



scribe

From your student board member

In a special addition to our Economics of Medicine department this month, a student board member discusses the stresses and strains of the cost of a medical education in today's world. News that reimbursements for primary care physicians (Page 9) may bolster the courage of current students. And discussions continue on how to make the most of the tools at hand—or how to create new tools—to control the cost of health care.

—Beginning on page 10

A publication of the Medical Society of Metropolitan Portland

www.msmp.org

New MSMP website provides doctors with services and one-stop information



By Cliff Collins
For The Scribe

The **Medical Society of Metropolitan Portland** this month announces the debut of its completely new, redesigned and enhanced website, found at www.msmp.org.

The MSMP's intent is to inspire Portland-area physicians to make the site their home page and to offer doctors a one-stop shopping destination in which they can obtain a wide range of information pertinent to their lives and practices.

"We're excited to introduce this new website," said **Bud Lindstrand**, MSMP's chief executive officer. "We believe we're providing a place for busy physicians in the Portland area to come together."

The site is constantly updated with general and medical news

and information. It includes an interactive, members-only forum feature to allow doctors to communicate with one another.

MSMP members also can post and respond to questions, anonymously if they choose.

"We are committed to make this an area where physicians can connect and can receive help in all aspects of their lives," he said.

articles and other scientific news; economic and general business news; and political and health-policy education and news.

In keeping with the interactive nature of the site, it contains a section called "What Do You Think?—What can we do better?" This allows a place for feedback, to give suggestions about what else doctors would like to see or obtain from the website, Borges said.

to the compassionate nature of our members," Troyer explained.

Troyer also serves as the project manager for the **MSMP Health Preparedness Program**. In it, MSMP works closely with other public health entities to help private medical clinics prepare for and respond to health or medical disasters.

As part of that effort, he posts in a special section on the website, news and information

Lindstrand said. "Our benefits far exceed, in monetary value alone, the cost of membership dues."

Among those benefits are:

- **Professional liability insurance:** Through partnership with **The Doctors Company**, the insurer offers malpractice premium discounts up to 12 percent for MSMP members. Also included are The Doctors Company's premium dividend program and its unique **Tribute Plan** of financial benefit to long-term clients.
- **Private banking program:** Through partnership with **OnPoint Credit Union**, MSMP offers special benefits, including discounts on closing costs for loans, reduced lending rates, a rate boost on CDs, and personal bankers.
- **Long-term care insurance:** MSMP offers a program with significant discounts to assure doctors of the best program to fit their needs.
- The pocket-size **Doctors' Little Black Book**, for locating physicians and other medical providers.
- **Salary surveys: Medical Society Staffing** conducts annual employee salary survey information, which is available to all members at no cost.

See **WEBSITE**, page 3

The objective is "to **develop interactive, easily understood** web pages, forums, blogs, that are engaging... and to **publicize worthwhile humanitarian, philanthropic and volunteer initiatives** that appeal to the compassionate nature of our members."

—Aaron Troyer, MSMP website administrator

Staff members will monitor the forum section to try to find answers for questions members pose, said **Amanda Borges**, MSMP general manager.

Like its predecessor at the same address, the new site continues to offer information to the public including referrals to member doctors.

But it also now gives all physicians time-saving access to news about local medical issues; reports from medical-journal

Aaron Troyer, MSMP's newly hired website administrator, updates and maintains the entire site. He posts links to articles, resources and other timely information from internal and external sources.

The objective is "to develop interactive, easily understood web pages, forums, blogs, etc. that are engaging to members, and to publicize worthwhile humanitarian, philanthropic and volunteer initiatives that appeal

relating to health preparedness, including resources such as for education and training.

Another key portion found on the home page is a listing of the array of services MSMP has arranged that give members financial and business advantages and discounts.

"These are essential business-related products that provide direct financial value, as well as service value, to both individual physicians and medical groups,"

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INSIDE THIS ISSUE

Free health fair



In conjunction with its annual general membership meeting, the Oregon Medical Association will hold a free health fair. Fair attendees will receive a variety of baseline treatments and diagnostics to help them better understand how to take care of themselves, and physicians attending those patients will get a closer look at something the OMA is focusing on for this year's meeting: poverty.

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History of Medicine



The Scribe's resident medical historian shares several "firsts" that happened in Oregon. Women received support for the advancement of suffrage, as well as for the right to hold leadership positions in medical organizations; patients undergoing dialysis can thank two Oregon physician pioneers for their work to make the treatment affordable; and Oregon has led the nation in efficient emergency care.

—Page 12

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Classes are held at Legacy Good Samaritan Medical Center from 6 to 7:30 p.m.

To register, visit www.legacyhealth.org/weight.



Kaiser study reveals significant variations in potency of vitamin D supplements

By John Rumler
For The Scribe

Vitamin D supplements are more popular than ever. For decades, adults and children alike depended on vitamin D to help strengthen their bones, while in more recent times vitamin D is becoming more widely used for boosting the immune system, combating Type I Diabetes or simply because patients don't get enough of the so-called "sunshine vitamin."

However, a new **Kaiser Permanente Center for Health Research** analysis published in the February issue of the *JAMA Internal Medicine* (formerly *Archives of Internal Medicine*) reveals that the potency of vitamin D supplements varies widely and often does not match the amount listed on the label.

Researchers found that the potency of the vitamin D they tested ranged from 9 percent to 146 percent of what was listed on the label. Not only was there a significant variation among different brands but also among different pills from the very same bottle.

"There is some room for variation in potency according to voluntary standards set by USP—but there is not supposed to be as much variation as we found in our study," said **Erin LeBlanc, MD, MPH**, from the Kaiser Permanente Center for Health Research and lead author of the study.

While it is possible but not likely for a person to take too much vitamin D, the far bigger concern for researchers and clinicians is people with extremely low levels of vitamin D in their blood.

"If they are consistently taking pills that contain very little vitamin D, they could face health risks," LeBlanc said.

The impetus for the study came about as KPCHR had recently conducted a randomized controlled trial of vitamin D in menopausal women using compounded study pills so that vitamin D and placebo pills would look the same. As part of study quality assessment, researchers sent the compounded study pills to a lab for testing and found a large degree of variability in the potency.

"This made me curious about the variability and accuracy of over-the-counter vitamin D supplements," LeBlanc said.

The USP verification stamp is probably the best way to get some reassurance that the amount listed on the label is at least close to what's in the bottle, LeBlanc said.

"In our study, the verification stamp didn't guarantee that every pill in the bottle contained the amount of vitamin D listed on the label, but when averaged together, the five pills from the USP verified bottle generally contained at least 100 percent of what was listed on the bottle," she said. "Therefore, given that the USP requires initial and periodic testing of the pills, the USP verification mark may give consumers more reassurance."

LeBlanc was surprised not by the variation but by the huge amount of variation in vitamin D potency.

"Physicians often suggest that patients take more vitamin D to strengthen their bones, and I expected that the dose listed on the label would match the dose in the pills," he said. "It was surprising to learn that this is not necessarily the case."

The prevalence of vitamin D deficiency varies depending on how deficiency is measured and defined, but it is quite common in America.

The 2005–2006 National Health and Nutrition Examination Survey reported that more than 41 percent of adult participants had significant vitamin D deficiencies.

The prevalence of low vitamin D levels has increased over the last 20 years. Risk factors for vitamin D deficiency are many and varied, LeBlanc explained.

