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To learn more, please see the flier in this month's Scribe, or go to msmp.org

Comprehensive Primary Care Initiative showing early positive results

By Cliff Collins
For The Scribe

Susan Clack, MD, was interested when she heard that the **Centers for Medicare & Medicaid Services (CMS)** was considering Oregon as one of a handful of states for a coordinated-care demonstration project.

That's because, as president of **Pacific Medical Group**, she helped implement patient-centered medical homes in the group's five clinical locations beginning in 2008. In addition, Pacific had been using electronic medical records since 2005. These factors were among the criteria CMS used in selecting participating medical groups around the country to be part of its **Comprehensive Primary Care Initiative**, or **CPCI**.


SUSAN CLACK, MD

The intention of the initiative, as part of the Affordable Care Act, is to foster collaboration between public and private payers to strengthen primary care. CMS works with commercial and state health insurers and offers bonus payments to primary care doctors who coordinate and improve care for their Medicare patients. The agency also gives primary care practices, chosen through a competitive process, resources to accomplish this.

Once CMS in September 2011 invited practices to apply to be in the program, Pacific Medical Group threw its hat into the ring. What CMS was proposing—to help primary care practices deliver better-coordinated, patient-centered care—aligned perfectly with what Pacific already was doing, said **Linda Kennedy**, executive director of Pacific Medical Group.

Nationally, CMS ended up selecting about 500 primary care practices in just seven markets to participate in the initiative. This represents 2,347 total providers serving an estimated 315,000 Medicare beneficiaries.

In Oregon, CMS chose 67 primary care practices comprised of 552 providers, six payers and an estimated 48,729 Medicare members served. Pacific Medical Group was one of only eight Oregon medical groups CMS accepted.

Among the selection factors CMS employed were practices' use of health information technology; accreditation as medical homes; service to patients covered by participating payers; "participation in practice transformation and improvement activities; and diversity of geography, practice size and ownership structure." CMS sought to enroll about 70 practices per market. "Markets will be chosen based on where a preponderance of health care payers apply, are selected, and agree to participate," the agency stated on its website.

Practices started delivering care services under the initiative in fall 2012. Under the four-year CPCI program, CMS pays providers for improved and comprehensive care management, and after two years offers them the chance to share in any savings they generate. The agency also collaborates with payers in local markets who commit to work with the primary care practices. Practices also receive compensation from those participating payers, which includes private insurers such as Regence BlueCross BlueShield of Oregon, Providence Health Plans and CareOregon, as well as the Oregon Health Authority.

CMS pays participating practices a risk-adjusted, per-member, per-month care management fee for their Medicare fee-for-service beneficiaries, Kennedy explained. Groups must gain renewal after each year, depending on how they met designated benchmarks.

At the end of the second year, groups are eligible to receive a bonus, she said. According to CMS, this is because many studies suggest that care costs less to provide to patients from primary care practices that offer comprehensive services, compared with practices that do not. Thus, after two years, all practices participating in the initiative have the opportunity to share in a portion of the total Medicare savings in their market.

Signs of better care

Providing resources to participating practices is an acknowledgment by the federal government that the current fee-for-service structure does not compensate practices for the additional work of tracking patients in a population, nor does it reimburse practices to hire needed additional personnel such as case managers and social workers, said **Michael Whitbeck**, administrator of **Northwest Primary Care**, another CPCI participating group. He said one of the areas that requires understanding and following is known as risk stratification: tracking patients who are most in need of care.

Clack, a member of the Medical Society of Metropolitan Portland, pointed out that many of the patients who most require monitoring don't come into the office on a regular basis. But under CPCI, practices are responsible for an entire set population of patients. A percentage of these patients have multiple chronic health problems that can be difficult and expensive to treat if patients don't take care of themselves and receive regular care, said **David A. Dorr, MD**, an **Oregon Health & Science University** researcher.

Dorr specializes in care management, coordination of care, collaborative care, chronic disease management, and the requirements of clinical information systems to support these areas. He gives practices participating in CPCI technical assistance on such things as risk stratification, as well as general support. He develops training programs and webinars, and also leads three meetings a year that bring together participating Oregon medical groups in one place to share their experiences and results.


DAVID A. DORR, MD

Dorr and his colleagues in OHSU's medical informatics department got involved in CPCI

*See **CPC INITIATIVE,** page 3*

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INSIDE THIS ISSUE

Off Hours—Hood to Coast

The annual Hood to Coast relay means thousands of runners—quite a few tied to the Portland medical community—will pound the pavement from Timberline Lodge to the sandy beach at Seaside 198 miles away.

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A complete cardiovascular circle of care — rounded out with cardiac rehab

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Legislature approves uniform credentialing, preauthorization

By Cliff Collins
For The Scribe

Two bills passed by the 2013 Oregon Legislature are intended to reduce medical office hassles related to two longtime banes of physicians' existence: credentialing and preauthorization.

The first, **Senate Bill 604**, establishes a single credentialing process that all insurers, hospitals and CCOs share. It represents a change that medicine had wanted badly and worked toward for many years: establishment of a single credentialing system for doctors in relation to all the insurers, hospitals and organizations their offices deal with.

This way, a standard form is used that employs the same criteria and questions asked by all, rather than each entity requiring different forms. Doctors currently have had to be credentialed by each hospital and insurance company separately.

The bill creates a uniform electronic credentialing database that each organization can access, which will greatly reduce physicians' administrative costs. Oregon is the first state to approve a mandatory system. The Oregon Health Authority has until Jan. 1, 2016, to create the program and put it online.

Sen. Alan Bates, DO, D-Medford, said various work groups spent a decade trying to agree on the system expressed in SB 604. The bill will save doctors a lot of time, he said, noting that his medical practice has to be credentialed each year by as many as 40 different insurance companies as well as two different hospitals. Each asks somewhat different questions, but it amounts to essentially the same information, he said.

The second piece of legislation, **Senate Bill 382**, calls for the Oregon Department of Consumer and Business Services, in consultation with the Oregon Health Authority, to develop a standard form for providers to use to request prior authorization for prescription drug coverage. Bates worked with provider groups statewide to create and pass the bill.

