



# GRIN

Great Lakes Research  
Into Practice Network

## 2013 Annual Report



### **Michigan's Practice-Based Research Network**

Dedicated to the continued growth and development of the field of  
primary care medicine



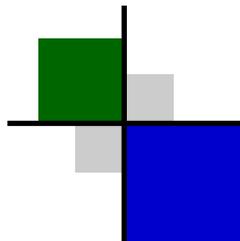
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### **Michigan's Practice-Based Research Network**

*Dedicated to the continued growth and development of the field of primary care medicine*

**GRIN website: [www.grinpbrn.org](http://www.grinpbrn.org)**



## From Our Directors...

We would like to welcome you to the 2013 Great Lakes Research into Practice (GRIN) Practice-Based Research Network (PBRN) Annual Report! 2013 has been a year of tremendous change in the healthcare environment with the continuing implementation of the Affordable Care Act. The Michigan health marketplace or insurance exchange enabled 212,000 Michigan residents to apply for health insurance from October 1 to December 28. The Michigan Medicaid program was expanded to provide access to 470,000 Michiganders in need. Accountable care organizations and organized systems of care are being implemented in various forms through public and private partnerships across the states. New care models and payment models are in the process of being implemented across the state. What does this mean for primary care practice and practice-based research? We hope GRIN research will help us all to understand.

In this environment of great change, GRIN has also witnessed unprecedented organizational change. In 2012, Michael Klinkman, MD, MS replaced Lee Green, MD, MPH as the University of Michigan lead. Lee Green now serves as Chair of the Department of Family Medicine at the University of Alberta. Rebecca Malouin, PhD, MPH, MS is the new MSU Director, taking over for Jodi Holtrop, PhD, MCHES, who now serves as Associate Professor in the Department of Family Medicine at the University of Colorado. Dr. Malouin has been studying practice transformation in the primary care practice-based research environment for many years. She also serves as Associate Chair for Research in the Michigan State University Department of Family Medicine and anticipates bridging the academic expertise of her colleagues to the research questions of interest in the community. You can read more about Dr. Malouin's background on page 11 of this report.

The GRIN Team currently includes Trudy Adler (research specialist, full-time at UM), Martha Boggs (Coordinator, part-time at UM), Amy Faucher (research associate, part-time at MSU), Laurie Fitzpatrick (research associate, part-time at MSU) and Molly Polverento (Coordinator, part-time at MSU). Support for GRIN staff at the University of Michigan comes through the Michigan Institute for Clinical and Health Research (MICHR), with funding from the National Institutes of Health, and the University of Michigan Department of Family Medicine. The staff at Michigan State University are supported by the Michigan State University Department of Family Medicine. The GRIN team meets every other month to discuss current and proposed research ideas, any research issues, and strategic planning. GRIN also has an advisory committee which meets twice a year to review progress and strategic planning. If you would like to serve on the advisory committee, please contact one of the GRIN team members!

With change, comes opportunity. We anticipate that new leadership and many new staff members will benefit GRIN through new relationships, new skills, and new perspectives. GRIN has a long history of success in partnering with practices and provider organizations to address questions of concern to practicing physicians and their teams. Our team is committed to continuing to solicit questions important to you. Over the next year, we will be reaching out to you through a survey and soliciting questions of importance to provider organizations and private practices. We will also try to have a larger presence at venues you might attend.

***See Directors...page 4***

## ***Directors continued from page 3***

We will be giving a presentation about GRIN at the Annual Family Medicine Research Day, at Grand Rounds events at hospitals across the state, and will apply for sessions at Michigan Academy of Family Physicians events.

We will also be sure to disseminate results from GRIN studies. As we become aware of published papers or oral presentations of results, we will send brief abstracts of important points to GRIN members. We will also include references to any publications in the Annual Report, and would be happy to send copies of the manuscripts upon request.

As primary care practices across Michigan face transformation, GRIN is in a similar time of transformation. We are in the process of entering improvement cycles to ensure we are as efficient and effective as possible. Over the next year, we will look to you for guidance on how we can better partner together to improve practice-based research and, ultimately, primary care practice in Michigan.

With our best regards,



Michael Klinkman, MD, MS  
University of Michigan



Rebecca Malouin, PhD, MPH, MS  
Michigan State University

## **GRIN is Working to Create a Long-term Community Partnership in Jackson, Michigan**

The Jackson Health Network (JHN), a partnership between Allegiance Health System, local healthcare providers, and the Jackson Health Improvement Organization, was established in 2010 to create a Clinically Integrated Network that can provide health care services to 160,000 residents of Jackson County, Michigan.

