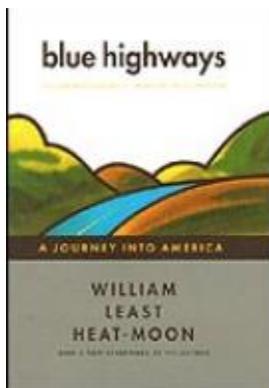


ORPRN “Blue Highways” Reflections

LJ Fagnan

12 April 2018

This is my 16th ORPRN Convocation and my first as the keynote speaker. During the past 16 years I have been the driver of the ORPRN bus that has traveled the “Blue Highways” of Oregon. On old maps the main roads were in red and the backroads in blue. ORPRN has been a backroads organization. Early in ORPRN's travels I was introduced to William Least Heat-Moon's book, *Blue Highways*, where he introduces his journey across America, “...describing the pull of the blue highways”. I feel that pull.



Recently, colleagues have been checking seeing how I am feeling, given my Swan Song appearance today. I have found preparing for my talk a bit like cleaning out the garage—therapeutic, with mostly good vibes. My reflections start early in my career with a personal story as my roots have contributed to what ORPRN has looked like. I will move on to the foundational ORPRN tenets, share a few early studies and observations during ORPRN's 16 year trip, and close with a couple of questions and challenges.

My career breaks down into four professional and developmental stages—medical school, three years with the Indian Health Service, 16 years in a family medicine practice on the Oregon Coast and 25 years at OHSU, 16 of these years with ORPRN. Four mentors have left their mark on me. My father, Lyle, taught me how to coach. George Brenneman, a pediatrician with the IHS in Bethel, Alaska taught me what leadership looks like. Rick McLean, a GP in Reedsport showed me what caring for a community as a family physician is about—“you can pretend to know, you can pretend to care, but you cannot pretend to be there”. Rick passed away this past year at age 96. My fourth mentor is the group of Oregon family physicians and primary care clinicians and their practice teams who have inspired me and continue to show me the truth during my stint with ORPRN.

I will start back to my young and clueless days. I was a member of the University of Oregon Medical School Class of 1971. My class was viewed as high maintenance, with a tendency to stir up trouble and spending too much time in the gym playing basketball. For many young people in the United States, this was an unsettling time for and we were not comfortable with the status quo. Twenty of us went into family medicine, completing rotating internships, with six of us joining the Indian Health Service. Merle Pennington, the father of one of my classmates, Paul Pennington, worked with Bill Fisher and others in 1969 to 1971 to lay the ground work for establishing the department of family medicine in 1971. Paul went on practice in Goldendale, WA and teach family medicine at the University of Washington. It was during my third-year of school that another classmate, Tom Duncan and I decided to make a road trip to rural Oregon to see what life was like as a family doctor. In Tom's red Alfa Romeo sedan, we visited family doctors in Burns, Umatilla, John Day, Pendleton, Enterprise, Baker City and Ontario. In Umatilla we met Dr. Marvin John, riding his lawnmower and visited his mobile trailer office. In Burns, we were introduced to the world of the cowboy doctor with Dr. Bert Campbell. We were intrigued with the lives of Oregon country doctors. These docs were a different breed with an independent streak, all holding a revered landmark status in their community. Tom proposed the "Duncan hypothesis" that rural communities were best served by a ratio one church to one tavern.

The Vietnam War era which ran from 1961 to 1975 influenced my post-doctoral education plans as the draft was not eliminated until 1973. The United States Public Health Service was one of the seven Uniformed Services that would meet the obligation of a two-year service requirement for my country. During medical school I met Dr. Ken Fleshman, Director of Pediatrics at the Alaska Native Health Center in Anchorage, who encouraged me to think about a career, working with the Alaska Natives. Following a rotating internship in Hartford, Connecticut, I joined the IHS and was stationed in Bethel, Alaska. Landing there with our 2-year old son, Jeff and my wife, Jeannie, 6-months pregnant with Jenna. Over the next three years In Bethel, I experienced and began to understand the connection between a doctor and their community. The Yukon-Kuskokwim Delta is about the size of Louisiana with over 20,000 natives in 48 villages. I was a general medical officer and the area community health director.

