
by Maggie McLain McDonnell, MPH, Project Manager

Model and Evidence
Project ECHO, or Extension of Community Healthcare Outcomes, is a telementoring program for primary care clinicians that utilizes videoconferencing technology to improve access to specialty care and appropriate referral patterns through knowledge transfer and skill building. Originally created at University of New Mexico in 2003, ECHO’s overarching goal is to better connect primary care with specialty care by training clinicians to handle cases for particular clinical topics, and when to refer. ECHO programs (also known as “clinics”) aim to improve access and patient outcomes, while reducing costs and improving job satisfaction of primary care clinicians.

Project ECHO has spread throughout the U.S. and world, with Project ECHO clinics focused on prevalent and complex conditions, such as hepatitis C and type 2 diabetes, as well as newer concepts such as clinical quality improvement and practice redesign. Project ECHO sessions typically last one to two hours, and include a 15-20 minute didactic presentation by a specialist(s), followed by case-based learning with specialists and a cohort of approximately 25 primary care clinicians.

A 2016 systematic review of 39 studies found that Project ECHO is an effective educational model, and a “potentially cost-saving” way to increase participant knowledge and improve patient access to health care. The ECHO Act, which became federal law at the end of 2016, will require the U.S. Department of Health and Human Services to report on the “use, integration, and impact of” ECHO clinics. This will support more rigorous evaluation which will hopefully demonstrate the benefits and potential return on investment of the ECHO model.

Project ECHO in Oregon
Since 2014, OHSU and other partners have conducted ECHO clinics for Oregon clinicians in the topics of psychiatric medication management, child psychiatry, child development, and addictions, with additional topics in the planning stages. In 2014 Mark Lovgren, Director of OHSU Telemedicine, and Christine Bernsten, Senior Manager of Delivery System Transformation at Healthshare Coordinated Care Organization (CCO) organized and funded initial efforts to bring ECHO to Oregon. Their first program covered the topic of psychiatric medication management, with Jonathan Betlinski, MD, a psychiatrist from OHSU as the faculty lead and primary curriculum developer. This ECHO is now in its third year, and has engaged over 75 clinicians total in the 40 session program.

Through his involvement with ECHO over the past three years, Mark Lovgren learned the keys to a successful ECHO program are “a curriculum that resonates, a motivated panel of specialists, and providers who are willing to be active participants and share their cases.” Lovgren continued, “ECHO is a model that works for many clinical diseases. If you understand the sweet spot of ECHO, it can be applied to different clinical topics.” Dr. Betlinski also shared that he found ECHO to be a powerful model to “share knowledge and serve communities that wouldn’t receive this support without Project ECHO”.

In fall 2016, ORPRN explored utilizing ECHO for quality improvement through the pilot of a five-session, team-based care ECHO program. This program engaged clinical teams (a clinician lead, behavioral health clinician, and practice manager) that are integrating behavioral health clinicians into their practice. Working closely with CareOregon CCO, ORPRN staff and the ECHO faculty engaged eight practices with nearly 30 active participants. Sessions on measuring team function, roles and goals, workflows and financial sustainability of behavioral health integration were explored. Nearly 90% of respondents on the post-program survey stated the ECHO model was an “effective way to learn more about team-based care”.

Additionally, in July 2016, ORPRN was awarded a nine-month contract from the Oregon Health Authority (OHA) Transformation Center to explore the creation of a statewide ECHO Hub. An Oregon Hub aims to expand the benefits and reduce inefficiencies of individual ECHO clinics by standardizing workflows, processes, documentation, and technology.

Through the OHA contract, ORPRN conducted a statewide clinician interest survey, which demonstrated that clinicians, particularly nurse practitioners, have strong interest in participating in an ECHO clinic in the future. ORPRN also engaged an 18 member ECHO steering committee which provided input that ultimately will be included in a business and financial sustainability plan for a statewide ECHO Hub.

Interested in learning more?