In partnership with GRIN co-director Dr. Klinkman, JHN has developed an innovative community care model that integrates behavioral health care, social services and community outreach into the PCMH and neighborhood while minimizing disruptions in the current health care environment. The care model proactively identifies at-risk individuals and engages them through active care management linked to the PCMH through an innovative health IT platform, available to all community providers, that brings together a core set of common IT “tools”: (1) a comprehensive Health Risk Appraisal developed by the HIO; (2) a structured medical, mental health and social problem assessment tool; and (3) a care management application that manages workflow, clinical documentation, and outcome monitoring. These tools, embedded in the community-wide EHR and available to providers not using the full EHR, provide the key IT functionality to integrate care coordination across the entire community without the need to create and maintain multiple health information exchange protocols.

***See Partnership...page 7***

## Comparing Practice-based Care Management to Health Plan Disease Management in Michigan

**Background:** There are different ways to deliver interventions targeted at patients with chronic disease to improve their self-management and reduce complications from their disease. Blue Cross Blue Shield of Michigan (BCBSM) has a health plan disease management program (or health plan delivered care management - HPDCM) called, “Blue Health Connection.” In this program, nurses deliver telephone-based disease management assistance to selectively targeted health plan members. Patients are identified based on claims-based risk algorithms and employer purchased benefits. BCBSM began a pilot project in 2010 to implement physician organizations/physician practices in the delivery of care management services. The Agency for Healthcare Research and Quality (AHRQ) funded Michigan State University and University of Michigan researchers to examine the implementation of provider-delivered care management, and compare the effectiveness of two care management delivery models.

Five physician organizations (POs) including 52 practices participated in this pilot. BCBSM members who normally would have been potentially offered the Blue Health Connection program were instead delegated (given) to the pilot-participating practices to manage. This form of care management is called provider-delegated or provider-delivered care management (PDCM). This study evaluated the relative effectiveness of these two models of care (HPDCM and PDCM) for BCBSM members with chronic disease.

The study aims were:

- 1) To extensively describe the implementation of provider-delivered care management (PDCM);
- 2) To compare the following patient-specific outcomes between patients offered PDCM versus HPDCM: a) engagement rates in care management, b) relevant clinical indicators, and c) health care utilization; and
- 3) To describe the practice environments and contexts in which BCBSM chronic disease patients receive their care and to identify care management implementation and practice features associated with improved patient engagement and patient-specific outcomes.

**Methods:** Based on prevalence and through collaborative discussions with their member practices, BCBSM identified five chronic conditions as priority for targeting their care management efforts: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes and asthma. Practices were responsible for hiring and training their own personnel, including those in newly hired roles of the care manager and those reassigned for care management responsibilities within existing roles.

A monthly data exchange between BCBSM and the five POs took place during the course of the pilot, which ran from spring 2010 – spring 2012. Utilizing a claims-based algorithm, BCBSM identified adult members having care relationships with primary care physicians (PCPs) within the pilot-participating practices affiliated with the five POs. A list of these members was sent monthly to POs. The POs matched the member lists to their patient records monthly and ‘accepted’ a member into the pilot when the following conditions were met: 1) the member was verified as a patient in a pilot-participating practice, 2) the member was verified as having one or more of five specific chronic diseases for which the practice could provide services, and 3) the practice had the capacity to deliver care management to the member should the need arise.

See *PDCM...page 6*

## ***PDCM continued from Page 5***

**Results:** The PDCM group targeted a higher percentage of members for care management efforts (36% versus 16% for HPDCM). There was some overlap of PDCM and HPDCM targeting. Seven percent (7%) out of all accepted members who were actually targeted by PDCM would also have been targeted by HPDCM. Additionally, PDCM members were engaged at a higher rate (51%; varying between 20% and 71% among POs). Although we were not able to calculate hypothetical engagement rates, the rate of engagement among other HPDCM members at the pilot start was 18% and 13% by the end of the pilot.

