WPF1: Strengthening Rural Primary Care Clinics by Identifying, Innovating and Implementing needed Operational Solutions.

SESSION DESCRIPTION:

Most health care solutions, designed and tested in urban areas, fail to consider rural primary care challenges. Rural clinics serve mostly patients in high poverty, and low health literate areas. Limited access to vendors and trained staff compound barriers. OSU Center for Health Systems Innovation (CHSI) supports rural primary care clinics located in health professional shortage areas by transforming practice operations to strengthen financial viability and enhance patient experience.

SESSION SUMMARY:

Oklahoma State University's Center for Health Systems Innovation (CHSI) supports rural primary care clinics located in Health Resources and Services Administration (HRSA) defined health professional shortage areas by transforming practice operations to strengthen financial viability, operational efficiency and enhance patient experience. Rural clinics serve mostly Medicaid and Medicare patients in areas with high poverty rates and low educational and health literacy levels. Limited access to billing vendors and a well-trained workforce create additional barriers.

CHSI has spent 2 years laying the foundation for a solution that aims to improve quality of life in rural Oklahoma by strengthening clinic workflow efficiency to increase access to and quality of primary care. The OSU Rural Clinic Efficiency Program (RCEP) was developed.

This program provides rural Oklahoma clinics with:

1) Initial workflow assessment and report of findings;
2) Solution identification and selection; and
3) Implementation support and evaluation.

RCEP is based on a definition of health care efficiency as technologies and processes that maximize inputs, minimize costs, and benefit society. The initial assessment is comprised of a suite of CHSI-developed proprietary tools:

- Clinic Efficiency Assessment Tool (CEAT)
- Clinic Profile Survey
- Patient Cycle Study
- Clinic Workflow Map

The program empowers Clinic Stakeholders to EASILY identify "clinic severe deficiencies" or "problem/issues" to be addressed and prioritize improvement areas in collaboration. CHSI staff conducts research regarding rurally viable solutions and, if needed, adapt existing approaches or create original solutions to meet the clinic's unique needs. RCEP engages all clinic staff throughout the process, capturing various aspects impacting clinic efficiency. The primary impact will be within Clinics and their community and include increased performance of workforce, increased access for patients as well as deeper organizational impacts including increased employee engagement, and a continuous improvement clinic culture. RCEP has been deployed through 1st year of grant funding and an additional 2 years of funding for expansion. Lessons learned through 1st year of funding within a rural clinic will be shared.

Panelists and their area of expertise.

1) Burden of Rural Primary Care environment
2) CHSI 3i Process and RCEP
3) Simple changes make big impacts

AUTHOR NAME:

Ipe Paramel, MHA; Marjorie Erdmann, MS; Stacie Pace

WPF2: Free Rides: Patient and Clinic Benefits in a Rural Pediatric Clinic

SESSION DESCRIPTION:

The Oklahoma State University Center for Health Systems Innovation (CHSI) partnered with a Rural Oklahoma Network (ROK-Net) pediatric clinic to innovate and implement a rurally viable model for rural clinics to provide transportation to patients who need a ride to scheduled appointments. Lack of transportation in rural communities contributes to the health disparities rural patients experience. Pilot program and detailed outcomes will be shared.

SESSION SUMMARY:

What is the benefit to the patients and clinic to provide free rides to patients in a rural community? In rural Oklahoma, access to transportation is a significant barrier to health care. Rural patients, who are sicker (CDC), face an even higher burden of illness and disease with decreased access to care. Rural clinics, who are frequently financially fragile, in turn bear the brunt to workflow and productivity of higher no shows, cancellation, rescheduled appointments, and late arrivals. In this pilot, rides free to patients were dispatched by appointment schedulers at the time of appointment scheduling and appointment reminders. Robust data about transportation, patients, and clinic benefits was gathered informing the innovation center for potential solutions and models for rural clinics.

Learning Objectives:
Participants will:
1. Discover the method used to create the transportation solution.
2. Understand the financial cost/benefit to the clinic in providing rides and explore a sustainable model.
3. Recognize the impact transportation had to the patients as well as to the clinic.