The bill states, among other provisions, that the form must be uniform for all providers; not exceed two pages; be electronically available and transmissible; and include a provision under which additional information may be requested and provided.

"This bill cuts through the administrative difficulty from the point of view of unnecessary paperwork for prior authorization of medications," he said. "The bill allows us the ability to have one single form for all insurers that dramatically decreases the difficulty of obtaining important medications exceptions for our patients."

Physicians and medical groups supporting the bill emphasized that having a standard form will simplify administrative and claims processes to improve access and efficiency while reducing redundancy and overhead costs.

"This is a small but meaningful step toward simplifying the insurance chaos," said **Cody K. Wasner, MD**, a Eugene rheumatologist and president of the Oregon Rheumatology Alliance. "Finally, a move to help the doctors and patients instead of the system."

In his practice, Bates counted more than 200 separate forms that insurers require Oregon providers to fill out when requesting authorizations so the patient may have needed diagnostic tests, prescriptions, durable medical equipment or access to a specialty physician.

"I've shared previously that I figured my clinic staff spends between 20 to 30 percent of our time managing insurance approvals and dealing with insurers, and it's an incredible impediment to providing patient care," he said.

Bates added that during the next 18 months, the department will adopt a form that is effective and accepted by all payers. "This will give them time to adjust their procedures to the new, single form that will be uniform across the system. This will not only make it easier to practice medicine, but also to have some significant cost savings for all of us in health care."

By reducing medical offices' administrative expenses, the bill also will provide "greater patient access, specifically in the primary care setting," said **David Walls**, executive director of Osteopathic Physicians and Surgeons of Oregon. "With reductions in administrative burdens, we can place a greater focus on preventative care services and shift the emphasis of our health care system from procedure-based interventions to wellness and prevention." •

How will uniform credentialing and prior authorization forms help your practice?
Visit the members forum section at msmp.org to respond.

MSMP would like to hear from you.

When you see this symbol accompanying end-of-article questions, please visit the Forum section at **www.msmp.org** *to respond.*

CPC INITIATIVE *from page 1*

"because we had been doing this for a long time: practice-based technical assistance," he said. A goal of CPCI is to provide a new type of incentive system to keep patients healthy and out of the hospital, and to reduce costs, he said.

"We reach out to practices in a way that's respectful and helpful," Dorr said. "We're working with the practices to make sure we do everything we can to help them make a difference in their practices. We learn from them about how they're doing and the challenges they face. We're learning from each other."

Meanwhile, Pacific Medical Group is about halfway through its first year in the CPCI program. Clack said the group is seeing some signs of better care, such as improved tracking of diabetics and prevention of hospital readmission for asthmatic patients. Moreover, added Kennedy, "We're starting to recognize some savings, which is very exciting." •

The federal and state governments are spending a lot of money on concepts designed to save money, such as medical homes. Is this is an effective strategy to cut health care costs?
Visit the members forum section at msmp.org to respond.

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Health systems expand in metro area

Kaiser opens westside hospital, Legacy breaks ground on lab and Providence relocates children's unit to Oregon City

By John Rumler
For The Scribe

Kaiser Permanente has opened its 38th hospital in the nation, its second in the Northwest and the first newly built hospital in Washington County in 40 years.

The **Kaiser Permanente Westside Medical Center**, located in Hillsboro's Tanasbourne district, opened for patient care Aug 6.

The $344 million, 122-bed (expandable to 240 beds), 421,000-square-foot facility provides general, medical, surgical, maternity and emergency care, and features 27 treatment rooms for emergency services as well as eight operating rooms. The hospital also serves as Kaiser's regional center for total joint replacement and robotic surgeries.

All 122 patient rooms are private and each features an advanced bedside patient information and entertainment system, the first of its kind in Oregon. A bedside touch screen allows patients to Skype with friends and relatives, to view movies and to order meals.

Kaiser Permanente embraces a total health environment concept, which holistically incorporates artwork, appealing landscaping and other aesthetic features with traditional brick-and-mortar hospital designs.

Kaiser Permanente's Westside Medical Center, which opened earlier this month in Hillsboro, features 122 beds expandable to 240, and incorporates artwork, appealing landscaping and other aesthetic features with traditional brick-and-mortar designs.

Photo courtesy of Kaiser Permanente Northwest

"The evidence indicates that the right hospital setting that includes art can help decrease a patient's blood pressure and stress levels and also reduce the need for pain medications," said **Willy Paul**, executive director of Kaiser Permanente National Facility Services Northwest.

The hospital's interior features tranquil Northwest landscape images throughout the building and poetry contributed locally. A huge ginkgo tree sculpture stands in the center of the hospital's atrium. About 900 pieces of art are displayed in the hospital, at an expense of $1.2 million.

Ellerbe Becket Architects and Petersen Kolberg & Associates Architects/Planners designed the hospital and Andersen Construction was the general contractor.

The project, which received LEED (Leadership in Energy and Environmental Design) Gold certification, features a brick-and-glass exterior and, because of the site's unusually high water table, an extensive waterproof underground consisting of a Preprufe membrane bonded with concrete that surrounds the area underneath the hospital with an impermeable layer.

Kaiser Permanente executives say the hospital's special features will save 6.5 million gallons of water annually and reduce energy consumption by 27%.

Located on Stucki Avenue near 185th Avenue, the facility is at the same site of Kaiser Permanente's Sunset Medical Office and will employ about 1,100 people.

A specialty care medical office with 60 physician offices and 90 exam rooms providing imaging, lab, and pharmacy services is under the same roof.

Legacy building Lloyd District lab

Legacy Health broke ground last month on its new **Laboratory Services Center** in the Lloyd District. The $20.5 million project will span 62,000 square feet on two stories next to the laboratory's present facility that it shares with **Legacy Research Institute** at 1225 N.E. Second Ave. Legacy executives, who are still reviewing bids for a general contractor, say the expanded headquarters, which is scheduled for completion by late fall of 2014, will dramatically increase energy and operational efficiencies.

Legacy Laboratory Services' increased business growth, combined with its large equipment, has created cramped facilities that are scattered throughout the Portland region, including the Legacy Research Institute and the Legacy Emanuel and Legacy Good Samaritan campuses.