UNM: http://echo.unm.edu
OHSU: www.ohsu.edu/ohsuecho

As an independent clinic, our partnership with ORPRN has given us access to consultants and expertise that we would not have had otherwise. Participating in clinic-based research studies and the support of ORPRN helped us move forward on health care reform at a faster pace than we could have done on our own. Hearing what other clinics across the state have been doing inspired us to keep our momentum going. Thank you to LJ and his team.

Daniel K. Paulson, MD
Springfield Family Physicians

Selected Recent ORPRN Publications

- Fagnan LJ. Moving Upstream—Health Extension and Primary Care. *J Am Board Fam Med.*

For full list of ORPRN Publications and links to the articles visit www.ohsu.edu/orprn

Practice Highlight: Springfield Family Physicians

Springfield Family Physicians has been on the path to improving health, and learning how to become a medical home for many years. They outlined the journey they have taken in the timeline below. Each project, and each decision described is one more step along the path to Becoming a Medical Home of excellence.

**SPRINGFIELD FAMILY PHYSICIANS**

Becoming a Medical Home of excellence with a focus on collaborative patient health care and well-being

As an independent clinic, our partnership with ORPRN has given us access to consultants and expertise that we would not have had otherwise. Participating in clinic-based research studies and the support of ORPRN helped us move forward on health care reform at a faster pace than we could have done on our own. Hearing what other clinics across the state have been doing inspired us to keep our momentum going. Thank you to LJ and his team.

Daniel K. Paulson, MD
Springfield Family Physicians
Columbia Gorge Region – Culture of Health Prize & Collaboration
by Robyn Pham, Project Manager

The Columbia Gorge is home to a vibrant community of engaged stakeholders and partnerships working in a spirit of collaboration. In September of 2016, the region was one of seven communities across the United States that received the Robert Wood Johnson Foundation Culture of Health Prize. The prize was awarded to recognize the region’s commitment to collaboration, effort to pursue healthier lives for all residents, and novel solutions that address community health issues.

The Veggie Rx program is an exceptional example for the region’s collaborative approach to addressing priority issues. With 1 in 3 residents in the region worried about running out of food, the Gorge Grown Food Network partnered with health departments, primary care clinics, social service organizations, farmers markets, and corner stores to screen residents for food insecurity and provide vouchers for local, healthy fresh fruits and vegetables.

The Columbia Gorge region also leads in its dedication to partnering with residents and community representatives in a variety of areas including project development and decision making. Following the creation of the region’s Coordinated Care Organization (CCO) in 2012, the Columbia Gorge Health Council conducted a regional health assessment to develop an action plan to improve the health of all members. Over thirty-nine organizations participated in the assessment to survey residents from three counties in Oregon and two counties in Washington. Findings from the needs assessment outlined a set of shared priorities that the region has focused on over the past couple years, and continues to serve as a roadmap for community partnerships. Today, the CCO’s Community Advocacy Council (CAC) serves as a unique vehicle, which enables community members to work in tandem with health care leaders to address health priorities. The CAC was featured by the Oregon Health Authority as a model for community engagement in 2016.

We celebrate the Columbia Gorge’s strides to improve health over the past year and their collaborative efforts that continue to fuel forward progress.

Eastern Oregon Transformation Community Benefit Initiative Reinvestments Program
by Anne King, MBA ORPRN Director of Healthcare Initiatives

The Eastern Oregon Coordinated Care Organization (EOCCO) just began the third year of its Transformation Community Benefit Initiative Reinvestments Program (TCBIR), which provides funding and technical assistance to health systems, clinics, public health, social service agencies and Community Advisory Councils in all of the 13 EOCCO counties aimed at improving health care and population health. ORPRN leadership and research staff administer the program and serve as a technical assistance (TA) team, providing consultation and training in evaluation, program planning and research methodologies. Thus far, the program has provided $2.7 million in funding and technical assistance for 41 projects, and is about to launch another 25+ projects for an additional $1.5 million in funding. Projects focus on improving statewide CCO quality metrics and/or on priorities in each county’s Community Health Improvement Plan which is a county-specific population health plan that is jointly developed by health care, social service, public health and Medicaid patients in each community.