AUTHOR NAME:

Marjorie Erdmann, M.S.; Ipe Paramel, M.H.A.; Stacie Pace

WPF3: Creating Mental Models to Understand and Improve Primary Care Practice Transformation: A Case Example of Practice Facilitation

SESSION DESCRIPTION:

The ability to elicit and build (shared) mental models can help individuals, organizations, and systems improve efforts to lead and evaluate transformation initiatives. A mental model is an individual's, team's, or group's understanding of how some aspect of their environment does or should function. Mental models guide behavior, and when a team does not share the same mental model of their work, it undermines their coordination and ultimately their performance. Initiating and sustaining transformation in primary care and across health systems requires a shared mental model both of what needs to change and how to change it. Making mental models explicit allows one to plan and execute transformation more strategically; it provides opportunities to check key assumptions, identify and address differences of belief, and better assess what actions are feasible. We focus on building a mental model of practice facilitation because of the important and increasing role facilitation plays in supporting primary care practice change and the lack of a clear understanding of what is needed for facilitation to be effective in specific and across contexts.

This will be a highly interactive workshop focused on (1) understanding the importance of mental models in increasing the effectiveness of primary care practice transformation, (2) teaching participants the basics of how to elicit and build mental models, and (3) guiding participants in applying these skills to develop a shared mental model of practice facilitation.

AUDIENCE ENGAGEMENT:

First, we will provide a brief overview of mental models and what they are. Second, we will work participants through an exercise to build their individual mental models of practice facilitation. Third, we will have participants move into small groups to compare and build a shared mental model. Finally, we will compare the different group's mental models and reflect on implications for both primary care research, practice, and this emerging profession.

AUTHOR NAME:

Georges Potworoski, PhD; Paula Darby Lipman, PhD; Zsolt Nagykaldi, PhD; Melinda Davis, PhD

WPF4: Getting to Know the Consolidated Framework for Implementation Research to Evaluate the Effectiveness of Practice Facilitation Support

SESSION DESCRIPTION:

Practice facilitation involves a range of complex activities to improve processes and outcomes in primary care, but less is known about how to evaluate. This workshop presents practical steps for designing an evaluation of an intervention in a primary care setting using the Consolidated Framework for Implementation Research to identify factors that can predict the likelihood of successful implementation and distinguish determinants that may act as barriers and facilitators.

SESSION SUMMARY:

Practice Facilitation (PF) involves a range of complex activities across multiple contexts to improve processes and outcomes in primary care. Consolidated Framework for Implementation Research (CFIR) is a theory based framework capable of systematically assessing potential barriers and facilitators in implementation and capture the complex interplay of activities across an array of scenarios. PFs can use CFIR as a practical guide to develop formative evaluations to assess specific contextual variables influencing implementation. The goal of this workshop is to engage people involved in practice facilitation and collectively discuss evaluation methods. Participants will discuss different qualitative and quantitative methods used to evaluate the effectiveness of PF support. After an open discussion, participants will break into small groups for a "real world" evaluation scenario. Participants will be provided with a short narrative and asked to score 4 CFIR constructs relative to the Inner Setting domain. As a group, participants will share evaluation scores and discuss how categorizing ratings can predict/potentially improve implementation effectiveness.

MEASURABLE OBJECTIVES:

Learning Objectives:
(1) Identify various qualitative & quantitative practice facilitation evaluation metrics
(2) Use the Consolidated Framework for Implementation Research (CFIR) to evaluate variables that influence implementation outcomes
(3) Organize qualitative data into CFIR constructs & assign ratings that reflect strength of the construct
(4) Compare the difference between high, medium, and low adopters to predict the likelihood of successful implementation and distinguish determinants that may act as barriers and facilitators

AGENDA/TEACHING METHODS:

Using an open Discussion Method, this workshop will foster an active learning experience.
Group discussion: Qualitative and quantitative evaluation metrics used to evaluate practice facilitation support
Introduce CFIR framework
Break into small groups for CFIR evaluation scenario
Group discussion: Categorize variables into CFIR constructs & distinguish high, medium, low adopters

NEEDS ASSESSMENT:

We will assess needs of participants during introductions. We will ask participants to describe their current work in Practice Facilitation and discuss any challenges they are facing related to evaluation. If inexperienced, we will ask participants to describe background/interest and questions they would like addressed during the workshop. Presenters will use participants' responses to shape content and group discussions. The evaluation scenario is appropriate for both inexperienced and experienced participants. If a majority of experienced participants are present, groups can use the CFIR evaluation worksheet to score a second scenario applicable to their involvement in primary care to discuss the evaluation method in more depth.