Non-Caucasians are more vulnerable as are those who are overweight, those in generally poor health, people with non-daily milk consumption and with no vitamin supplement use, as well as seniors, females and those who are pregnant.

Also, limited UV exposure due to geographic location, season, or institutionalization can be contributing factors.

Medical conditions that may increase a person's risk of vitamin D deficiency include malabsorption syndromes, granuloma-forming disorders, some lymphomas and the use of some medications.

Severe deficiency of vitamin D causes a mineralization defect in the skeleton. In children, deficiency results in skeletal deformities classically called rickets. In adults, severe deficiency can result in osteomalacia, which is associated with decreased bone mineral density and diffuse bone and joint pain, muscle weakness and difficulty walking.

Vitamin D deficiency may also contribute to declines in bone density, muscle strength, and muscle mass and has been associated with increased risk of falls and fractures in the elderly.

Whether someone needs a supplement and the type and dose of vitamin D depends on many factors, LeBlanc said, including a person's diet, geographic location, sunlight exposure, medical problems and medicines.

"Therefore, people who are concerned that they might not be getting sufficient vitamin D should talk to their health care provider about whether they need vitamin D supplements and the amount of supplementation they should take," she said. •

Vitamin D study may just be tip of iceberg

While the Kaiser study only looked at vitamin D, LeBlanc said he didn't know with any certainty that other vitamins had similar problems.

"I would imagine that this inconsistency could likely occur with other supplements as well," he said.

Pieter Cohen, MD, assistant professor of medicine at **Harvard Medical School**, would certainly agree. He points out in a recent *New England Journal of Medicine* editorial that while upwards of 100 million Americans spend around \$28 billion on vitamins, herbs and supplements annually, regulation of the industry is weak or almost non-existent.

Since the current framework for regulating dietary supplements—known as the Dietary Supplement Health and Education Act—was adopted in 1994, the number of dietary supplements has exploded from about 4,000 to more than 55,000.

However, the **U.S. Food and Drug Administration** has received adequate notification for only 170 new supplement ingredients since 1994.

Both the industry and the FDA acknowledge that many new products have been introduced without any assessment of safety. In July of 2012, the FDA proposed new guidance to rectify the situation.

However, the proposal is under heavy attack from the supplement industry.

"Anything can be introduced on the market without any form of pre-assessment," said Cohen. "The FDA needs to identify a significant risk before a product can be removed, and even when they do so, it's a Herculean task to have it removed from the marketplace."

Cohen used ephedra as an example, adding that despite all the problems, the FDA worked for 10 years and undertook an extensive court battle before ephedra was finally removed. •

Website: "Invaluable resource and social focal point for members"

CONTINUED FROM page 1

In addition, the following benefits found on the website are specifically designed for group practices. All physicians in a group must be members of MSMP:

- **Medical staffing services:** A 10 percent discount on MSMP's own medical staffing service, Medical Society Staffing. It finds and supplies staff for all levels of office needs other than physician recruitment.
- **Electronic banking:** Through partnership with OnPoint Credit Union and **NXGEN**, MSMP offers a special banking system for physicians' offices. Two key features of this program involve website payments and reduced processing costs.
- **Bill collections and pre-collections:** Through partnership with **I.C. System**, MSMP offers a 32 percent discount for

collections and a 10 percent discount for slow pays.

- **IT services:** Through partnership with **Pavelcomm Inc.**, member MSMP medical groups receive a 15 percent discount on labor services for data and communication technology services.
- Substantial **discounts** with **Medline**
- **Special rates** for medical group managers for electronic payments and merchant services
- **401K administration:** Through partnership with **Pension Plan Specialists PC**, MSMP offers a 10 percent discount on first-year plan administration as an exclusive to medical group managers.

With all these features and services and more to come, "Our intent is to make the Society an invaluable resource and social focal point for members," Lindstrand said. •

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The Portland Physician Scribe is the official publication of the Medical Society of Metropolitan Portland.



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Subscriptions are available for \$125 per year. For more information, please email linda@llm.com. For payment information, please email accounting@llm.com. To change your address or remove yourself from the mailing list, please notify: The Portland Physician Scribe, 4380 SW Macadam Ave, Ste 215, Portland, OR 97239, or email amanda@msmp.org.

Oregon Medical Association to offer free health fair as part of its annual meeting April 19

By Jon Bell
For The Scribe

The **Oregon Medical Association's** 2013 annual general membership meeting, coming up on April 19–20, has been built around a single, topical issue: poverty.

The title for the event, "Poverty Stricken: Providing Care in Challenging Times," sets the initial tone. The presentations, from "Poverty and the Impact on Health Care: A Personal Story" to "Caring for the Poor in the 21st Century: One Physician's Perspective" reinforce it.

And **Care Connection 2013**, the OMA's first health fair and screening event—free and open to the public—actually gives the medical community in Portland the opportunity to confront the issue head-on and do something about it.

"Providing medical care for the needy has been at the heart and soul of our profession throughout the ages," said **William "Bud" Pierce, MD**, the 2012–13 OMA president. "The physician, physician assistant, and student members of the Oregon Medical Association honor this commitment by serving at a health fair at our annual membership meeting."

The health fair, which will be held from 8 a.m. to 3 p.m. Friday, April 19, at the Oregon Convention Center, will offer free screening services and education for the uninsured and underinsured in the Portland metro area.

The services available will include vision, hearing, blood pressure, diabetes and glaucoma checks provided by the **Lions Club**, immunizations, dental services, BMI screenings, nutrition counseling and foot exams. All of those will

be available on a first-come first-served basis.

In addition to the services on hand, there also will be medication counseling and education, referrals to safety-net clinics and addiction, mental illness and PTSD services for veterans. The fair also will feature healthy cooking demonstrations, smoking cessation education and more.

Invite members of your health care team, interested colleagues and others who want to learn more about providing the best possible care to those in need.

— William "Bud" Pierce MD
2012–13 OMA president

According to the OMA, physicians, physician assistants and medical and PA students from around the region have partnered with the OMA to put on the fair. Participating organizations included everyone from **Project Access Now** and the **Oregon Health Authority** to **Medical Teams International** and the **Portland Farmers Market**.

The Friday, April 19, will be dedicated to the health fair. On Saturday, the OMA will convene for the traditional aspects of its annual meeting: speakers, exhibits and a fund-raising reception.

Pierce noted that the meeting isn't just for OMA members.

"Please invite members of your health care team, interested colleagues and others who want to learn more about providing the best possible care to those in need," he said.

Additional presentations include "Making the Connection: Strategies for Managing Patients" and "Do Unto Others ... Doesn't Always Work: Lessons on Improving Health Care for Marginalized Populations."

There also will be a closing keynote from **Anthony B. Iton, MD**, senior vice president for healthy communities at **The California Endowment**, a state-wide foundation aimed at expanding access to affordable, quality health care for underserved individuals and communities.

Closing out the event will be a fund-raising reception from 8 to 10:30 p.m. at **The Nines** in downtown Portland. The event, which will raise money for the OMA's new Medical Scholarship Fund, will feature **Jeannette Walls**, a journalist and the bestselling author of "The Glass Castle."

"[This meeting] is quite different from the House of Delegates meeting we would have just three years ago," Pierce said. "This meeting is really about bringing people together to learn, to give back and to celebrate together. That's what the OMA is really about."