The new facility will employ about 250, and will allow Legacy Laboratory Services to operate at maximum efficiency and capacity by doubling the amount of room the lab currently has and creating two floors of dedicated lab space. In addition, consolidating several locations into one central facility will optimize lab services by increasing workflow efficiencies and decreasing transport time for specimens, people, supplies and equipment.

"We've grown tremendously in recent years and the new expanded headquarters is essential, as it will allow Legacy Health, as a whole, to continue to deliver the most integrated, coordinated care in the most efficient and effective way possible," said **Don Toussaint**, vice president of Legacy Laboratory Services.

Legacy Laboratory Services' expansion, planned by GBJ Architecture, includes a highly energy-efficient mechanical design to achieve an aggressive 4% savings compared to typical labs of similar size and function. Legacy Central Laboratory will also include on-site storm water treatment systems; state-of-the art energy-efficient lighting including LED sources; and automated controls for lighting and mechanical systems that will adjust energy usage to match building occupancy.

The project's design also includes many exterior improvements, including new stepped rain gardens, 70 new trees, sidewalk improvements and benches.

A regional laboratory service in operation since 1991, Legacy Laboratory Services employs about 600 at its locations in Portland, the south metro area, Eugene, the central Oregon Coast and Vancouver, Wash. Among other services, it provides specimen testing for Legacy and independent hospitals and physicians, and toxicology testing services to law enforcement agencies and employers.

*See **EXPANSION,** page 13*

MSMP remembers Dr. Eugene Blank, Portland pediatric radiologist, author and Shakespeare scholar

Dr. Eugene Blank of Portland passed away suddenly on July 15 at age 89. Dr. Blank was born on May 8, 1924, in Baltimore, Md.

After briefly attending St. John's College in Annapolis, Dr. Blank enlisted in the U.S. Marine Corps during World War II, serving in the Pacific theater. Upon his return from the war, he received his undergraduate degree from Johns Hopkins University and his doctorate of medicine degree from The Johns Hopkins University School of Medicine, in Baltimore.

After graduating from medical school in 1954, Dr. Blank practiced pediatrics in Bennington, Vt., then returned to train in pediatric radiology at the University of Pittsburgh Children's Hospital. He served as the pediatric radiologist at Oregon Health & Science University from 1970 until his retirement in 1991.

An avid reader and prolific writer, Dr. Blank published two books, one on the pediatric cases encountered throughout his radiology career, titled *Pediatric Images: Casebook of Differential Diagnosis;* and the other on his experiences during the war, *USMC 457703*.

A devoted Shakespeare scholar, Dr. Blank spent his spare time reading his favorite plays and sonnets, or listening to them as he drove through the streets of Portland.

Dr. Blank is survived by his beloved wife of 55 years, Esther, his three adoring daughters and sons-in-law, and six grandchildren—Lisa and Isaac Bankman of Clarksville, Md., and their children, Judy and Danny; Anne and Peter Mathers of Morgantown, W.Va., and their children, Emma and Samuel; and Linda and Kurt Hofgard of Louisville, Colo., and their children, Elyssa and Jake.

Dr. Blank always had a profound compassion for those who were less fortunate and in need of help. Donations to a charity dedicated to helping people in need would be a meaningful tribute to his memory. •

From your MSMP Student Member

Lessons from year one

Best medical practice one in which practitioner uses expertise to help patient with health puzzle

By Gabriel Edwards
For The Scribe

The first year of medical school was an introduction to a 20,000-piece puzzle. Every day, I'd pick up a (large) handful of pieces and it was, and is, my job to put them together. Not all the pieces had somewhere to go immediately, and after a short time I found myself as if floating at sea, clinging to the bits of knowledge I'd been able to integrate, surrounded by thousands of orphaned pieces waiting to be joined as a part of a whole.

The practice of medicine is a lifelong process of learning; that is one of the aspects of medicine that drove me to apply to medical school in the first place. The puzzle of medicine is never completed and takes some adjustment for students coming off undergraduate degrees that were far more perfectible and neater than the amorphous truths of human health.

At the same time, being a medical student has an immediate effect on your interactions with others. From the moment of acceptance to medical school, you begin the transformation into, among other things, a conduit for the hopes, fears, and minutiae surrounding the health of your relatives, friends, and even casual acquaintances.

The fact that the change in how others treat you precedes the actual learning of medicine is telling in terms of the future doctor-patient relationship. It can't be based primarily on the knowledge we are learning; a great chunk of what a medical student will learn is searchable on the Internet, by anyone. As medical students, we often refer to the same resources that anyone would when trying to learn about different systems and processes. We are not learning some mystical language unknowable to anyone else. What are we really learning, then?

Recently, I was having dinner with friends at a restaurant on East Burnside, and one of them was relating their recent negative experience with a doctor. Chest pain, the symptom he experienced, is a symptom of many different things. But what was his main complaint? His doctor acted like he knew exactly what was going on, which he didn't feel was warranted given the ambiguity of his pain. My friend would have preferred a physician who acknowledged the unknowable aspects of the situation.

Being a medical student affords us a certain luxury: We are incentivized to spend more time simply talking to patients. Compared to clinicians, we have fewer demands on our time, and our lack of formal medical training compels us to play to our greatest strength—our desire to learn as much as we can from patients, and the joy and excitement that comes with seeing things for the very first time. We are distinctly aware of things to which we might later be inured.

We are also distinctly aware of how much we don't know which, if the first year of medical school teaches us anything, is the most important lesson of all. As I go through my education, I try to keep in mind that the process of life and illness in general is a lot like the first year of medical school. It is a growing awareness of the multitude of facts surrounding one's life in all directions, some fitting together in rafts and others floating free. If I were to act like I know everything (an act I could pull off for maybe five seconds, tops), I'd not only diminish the patient's ability to relate to me, but also miss a key lesson I learned this year, one I will try to remember for the rest of my life.

The best kind of medical practice is one where both patient and practitioner embrace the sea of facts that neither can fully fathom, and the latter uses his or her expertise to help guide the process of putting them together in concert with the former. In this process, we will continue putting pieces together for ourselves as practitioners, and grow into wiser and more effective clinicians throughout our careers. •

If the secret to better patient care is time, what elements of communication are best suited given the obstacles of managed care and visit lengths?