AUDIENCE ENGAGEMENT:

Two-way communication between participants and the workshop facilitators will encourage people to share their experiences and ideas. Audience engagement is very welcomed.

EVALUATION:

We will ask participants to complete a brief evaluation asking about their level of experience in this area, their level of agreement as to whether the session met its 4 measurable objectives, and a brief description of what they would like to see as a next session on this topic.

DISCUSSION/RELFECTION/LESSONS LEARNED:

This session grew out of field experience. Presenters are experienced in practice facilitation and evaluation methods used for research purposes.

RELEVANCE STATEMENT:
The evidence supporting practice facilitation as an effective technique to improve primary care is growing. Using a comprehensive, theoretical framework to evaluate the implementation process can strengthen the understanding of how practice facilitation is effective for adoption of evidence-based guidelines.

AUTHOR NAME:

Katherine Bernero, BSPH; Jeremy Thomas, MSW; Hazel Tapp, PhD; Tom Ludden, PhD

WPF5: Meta-PBRN Infrastructure: The PBRN Coordinator Role

SESSION DESCRIPTION:

This workshop will describe the role of the PBRN coordinator, including his/her role within, and across, the structure of PBRNs. We will also describe how the role differs when working with a meta-network of other PBRNs. PBRN staffing roles and functions will be discussed, along with a description of PBRN staff roles. Attendees will leave with a better understanding of the PBRN coordinator role, as well as how to apply staffing structure to their own PBRNs.

SESSION SUMMARY:

The PBRN coordinator role is often complex, elusive, and is complicated by the fact that PBRNs staff differently, role titles are not universal, and overlap exists in tasks and roles. Due to competing demands of a PBRN director and/or co-director, a "go-to" person is ideal for project progression and practice engagement. This workshop will not only describe various roles within PBRN staffing structures, but will serve as a safe space to discuss the challenges and opportunities of coordinating PBRN work.

MEASURABLE OBJECTIVES:

Attendees will be able to:
(1) Describe role(s) of coordinators in PBRN staffing
(2) Describe role(s) of coordinators in PBRN research
(3) Identify skills necessary for PBRN coordinators
(4) Develop common roles/perspective definitions across PBRNs
(5) Define how roles apply to own PBRN structure

AGENDA/TEACHING METHODS:

This workshop will take attendees through both didactic hands-on activities and group discussions in order to develop a more common understanding of how a coordinator functions within a PBRN, as well as with a meta-network of PBRNs. Worksheets and small group discussions will help attendees work through brainstorming sessions and the development of common language.

The following agenda is proposed (90-min total):
1. Introductions/Poll Everywhere for attendees (10 minutes, Large Group)
2. Background and brief description of meta-PBRN networks (15 minutes, Large Group)
3. "What do roles look like in your PBRN?" (15 minutes, Breakout Groups)
3a. Share Out (10 minutes, Large Group)
4. Roles and PBRN staffing structure (15 minutes, Breakout Groups)
4a. Share Out (10 minutes, Large Group)
5. Challenges and Opportunities, Best Practices, IRB (10 minutes, Large Group)
6. Closing Thoughts (5 minutes, Large Group)

NEEDS ASSESSMENT:

Understanding the complexity of the PBRN Coordinator role, this workshop intends to detangle PBRN roles and responsibilities, share stories of success, describe meta-network collaboration, and touch on mentorship and IRB.

AUDIENCE ENGAGEMENT:

The workshop will begin by engaging attendees in a series of poll questions to understand a bit more about those present, their role and location, and anticipated takeaways. The workshop will use both short presentations by coordinators intermixed with breakout discussion in order to keep the audience engaged in responding and learning from others.

EVALUATION:

Attendees will be asked to complete a brief survey to assess knowledge gain and application to their own PBRN. We will also assess how well our learning objectives were met by using a Likert scale structure.