Preliminary examination of these clinical values: A1c, blood pressure, LDL and weight, revealed little significant differences between groups for either targeted or engaged groups. The PDCM targeted patients appeared to improve LDL over time (2% to 3% more patients had LDL under 130 or 100). The HPDCM targeted diabetes patients had a 5% increase in the proportion of patients meeting the criteria for optimal care, which was a significantly higher increase than the PDCM group, although the overall proportion was still higher in the PDCM group (29% versus 33%). Due to the focus being on completing clinical services, the data gathered from medical records and PO registries is often not as complete as that collected specifically for research; therefore, there is often abundant missing data. Further, patients with differential conditions are difficult to study together because they have different clinical values causing essentially a smaller sample size of any specific set of clinical values. Further analysis will examine each PO and specific conditions within all POs since there was wide variability in the implementation of care management in the PDCM efforts of the participating POs.

Utilization analysis did not reveal significant cost differences for either targeted or engaged patients across PDCM and HPDCM within the first year. This is not unanticipated because the type of care management studied in this investigation may take longer to realize improvements in costs; especially for the PDCM targeted patients who were not often in need of reduced utilization to begin with [pre-engagement cost trajectory indicated these patients were not highest risk/cost patients]. Regardless, without factoring in the cost for care management, patients who participated in care management at the practice level were not more costly (and trended toward medical cost saving of at \$114 per member per month per patient,  $p=.28$ ) than those in health plan disease management one year post engagement.

Qualitatively, although PDCM was often of good-high quality, we found that implementation of PDCM was highly variable on multiple dimensions. We discovered specific areas where routine use of care management broke down. Although not common, the most significant was having a poorly functioning care manager. Lacking physician buy-in to using the care manager, and lacking resources to support care management also impeded implementation. Because there were many other benefits as reported by patients and care teams regarding practice-embedded care managers, the fact that they did just as well at controlling claims/costs, we suggest that it is wise to encourage care management at the practice level. Care managers centralized at the PO were not utilized as consistently or as well as care managers who were part of the care team at the practice level.

A key area of importance is that of the care manager. Special attention must be made to having a well-trained, qualified and “right fit” care manager in the practice setting. Otherwise, poor quality care management occurs. In practice situations with no oversight for quality, this lack of effectiveness may not be discovered (and likely poor or no positive outcomes result). Targeting and engagement rates varied greatly depending on the offer strategy. Care

***See PDCM...page 7***

## ***Partnership continued from page 4***

With funding from the Flinn Foundation and the federal Medicaid Match program, a research team composed of community members, the Allegiance Research unit, GRIN staff, and researchers from the University of Michigan Depression Center has begun to implement and evaluate the feasibility, clinical effectiveness, and sustainability of this approach in improving behavioral health care in community PCMH practices.

We expect this partnership to serve as a model for GRIN to develop long-term strategic partnerships with other provider organizations or community partners, and we welcome inquiries from groups interested in partnering with GRIN. We will report on our progress in upcoming Newsletters.

## ***PDCM continued from page 6***

managers cold calling patients resulted in higher targeting rates, but lower engagement rates. Physicians offering the care management generally resulted in lower targeting rates and higher engagement rates, although clarity is needed on this latter point because physicians in this study were offering care management to all patients and we only have data on BCBSM-insured patients. An advantage of the health plan model was the ability to utilize data to identify the highest risk patients. Combining risk data with patient relationships might prove to be the most powerful combination for identifying and reaching the patients with the most potential for improvement.

**Implications:** This work supports the placement of care managers in primary care as a means of helping patients with chronic conditions to better self-manage. Primary care practices need mechanisms for reimbursement to continue practice-based care management. Small solo practices may not have enough patients to reach the economies of scale to place a full time care manager in the practice. Sharing a care manager among practices or having a split role may be needed. To the extent possible, primary care practices should carefully select and properly train and resource care managers to work within their own practices. Our qualitative work led us to conclude that the closer the care manager is to the practice team, the better the use of the care manager and participation of the patients in care management. Further research is needed regarding the optimal mechanisms for identification of patients for participation to maximize clinical and cost/utilization benefits.