Visit the members forum section at msmp.org to respond.

Gabriel Edwards is about to begin his second year of medical school at Oregon Health & Science University and is interested in internal medicine, where he hears that making puzzle analogies are extremely cliché. When he isn't studying he enjoys getting out of Portland and photographing the stunning natural beauty of the Pacific Northwest. He can be reached at edwargab@ohsu.edu.

Welcome New Members

Kelly Bartholomew, PA-C
NW Urological Clinic, PC
2230 NW Pettygrove St #200, Portland, OR 97210
503-223-6223
Specialty: Urology
Graduated: Pacific, 1999

Jennifer Kim, MD
Oregon Sleep Associates
2228 NW Pettygrove St #150, Portland, OR 97210
503-288-5201
Specialties: Pulmonary and Sleep Medicine
Graduated: Wake Forest University School of Medicine, 2001

Greg Sarish, MBA
NW Urological Clinic, PC
2230 NW Pettygrove St #200, Portland, OR 97210
503-223-6223

James Tycast, MD
NW Urological Clinic, PC
2230 NW Pettygrove St #200, Portland, OR 97210
503-223-6223
Specialty: Urology
Graduated: St. Louis Univ. School of Medicine, 2004

Mandy Williams, PA-C
NW Urological Clinic, PC
2230 NW Pettygrove St #200, Portland, OR 97210
503-223-6223
Specialty: Urology
Graduated: OHSU, 2007

MEDICAL SOCIETY OF METROPOLITAN PORTLAND

The desire to escape

Food first comforts, then cripples, physician struggling with addiction

This article, by a medical professional who wishes to remain anonymous, is part of a series of personal essays exploring life challenges of Portland-area physicians. It is a part of MSMP's goal to better support and connect members of the region's medical community.

Do you have a personal story to share with Scribe readers? If so, please contact the editors at scribe@llm.com or 360-597-4909.

To share your thoughts and respond to this essay online, please visit the Forum section of MSMP's website at www.msmp.org.

I never chose addiction. I did choose medicine and yet, because medicine wasn't truly my heart's desire, it fueled my addiction—the desire to escape and act out. Today I am mostly at peace about being an addict and a doctor, but the road has been bumpy and, at times, horrid. I expect more bumps. I'm not cured of conditioned hypereating and alcoholism. However, I am committed to abstaining from the substances that will trigger me; in recovery I have discovered I do love taking care of myself.

I was born into a strict evangelical cult, where silliness and pleasure were banned because they played no role in pleasing the Lord or bringing other people to salvation. My family didn't celebrate Halloween or Christmas because they had pagan roots, and we had no TV in the house. I didn't fit in at school because I wore long skirts and I wasn't allowed to wear makeup or earrings. I was nervous and felt I had to be perfect all day at school; after school, I would go home and binge on junk food. I didn't realize it then, but I was trying to escape the humiliation, confusion and rage I felt.

The plan for my life was that I would meet my future husband in the cult, get married and have children. That plan changed when I was 15 and my family left the cult. I thought I'd better choose a profession that would allow me to support myself in case I didn't get married. I figured being a medical missionary was a good way to go.

My eating addiction grew during college, due to the plethora of choices in the dining hall, the pressures of being pre-med, and my confusion over what to do with my life. I was scared to death of getting fat, so I had a secret restrict-and-binge cycle. I began drinking more heavily to relieve stress and reward myself for studying hard.

Early in my residency, I had gained about 20 pounds and felt like a fat, scared failure. I found myself eating stale donuts from the nurses' station, stuffing my pockets full of treats that specialists bought for the medical staff, stealing ice-cream cups and crackers from the nursery on the pediatric floor—and then bringing up all that food with my fingers down my throat, doubled over on the bathroom floor. I chose the bathroom near the emergency room because it had a lock on it. I would put plastic gloves on my hands while throwing up. Afterwards, I would take off the gloves, wash my hands, and put on another pair of gloves in the emergency room for admitting patients. I was a sick doctor, and I couldn't help myself.

As strange as it sounds, a lost cookie—and the pause and behavior changes that followed—encouraged me to explore the things I love to do and to realize what really mattered in my life. •

In next month's Scribe, the author will describe what it was like hitting rock bottom and how attempting suicide led to a new sense of purpose.

Off Hours

Sore muscles, team camaraderie, life connections

Runners look back while lacing up for this year's Hood to Coast relay

By Jon Bell
For The Scribe

If you are in between Mount Hood and the Oregon Coast on Aug. 23–24, and you happen to see a few thousand people running along the side of the road being shadowed by a parade of vans, don't fret. It's just Hood to Coast back for another year.

Billed as the largest relay in the world, Hood to Coast finds more than 1,000 teams of eight to 12 runners pounding the pavement from Timberline Lodge all the way to the sandy beach at Seaside, 198 miles away. Each runner puts in three legs of between three and eight miles during the two-day relay. Teams come from around the country and the world to run in Hood to Coast, but there are plenty of local teams and runners, too, including quite a few tied to the Portland medical community.

We talked to three of them in advance of this year's Hood to Coast.

Erika Lewis, a physical therapist at Providence Sports Care Center, does a victory leap at Seaside after completing the 2011 Hood to Coast relay. Lewis will compete in her fourth Hood to Coast event this year and says it's all about having fun.

Erika Lewis

Providence Sports Care Center

For Erika Lewis, a physical therapist at Providence Sports Care Center, one of the biggest challenges of running Hood to Coast is not a physical one, but a mental one.

Since the relay usually runs more than 24 hours, there's plenty of running to do at night. And when you're out there in the dark, fairly alone, running through the Coast Range with just a few head lamps visible ahead and behind, well . . .

"It gets a little spooky at night," Lewis said. "You haven't really slept, so it's kind of this dream world. I always think there is going to be some animal that jumps out and gets me."

That's not happened—yet—so Lewis is back for her fourth Hood to Coast this year, running on one of two teams from Providence, which is the title sponsor for the event. Her team comprises primarily coworkers from the rehab area at Providence, while the other team is mostly marketing folks. Lewis said it's all about having fun, so there's no competition between the two.