DISCUSSION/RELFECTION/LESSONS LEARNED:

The presenters will share personal experiences, challenges and opportunities, and results from an informal, anonymous evaluation survey sent to presenting coordinators prior to the workshop. We will describe lessons learned from our many combined years of coordinator experience and expertise.

RELEVANCE STATEMENT:

This workshop will help PBRN coordinators and other PBRN staff recognize roles and develop best practices. Presenters will also share the benefit and importance of working with a meta-network of PBRNs to increase the breadth of knowledge and skills, partner with more practices and PBRNs, share in the burden of IRB-related needs, discuss challenges and lessons learned, and provide mentorship.

AUTHOR NAME:

Mary Fisher, MPH; Jeanette Daly; Amanda Hoffmann, MPH; LeAnn Michaels; Katrina Murphy; Sonya Howk, MPA; Angela Combe, MS; Dominic Dharam, MPH; Rowena Dolor, MD; Kathy Chmielewski; Sabrina Guay-Bélanger, MSc, PhD; Rabiya Siddiqui, PMP, BSc

WPF6: Co-construction' of community infrastructure to reduce health disparities: exploring sociotechnical design in the Jackson CBRN and Longmont Enabling Caring Communities projects

SESSION DESCRIPTION:

Fragmentation and sequestration of information undermines the multidisciplinary teamwork often necessary to provide effective care and causes significant gaps in our understanding of the interplay of social determinants, behavioral health, and chronic illness in achieving better health outcomes. In this Forum we describe work underway to overcome this problem in 2 communities to stimulate discussion on effective methods to develop partnerships and employ sociotechnical design in this space.

SESSION SUMMARY:

In most communities, information related to individuals' health and well-being is distributed across the multiple unconnected care siloes created to support medical, behavioral, and community service providers. While progress has been made toward interoperability of EHRs for the medical enterprise, community-side information remains highly fragmented and sequestered. The result is that community care providers too often work with incomplete information, cannot connect to the broader system of care, and unintentionally create complex pathways of care that fail to effectively address health disparities. It is unlikely that this classic 'wicked problem' will be solved by entering more social data into the medical enterprise EHR.

Over the past few years, a community-academic partnership in Jackson (MI) has engaged in a sociotechnical design process to co-construct a shared 'community-side' IT infrastructure that can link care and service providers across the community. The infrastructure supports a common screening and referral process, enables limited information exchange between care providers, and connects to the local EHR. The partnership's long-term goal is to employ this infrastructure as a central component in a community-based Learning Health System. A similar community-academic partnership has emerged over the past year in Longmont (CO), catalyzed by a joint invitation by the City and a new local hospital. The Longmont partnership has constructed a map of the web of community service organizations (CSOs), convened CSOs to evolve consensus on a sociotechnical design approach, and is now bringing other healthcare organizations to the table to explore development of a data-sharing infrastructure.

This Forum seeks to bring together anyone interested in partnering with communities to better integrate care to collectively develop methods to guide this work. We will briefly compare and contrast our experiences in Jackson and Longmont, focusing on critical points in the co-construction process, as a means to explore pros and cons of a sociotechnical design approach in this work. We will then open the floor for full group participation, where participants can share their own experiences and learnings in this area - participatory design work with communities, addressing social determinants of health, community-partnered work on related topics. Participants will be encouraged to question assumptions, provide additional perspectives, and propose new approaches for developing effective partnerships. We have 3 goals for the session:
1. To demonstrate core principles of sociotechnical design and illustrate its usefulness as a framework to organize work on community health problems
2. To develop a 'methods toolbox' to guide researchers and communities in this challenging work
3. To build a collaborative community of researchers engaged in this work: it is difficult, humbling, frustrating, and peer support can be a lifeline

Please provide detailed information regarding the panel presentation proposed. Please including all panelists and their area of expertise.
Presenters and areas of expertise:
Michael Klinkman, MD, MS: Family physician and researcher, with expertise in health information technology design, community-academic partnerships, health care integration, leading multidisciplinary teams, and PBRN network director
Donald Nease, MD: Family physician and researcher, with expertise in health information technology design, community-academic partnerships, leading multidisciplinary teams, large-scale PBRN research, and PBRN network director
Ken Toll: CEO of Jackson United Way, with expertise in IT systems development, community service organization networking, nonprofit fundraising, extensive experience in building broad community coalitions
Ayse Buyuktur, PhD: Research coordinator and health informatician, with expertise in sociotechnical design, qualitative and ethnographic inquiry, and significant field experience in design and implementation of health information technology