### **Principal Investigator (PI) and Study Team Members:**

PI – Jodi Summers Holtrop, PhD, University of Colorado Denver (formerly Michigan State University)  
University of Michigan: Lee A. Green, MD, MPH (now University of Alberta, Canada);  
Georges Potworowski, PhD (now University at Albany–SUNY); Michael Feters, MD, MPH;  
Gretchen Piatt, PhD, MPH; Jean Malouin, MD, MPH; Amy Kowalk, MA, CHES, Trudy Adler, MSW  
Michigan State University: Laurie Fitzpatrick; Zhehui Luo, PhD; Denise Hershey, PhD, FNP-BC  
Blue Cross Blue Shield of Michigan: Min Tao, PhD; Ann Emeott, RN, MS; Hsiu-Ching Chen, PhD;  
Margaret Mason, MHSA; Lisa Rjat, MSW  
Altarum Institute: Rochelle May-Gentile, Anya Day, Brad Hinks, Kirsten Werner (now Gray)  
Physician Organizations: Ruth Clark (Integrated Health Partners), Cara Seguin (Henry Ford),  
Cecilia Sauter (University of Michigan), Jennifer Bailey (Lakeshore Health Network), Cathy Heiman  
(Genesys)

**Questions:** Contact the PI, Dr. Jodi Holtrop at the University of Colorado Denver School of Medicine; [Jodi.holtrop@ucdenver.edu](mailto:Jodi.holtrop@ucdenver.edu)

## 2013 GRIN Studies

Title	Principal Investigator/ Institution	Project Description	Funder & Amount	Community Partners
<b>Currently Funded, Active Studies</b>				
Integrating a Behavioral Health Care Manager into Primary Care Practices Utilizing the Michigan Depression Outreach and Collaborative Care Program	Michael Klinkman, MD, MS UM Family Medicine	This project tests the feasibility, effectiveness, and scalability of a tailored depression care management support protocol and a custom-designed health IT application in selected primary care practices in rural south central Michigan.	DHHS- MDCH; 10/1/11 – 9/30/14; \$458,017 direct plus community match; 894805/572950	Practices of the Jackson Health Network and Hillsdale County; LifeWays (CMH)
Implementing Sustainable Diabetes Prevention and Self-Management in Primary Care (PC-MAP)	Jodi Holtrop, PhD University of Colorado Denver (formerly MSU Family Medicine)	This study will implement Chronic Care Model-based diabetes prevention and self care in primary care, remove barriers to sustained care delivery (including financial sustainability), and measure the effect of this implementation on care processes, health care costs, and patient's clinical, health behavior and care satisfaction outcomes.	NIH; R18; \$2.01M; 7/15/10-6/30/14; 1R18 DK082377-01A2	Practices of Integrated Health Associates (IHA)
Decision Aid to Technologically Enhance Shared Decision Making (DATES)	Jimbo Masahito, MD, PhD, MPH UM Family Medicine	This project will test a web-based tool used to make decisions relative to appropriate colorectal cancer screening.	NIH; R01; \$2.4M; 4/1/11-3/31/15; 1 R01 CA152413-01A1	Practices of Oakland-Southfield Physicians Group
Enhancing Informal Caregiving to Support Diabetes Self-Management	Jim Aikens, PhD UM Family Medicine	Patients with diabetes mellitus will undergo weekly telephone monitoring. A summary will be emailed to an in-home caregiver to assist with DM management.	NIDDK; R18; \$2.5M; 8/5/2011 – 4/30/2016; 1R18DK088294-01A1	GRIN Practices Statewide
DECIDERS	Susan Goold, MD, MHSA, MA UM Internal Medicine	This study will develop and evaluate a mechanism to engage communities, particularly minority and underserved communities, in informed deliberations about health research spending priorities.	NIA; R01; \$2.8M; 9/1/11-8/31/16; 1-R01-AG-040138-01	GRIN Practices Statewide
Telemonitoring-Enhanced Support for Depression Self Management	Jim Aikens, PhD UM Family Medicine	Patients with physician-identified depression will undergo weekly-automated telephone monitoring with tailored advice on self-management.	NIH; R01; \$2.9M; 9/18/2012-6/30/2017; 1R01MH0966901A1	GRIN Practices Statewide
Examination of Office Visit Patient Preferences for Clinical Summary Content/Formats	Kathy Dontje, PhD MSU College of Nursing	This study asks patients about the preferred content and format of clinical summaries provided to them as part of Meaningful Use	MDCH; \$565K; 10/1/2013-09/30/2014	Practices of MSU and Sparrow Health System