For more information about the fair, or to register for the annual meeting, visit www.theoma.org/generalmeeting2013 or call 503-619-8000.

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Kaiser switches Clark County hospitals, inks deal with Legacy

By Cliff Collins
For The Scribe

Kaiser Permanente has signed an agreement with **Legacy Salmon Creek Medical Center** designating the Vancouver facility as Kaiser's health plan hospital for its 100,000 members in Clark County.

Pending regulatory approval by the Washington insurance commissioner, the new seven-year agreement will take effect Oct. 1, supplanting an existing exclusive contract Kaiser has held with **PeaceHealth Southwest Medical Center** for the past 15 years.

The new arrangement came about after Legacy Health "reached out to us awhile back about pursuing a contract," said **Thomas A. Hickey, MD**, vice president and associate medical director for Northwest Permanente. "We thought it made sense," and that it might build on further relationships with Legacy, he said.

Specific services Kaiser patients would receive at Salmon Creek are yet to be worked out, but obstetrics care "definitely" will be one of them, though at-risk births that may require a neonatal ICU will be sent to **Providence St. Vincent Medical Center**, Hickey said.

Kaiser hospitalists who now work at Southwest, including those in obstetrics and the emergency department, will move to Salmon Creek once the new partnership begins, he said.

PeaceHealth officials, disappointed over the loss of the Kaiser contract, say that for the past couple of years, Kaiser has been sending most of its members who need hospital care to **Kaiser Sunnyside Medical Center** in Clackamas. Obstetrics is about the only hospital service left that Kaiser has continued to refer its members to Southwest for care, said **Ken Cole**, spokesman for PeaceHealth Southwest.

"We're a managed care organization," responded Hickey. "We want to manage as much medical care as we can in our facilities, and Legacy is well aware of that."

In fact, that element and Kaiser's general philosophy of seeking both quality and affordability are "embedded in our contract" with Legacy, he said.

Referring to Kaiser and Southwest, Cole said, "There definitely has been tension between the two organizations" over the past two years, and the new arrangement with Legacy is "not a surprise to us."

But Hickey said the tension between the two is not unique but "reflects the challenge of health care right now," where an environment exists of shrinking health care dollars.

"There's always tension among all the hospitals, because we operate Sunnyside" and will be opening Kaiser's new **Westside Medical Center** in Tanasbourne in August, and because of Kaiser's coordinated approach to care, Hickey said.

"We want to, obviously, take care of patients in our facilities."

St. Vincent earlier faced similar circumstances after Kaiser ended a long-held contract with Providence to provide cardiac care services for Kaiser patients, once Kaiser Sunnyside opened its own open-heart surgery and catheterization facility in 2009.

Kaiser and Legacy intend to merge electronic health records—both use Epic—so that Salmon Creek staff will be able to access Kaiser patients' medical records seamlessly.

The switch to Legacy is a coup for its Clark County hospital, which opened in 2005 and initially added a large debt burden to Legacy Health. Salmon Creek is licensed for 220 beds, and runs an average daily census of about 115 patients.

Hospital officials expect that average census to rise by about 30 patients a day

with the Kaiser contract, said hospital spokesman **Brian Willoughby**.

Legacy officials expect to see an additional 8,000 patients a year in the emergency department and to deliver about 1,000 additional babies each year. Currently, about 2,200 babies are born at Legacy Salmon Creek annually, he said.

To handle the growing capacity, the hospital expects to spend around \$6 million in renovations including adding a third operating room in the maternity wing and to hire about 210 to 220 additional staff, Willoughby said.

At the same time, Southwest Medical Center is counting its losses. Officials estimate patient volume dropped by 987 patients in the 12 months ending in June 2012 compared with the year ending in March 2010, or a drop of \$8.1 million in revenue, Cole said.

"However, we estimate the total Kaiser commercial-patient out-migration to Kaiser Sunnyside from Vancouver in 2011 was more than \$38 million."

Southwest remains concerned that Kaiser patients are given "the impression they can receive care locally, when their health plan has been consistently redirecting them out of our community for more than two years," Cole added.

Hickey said Kaiser physicians have "specific protocols based on each service line" for determining where patients should be treated.

"Because we do that, that can create tension with any facility."

But he said Kaiser is "excited about," the Kaiser-Legacy agreement, because "we're working on improving patient care." •

Good Samaritan first in North America to adopt new health care improvement program

By Dawn Weinberger
For The Scribe

Increased efficiency. Less waste. Improved patient care. Every hospital wants these things. But with today's financial pressures and time constraints, figuring out a way to implement changes that will lead to such improvements can be quite the challenge.

Enter **The Productive Operating Theatre**, or TPOT. TPOT is a health care improvement program created by England's **National Health Service**. Designed to streamline process and procedure, the program's goal is to deliver a more coordinated approach to patient care from admission to discharge.

Thanks to a training grant from **CareOregon**, a non-profit organization that provides health care to low income Oregonians, **Legacy Good Samaritan Medical Center** is the first facility in North America to put the program into practice.

TPOT is already in use in several other countries around the globe, including Australia, New Zealand, Denmark and Qatar, as well as England itself.

The CareOregon grant covered the costs of bringing TPOT experts and trainers to Portland from the United Kingdom to show Good Samaritan staff and physicians the proverbial ropes. Additional expenses, such as the cost to license various hospital departments to use the program, are covered by the hospital itself.

"[TPOT] is a terrific approach," said **Barbara Kohnen Adriance**, CareOregon's senior manager of special projects and governance. "It empowers

people to make the changes and to build on their resources that they [already] have."

CareOregon opted to work with Good Samaritan on TPOT due to the hospital's previous success with another NHS program, **Releasing Time to Care**. Releasing Time to Care strives to increase the amount of time nurses spend with patients at their bedside.

According to **Tony Melargno, MD**, chief administrative office of Good Samaritan, TPOT is helping Good Samaritan examine how it is doing things while also finding ways to do better whenever and wherever possible.

He hopes to roll the program out to additional areas of the hospital in the future. For now, TPOT is specifically targeting surgical units.

Surgeons and staff from four areas—the operating room, post-anesthesia care, pre-admission services and short stay—attended a three-day training session in January where they learned how to track and measure outcomes. From there, each department came up with their own process-improvement plan. Materials for the training were all provided by NHS.

Melargno likens the materials and methods to very thorough step-by-step cookbook.

"That is what I like about it," he said. "It provides a model to follow."

Implementation of the practices covered in the training began almost immediately. Staff, Melargno said, are already well on their way to reaching their overall goals—goals such as more flexibility in scheduling, the ability to provide autonomy for staff and the ability to leverage staff time and resources for everyone's advantage.

Plus, they are excited about it.

"As they go through the training, they [found that they] like having the structure and methodology that [TPOT] provides," Melargno said. "Even our process improvement engineer was impressed."

Ultimately, the program is designed to help doctors and staff develop their own ways of streamlining care based on their own department's needs rather than just a generalized system.

One example, Melargno says, is taking a close look at the percentage of surgeries that begin on time.

If 60 percent currently start on schedule, what is holding the other 40 percent up? And what can be done to ensure that most—if not all—surgeries start on time?

"We want to waste as little time as possible, and this is what we are focusing on," he said, adding that timely surgeries are better for the surgeons, better for the patients and better for all of the families involved.