LEARNING OBJECTIVES
This session will help participants:
(1) understand the importance of connecting community and medical information silos to support integrated health care
(2) understand the core principles of sociotechnical design as a framework to organize work on community health problems
(3) work toward developing a methods toolbox to support their own efforts to build long-term community partnerships
(4) build collaborative relationships with the small community of PBRN researchers actively working in this area

AGENDA/TEACHING METHODS
Introductions of panelists and all participants (5-10 minutes)

Presenters will briefly describe core learnings from their work to date (30-40 minutes with time for questions and comments): some examples
- concepts of opportunistic discovery, emergent communities, community resolve and stamina
- how sociotechnical design principles have guided work (differently) in the 2 communities

- the use of 'boundary objects' to advance community collaboration
- some milestones achieved in each community

Full group session (30-40 minutes):
Full group participation, facilitated by presenters.
Participants can share their own experiences, provide additional perspectives, and propose new approaches/ methods/ techniques for developing effectivepartnerships.
Depending on number and experience of participants, we may divide into small groups for more in-depth discussion (for example, basic approaches to community discovery vs. methods for community mapping).

Summing up, and next steps (10 minutes).

NEEDS ASSESSMENT
We will assess needs of participants before session and during introductions.
We will ask participants to describe of their current work in this area, challenges they are facing. If inexperienced, we will ask them to describe background/interest and questions they would like addressed in the session.
Presenters are highly experienced facilitators, and will use responses to shape content and group discussion in session. For example, if a sufficient number of inexperienced participants are present, group session can be broken into smaller groups - one to discuss methods in depth, another to work through some basic issues in beginning to work with communities to create COS.

AUDIENCE ENGAGEMENT
Opening introductions of all participants, including description of their current work in this area or background/interest in this area - this will allow presenters to shape session and carry out needs assessment.
Open encouragement for questions and discussion at any point in session, including initial presentation
Full-group participation for majority of session to share ideas and collectively develop methods to carry out this type of work. This will be organized as small-group, or full-group, depending on number of participants.

EVALUATION
1. We will ask participants to complete a BRIEF evaluation asking about their level of experience in this area, their level of agreement as to whether the session met its 4 measurable objectives, and a brief description of what they would like to see as a next session on this topic
2. We will offer to host a virtual learning collaborative on this topic; the response will provide another measure of our success in engaging participants in this work. NOTE: Our Forum at the 2017 PBRN meeting led to the development of a new local collaborative in Lehigh Valley and establishing regular virtual meetings of 4 groups actively engaged in this work.

DISCUSSION/REFLECTION
This session grew out of the cumulative field experience of the presenters over several years of work in this area. The primary lesson learned is that there is no single, linear pathway to success in this work. We need to be able to bond with our partners and adapt to local conditions and needs. That requires both a full methods toolbox and a diverse learning collaborative to fill it.

RELEVANCE STATEMENT
Partnering with communities to study and solve 'wicked problems' such as effectively sharing information to support integrated health care is very important - and incredibly challenging. In this session, we will collectively explore and develop methods to guide and support this work.

AUTHOR NAME:

Michael S Klinkman, MD, MS; Donald E. Nease, MD; Ken Toll; Ayse Buyuktur, PhD;

WPF7: Measuring quality in primary care: how do we know what we're doing is working?

SESSION DESCRIPTION:

Group discussion to generate and prioritize practical measures of success in efforts to measure quality in primary care.

SESSION SUMMARY:

Participants will consider two examples of measurement of quality in primary care from Ontario, Canada as context for a discussion about how to measure success in quality measurement. The first is a voluntary performance measurement initiative with high and sustained participation of primary care teams over 3.5 years and 7 iterations. The second is an alliance of organizations covering the primary care sector in Ontario who are collaborating to streamline the performance reports produced by each member of the alliance. These stories will be shared to start conversations among participants centered on the question: "How can we know if and how our various different efforts to measure quality are working?". The collected suggestions for tracking progress in quality measurement will be prioritized by the group as a short list to help participants and workshop leaders alike get even better at measuring quality when they return to their practice settings.