## 2013 GRIN Studies

Title	Principal Investigator/ Institution	Project Description	Funder & Amount	Community Partners
<b>Studies Under Review/Pending</b>				
Early Audiology Referral in Primary Care (EAR-PC)	Philip Zazove, MD UM Family Medicine	Participating practices will test the feasibility of using automated electronic tools to increase the rate of diagnosis of mild to moderate hearing loss.	NIH; R21; \$2.1M	GRIN Practices Statewide
<b>Funded, Completed Studies</b>				
A Comparison of Provider Versus Health Plan Delivered Care Management in Michigan (PDCM)	Jodi Holtrop, PhD University of Colorado Denver (formerly MSU Family Medicine)	This project will complete a comparative effectiveness study of provider-delivered care management versus health-plan delivered care management for BCBSM members/patients with specific chronic conditions and determine patient-specific, implementation and cost outcomes.	AHRQ; R18; \$1.8M; 9/30/10-9/29/13; 1R18 HS020108-01	BCBSM PGIP Practices
Multi-method Evaluation of the Physician Group Incentive Program for PCMH Transition	Mike Feters, MD, MPH, MA UM Family Medicine	This project will quantify member practices' progress toward PCMH goals, and use the quantitative data to guide sampling for in-depth qualitative analysis of how practices have made or not made that progress.	AHRQ; R18; \$477,496; 7/15/2010-12/31/2012; 1R18 HS019147-01	BCBSM PGIP Practices
Implementation of Clinical Reminder System By Cognitive Engineering of Organizational Routines	Lee Green, MD, MPH UM Family Medicine	This study will demonstrate the use of cognitive engineering tools to guide successful implementation of health IT in several Federally-Qualified Health Centers, and show improved process measures of quality of care. It extends GRIN's and MICH's partnership with the Michigan Primary Care Association, the statewide network of FQHCs, and develops a working relationship between MICH and the internationally known Altarum Institute.	AHRQ; R01; \$1.2M; 12/1/09-11/30/12; 1R18 HS018170-01	Michigan Primary Care Association (Federally Qualified Health Centers)
Using Community Based Screening Mammography Encounters as Teachable Moments for Cancer Control and Prevention (Mamm)	Ruth Carlos, MD UM Radiology	This study will determine if women who are receiving screening mammography are receptive to information on additional screening and prevention services. The aim is to close the gap between behavioral intention and completion of those additional screenings through referral to a primary care physician.	GRIN In-Kind Funds	GRIN Practices in Grand Rapids and Detroit areas

## **GRIN Board of Directors**

**Philip Zazove, MD**

**Chair, Department of Family Medicine, University of Michigan**

**William Wadland, MD, MS**

**Chair, Department of Family Medicine, MSU-CHM**

**Linda Casaceli**

**Practice Manager, Morang Chester Clinic**

**David Klee, MD, FAAFP**

**Physician, Munson Family Medicine**

Originally from Rochester, Minnesota, Dr. Klee attended medical school at the University of Minnesota-Duluth. He completed his Family Medicine Residency training at Mid-Michigan Medical Center in Midland, Michigan in 2000. Following three months of volunteer medical service in Liberia, West Africa, he moved to Ashland, Wisconsin, where he practiced for nine years in a rural clinic located on Lake Superior. Dr. Klee's practice involved full spectrum family medicine including high risk obstetrics and emergency medicine. When the possibility arose to join the full time teaching faculty in beautiful Traverse City, Michigan, Dr. Klee and his family decided to embrace the opportunity. His medical interests are diverse and include: emergency medicine, international medicine, cardiology, simulation and clinical research. Outside of medicine he enjoys spending time with his family (wife Christina, son Elijah and dogs Charlie & Jellie), soccer, gardening, and international travel.

**Mazharullah Shaik, MD, MBA**

**Chief Clinical Officer and Director of Quality and Clinical Services**

**Michigan Primary Care Association (MPCA)**

Dr. Shaik directs MPCA's clinical affairs department, which includes clinical quality, clinical workforce, and clinical information technology supporting Meaningful Use, Patient-Centered Medical Home, Pay for Performance, and quality-related research activities. He works with community health centers and their clinical leadership to foster clinical quality capacity-building, coordination, and alignment efforts.

Dr. Shaik is a senior healthcare professional with 20 years of combined clinical, administrative, and program management experience, including 17 years in an academic setting (Wheeling Jesuit University, Wheeling, WV) as a researcher, educator, and principle investigator. Prior to joining MPCA Dr. Shaik worked as the Managing Director, ONC's Regional Health IT Extension Center of Michigan (M-CEITA). He currently serves as board member of MWCN (Mid-West Clinicians Network). He earned his Doctor of Medicine from Osmania University, India, Masters in Business Administration (MBA) specializing in Health Services Administration, from Wheeling Jesuit University.