An avid runner for the past decade or so, Lewis first ran Hood to Coast in 2004, when a Providence team needed a runner at the last minute.

"It was phenomenal," she said. "It's a really challenging race, but it's so much fun."

In addition to the nighttime spooks and the physical demands, Lewis said just the way the race works, with runners knocking out their miles then sitting in a van for several hours, not getting any real sleep and trying to stay well-nourished and hydrated, throws people off their normal running game.

"We all have these normal pre-race preps," she said, "but all those rituals get pretty mixed up."

She also said that all of her Hood to Coast runs have kind of followed the same path.

"On the first leg, you're bold and brave," she said. "Then the second leg you're like, 'this is tough,' and then on the third leg you're like, 'is it over yet?' But then you get to the beach and it's like, 'wow, this is amazing. Let's do it again.'"

Jim Chesnutt

OHSU Sports Medicine Program

In a way, running Hood to Coast helped Jim Chesnutt, MD, find the woman he would marry.

Chesnutt, now medical director of the Sports Medicine Program at OHSU, was in college when he ran the relay back in 1984, only the third year of the event. The next day, Chesnutt met a woman whose brother had just run the race as well. The two swapped stories and the rest, as they say, is history.

"It's funny because speaking about Hood to Coast was one of the things that really focused our conversation," said Chesnutt, who's been married to his wife, Karin, for more than 25 years now.

Chesnutt has other connections with Hood to Coast, as well. As a board-certified specialist in sports medicine, he worked during the relay for 18 years. He was also one of four OHSU researchers behind a study to see if antioxidant-rich tart cherry juice reduced muscle damage and pain during strenuous exercise. The study, published in 2010, focused on 54 Hood to Coast runners, half who drank cherry juice and half who drank a placebo before and during the run. While both groups naturally reported increased pain after the race, the cherry juice group's increase was much smaller.

Jim Chesnutt, MD, medical director of OHSU's Sports Medicine Program, ran his first Hood to Coast relay as a college student in 1984. Since then he has participated several times as a runner; he also has worked the relay as a sports medicine specialist and researcher.

Chesnutt returned to the relay last year as a runner, not a working physician, and will be back in it again this year. His team, called "Chesnutt and Friends," is pretty much just that: Chesnutt, his two daughters, a few colleagues, friends, and Chesnutt's pastor and the pastor's daughter.

"It's going to be a lot of fun," Chesnutt said. "It's really a big social event, so it's going to be a lot of fun in that regard."

However, "Chesnutt and Friends" won't be staying for the annual Saturday afternoon and evening blowout on the beach that caps Hood to Coast every year.

"We have to drive back for church," Chesnutt said. "The pastor needs to be there."

Sue Reynolds

Legacy's Randall Children's Hospital
Randall Children's Urgent Care, Beaverton

Running a nighttime leg out in the industrial area of northwest Portland during an earlier Hood to Coast, Sue Reynolds caught a glimpse of something big slithering across her path.

"It was a huge snake, four feet long, just crawling across the road," said Reynolds, nurse manager of the children's emergency department at Legacy's Randall Children's Hospital and at Randall Children's Urgent Care in Beaverton.

*See **OFF HOURS,** page 14*

Kimberlynn Heller, DO

Reaching out to people of color

Drawn to medicine at a young age, Kimberlynn Heller promotes professional diversity, healthy choices

By Jon Bell
For The Scribe

> **"I saw what my mother had to go through** and what I had to go through, and **I knew I wanted to help other people** so they wouldn't have to go through what we did."
>
> — Kimberlynn Heller, DO
> *Osteopathic physician, The Oregon Clinic*

A birth defect in her right arm led **Kimberlynn Heller, DO,** toward the field of medicine at a very young age.

Born and raised in Flint, Mich., Heller said the defect actually inspired her to help other people. She felt the same way after watching her mother gain a lot of weight after she had Heller and her sister.

"I saw what my mother had to go through and what I had to go through, and I knew I wanted to help other people so they wouldn't have to go through what we did," said Heller, 38.

Now an osteopathic physician in the obstetrics and gynecology division at The Oregon Clinic, Heller earned her bachelor's degree from Howard University and her D.O. degree from Michigan State University. After a residence and some time as a clinical instructor at the University of Illinois College of Medicine at Peoria, Heller ended up in Portland with her husband, who was doing a rotation here. Heller did a rotation herself at Oregon Health & Science University, and the couple decided to stay.

"I really like it out here," she said. "And I really don't like shoveling snow."

Heller, married and the mother of a young daughter, is also an advocate for birth control and safe sex for young women, prevention of sexually transmitted diseases and encouraging more women of color to consider careers in health care. She talked with *The Scribe* recently about all that, plus her next new efforts.

***The Scribe:* When and why did you first get involved with some of the causes you work on today?**

Heller: It actually started early, when I was a teenager. I used to volunteer for Planned Parenthood, and I used to talk to girls about birth control and STD prevention. So many of my counterparts back then had no clue. It was so cool to me that I had that information and could share it with them to help keep them safe and able to make well-informed decisions for themselves.

***The Scribe:* And you're still working in these areas?**

Heller: Oh, yes. I volunteer to go and talk to young ladies at different organizations around. I've talked to students through the local chapter of my sorority, Zeta Phi Beta.

***The Scribe:* What would you say are some of the biggest challenges in getting this kind of information out there?**

Heller: I think there are a lot of myths out there. There are so many myths on the Internet, so trying to fight those is a big challenge. It's so different now. There are so many more options (for birth control and STD prevention), but then you always have to keep in mind things like how are people going to be able to pay for this,

See ***PROFILE,*** *page 14*

Ask the Expert

Managing medical school debt

Among 2012 medical school graduates, 86 percent reported having education debt, with a median amount of $170,000. Debt levels for indebted medical school graduates and the cost of medical school attendance have increased faster than inflation during the last 20 years. Indeed, both continue to climb and are at record levels.

These sobering realities were highlighted in the Association of American Medical Colleges' report "Physician Education Debt and the Cost to Attend Medical School, 2012 Update."