Although initially thinking I would end up as a pediatrician, my stint as a GMO showed that I was a generalist at heart. As I thought about my next career step I had difficulties finding a family medicine residency, there were about 250 residencies across the country and the ones I was interested in were full. Each year as I headed to the lower 48 I would meet with Ted Phillips, a general practitioner from Sitka, Alaska who was the founding Chair of FM and later Dean of the SOM at the University of Washington. Ted finally pointed to a program being developed in Idaho. I joined the University of Washington, Southwest Idaho FM Residency in Boise, Idaho as one of four physicians starting as a second-year resident.

Bethel provided me a wealth of clinical experience and education, allowing me to spend much of my time planning for my first practice. At the start of the third-year of residency, I

came across an application on the program director's desk for the Robert Wood Johnson Foundation's Rural Practice Project. The RPP was developed with the plan to identify a few young family physicians trained in modern scientific medicine and support them in their desire to have a career as a small town healer and community health leader. The requirements include working with a high-need community, creating a non-profit organization, hiring a full time trained administrator, and planning for a team-based practice. The project had a goal of funding twenty-five model rural practices. Dunes Family Health Care in Reedsport was founded in 1977 as one of thirteen practices in the United States funded by the RWJ Foundation. Only three of the RPPs were west of the Rockies, in addition to Dunes there was a practice in St. Ignatius, Montana on the Flathead Indian Reservation and a practice in Toole, Utah. DFHC started with community board of directors, a family physician, a physician assistant, a dentist, two part-time psychologists, a health educator and an administrator. During the 5-years of the project, the thirteen practices held an annual convocation where we shared our experiences and approaches to community engagement and connected with national thought leaders. I had the privilege of inviting Fitzhugh Mullan, a pediatrician, activist in the civil rights movement and author of *White Coat, Clenched Fist* and founder of the Beyond Flexner movement to one of our convocations.

It was difficult to have the stimulation and connections of the RPP end and I felt a bit lost. I was able to connect with Dr. Larry Green at the University of Colorado with an invitation to participate in practice-based research. DFHC became practice #29 in the Ambulatory Sentinel Practice Network (ASPN) which had 140 practices in the United States and Canada. ASPN also held annual convocation of practices, where the family medicine physicians in the trenches of day-to-day practice took center stage.

Dunes participated in over a dozen studies, contributing to the knowledge base of primary care and in some cases changing the standard of care, such as the use of dilatation and curettage for spontaneous abortions. Much of ASPN's work was disease and condition-focused. A requirement for participation was an age and sex registry of our active patients. We used a simple data collection tool—cards that I sent into Denver once a week.

Life in Reedsport as a family physician was an enriching experience—knowing my patients and the community as part of my extended family. I had the privilege of working with Dale Harris and Michelle Petrofes, who are now in their 32nd year as family physicians at DFHC. Other alumni include Robbie Law, with 22 years at Dunes and Janet Patin, with 17 years of service and Sheri Aasen, ORPRN Steering Committee member has been the clinic manager for the past 21 years. I attended the 40th Anniversary of DFHC last September and met a dynamite group of clinicians and staff. The commitment to moving health beyond the walls of the clinic to the community and providing high quality team-based care endures.

Like many of you, our impact in our communities is a partnership with spouses who are a community force and leader. Jeannie was on the school board for a dozen years, chairing the board for much of the time. She became the President of the State School Boards and would

have had a career in politics if children and my career didn't get in the way. In 1993 I joined the Department of Family Medicine at OHSU with a clinical practice at Gabriel Park Family Health Center. GP was the first "off-the hill" OHSU primary care clinic and I was able to work with a great group of clinicians, staff and residents.