## GRIN Staff

### GRIN Co-Directors



Michael Klinkman, MD, MS, University of Michigan  
mklinkma@med.umich.edu, 734-998-7120 x 320

Dr. Klinkman is a Professor of Family Medicine at the University of Michigan Medical School. He is a Michigan native who is first and foremost a practicing family physician, with an active part-time practice in Ann Arbor where he has served his patients for over 20 years.

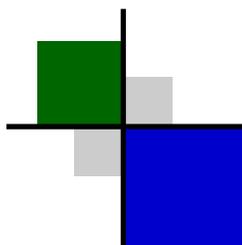
Dr. Klinkman's first funded study in Michigan, a study of chest pain in primary care, was based in the practices of UPRNET and MIRNET, the 'parents' of GRIN. He has led or co-led several large studies of mental health care in the primary care setting. He has been part of the University of Michigan Depression Center leadership team since its inception, and has led several of the Center's primary care initiatives over the past 10 years. His academic efforts at Michigan have been focused on health information technology, mental health care in the primary care setting, and practice-based research.



Rebecca Malouin, PhD, MPH, Michigan State University  
Rebecca.Malouin@hc.msu.edu, 517-884-0453

Rebecca A. Malouin, PhD, MPH is a tenure-system assistant professor, jointly appointed in the Department of Family Medicine and the Department of Pediatrics and Human Development. She is also Director of the Primary Care Research and Evaluation Program and Associate Chair for Research in the Department of Family Medicine.

She received her PhD and MPH from the Johns Hopkins University, and an MS in epidemiology from Michigan State University. Dr. Malouin is a health services researcher with a strong background in mixed-methods research and extensive experience with implementation research and evaluation. She has served as an evaluator for several medical home projects and initiatives and is currently the principle investigator of an AHRQ K01 Research Mentored Scientist Award on the topic of the measurement of primary care and patient-centered medical homes. She also is the author of *Measuring Medical Homes: Tools to Evaluate the Pediatric and Patient- and Family-Centered Medical Home* and *Positioning the Family and Patient at the Center: A Guide to Family and Patient Partnership in the Medical Home*, both published by the American Academy of Pediatrics and National Center for Medical Home Implementation with funding from the Health Resources and Services Administration.



## GRIN Staff (continued)

### GRIN Coordinators



**Martha Boggs, CRCC, University of Michigan**  
**haabme@umich.edu, (734) 998-7120 x 338**

Martha is the Research Coordinator at the University of Michigan for GRIN. She works to help facilitate GRIN activities with the University of Michigan and Department of Family Medicine. She has over ten years of experience in managing research studies. Prior to joining GRIN she worked as a coordinator and monitor for cancer prevention and dermatology studies.



**Molly Polverento, MEd, Michigan State University**  
**molly.polverento@hc.msu.edu, 517-884-0434**

Molly is an Outreach Specialist at MSU and is the MSU Coordinator for GRIN. Her primary responsibilities are to promote GRIN to MSU-based researchers and to coordinate the evaluation of GRIN activities and outcomes. Molly also works on activities to bridge public health and primary care practice. Molly has worked in public health program administration and policy since 2000 and holds multiple public health leadership positions.

### Network Research Specialist and Research Associates



**Trudy Adler, MSW, tadler@med.umich.edu, 734-262-3563**

Trudy R. Adler is the Network Research Specialist for southeast Michigan. Trudy has over 10 years direct clinical expertise in healthcare, including hospice, chronic disease management and inpatient settings. Trudy is a fully licensed clinical social worker with experience in policy evaluation, publication development, and research. Trudy received her MSW from the University of Michigan, where she was a Geriatric Fellow.



**Amy Faucher, MS, amy.faucher@hc.msu.edu, 517-884-0462**

Amy Faucher is the manager of the Primary Care Research and Evaluation Program in the Department of Family Medicine and Department of Pediatrics and Human Development at the Michigan State University College of Human Medicine. Amy earned her Master's in Survey Methodology from the University of Michigan and has experience in project management and mixed methods research.



**Laurie Fitzpatrick, BS, laurie.fitzpatrick@hc.msu.edu, 616-234-2824**

Laurie Fitzpatrick is a Research Associate in the Department of Family Medicine at Michigan State University's College of Human Medicine. Before coming to MSU, Laurie worked in local public health as a health educator in health promotion/ chronic disease prevention. For the past 8 years, Laurie has been involved in a variety of research projects focused on health behavior change interventions in community and primary care settings. She has experience in project management and mixed methods research.