Melargno says staff members are all embracing the processes, procedures and goals they are coming up with, and while it always takes time to put something new into practice so far it seems like a great investment in the hospital's future and a great way to streamline costs.

"It takes a commitment," he said. "But time is money and if you want to do things better...you must be willing to take steps to improve."

Likewise, Kohnen Adriance is confident that TPOT will help benefit Good Samaritan's bottom line.

"With better teamwork, scheduling and measurement in all the areas, I am sure it will bring down costs," said Kohnen Adriance. •

Putting patients first makes primary care “exciting again,” medical resident-author says

By Cliff Collins
For The Scribe

A Portland family medicine resident is one of three co-authors of a recent article in the *New England Journal of Medicine* outlining the future of health care.

“The Developing Vision of Primary Care,” published in the Sept. 6, 2012 edition, was penned by three primary care physicians-in-training while they were at the

Harvard School of Public Health seeking a master’s degree in public health, said **Jason C. Kroening-Roche, MD, MPH**, now a first-year resident at **Oregon Health & Science University** and one of the three authors.

“It stems from breakfasts I had with the co-authors,” he explained. “We said, ‘Why don’t we put some of these thoughts in writing?’ It was a big honor for us to be published.”

The *New England Journal* is primary care-focused, he said, and “they seem to publish one or two articles a year by students. We were ecstatic to be part of their journal.”

Kroening-Roche obtained his MPH and now is in his first year of residency at OHSU and at OHSU’s **Family Medicine at Richmond** clinic. He is one of 10 other OHSU family medicine residents who comprise what he describes as the first

group of the Hill’s family medicine residents to undergo specific training “to become leaders in primary care” under health reform.

And that theme dominates his and the others’ journal article.

New primary care doctors need a variety of new skills that physicians in the past did not require, he said. These include data management and leading teams under **coordinated care organizations**, or CCOs, in patient-centered medical homes.

The old model of care, where a physician spends at most 10 or 15 minutes with a patient, is “completely outdated,” because patients cannot be expected to grasp all they need to understand about their disease and how to cope with it in that short a time, Kroening-Roche said.

Instead, health care teams need to “meet them where their needs are. That’s where health care is going; that’s where primary care needs to go. There’s a lot of exciting momentum in that in general right now.”

He said that in order “to influence health, you have to start with primary care,” and the new federal and state care reform laws are a step in the right direction.

“The **Affordable Care Act** expands coverage, emphasizes population health and primary care services, and establishes accountable care organizations that require strong primary care foundations,” the authors wrote. “The patient-centered medical home model that is spreading across the country entails a commitment to promoting health rather than merely treating disease.”

“With funding available from the **Center for Medicare and Medicaid Innovation** for experimenting with new ways of delivering health care, we believe the revolution has begun.... “[W]e share a vision of primary care as the key to improving health and health care in the United States.”

In the article, the authors describe a typical workday in a primary care clinic of the future, but one that Kroening-Roche said is already happening in spurts here and all around the country.

“[A] day in a primary care office would begin with a team huddle of medical assistants, registered nurses, nurse practitioners, physician assistants, front-desk staff, behavioral therapists, clinic managers, social workers, nutritionists and physicians,” the authors wrote.

“The team would discuss the day’s patients and their concerns. They would review quality metrics, emphasize their quality-improvement cycle for the week, and celebrate the team’s progress in caring for its community of patients. Because everyone would feel responsible for patients’ health, coordinating care and teamwork would take on new importance.”



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Providence Brain Tumor Center medical directors, from left: Edsel Kim, M.D., head and neck surgery, The Oregon Clinic; Daniel Rohrer, M.D., cranial services, Comprehensive Neurosurgical Consultants; and Pankaj Gore, M.D., cranial services, The Oregon Clinic

See *PRIMARY CARE*, page 13



OCHCP panel showcases full range of perspectives on financial aspects, outcomes of health care issues

By Jon Bell
For The Scribe

Keep the medical home model. Ditch it. Implement electronic medical records put out by the biggest names in the business or develop your own model from scratch. Build bigger all-encompassing hospital towers, or find new ways to deliver targeted care in smaller doses.

The ideas and conversations spanned the spectrum at the **Oregon Coalition of Health Care Purchasers' "Innovations in Health Care Delivery, Payment & Benefits"** forum, held Jan. 24 at the **Multnomah Athletic Club**.

The event, attended by more than 100 in Portland and simulcast to OCHCP members in Springfield and Bend, featured a lively panel discussion moderated by **J. Bart McMullan, MD**, former president of **Regence BlueCross BlueShield of Oregon**.

The panel included: **Claire Celeste Carnes**, regional director, digital health services, at **Providence Health & Services**; **Brian DeVore**, director of

healthcare ecosystem and strategy for **Intel Corp.**; **Kevin Larson**, president of **EMBS Inc.**, a health management solutions company in Billings, MT; and **Dave Sanders, MD**, co-founder and president of **ZoomCare PC**.

Each member of the panel brought a different perspective to the topic at hand.

Carnes brought that of a traditional health care provider, Providence, that is working to adapt and innovate for today's changing times.

DeVore's insight came from his work at Intel where he's been trying different approaches to health benefits for the company's employees to see what produces the best outcomes for the lowest cost.

Larson talked primarily about his company's results implementing on-site health care clinics for various employers, and Sanders shared his thoughts from his experience with ZoomCare, which offers flat-rate, on-demand health care at a series of clinics in Oregon, Washington and Idaho.

In his introduction, DeVore shared some of Intel's experiences with health insurance for its employees. He said Intel, which is self-insured and employs about 17,000 people in Oregon alone, has always been on a "journey of innovation" and has "never been quite satisfied with the status quo" in everything from computer processors to health care benefits for employees.

About 10 years ago as Intel began to lose control of its health care costs and quality, DeVore said the company became an early adopter of higher deductible plans for employees. A few years later, the company added on-site clinics and biometric checks with an incentive for employees to get on a healthier track.

"That moved the needle a little bit, but our chronic and our unhealthy are still chronic and unhealthy," he said. "The ones who are showing up for the biometric checks are the triathletes who want the \$250. So we found the system works well for those who don't need it at all."

Where some employers have opted to address one area of health insurance to focus on—payments, benefits, measurement or delivery—Intel decided two years ago to work on every aspect for improvement in two of its locations, Oregon and New Mexico.

The company came up with its own set of performance measures and, in Oregon, picked three vendors—**Providence, Kaiser Permanente** and **Greenfield Health**—to compete against each other and provide the best outcomes. How those providers achieve those outcomes is up to them.

"We are looking for outcomes," DeVore said, "not process."

With the launch of ZoomCare in 2006, Sanders said he was setting out to deliver health care in a new way, a way that many doubted would work at the time.

"When we began a number of the wise heads said, 'You guys are on a fool's errand. You guys are going to lose your shirts,'" he said.

So far, those predictions have not come to pass for ZoomCare, which now runs 16 clinics that charge a flat, upfront fee for most services. For example, an injury or illness visit costs self-payers \$105.

Sanders said the ZoomCare approach has worked because it has identified key components that most health care consumers desire, including complete care when and where they want it at a single price and with a guarantee.

"We try to see the world in our own way," he said.

Part of that perspective, Sanders said,

wonders whether the medical home model of care is really what ZoomCare's patients, which he generalized under the name "Sarah," want.