In 2002, voters in the state of Oregon passed the Oregon Opportunity bond initiative, which was created to enhance the research and technology capacity of OHSU. President Peter Kohler focused on connecting with rural Oregon through this effort. I was feeling the tug of the Oregon Blue Highways and we founded ORPRN, connecting rural Oregon through research projects.

The ORPRN Blue Highway travels began by planning for our first road trip. We started small with ten rural communities—Reedsport, Baker City, John Day, Lakeview, Union, Elgin, Hood River, Lincoln City, Pacific City, and Klamath Falls. At our first convocation in September of 2002, six family physicians met with 24 OHSU faculty in the basement of Emma Jones Hall. We were on our way to delivering on the promise of the Oregon Opportunity. That same year ORPRN became a part of the national PBRN scene with recognition and support from AHRQ, the Agency for Healthcare Research and Quality.

Since ORPRN's founding we have conducted over 90 research studies that have connected us with practices and communities across the "Blue Highways" of Oregon. The ORPRN team has logged a fair number of windshield miles visiting practices across the state and growing rapidly. We observed that life in rural communities and family medicine practices was changing surrounded by "high waters" resonating with Bob Dylan's lyrics: *"If your time to you is worth saving' then you better start swimming' or you'll sink like a stone, for the times they are a-changing'."*

Responding to rising waters surrounding primary care, PBRNs such as ORPRN are a life preserver, valuing and respecting the lives and work of clinicians and practices. When we started the network, most of the rural practices we connected with were independent and physician-owned, looking for a "mothership" to relate to. ORPRN provided the "mothership" lifeline.

As ORPRN does not own any practices we have become practice recruitment masters with an emphasis on the well-being of practices—balancing "the ask" with being responsive to practice needs. We respect practice wisdom and knowledge, supporting the PBRN goal of linking questions from practice to answers from practice. True north lies at the local level, addressing the "So what?" question with our research.

Recruitment of clinicians and their practices is a universal challenge for PBRNs. We sought to develop an understanding of **Why family medicine clinicians participate in ORPRN studies?** We conducted an ORPRN survey and national interviews. The survey study reported that the strongest motivating factor was to the statement: "I want to improve the quality of care to my

patients.” The strongest demotivating factor was to the statement: “I have sufficient time to participate.”

With our stories project we found that creating and applying the primary care evidence base and staying up to date was a motivator. Clinicians reported that the PBRN provides the antidote to the intellectual isolation and loneliness associated with day-to-day primary care practice

One of our coastal rural family physicians commented: *“What motivates me in particular is that I am involved, not just with research, but with a group that is interested in doing research based on the patient population we see, which is rural and has special needs that aren’t going to show up in an urban setting.”*

ORPRN was built around developing an understanding of what will improve the lives of clinicians and their communities. To that end we established a structure of “at-the-elbow” support with Practice Enhancement Research Coordinators (PERCs). The PERCs have been a presence throughout our 16-year history. Many of you have met an ORPRN PERC and may have a sustained relationship with your PERC. The PERCs are viewed as a practice ally, developing an understanding of your practice’s values and preferences. I have heard from you over the past 16 years, that it is the PERC that makes your participation in research possible.

The ORPRN Steering Committee created our Vision Statement of Connecting, Involvement, Community Health. These four words are GPS navigation tool for the Blue Highways bus.