NEEDS ASSESSMENT

There is a fair amount of data that demonstrates the need to improve quality in primary care in terms of safety, efficiency, patient-centeredness and/or provider joy. Measurement is widely known to be an important first step of improving quality. However, there are numerous ways of both measuring and choosing the metrics themselves. As a sector, we need to better appreciate the extent to which what we are doing with measuring quality is effective at changing knowledge and behaviours. We need to measure our progress with measuring!

Measurable Objectives: participants will be able to

- list 3 measures they can track to monitor their success in measuring quality
- estimate how well their own efforts to measure quality are working based on these measures
- better evaluate the potential usefulness of new approaches to measuring quality

Agenda

- Present examples (didactic)
- Share local measures used to track success of quality measurement (small group discussion).

Examples presented to stimulate debate include:

- o Participation
- o Durability/sustainability (ie how long has participation been sustained)
- o Review of data
- o Use of data
- o Evolution of the measurement process
- o Consistency/specificity of definitions
- o Improvement in performance
- o Relationship to other less ambiguous outcomes
- o Satisfaction of users
- o Comprehensiveness
- Prioritize suggestions from group (small group discussion)
- Implications for local application (large group debrief)

AUDIENCE ENGAGEMENT

Audience is expected to share suggestions from their own experience to generate collective wisdom on how to improve our various measurement efforts. Participants will be asked to comment on their confidence in using the prioritized indicators in their own work post-conference.

DISCUSSION:

In addition to potential providing participants with food for thought on whether their own existing measurement efforts are working in their own practice (and why or why not), this workshop is an opportunity to advance consensus among leaders in primary care research on the subject in a forum uniquely dedicated to the subject, ie the PBRN conference. It is expected to contribute considerable knowledge to the participants AND the leaders to guide ongoing efforts to support improvement in primary care.

PRESENTERS:

Dr Carol Mulder, Provincial Lead for Quality Improvement and Decision Support for the Association of Family Health Teams of Ontario, whose members serve about 25% of population of Ontario, Canada. Carol is lead for the Data to Decisions (D2D) initiative and is completing her doctoral thesis research on quality improvement in primary care.

Dr David Kaplan, Provincial Primary Care Lead for Heath Quality Ontario, the lead organization for quality in Ontario's healthcare system. Among other things, David is the lead for HQO's provincial primary care quality advisory committee and primary care reporting alliance.

WPF8: Building primary care research infrastructure: Reflections and achievements of AHRQ Research Centers in Practice-Based Research and Learning (P30 awards)

SESSION DESCRIPTION:

AHRQ awarded P30 grants to organizations with successful records of conducting primary care research. Panelists (P30 directors) will describe accomplishments, challenges, and insights acquired as nationwide collaborations of PBRNs, and will participate in a facilitated discussion to share lessons learned on accelerating primary care research under this 5-year initiative.

SESSION SUMMARY:

AHRQ awarded P30 grants to organizations with successful records of conducting primary care research. Panelists (P30 directors) will describe accomplishments, challenges, and insights acquired as nationwide collaborations of PBRNs, and will participate in a facilitated discussion to share lessons learned on accelerating primary care research under this 5-year initiative.

AHRQ awarded eight P30 grants in 2013 to organizations with a demonstrated track record of success in conducting primary care research. The centers were expected to foster collaborative, interdisciplinary research; leverage common resources; and develop a robust and productive research and dissemination infrastructure. The objective of the panel presentation is to (1) hear from P30 Directors on their organizational structure, goals, activities, and accomplishments as well as challenges and lessons learned as they attempted to achieve stated goals and (2) present preliminary findings from a program evaluation study to synthesize the valuable knowledge and experience that P30 Centers have acquired as nationwide collaborations of PBRNs.