"I question if Sarah's hungry for a medical home, or if that's more of a public policy view of the world," he said. "I don't know if that's everyone's taste preference for care. Maybe it is for some, but not for everyone."

Carnes, however, said that the medical home model, which Providence adopted early on, has been an effective way to address and streamline a patient's "total experience of care."

And while she recognized that some people may not prefer a medical home approach, some employers, who are often the ones paying for care and therefore want employees to keep up on their own health, do.

"There's lots of opportunity for tension between what a consumer or an employee wants to do and the employer, who covers the entire health care cost," she said.

The panel also took up the issue of major hospital systems in some communities continuing to build and add capacity that may not even be needed. Sanders called that "the old way," and DeVore likened it to an arms race. Hospitals that build unnecessarily or try to be a one-stop shop for patients, he said, wind up "stuck with a real estate empire you've got to bond and fill."

"Everywhere, I see more towers going up even when people are saying we don't even need this," he said. "Why? Reimbursement's really good for that."

He also noted that some hospital systems have already taken steps to get out of certain sectors of health care that may not make sense for them from a quality or financial standpoint.

One example DeVore cited: **Virginia Mason Hospital & Medical Center** in Seattle, which got out of labor and delivery services years ago, in part, because of a lack of demand and its inability to compete.

"I think we're going to start seeing hospital systems carving up pieces of their business," he said.

The more traditional approach to care and the less mainstream approaches fully united on the issue of change and innovation. Everyone on the panel agreed that the times have changed and that new health care ways are needed.

"I think the ZoomCares, the big boxes, other people, are pushing the more traditional organizations to think differently," Carnes said. "It's going to happen. We shouldn't fear it."

"I think we should look for the best opportunities to partner, to share information and to work together." •

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Starting March 1, FamilyCare raises reimbursements to primary care providers, doubles Medicaid rate

By John Rumler
For The Scribe

FamilyCare, Inc., which serves approximately 50,000 patients on the **Oregon Health Plan** in Clackamas, Multnomah and Washington counties, has increased its reimbursements to primary care providers beginning March 1.

The state of Oregon's **Medicaid** program currently reimburses primary care providers about \$40 for an average primary care office visit while FamilyCare, along with other Medicaid managed care plans, paid approximately \$50 per visit.

But under the new arrangement, FamilyCare will begin compensating its primary care providers approximately \$75 per office visit, nearly double the base Medicaid rate. This reimbursement rate increase for Medicaid patients is separate and above the rates that the **Centers for Medicare and Medicaid Services** announced in January 2013.

Under the new reimbursement plan, FamilyCare hopes primary care providers will be able to open their practices to more Medicaid patients and be able to spend more time with them, giving patients increased access to providers and preventive care.

Jeff Heatherington, president and chief executive officer of Portland-based FamilyCare, Inc., the first CCO in the tri-county area, says a strong primary care system is proven to be the foundation for delivering low cost, highly effective care.

"Having access to primary care providers is critical to receiving the right kind of care at the right time, which helps our patients stay healthy and avoid costly trips to the emergency room," said Heatherington.

"By establishing a relationship with a provider and better managing chronic diseases, patients will not have to use hospitals as their main source for medical treatment. We know it will make a difference in the quality and cost of care in a relatively short period of time."

During the past three decades, the shortage of primary care providers has become increasingly widespread throughout the U.S., and unless there are changes in our medical system it appears likely to worsen. Consider the following:

Andrew Bazemore, MD, the director of the **Robert Graham Center for Policy Studies in Primary Care**, said the US will need at least 52,000 additional family doctors by 2025 to deal with the nation's aging population.

The number of medical graduates selecting primary care as a career dropped from 5,746 in 2002 to 4,210 in 2007, about 27 percent.

Figures compiled by the **Association of American Medical Colleges** (AAMC)

show that very few of the 17,346 new doctors who graduated from medical schools in 2011 selected primary medicine as a career. Money is likely a contributing factor, as the estimated financial gap between a generalist and a subspecialist is nearly \$3.5 million over the span of a 40-year career.

The AAMC projects a shortage of 45,000 primary care physicians by 2020.

News of FamilyCare's increase in reimbursements moved quickly through Oregon's medical community and reached **Bruce Goldberg**, the executive director of the **Oregon Health Authority** (OHA) the state government agency that spearheaded the move to CCOs in Oregon beginning in 2012 and now monitors and certifies all the CCOs in the state.

"Promoting primary care is a great move by FamilyCare and one of the many innovations Oregon CCOs are making to improve care and lower costs," said Goldberg. "This is a smart investment in FamilyCare's providers and in the health and well being of their members."

Health Share of Oregon is the largest CCO in the state and is a direct competitor of FamilyCare, Inc., providing care to nearly 40 percent of all Oregon Health Plan enrollees.

"Clearly, we cannot continue paying providers the same way and expect them to spontaneously change their behavior," said **Health Share** chief executive officer **Janet Meyer**. "Alternate payment methodologies are one of the state mandates for all coordinated care organizations."

"Raising primary care provider rates is one approach to alternate payment methodologies, and that is the one FamilyCare is exploring to try to bend the cost curve."

FamilyCare's increase in reimbursements will make a positive impact on a significant number of people and primary care providers in the Tri-Country area, including **Oregon City Medical** (OCM) a nurse practitioner-led community clinic founded in 2004.

Oregon City Medical's relationship with FamilyCare, Inc., started nine years ago when it first opened its doors, said **Danielle Blackwell**, the clinic's senior nurse practitioner.

"FamilyCare was not as large as some other health plans in Oregon, but they had the biggest dream of all, to integrate mental health and physical healthcare," Blackwell said.

During the past nine years, FamilyCare has kept growing and adding more benefits to their repertoire of services, Blackwell said, and by doing so, contributed to increasing the quality of care that OCM and other primary care providers deliver to their patients.

"FamilyCare established themselves as an authority in their field by pioneering health care models that improve quality and health outcomes for patients in Oregon while also achieving cost savings," Blackwell said.

While serving the Medicaid and uninsured population of Clackamas County, Oregon City Medical also kept growing and expanding its primary care services to include mental health, drug and addiction counseling, naturopathic medicine and chiropractic medicine and pain management assistance.

These services usually are not available under one roof to Medicaid patients because of cost and health plan limitations and exclusions, but by partnering with state agencies and health plans, OCM offers these services to their patients at no cost.

In 2012 OCM, which serves about 5,000 patients, expanded to Beaverton to serve the Medicaid population of Washington County, and now **Beaverton Family Medicine** (BFM) serves close to 500 patients.

About 80 percent of the OCM/BFM combined revenues come from Medicaid payments and sliding scale fees for services from the uninsured patients. The remaining 20 percent comes from commercial insurance.

The two clinics employ six nurse practitioners, one physician assistant, one doctor of osteopathy, one MD, three naturopathic physicians, one chiropractor, one licensed social worker and one licensed massage therapist.

While applauding FamilyCare for redistributing the federal incentive money and raising their reimbursements to primary care providers, Blackwell said it is time that the health care system recognizes primary care's value to the community.

"Primary care is undervalued, underpaid, understaffed, overworked, and very often the providers are burned out," Blackwell said. "But we are the first line of defense of the health care system. We are the first medical person or provider a patient contacts when they need help."