Relationships require connections--our Annual Convocation is a critical pieces of ORPRN’s sustained success. Even early on, ORPRN Convocations were not the typical CME. Feedback from our 2005 Convocation included a comment, *“This has been a great meeting. It was totally different than any meeting I have attended. It is a good different.”* As the years have progressed we are probably getting a little weirder, moving from presentations on clinical care to conversations with “meaty” topics that attach meaning to what we do in primary care. Over the course of time our Convocation themes and invitees and presenters have included Community Partners, Community Health Workers, and our Patients. For the past eight years, the ORPRN Convocation has been held in conjunction with the Annual OAFP Spring Meeting. We appreciate the partnership with the Academy and the leadership of Kerry Gonzales who is stepping down as the OAFP Executive Director. Thank you Kerry. *The times they are a-changing.*

Looking through the ORPRN windshield we see Practice Survival stories. As ORPRN was getting off the ground in 2002, Paul McGinnis from the Office of Rural Health and future ORPRN Community Health and Practice Development Director and I were invited to an Eastern Oregon afternoon workshop in Burns, Oregon addressing practice survival issues organized by Jon Schott from Baker City and Tom Fitzpatrick from Burns. Burns was using Centricity EHR and

Baker City wanted to implement an EHR. Baker City has just converted to Rural Health Clinic Status and they had recommendations regarding logistics and financials. My role was primarily to listen to their priority survival issues. This is an example of where the practices take charge and define the ORPRN agenda, including our staffing plans.

In our early travels we observed that life in practices along the Blue Highways was vibrant with innovation and local improvement projects happening. These were research ready practices, primed for something new and ready to trust the relationship and willing to take some risks. As opposed to survey studies and mining data, ORPRN studies often require heavy lifting. Our practices had a high tolerance for projects that were somewhat disruptive. A few of the early projects provide a glimpse as the ORPRN foundation.

RxSafe was a patient safety study led by Paul Gorman at OHSU and Karl Ordelheide, a general internist in Lincoln City. RxSafe was a medication reconciliation study to improve safety for rural elders, recruiting the local hospital, all the community pharmacies, the primary care practices, and three of the long-term care facilities

The Oregon Rural Learning Collaborative was a novel effort. In partnership with the Oregon DHS prevention and chronic illness program and Acumentra, Oregon's QIO ORPRN set out to make the principles of the Chronic Care Model more accessible to rural healthcare clinicians for the management of diabetes and heart disease. Thirteen rural practices participated using a disease registry (CDEMS), PERC facilitation, and distance learning to apply CCM to their patients. The Lincoln County Chronic Disease Committee, led by community members were the driving force behind recruitment on the coast, encouraging practices to participate in the learning collaborative, getting to yes and signing a participation agreement letter.

Kristen Dillon, ORPRN SC Chair has summarized why testing **new models of care** is an ongoing ORPRN priority-- *"I think it is imperative for rural clinicians to reinvent how they do things. Our communities depend on us for a huge portion of their health care, and we need to be present in a way that's sustainable and viable. A lot of rural Oregonians need cared for, and we can't serve them if we keep doing things in the same way."* ORPRN studies have introduced practices to key areas of practice change and transformation.

Behavioral health integration. BHI has been a focus of several ORPRN studies with practices having invested space, time and money to incorporate BH into the clinics. Last year I sat in on a meeting at Springfield Family. There were 12 clinicians along with the practice manager and staff at the meeting. Five of the clinicians were behavioral health providers and several were non-physician clinicians. This independent, physician-owned practice has made the BHI leap.

Speaking of making the leap, one of ORPRN's pioneer practices, Eastern Oregon Medical Associates, led by Jon Schott, was named as one of 31-practices honored by the Robert Wood

Johnson Foundation’s Learning and Exemplar Ambulatory Practices. Jon pointed to participation in several ORPRN Practice Transformation/Practice Change studies as an important factor in being recognized as a LEAP practice. This afternoon you will hear from several practice managers who will share their lessons on how to become 5-Star Medical Homes.

Our Patient Self-Management Support study, INSTTEPPS involved four practices who have innovation in their DNA—Springfield Family Physicians, EOMA, Portland Family Medicine NE and Winding Waters in Enterprise. The foundation of the study was convening the four practices for a day-long “Boot Camp” session. Each practice brought a clinician, a nurse care manager, and two patients to help design the study and describe what SMS is. We were impressed with the engagement of the practice teams, respecting and making room for the patient voice.