The P30 program evaluation study, conducted in several phases from June 2017 through January 2018, was designed to gather information to explore P30 center goals, organization and operations, activities, products and outcomes, dissemination and sustainability plans, and lessons learned. All of the eight P30 directors agreed to participate and share relevant information for the document review phase, which was followed by semi-structured key informant interviews with two P30 leadership members in each center. Collaborations within and between P30s contributed to the launch of several successful initiatives, including the PBRN Certificate Program, PBRN Best Practices, several training programs and an international conference on practice facilitation, and the PBRN Fellowship Program. While the lack of dedicated research funding for the P30s led to fewer opportunities to work on projects, some difficulty maintaining fidelity to original goals, and fewer research projects undertaken or attempted, this circumstance motivated the PBRNs to come together to find new solutions, work with other P30s, and to focus energy on non-research activities such as capacity development, education and training, and developing and disseminating products and best practices.

Attendees will be invited to address questions to members of the panel, who will participate in a facilitated discussion to share key insights about how their P30 accelerated primary care research over the course of the 5-year project, components of the P30 worth replicating, and whether and how research and training activities and collaborations were sustained. The participants will reflect on lessons learned in building a national primary care research infrastructure and partnering with other PBRNs, and will offer suggestions for AHRQ on how to further facilitate the collaborative work of PBRNs at the national level. Through sharing of study findings with the PBRN community, we hope to engage members and other stakeholders to inform the development of the content and dissemination strategies for knowledge and resources emanating from P30s, and explore the feasibility of making P30 resources available online for national dissemination.

PRESENTERS

Paula Darby Lipman, PhD: CoCoNet2 Co-investigator and P30 Program Evaluation Study Co-investigator; will moderate the panel session and present preliminary findings from the Evaluation Study.

Zsolt Nagykaldi, PhD: CoCoNet2 PI and PI for the P30 Program Evaluation Study; will describe P30 accomplishments and provide insights into the conduct of collaborative PBRN research.

Rebecca Roper, MS, MPH: Former Director of the PBRN Initiative at AHRQ is an expert in implementation science; will facilitate discussion on lessons learned and future directions with panelists.

Other panelists - Kim Kimminau, PhD; Jonathan Tobin, PhD; Lyle J. Fagnan, MD; Nancy Elder, MD, MSPH: All directors or key members of P30s and leaders in primary care research; will describe P30 accomplishments and provide insights into the conduct of collaborative PBRN research.

WPF9: ROK-Net: An Innovation Collaboration at Oklahoma State University

SESSION DESCRIPTION:

What do you need? The Oklahoma State University Center for Health Systems Innovation, a center with a mission to transform rural and Native American health, started in 2014 with a simple question about rural health needs. After two years of rural research, CHSI launched ROK-Net and a collaboration between primary care providers, researchers, innovators, and corporate partners.

SESSION SUMMARY:

The OSU CHSI, a partnership between the Spears School of Business and the Center for Health Sciences, solves problems at the intersection of business and health. The CHSI began its focus on rural and Native American health in 2014 and launched ROK-Net in 2016. CHSI created ROK-Net based on the likelihood that most viable pathway to innovate and expand rural health is in collaboration with the rural primary care community. Primary care is the crux of rural care.

The CHSI and ROK-Net partnership is naturally synergistic as innovation methods and PBRN methods share common values such as being user/member driven, choosing targeted problems, leveraging the power of community, and moving at a fast pace. ROK-Net members are engaged in informing innovators of greatest needs, participating in research, testing innovations, and attending innovation events. Many corporate partners are interested in the rural space yet find it difficult to engage with rural care as it is often fragmented. ROK-Net creates a rural voice, a rural collaboration, and a conduit for the betterment of rural health. Together ROK-Net and CHSI are identifying, innovating, and implementing rural health solutions.

Please provide detailed information regarding the panel presentation proposed. Please including all panelists and their area of expertise.

1. Explore the synergy between a PBRN and an Innovation Center.
2. Understand the value of innovation to Oklahoma and other rural care areas as rural care struggles to implement solutions often researched and defined in urban areas.
3. Learn about the ROK-Net member response to engaging in innovation sensing, development, and testing.

AUTHOR NAME:

Marjorie Erdmann, M.S.; Stacie Pace; Ipe Paramel, M.H.A.