There are, however, bright spots in terms of programs and policies to help students manage debt. **Justin Kribs, CFP®**, manager of the Student Debt Counseling & Financial Management Program at Oregon Health & Science University, took time recently to share his thoughts on the subject.

The Scribe: **What state and/or federal policy/program changes have occurred recently that have had or will have the most significant impact on borrowing conditions and the student debt outlook for medical students?**

Kribs: Great question. It is hard to pinpoint which program, state, federal or otherwise, will have the biggest impact. It is just good to see so many options available to students as it gives them choices regarding how they will be able to plan for the career path they want to take.

Federally, I am happy to see an active discussion regarding the cost of student loans. Even if the interest rate reduction currently being voted on by Congress is short term, it will still help a great many students for the time being.

The income-driven plans also help students manage their repayments after graduation and have some great features to them. With these plans a medical student can start repaying their debt a little bit at a time and still plan for the future. Public Service Loan Forgiveness is another program that offers some relief, but considering the time line (10 years) it is hard to say how many students will be able to actually benefit from this program given the range of career choices many physicians have.

At the state level, there has been significant focus on encouraging students to practice in rural Oregon and primary care through investment in several tuition relief programs. Students wishing to practice in rural Oregon have the potential to utilize Oregon's Partnership State Loan Repayment Program (SLRP) and the Primary Health Care Loan Forgiveness Program, which allow participating students to have a portion of their debt paid in exchange for practicing primary care in a rural part of the state. State tax credits for rural providers have also been a useful tool in providing incentive for physicians to practice in underserved areas of Oregon.

Finally, I am extremely pleased with the passing of Senate Bill 2, which creates the Scholars for a Healthy Oregon Initiative. By prioritizing first-generation college students as well as students from rural or underserved areas, this program will help recruit students to OHSU who are more likely to serve Oregon where providers are needed most, but who might not even consider medical school because of the debt burden. Beginning with the class of 2014, students who are admitted into eligible health care programs—and who also commit to practicing in a designated service site in Oregon for one year longer than the length of their health care education degree—will receive a scholarship for the full amount of tuition and fees. The Scholars for a Healthy Oregon Initiative will not only benefit the students by significantly decreasing the amount of their debt at graduation, but it will also increase the distribution of health care providers to Oregon's rural and underserved communities.

Each of these federal and state programs plays an important part in a student's ability to manage their debt during their time as a student and as they continue on into their careers. Simply put, the more tools the better.

The Scribe: **What two or three pieces of advice would you offer medical students striving to better manage their academic debt? Some examples we've read about include loan forgiveness programs and financial coaching focused on a student's overall financial picture.**

Kribs: There are few 'blanket' words of advice as each student has their own unique situation, but if I had to say the same thing to everyone it would include:

- **Have a plan.** Even if the plan is a basic plan, have a plan about how you are going to borrow, how you are going to live on the amount borrowed, and how you are going to pay back what you have borrowed.
- **Understand your options.** As stated earlier, every student will have a unique set of circumstances in their life, and thus will have a set of options unique to themselves. The better a student understands their own circumstances and options (planning) the better they will be able to manage their own debt.
- **Stick to your budget.** If you don't have a budget, make one and live by it. After graduation a student will only have so many resources to pay down debt, live a life, and save for retirement. If they can budget now as a student, then it will be easier to do so as a resident and later on in their careers.

The Scribe: **OHSU's board recently adopted a budget that includes the "tuition promise." How have high debt burdens influenced the practice specialties students choose to pursue, and the geographic location in which they choose to practice? And how significant of a concern is it given the shortage of physicians that's predicted?**

Kribs: For many of the students that I sit down and plan with, future income levels or the ability to pay down debt play a small role in their choice of profession. This coincides with a presentation by the AAMC, which showed that education debt, and income expectations, played a smaller part in a student's specialty choice compared to items such as specialty content and personality fit[1]. Students do ask about repayment and their ability to repay their debt, but are more concerned with being satisfied with their careers in the long run.

*See **ASK THE EXPERT,** page 12*

Regence–Legacy deal continues expansion of total-cost-of-care model

By Cliff Collins
For The Scribe

Legacy Health considers its new collaborative agreement with **Regence BlueCross BlueShield of Oregon** an important step in facing a new environment, but just one of several the health system is discussing with other payers.

Legacy and Regence announced last month the creation of an accountable care partnership payment model that shifts from fee-for-service arrangements to a population-based model emphasizing quality and total cost of care.

"This is a new thing for us and a new thing for Regence," said **Trent Green**, Legacy's senior vice president for strategy and planning. "For us, it gives us some exposure to managing risks. We're assuming some overall risk for this population."

The accountable care arrangement involves a payment model that includes "a risk-based accountable health program with shared incentive measures based on quality and cost benchmarks," according to a joint announcement.

Individual physicians will not bear risk at this time, only Legacy and Regence, though doctors may in the future, Green said.

"Let's say 10,000 patients sign up. If we don't manage the population well—utilization is higher than what we collected—Legacy and Regence will share that cost overrun," he explained. "On the upside, if we manage that population well and dollars are left, we would share in the upside, assuming quality measures are met."

The agreement initially will focus on offering a product for individuals through the state's insurance exchange, via Regence's newly created **BridgeSpan Health Co.** But at some point it also will be offered to interested employers not through the exchange, Green said.

The risk-sharing between the two health care giants "will allow Regence to offer lower premiums compared to the current marketplace and add features aimed at engaging members in their health care decisions," according to the announcement.

Regence's deal with Legacy follows earlier arrangements with Adventist Health and Tuality Healthcare, and with Willamette Valley Medical Center in McMinnville, but this one amounts to a larger agreement because of Legacy's size. The insurer said it is developing additional collaborative arrangements with doctors and hospitals throughout the Northwest, with new announcements expected in the coming weeks.

Regence calls the Legacy agreement the "most advanced" of initiatives within its parent company's comprehensive accountable health strategy in Oregon, Utah, Washington and Idaho "to help foster collaborative physician-patient relationships that improve quality of care."

Legacy "is completely committed to transforming health care in our region," said **George J. Brown, MD**, president and CEO. "We were an early leader in adopting the primary care health home model in our clinics, and are working to make care and health advice ever more accessible to our patients."