The standard relative value unit (RVU) is about \$27 for providers who accept Medicaid and \$34 for providers who take Medicare. However, nurse practitioners are paid 85 percent of the \$34 because they are not physicians, resulting in a \$28 per unit of care.

Now with FamilyCare's 50 percent increase, Blackwell's reimbursement will double from \$75 to \$150 for most of her complex patients.

The extra money paid by FamilyCare will allow OCM, and clinics like it, to hire more staff and to train them better, to spend more time with patients and to

improve the overall patient services they deliver.

"Nurse practitioners' clinics like ours will be able to afford the services of a primary care physician [MD or DO] to care for the medically-complex patients and reduce the unnecessary cost driven imaging or referrals, while improving patient care," Blackwell said.

The increase also will promote access to primary care services by increasing coverage. OCM can hire three more providers, and BFM can add one more provider to the staff translating into 4,000 more people becoming clinic patients.

Blackwell hopes Heatherington's actions will be followed by other health plans and will motivate medical students to become primary care providers.

"Primary care providers are not getting any younger, and we do need to think of enlisting and training the next generation to replace us for a healthier America," Blackwell said.

Members of Congress also are concerned about the looming primary care shortages. A special subcommittee composed of members of Senate called **Health, Education, Labor and Pensions** (HELP) convened last month to explore possible solutions.

Chair Bernie Sanders (D-Vt) reported that up to 45,000 people die each year because they have no health insurance and do not get to a doctor on time. The report also suggested that Medicaid was partially to blame, as it promotes the growth of residencies in specialty fields by providing \$10 billion annually to teaching hospitals without requiring any emphasis on training primary care doctors.

Possible mechanisms to address the shortages were discussed, including clinic reimbursements, federal loan repayment programs such as the **National Health Service Corps** (NHSC) and ways to improve the "prestige" associated with primary care.

It's clear, however, that Oregon's health care leaders are not waiting for Congress to solve our health care problems.

"We know primary care providers are critical to the success of health care transformation and each CCO is exploring their own approaches in this regard," said Meyer.

Heatherington pointed out that FamilyCare was built on the foundation that the relationship between primary care providers and patients is the key to quality coordinated care.

"This belief is aligned with the principles of coordinated care organizations, which is why FamilyCare made this important investment," Heatherington said. •



From Your *Student Member*

On the economics of an education in medicine

By **David Steinhardt**
For *The Scribe*

Many physicians seem to look back at their years in medical school fondly. "It was the best and worst time of my life," I've often heard people say. As a current first year medical student at **Oregon Health & Science University**, I can, thus far, confirm that dichotomy.

Medicine, even in its early stages and from my novice outlook, is a remarkable field to be a part of. For everything you do, there is a person on the other side, a recipient of your hard work. To add to the empowerment and the pressures that come with serving the population, the field is constantly in a state of flux. New medications, new procedures and even new diseases are being discovered and tested every day.

To me, nearly everything about the biology of the human body was a mystery about six months ago. Now, thanks to a whirlwind of late nights and countless hours, I feel like I have a solid foundation of human anatomy, cellular biology, genetics and physiology, along with a working knowledge of physical exams and other aspects of clinical medicine. It is obvious that a complete mastery of modern medical knowledge is unattainable, but it is this special quality—the field's absolute vastness in breadth and flux—that makes it so exciting and full of potential.

The science of medicine is not the only thing that is constantly changing; the economics and financial aspects of health care are equally dynamic. I'm sure this is not news to anyone, but the way our country provides health care is transforming, and it is happening right now.

As a first-year medical student, I will not be a fully certified, independent physician for at least seven years. Accounting for the amount of time it takes to train a physician along with the current state of our country's health care system, there is much uncertainty as to what kind of circumstances current medical students can expect to find themselves in once they become doctors.

The medical field is wrought with passion, and as a result people are more likely to refer to being a doctor as a calling rather than a job. These days, however, becoming a physician is an extremely expensive calling. As an example, the current tuition at OHSU, discounting fees and living expenses, is \$37,399 for Oregon residents and \$52,197 for out-of-state students. The best loans available through the United States government collect 6.8 percent interest, and no loans from the federal government are subsidized. Thus, my loans are accruing interest right now, during my first year of school.

The combination of a heavy debt burden and an unclear picture of what medicine will look like ten years from now leaves medical students in a tough predicament. We are supposed to decide what kind of doctor we want to become, but in many ways it is difficult to know upon which factors to base this decision. In medical school, it is practically taboo to bring up the financial prospects of different specialties. Rather, we are instructed to choose specialties based on what we want to do the most, ignoring the financial results of our decisions. We are sometimes given presentations on debt management and financial planning, which help us make sense of these

murky topics to a certain extent. Even so, it is hard to truly wrap our heads around making plans about finances; we won't be earning a full salary for at least seven years, and when we finally do it is impossible to project what it will be.

I would argue that the current landscape for medical students is unhealthy for the field as a whole. We entered medicine because we want to make a difference, but the financial realities of medical school along with the uncertainty of future earnings make it difficult to blindly follow our passion. I may want to run a family clinic in a suburb of San Francisco or Portland, but the question remains: would that allow me to pay back my out-of-state loans as well as support a family? It would be very difficult, without a doubt. There are currently loan forgiveness plans in place for physicians who commit to serving rural or low-income populations, but even they are limited and filled with uncertainty. Most loan forgiveness plans are subject to government legislation, and as a result could be revised or eliminated at any time.

To be in medical school is an honor. It really is. Throughout this school year I've confirmed again and again that I want to be a physician. However, when we talk about the economics of medicine, and how this country is going to pay for health care, and the incredible need for primary care physicians, it is amazing to me that doctors constantly get left out of the equation. Perhaps if incentives for medical students were less complicated—if debt wasn't such a big part of becoming a doctor—we could provide our population with more people at the primary and preventative care levels.

As the literature clearly shows, the best way to save money in the long run is to keep people healthy rather than treat them only once they get sick. Thus, I wonder why financial incentives for medical students funnel our country's future doctors toward specialties and sub-specialties that society still needs, but not nearly as desperately in these times. •

Medical Society announces board nominees



The Medical Society of Metropolitan Portland is pleased to report that the following physicians have been placed in nomination for positions on the MSMP Board of Trustees for the 2013–2014 leadership year:

Board of Trustees

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Brenda Kehoe, MD, Obstetrics/Gynecology

Past President
Marianne Parshley, MD, Internal Medicine

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Maria Peila

Completing Board Service

At-Large
Michael Dorsen, MD, Neurological Surgery
Joshua Reagan, MD, Family Medicine

Medical Student
Richard Bruno

The MSMP Annual Meeting and Inauguration will be held on April 16, 2013, at the Portland Art Museum. All MSMP members will receive a formal invitation to spend an evening celebrating the profession of medicine and recognizing those who lead the Society. Further, there will be great food, conversation, and conviviality.

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Hospitals lower early birth rates by instituting “hard stop” policy for unnecessary C-sections

By Cliff Collins
For The Scribe

Statistically, full-term births turn out better and are less expensive and healthier for everyone involved, a fact many people had forgotten until Oregon put a stop to early-induced births done for convenience.

Make that a “hard stop.” That’s the term used when hospitals set a policy that they won’t allow early-scheduled inductions unless physicians can give a written, medically-related reason why the baby should be delivered earlier than 39 weeks.