In the next session you will hear **what is keeping ORPRN occupied in 2018**. There are opportunities for you to sign up for studies, improve your practice and generate new knowledge. CASCADES will create the evidence for the standard of skin care for newborns. A number of pediatric practices have signed up. We need family medicine to show up. CAPTURE is a study to validate a 5-question tool to implement into routine practice to identify patients with COPD before they become symptomatic. Over half of the patients with COPD have not been identified clinically. RAVE, is a partnership with the State of Oregon Immunization Program to improve HPV screening rates. The Meta-LARC Advance Care Planning is about teaching clinicians, practices, patients and care givers to have one of the most important conversations we have in our lifetime.

I want to close with a few observations, sharing my perspective and biases regarding the changes in the **rural health care landscape since ORPRN’s early period**. I see a mixed bag with pluses and minuses to reflect on for future work. I expect some push back on these points of view.

- a. The independent, physician-owned practices are in the minority—perhaps a third of practices, down from 2/3 of practices. The rural “Mothership” has arrived and it is the health systems and large hospitals. **What do we lose when the independent practices vanish?** From my vantage, four losses:
 - 1) We lose our change agents and innovators
 - 2) The practice-community linkage is fractured. The primary allegiance is to who provides your paycheck.
 - 3) The employees are somebody else’s responsibility as opposed to being a part of our practice family. In back to back months I made a visit to a practice that had an ownership transition. Within that month the name badge for the practice manager changed reading “Site Manager” as opposed to practice manager. What does this name change say about practice autonomy?

- 4) Recruiting clinicians and practices for research studies is more difficult and expensive.
- b. The scope of family physicians is decreasing with physicians spending most of the time in their office.
 - 1) Less than a fifth of FPs are providing obstetrical services.
 - 2) Fewer family medicine practices are the medical home for children in their community.
 - 3) Few FPs are providing inpatient care for their patient panels. How do we provide continuity of care when we are not present at a patient's most vulnerable times, needing to talk to their doctor?
- c. Electronic health records are universal; but few clinicians are pleased with their EHR.
 - 1) Clinicians spend more time with their computer and smart phones than they do listening to their patients. The EHR is having a negative impact on personal time and time with family.
 - 2) EHRs are coming up short as a tool for quality improvement.
 - 3) Considerable opportunities exist to increase the value of the EHR— asynchronous communication with patients, increasing patient self-management support
- d. Practices are less physician-centric and this is a good thing.
 - 1) Implementing team-based care
 - 2) Care coordination is improving the care of complex patients
 - 3) Broader scope of responsibilities for staff and non-physician clinicians.
 - 4) Practice managers and administrators are important change agents and improve the quality of our lives.
 - 5) Practices are making time for quality improvement, see our Healthy Hearts Northwest study findings.
- e. Linking community health to primary care practices is becoming a priority in our exemplar practices.

A final word about resiliency. Rural Oregon communities have lost jobs. My practice community of Reedsport lost commercial fishing in the early 1970s and over the next twenty years the timber industry jobs disappeared. This can lead to feeling depressed walking down Main Street. But rural Oregon communities are resilient with craft breweries arriving in a big way. Although only 35% of Oregonians live in rural Oregon, 44% of the 261 Oregon craft breweries are in rural Oregon.

On my visit to celebrate the 40th anniversary of Dunes Family Health Care, Dale and Michelle took me to the newest source of pride in Reedsport—a craft brewery called the Defeat Brewery. The Smith River was called the Defeat River at one time. The story is at www.defeatriverbrewery.com. This leads me to a revised Duncan Hypothesis: In rural Oregon

communities are best served when the ratio of a level three and above Patient Centered Medical Home and a Craft Brewery is one to one.

In closing I want to challenge each of you to be involved in moving care beyond the walls of your clinic, generating new knowledge, and creating new models of care. Getting to know you has been a privilege and I look forward to following the ORPRN Blue Highways travels in future years.