"The Regence and Legacy agreement represents an advanced model of care leveraging Legacy's medical homes to transform care delivery in a way that aligns incentives, setting high standards for quality outcomes and cost reductions," said **Patti Laughren**, vice president of accountable health systems and provider innovation for Regence. "This agreement is fueled by robust reporting and state-of-the-art data exchange to enable achievement of the Triple Aim. Physicians will be increasingly rewarded based on patient outcomes rather than the amount of services provided."

The Triple Aim refers to an ongoing initiative sponsored by the Institute for Healthcare Improvement intended to encourage models of care that improve the health of populations and the patient experience while lowering per-capita health care costs.

Green stressed that the agreement with Regence does not represent "an exclusive relationship," and that Legacy continues holding discussions with other payers about potential relationships that reduce health care costs and improve quality. He noted that unlike Kaiser Permanente and Providence Health & Services, Legacy does not own an insurance plan, and must look outside itself for forming payer relationships.

The type of agreement Legacy has struck with Regence "is very consistent with the way Legacy is viewing the future," as an organization committed to optimizing health and improving outcomes and value, Green said. •

Regence says the accountable care arrangements it is making with health systems will improve quality of care and patient satisfaction while lowering costs. Do you agree that these types of agreements improve quality of care? Visit the members forum section at msmp.org to respond.

Regence opts to outsource some functions

As further proof that Oregon's largest health insurer is changing the way it does business, Regence BlueCross BlueShield of Oregon is outsourcing its claims processing and certain member functions to a multinational corporation.

"The new health care landscape offers challenges and opportunities requiring investing in some areas and reducing investments in others," said Regence spokesman Jared Ishkanian. "Our focus is on our core competencies of providing our members quality health outcomes and superior customer service at an economically sustainable cost."

To that end, Regence has engaged New Jersey-based **Cognizant Technology Solutions** to perform "specific transactional, non-member-facing job functions in the areas of claims and membership," he said. "This decision allows Regence to improve quality, efficiency and service and pass along millions of dollars in savings to our members."

Cognizant Technology Solutions, a Fortune 500 company, claims on its website the following: "Choose Cognizant as your partner. Fifteen of the top 20 health care plans in the U.S. already have." According to Regence, Cognizant provides business consulting, technology and processing services to these health care plans, and has facilities in more than 50 international locations.

Cognizant employs a reported 162,700 employees worldwide. According to Wikipedia, over 100,000 of them are in India.

Regence is eliminating the positions of about 55 employees who previously handled these functions within the company. •

Ask the Expert: Managing medical school debt

***CONTINUED** from page 10*

Nevertheless, rising tuition does place a burden on students seeking degrees as health care professionals. OHSU is sensitive to this burden and is committed to assisting our students. As a result, the OHSU Board approved the OHSU Tuition Promise, which essentially will "lock in" the 2013–14 tuition rate for students currently enrolled in eligible clinical degree programs. Programs such as the OHSU Tuition Promise allow for students to plan accordingly without having to worry about rising tuition costs.

The Scribe: **Please feel free to address any other issue you believe is pertinent.**

Kribs: OHSU is taking a different approach to addressing the topic of medical student indebtedness by offering a variety of resources for students to utilize. My position is unique in that I am not a 'financial aid counselor' but a financial planner, so my focus isn't just on debt or repayment, but on a student's overall individual situation. We discuss their life circumstances and help come up with ways to address them in a manner that is specific to each student. OHSU has also taken steps to significantly increase the amount of scholarships awarded to medical students. This, in combination with the *OHSU Tuition Promise* and the individualized services I provide, enables OHSU to help a student plan for their time as a student and for what will come after graduation. •

Has the cost of education led to a shortage of doctors in the Portland metro area?
Visit the members forum section at msmp.org to respond.

Endnotes

1. Youngclaus, Jay. "Repayment Programs by the Numbers." Presentation AAMC 2013 PDC, 01/15/2013

Expansion

***CONTINUED** from page 5*

Providence opening new children's psychiatric unit

Providence Health & Services is moving its child and adolescent psychiatric services from its home of 30 years at Providence Portland to a new center at **Providence Willamette Falls Medical Center** in Oregon City. Willamette Falls Hospital operated independently until it was purchased by Providence three years ago.

The location, which will begin caring for patients on Aug. 23, was selected from all of Providence's hospitals and clinics in the region because the space was available, and because Clackamas County is underserved, according to the new unit's medical director, **Ken Ensroth, MD**.

"It's a rare opportunity and a privilege to be opening a new facility such as this," Ensroth said. "There are only two acute psychiatric units for children in the entire state."

Ensroth said that Providence executives had decided on the relocation about a year and a half ago and were awaiting completion of a $7.5 million renovation of 13,600 square feet of unfinished patient care space directly above the emergency department at Willamette Falls.

The unit will accommodate as many as six children ages three to 12, and 16 adolescents ages 13 through 17 in private rooms, with the exception of two adolescent rooms that will accommodate two patients when it is an appropriate part of their care plan. The capacity will allow Providence to increase the number of patients by 10 percent. In 2012, Providence cared for 514 patients with an average stay of nine days.

The new location will feature an outdoor space for physical activity which was not available in the previous location. In addition, an outpatient psychiatric clinic for children and adolescents will also begin operating at the hospital.

The unit will feature enhanced communications technology, such as secure video conferencing, to improve patient care for the inpatient population. As Providence provides psychiatric health care to children from every corner of Oregon, the upgrades will allow better communication with families, physicians and other community care providers from across the state.

About 50 Providence employees will staff the unit, including physicians, nurses, social workers, health unit coordinators and other support staff. •

Providence Willamette Falls Medical Center will hold an open house for the new Children's and Adolescents Psychiatric Unit from 2–4 p.m. Aug. 14, and from 6–8 p.m. Aug. 15. For more information, please call 503-650-6262.

Pat Markesino, RN, Providence Willamette Falls Medical Center chief nurse executive, and Bobbi Vidourek, RN, review next steps for an adolescent day room that will be part of Providence's new child and adolescent psychiatric services unit under construction in Oregon City. The day room, where staff and patients will gather for meals, group games and free time, also accommodates baking and cooking, important life skills during this developmental stage.