In 2017, EOCCO’s program consists of grants designed to support primary care practices’ connection to a clinical and claims data aggregation software purchased by EOCCO, and to validate the clinical data prior to upload. Reporting on clinical data can be a challenge for primary care clinics, particularly small practices that don’t have information technology or reporting staff dedicated to ensuring the data is valid and available. The advent of coordinated care organizations and state-mandated incentive measures has added to the reporting burden of primary care, and EOCCO hopes that their grant program will help reduce this burden.

In addition to improving practices’ data collection, other planned investments for 2017 include grants for practices to reach individual incentive measures. These include a project for clinics and their community partners who want to conduct adolescent well care (AWC) “events” that increase capacity and access to AWC visits, a colorectal cancer screening project in which EOCCO will partner with clinics to conduct a FIT test mailing and reminder calls, and an ECHO based learning collaborative for Eastern Oregon clinical teams to learn how to optimize the role of the community health worker (CHW) within the practice. For this ECHO ORPRN is teaming up with Oregon State University faculty who run a state-approved CHW training program.
In the past fifteen years, ORPRN has conducted or participated in over 80 studies and projects. And while all provide valuable information to improve processes and community health, some projects leave a more enduring impact on communities and practices. Two such enduring projects are Implementing Networks Self-Management Tools Through Engaging Patients and Practices (INSTTEPP) and Colonoscopy in Rural Oregon Practice (CROP). We asked two of the practices that participated in these projects to describe why the lessons and resources have endured.

Implementing Networks Self-Management Tools Through Engaging Patients and Practices (INSTTEPP)
by Randi Movich, RN, Winding Waters Clinic

Winding Water Clinic’s “The Diabetes Health Guide” was developed through a collaborative process with several clinic patients and providers who attended the INSTTEPP Boot Camp three years ago. One of the self-management tools presented was a very simple body diagram with vital signs and diabetes related lab values. This tool resonated with patients because it tied together diabetes health maintenance and labs values directly related to their own health. After working with ORPRN and INSTTEPP staff and patients to improve the self-management tool, the Nurse Care Manager (NCM) Randi Movich, RN at Winding Waters Clinic brought together the three patients from their clinic who attended Boot Camp to continue refining the “Body Diagram” and make the tool as patient friendly as possible. The NCM used same principles to create “Your Heart Health Guide”.

Currently the tool is used daily by the NCM and MAs to help engage patients who have diabetes and hypertension. The tool has not only been used to increase patient engagement, but has significantly helped to improved diabetes metrics in the clinic. We hope that "Your Heart Health Guide" will also be part of the equation for improving CVD outcomes.

Colonoscopy in Rural Oregon Practice (CROP)
The Clinical Outcomes Research Initiative (CORI) and ORPRN collaborated in a 3-year study of colonoscopy screening in rural Oregon practices, in which the procedure was performed by non-gastroenterologists. The study examined over 5000 colonoscopies, and found that ORPRN sites performed well on most colonoscopy quality measures, suggesting that high-quality colonoscopy can be performed in rural settings. The study, Quality of Colonoscopy Performed in Rural Practice, was recently published in the Journal of Rural Health (See Publications on Page 8). We asked two of the participating family physicians and a general internist to share their perspectives on the value of the study.

“Access to colonoscopy in rural Oregon is critical. Living in the poorest county in the state, my patients cannot afford to drive over 40 miles to see a gastroenterologist for screening exams. As the only family doctor providing colonoscopy in my community, I need to know that my patients are receiving care that is comparable to that in a larger center. The quality tracking and reporting made available to me through the CORI project was invaluable in determining my own metrics and comparing them to other clinicians both in rural Oregon and at tertiary care centers. Participating in the research has equipped me to track my own metrics even after the project has ended. I can assure my patients that the likelihood of a complete exam and the likelihood of detecting polyps when present will be comparable to that of a major referral center.”