When 17 major birthing hospitals in the state agreed to institute such a policy beginning in October 2011, the results became evident rather quickly. Some of the 35 of 53 Oregon birthing hospitals now participating in a “hard stop” program are showing significant reductions in non-medically necessary inductions and cesarean sections done before full term is reached.

In the **March of Dimes** Premature Birth Report Card, Oregon’s preterm birth rate dropped from 9.9 percent in 2010 to 9.1 percent in 2011, earning

the state a grade of A on the report card, second only to Vermont.

Of the four states earning an A this year, Oregon recorded the highest percent decrease in premature birth at 8 percent, followed by Vermont, New Hampshire and Maine.

Among specific hospital examples:

- **Tuality Healthcare** reported an 86 percent decrease, reducing its early elective delivery rate from 9 percent to 1.3 percent.
- **Providence Portland Medical Center** saw a 62 percent decrease,

going from a rate of 16.7 percent to 6.3 percent.

- **Providence St. Vincent’s Medical Center** achieved a 56 percent decrease, from 9.6 percent to 4.2 percent.

The **March of Dimes Greater Oregon Chapter**, the **Oregon Health Leadership Council** and the **Oregon Health Authority**, in cooperation with the **Oregon Association of Hospitals and Health Systems**, led the “hard stop” challenge with a campaign called “Healthy Babies Are Worth the Wait,” with the goal of lowering early-term births.

Research has shown that a baby’s brain nearly doubles in weight in the last few weeks of pregnancy, and important lung, liver and kidney development also occurs at this time. Morbidity rates double for each gestational week earlier than 38 completed weeks, and the risk of death is nearly double for infants born at 37 weeks of pregnancy, when compared to babies born at 40 weeks.

Babies delivered too early “don’t breastfeed as well,” and are more likely to be jaundiced and have other health problems, said **Carey L. Winkler, MD**, an obstetrician-gynecologist and maternal fetal medicine specialist with **Legacy Medical Group’s** Maternal-Fetal Medicine.

Babies born at full term are less likely to have vision and hearing problems after birth, more likely to be born at a healthy weight and thus able to stay warm easier, and better able to suck and swallow and stay awake long enough to eat after they’re born.

The “Healthy Babies Are Worth the Wait” campaign “encourages women to allow labor to begin on its own if their pregnancy is healthy, and aims to dispel the myth that it’s completely safe to schedule a delivery before 39 weeks of pregnancy without a medical need,” said **Joanne Rogovoy**, state director of program services and public affairs for March of Dimes Greater Oregon Chapter.

For a variety of reasons, more and more deliveries were being done earlier, a trend that uses more health care resources, costs more money and increases the rate of C-sections, Legacy’s Winkler said.

To try to prevent inductions at 37 or 38 weeks, doctors used education protocols in an attempt to convince women that the risks were higher, he said.

“But studies show that you have to have a ‘hard stop,’” he added.

All Legacy Health hospital birthing units are experiencing a decrease in early elective deliveries since the “hard stop” was put into place, including **Salmon Creek Medical Center**, which is below 4.5 percent, said **Helen Phillips**, director of women’s health at **Legacy Emanuel Medical Center**.



The Medical Society of Metropolitan Portland requests your presence at the

129th Annual Meeting

We are pleased to invite the members of the Medical Society of Metropolitan Portland to join us in celebrating the installment of our 129th president, **Brenda Kehoe, MD**, followed by the announcement of the 2013 Officers and Trustees.

Partake in a private viewing of the Center for Modern and Contemporary Art galleries, savor food and spirits amidst the ambiance of live piano—and of course, hear from our prestigious speaker, **Dr. Louise Aronson**.

Dr. Louise Aronson is an associate professor of medicine at the University of California San Francisco. She holds an MD from Harvard Medical School and an MFA from the Warren Wilson Program for Writers and has recently published her first book, *A History of the Present Illness*, to renowned acclaim from both the medical and literary communities. Dr. Aronson will be signing copies of her book following her presentation. Each attending member will receive a complimentary copy of *A History of the Present Illness*.

WHEN: April 16, 2013

WHERE: Portland Art Museum
1219 SW Park Ave, Portland OR 97205

5:00–6:30 pm Registration & Gallery Viewing

6:00 pm Dinner Begins • 6:30 pm Meeting Begins

7:00 pm Speaker, Louise Aronson, MD, MFA

No cost for members and one guest

Please **RSVP** by calling **503-944-1138**
or email aislynn@msmp.org

See **HARD STOP**, page 13



Oregon: Home to “firsts” and historical milestones; women and men contributed equally to medicine

By **Maija Anderson**

OHSU Historical Collections & Archives
For The Scribe

Oregon has a long history of innovations and milestones in medicine, but only a few of these “firsts” receive widespread, national recognition.

In recent history, a “first” that is familiar to the general public is the 1997 **Death with Dignity Act**, which made Oregon the first state to legalize physician-assisted suicide. In medical research, OHSU is strongly associated with **Albert Starr, MD** and **M. Lowell Edwards’** invention of the first artificial heart valve, as well as **Charles Dotter’s** introduction of transluminal angioplasty. But Oregon boasts many more historic medical “firsts” that are less well-known to the general public.

Oregonians today know **Dr. Esther Pohl Lovejoy** mainly for her work in the woman suffrage movement. But before helping earn Oregon women the right to vote in 1912, Dr. Lovejoy had already made her mark in the field of public health. In 1907, she became the first woman to serve as the public health officer of a major U.S. city. Her leadership brought national public health standards to Portland, improving sanitation, food safety and communicable disease prevention. Her experience in Portland led to a long career in international health reform.

As a professor at **University of Oregon Medical School**, **Dr. Edwin E. Osgood** spent more than 30 years conducting groundbreaking research in hematology. In 1939, Osgood attempted what is arguably the first bone marrow transplant. Unfortunately, Osgood’s experiment failed. In 1956, **Dr. E. Donnal Thomas** performed a successful bone marrow transplant in New York. Later in his career Osgood and his team were the first to uncoil a human chromosome, making it



Dr. Esther Pohl Lovejoy, 1894



Dr. Edwin E. Osgood, hematology and oncology pioneer, circa 1940s



Dr. Esther Pohl Lovejoy (sitting in a chair at left with her gaze turned towards the window) and the staff of the Portland Health Department, 1907.

All photos courtesy of OHSU Historical Collections & Archives

possible to study its structure. Osgood made numerous other historic contributions to hematology and oncology.

As attitudes towards gender reassignment evolve, some may be surprised to learn of the long history of medical procedures associated with this process. The first documented female-to-male reassignment surgery in the U.S. took place in Oregon in 1917–18. The patient was **Alan L. Hart, MD**, a graduate of University of Oregon Medical School who had been born Alberta Lucille Hart. The radical procedure was performed

by **Dr. Joshua Gilbert**, who published a case study in 1920. Hart himself went on to conduct important research on tuberculosis.

Like Esther Pohl Lovejoy, **Dr. Leslie M. Kent** of Eugene broke ground nationally for woman physicians: In 1948, she was elected president of the **Oregon Medical Association**, making her the first woman to head a state medical association. Dr. Kent led the way in women’s leadership of medical organizations, but national progress was slow. It was not until 1989 that the **American Medical Association** elected **Dr. Nancy Dickey** as its first woman president.