Photo courtesy of Providence Willamette Falls Medical Center

News briefs

County, CCC program earns national award

Multnomah County received an Achievement Award from the National Association of Counties for its Homeless Benefits Recovery Program. The program, implemented by **Central City Concern's Benefits & Entitlements Specialist Team (BEST)**, attained federal disability benefits for 117 people of 143 who exited the program, improving lives and resulting in more medical providers getting paid for their work. The majority (85 percent) of those who received federals benefits had a mental health disability.

The program was designed to help disabled individuals who are homeless or at risk of homelessness apply for Social Security Disability and Medicaid benefits. Central City Concern has operated the BEST program since 2008 and has secured benefits for 782 people. •

Kaiser receives genome sequencing study grant

The **Kaiser Permanente Center for Health Research** will receive $8.1 million from the National Institutes of Health to conduct a novel clinical trial using whole genome sequencing to test women and their partners for mutations that could cause rare but serious diseases in their children.

The project is one of three multimillion-dollar grants awarded this year by the NIH's National Human Genome Research Institute as part of its Clinical Sequencing Exploratory Research program, which funds innovative projects that explore how to use whole genome sequencing in clinical practice. •

Vivek Dogra opens Portland sleep treatment center

Vivek Dogra, MD, recently opened **Somnique Health** to treat a wide range of sleep conditions, including snoring, sleep apnea, insomnia, narcolepsy, sleep-related breathing and movement disorders and other conditions causing sleep deprivation or deficiency.

Dogra completed his internal medicine residency at Kingsbrook Jewish Medical Center in Brooklyn, N.Y., and did a two-year research fellowship in cardiology at Oregon Health & Science University. He previously worked with Providence Health System and at Kaiser Permanente before serving as medical director at Arete/Advanced Sleep Health. •

Off Hours: Hood to Coast

CONTINUED FROM *page 8*

Providence typically sponsors two teams for Hood to Coast. One of its 2010 teams included members of its rehabilitation department: *(from left)* **Tori Reichman, Becky Sander, Mandi Murtaugh, Michele Kropf and Erika Lewis.**

"I did a little 'eek!' and kept going. It was a nice little adrenaline boost."

This year will be Reynolds' third Hood to Coast. Her team, "A Legacy of Sore Muscles . . . for Randall Children's Hospital at Legacy Emanuel," includes a mix of Legacy employees, from nurses to human resources people and a vice president, some of whom have done the relay before. Reynolds said she enjoys the camaraderie that comes with the event, and she also likes coordinating the various runners and vans. She sees it as a great way to support the children's hospital.

"I think it's just great representation for our state and for our hospital," Reynolds said.

In addition to the snake incident, Reynolds said her team has shared laughs over one runner who always seems to get stuck running extra miles to get to the exchange point because of bad traffic. Another time, Reynolds was cleaning out one of the vans after the race and found a pair of lace underwear, which no one owned up to.

"There was lots of speculation," she said. "We were just hoping it wasn't one of the guys'—their lucky underwear or something."

Those kinds of lighthearted memories from her prior Hood to Coast experiences have Reynolds and her whole team looking forward to this year's race.

"I think there's an anticipation of what's going to happen this year," she said. "That makes it really exciting as a team." •

Do you have training tips or advice for people running Hood to Coast? What was your strangest or most amusing Hood to Coast experience? Visit the members forum section at msmp.org to respond.

Participants at the Hood to Coast starting line on Mt. Hood.

Profile: Kimberlynn Heller, DO

CONTINUED FROM *page 9*

something like long-term birth control. That's why I'm so happy about Obamacare, because more people are going to have better access to it.

The Scribe: **How about the future? Do you see yourself getting involved with any other issues or causes?**

Heller: I really want to become a certified lactation consultant because that's something that's really lacking in the black and Hispanic communities. Portland has one of the highest rates of breastfeeding in the nation, but it's still very low with blacks and Hispanics. There are a lot of myths and misconceptions out there, and I think also that a lot of men have issues or concerns. I want to get men involved and help people get past the misconceptions and the social aspects that have created a lot of roadblocks. I am also currently working on the formation of a Physicians of Color group. I have lived in a lot of large cities, but never have I lived in any city that did not have a group to help recruit, retain and support physicians of color. These organizations go a long way in helping to increase diversity in the medical field. My goal is to have the first meeting this fall.

The Scribe: **Can you talk a little bit about your efforts to encourage kids to think about careers in medicine?**

Heller: That is a program called Sistah Care, which is a summer program for young ladies through the International Center for Traditional Childbearing (an organization that Heller sits on the board of). I was invited to speak about health care in general, but I also talked about education and goals. It seems like I take any chance I can to get around these young people to talk about these options and about helping to get more of them into health care. I've also been mentoring some students to keep them going and encouraged. One medical student from Illinois found me online and we've been emailing and calling for the past six months. I just try to provide some encouragement and answer her questions.

The Scribe: **Do you think there's enough mentoring in medicine today?**

Heller: No, there's not enough mentoring. The problem is when you are a student, you don't really know how to go and ask someone to be your mentor. And when you are a physician, you are so busy the last thing you think about is mentoring someone. Luckily ACOG (the American Congress of Obstetricians and Gynecologists) has recognized the importance of mentors and is helping to create more opportunities.

The Scribe: **What do you enjoy most about your work and these efforts?**

Heller: I love the fact that I can have a lasting impression on someone. When that doctor's office door closes behind them, they are a part of my family. That's how I talk to them, like a sister or a daughter or a mother. With many of the young ladies, no one has talked to them about education or their goals. The greatest reward is when you see someone three or four years down the line and see what they've accomplished. I have one young lady who is just about to graduate, and a few years ago she wasn't even thinking about college. •

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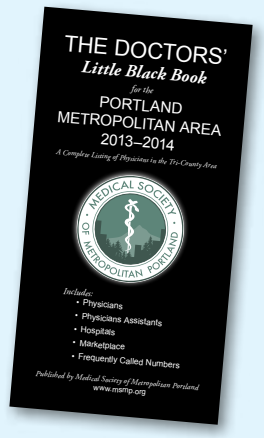

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