Gary M. Plant, MD
Madras Medical Group

“Practicing in a rural area, that at times does not have access to all specialties, gives me the opportunity to practice medicine and perform procedures frequently covered by other specialties. Colonoscopy is a prime example of a test that might not always be available in rural areas if not performed by a local primary care physician. I think it is important to study outcomes and best practices of procedures so that baseline competencies can be documented and followed by those performing procedures generally outside of their specialty. This, in turn, encourages appropriate training and execution of these procedures and allows standard of care comparisons to accurately access competencies.”

Bob Jackman, MD
Cascades East Family Medicine Residency
Klamath Falls, Oregon

“It takes a very big "village" to get all the colonoscopies done that need doing in this country. And according to that study the rural contribution to that task is worthy! Glad to be a part of that.”

Karl Ordelheide, MD
Samaritan North Lincoln Hospital
Lincoln City, Oregon
isolation and the need for practice support. Living on the coast also tends to be somewhat isolating and my involvement with ORPRN staff and members has been and continues to be a source of inspiration as well as professional growth. Also in those days I was the sole proprietor of a medical practice with 3 providers and the additional practice supports provided by ORPRN proved vital for our success. As with so many, my practice setting has now changed but I continue to benefit both personally and professionally from participation with ORPRN as we seek to actively contribute to health care in new directions.”

Albert Thompson, MD
Pacific City, Oregon

Over the last fifteen years, ORPRN has become part of the fabric of St Luke’s Eastern Oregon Medical Associates. I met Dr. Fagnan initially as a medical student when he was a faculty member for the clinical portion of the curriculum at OHSU. By 2002, the initial panic of being a rural physician just out of residency had begun to abate but was quickly being replaced with a new sense of angst; how do we survive out here? All of my partners were new physicians at the time and all of us felt that staying connected to academic medicine was critical for many reasons. We actively sought the opportunity to host medical students and tried to maintain connections with faculty.

I believe Dr. Fagnan made his first trip to our clinic in the summer of 2002 to talk about his ideas for the research network. I quite honestly had no idea of its potential but clearly saw it as a way to build relationships with OHSU and to stay connected. In no time, ORPRN staff and leaders became essentially part of our clinic and friends and mentors. Our introduction to the Rural Health Clinic program came through Paul McGinnis who was at ORPRN at that time. That one thing was essentially foundational to our clinic’s existence and ability to recruit and grow. ORPRN introduced us to what it means to function in teams and plan care for patients rather than just react to care needs as they arise in the exam room. They helped us build community relationships and introduced us to a network of clinics that were dealing with similar issues across the state. They helped us learn what it meant to make patients part of the clinic and truly engage them in a meaningful way. They led us through a process that ultimately made quality improvement part of the daily work done with accountability for it from the front office to the back office.

We certainly haven’t done it all right and we absolutely have a lot more to learn and none of it has been easy though most of it has been a lot of fun. Just like patients with severe chronic conditions who struggle to see the importance of making lifestyle changes and are just trying to survive day to day, there were times where making the decision to be part of a project or make time for a meeting was a conscious decision. Recognizing that from this point of time, as I’ve said before, I don’t think there would be a SLEOMA today if it weren’t for ORPRN.

Jon Schott, MD
Baker City, Oregon


Health care is a collaborative effort where multiple gaps occur (Long, BMC Research 2013). These gaps include the clinician-patient relationship (shared decision making) and the clinic-community relationship (linking personal health behavior change to community resources). ORPRN has built sustained and trusted relationships, and functions among clinics, health systems and communities as a knowledge broker, sharing knowledge between groups and spreading “best practices” and “good ideas” across settings. The broker attribute has enhanced ORPRN’s reputation for innovation and learning, supporting behavioral health integration, practice transformation, patient self-management and developing local capacity for quality improvement. ORPRN is all about Connecting, Involvement and Community Health across Oregon.