In 1964, **Charles Bernard Willock** a self-trained engineer and inventor, had a chance meeting with a nephrologist, **Dr. Richard Drake**. Drake told Willock about the plight of a patient who had been forced to sell his home to cover the costs of dialysis treatment. Willock was inspired: Using spare parts in his basement he constructed a small dialysis machine, and Drake conducted the first tests at **Good Samaritan Hospital**. Soon after, the two collaborators founded the **Drake-Willock Company** in Milwaukie, Oregon. The company developed the original prototype into an effective and widely used home dialysis machine—the first of its kind.

Since it was established in 1985, the **Oregon Trauma System** has become a national model. While Oregon wasn’t the first to develop a state trauma care system (that honor went to Maryland in 1969) it was the first to integrate small rural hospitals with large facilities in urban centers. The Oregon model ensures that efficient emergency care can be delivered throughout the state.

In the early 1990s, **OHSU’s Center for Ethics in Health Care** convened health care agencies and providers to improve communication about patients’ wishes for life-sustaining treatment. The result was **Physician Orders for Life-Sustaining Treatment (POLST)**, a standardized form that seriously ill patients may use to definitively communicate their wishes about end-of-life care. The first POLST form was used in 1995. Washington, California and more than 20 other states have followed Oregon in developing POLST programs.

The **History of Medicine in Oregon Project** launched a website that recognizes these and many other milestones in our state’s medical history: <http://historyofmedicine.org>. More highlights from health care history in Oregon will be on display in the exhibit “OHSU: 125 Years of Healing, Teaching, and Discovery,” from March 14 to June 2 at the **Oregon Historical Society**.



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Society of Physicians for Wine and Health provides history, shares positive aspects of drinking wine

By Tom Dunham, MD, Executive Director
The Society of Physicians for Wine and Health
For The Scribe

The medical profession has long recognized healthful and nutritive properties of wine for thousands of years beginning with ancient China and Mesopotamia. The ancient Greek physician **Hippocrates** in the 5th century BCE recommended wine as a treatment for almost all illnesses except meningitis. His particular favorite was Vermouth. Later **Galen**, the notable Roman physician and surgeon (131–201CE), was a strong proponent of wine and even a respected wine maker.

Much more recently in the 1970s in the renowned **Framingham Study**, the moderate consumption of alcohol conveyed about a 50 percent reduction in deaths from coronary artery disease, though the **National Institutes of Health** excluded this data.

In 1991, the **French Paradox** was described with primarily wine consumption having preventive effects in

the development of arterial disease in the presence of a high cholesterol and saturated fat diet. In more recent medical literature, wine consumption has been further validated as beneficial in preventing the development of vascular disease, dementia and other maladies of advancing age.

The **Society of Physicians for Wine and Health** (SPWH) is a society of physicians that has been in existence since 1994. It was closely patterned after a pre-existing organization, the **San Francisco Medical Friends of Wine**, which had its inception in 1939.

The late **Dr. Cecil Chamberlain**, a retired child psychiatrist, was instrumental in the founding of our wine society after spending some time in the Bay area during his medical training. Other founders of the society were **Dr. George Porter** and **Dr. George Caspar** with **Rupert Koblegarde** as our long-standing legal counsel.

Also included in the founder group were **Drs. Fred Benoit, Joe Campbell**

and **John Bauers**— all physician winery owners in the northern Willamette Valley.

The mission of the society has been to better understand the efficacy of drinking wine and to enhance both professional and public knowledge concerning the health benefits of moderate wine consumption. In addition, the society wants to encourage and study the scientific research on wine and to promote an enjoyable fellowship of enophiles including the pairing of wine with fine food.

Society events include two gourmet dinners a year, with guest speakers and celebrations of Oregon wineries; tours of Oregon and Washington wineries; and wine tastings. For more information on the society, visit their website at: physiciansforwineandhealth.org, or contact MSMP member, George Caspar, SPWH membership chair at 503-292-1343 or 503-539-4952. •



Primary care: Opportunity to offer patients real change in care

CONTINUED FROM page 7

"It's easy to say it's utopian," Kroening-Roche noted. But "people are recognizing this is not far off from reality."

Indeed, the OHSU Richmond clinic where he practices already "looks like this model," he said.

The change in reimbursement in which primary care is paid at a higher level than previously will greatly aid this transition, he believes.

"Whether we like it or not, payment drives health care, and so the new health care law allows us to change the way doctors are paid," he said.

Both nationally and in Oregon, that means physicians will be compensated for taking care of their whole population of patients and keeping them healthy.

As the authors put it: "The physician would now see fewer patients in the office, leaving time for responding to questions emailed by patients the previous night and for calling those who would otherwise be headed to the emergency department."

"Clinic visits would ideally be nearly twice as long as they are now, since physicians would focus on patients with complex conditions and would have time to address care coordination, answer patients' questions fully, and understand their personal health goals in order to guide treatment."

Kroening-Roche, who sought to be trained at OHSU because of its reputation as what he calls "one of the strongest family medicine departments in the country," believes the transformation in health care will draw more medical students to choose primary care.

"Generally, if you talk to primary care doctors, they're excited," he said. "I think there's a lot of hope that focusing on innovation in primary care will attract more students."

Medical school debt plays a part in students' selection of a specialty, but they "pay more attention to income disparity than debt" when weighing whether to go into primary care or a subspecialty, he said.

Therefore, the improvement in primary care reimbursement, coupled with the chance to have a stronger influence on the health of individuals and the community, should persuade doctors to choose primary care, Kroening-Roche said.

"That's what was exciting for us: the opportunity to effect real change in patients' lives," he said.

"Primary care is exciting again. This is where health is truly being improved, by putting the patient first." •

The article "The Developing Vision of Primary Care" can be found at: www.nejm.org/doi/full/10.1056/NEJMp1204487

Hard stop: "It's just better for the babies to be 39 weeks"

CONTINUED FROM page 11

"It's going very well," said Winkler. "I think there was a lot of resistance and angst initially. They wanted to get all health systems to buy into this."

Otherwise, if one hospital refused to deliver early for convenience's sake and another accepted the patient, the overall point of the policy would not be effective, he explained.

"It's going very well.

I think there was a lot of resistance and angst initially.

They wanted to get all health systems to buy into this."

— Carey L. Winkler, MD
Legacy Medical Group

But after area hospitals all agreed to do this, the change took some pressure off physicians, Winkler suggested.

Now when a patient wants a scheduled delivery earlier to accommodate

vacations or family visits or for any other reason, the doctor can just respond, "Sorry, I can't do it; it's hospital policy."

The consistent guideline "makes it easier to say that," Winkler explained.

But physicians have the right to appeal if they are denied for reasons they think are appropriate, with appeals handled first by the charge nurse and then by the doctor who is the department head, he said.

Members of the nursing staff also appreciate the move, because they spend more time with the patient than anyone else, and they know that early deliveries often translate into a two- to three-day process and tie up the labor and delivery department, he said.

Patient reaction has been more mixed, according to Winkler.

First-time mothers who are told that early induction doubles their risk of getting a C-section may be more likely to accept the policy, but women who previously have been induced without incident earlier may be less inclined to understand the change, Winkler said.

Even some doctors thought that earlier inductions had gone better than they really did, he said, but studies have contradicted that notion, showing that statistically babies are healthier at full term.

"It's just better for the babies to be 39 weeks," Winkler said. "It's just better for everybody." •

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