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Coming soon: Oregon's insurance exchange

Health Insurance Marketplace, CCOs bring doctors concern, confidence

By Cliff Collins
For The Scribe

Ready or not, the state health insurance exchange is coming soon to patients near you.

Beginning in October, the exchange, which government now officially has dubbed the Health Insurance Marketplace, will make available online health insurance comparisons for Oregonians shopping for their own coverage, effective Jan. 1, 2014.

The exchange is a key component of the Affordable Care Act, along with coordinated care organizations, or CCOs, which already are in place around the state but are still quite new.

"Uncertainty" is the most common description doctors give when asked what these changes will mean for physicians and medical groups, both primary care doctors and specialists. Physician leaders say many doctors are so busy taking care of patients right now that they have not given a lot of thought to if or how the changes brought about by the health reform law will affect them and their practices.

"I don't think we really know," said **Craig S. Fausel, MD**, a gastroenterologist and chief executive of **The Oregon Clinic**. "It remains to be seen."

"There's a fair amount of uncertainty about these changes," agreed **W. Gary Hoffman, MD**, an obstetrician-gynecologist who is a member of the **Medical Society of Metropolitan Portland** and one of two physician board members of **Health Share of Oregon**, one of the two CCOs in the Portland metropolitan area. "A lot of these things haven't registered yet with busy physicians."

"It's fair to say that everybody is a little tentative," said **Ralph M. Prows, MD**, president and CEO of **Oregon's Health CO-OP**, a new, consumer-operated health plan. "We don't know what the population (of patients signing up) will look like."

For the change involving the exchange, in October Oregonians can begin comparing rates and benefits offered by all participating health plans in their area. For the first time, individuals and small businesses will be able to see listed side by side what carriers offer them based on price, benefits, quality and other features. Insurers are required by the law to offer the same core set of essential benefits. No plan can reject a person for having a pre-existing condition.

The website **Cover Oregon**, which manages the exchange for the state, also will inform patients whether they qualify for free or low-cost coverage available through Medicaid or the Children's Health Insurance Program.

The second big change, CCOs, are networks of all types of health care providers—physical health care, addictions and mental health care and, eventually, dental care—who have agreed to work together in their local communities to serve patients covered under the Oregon Health Plan. CCOs are focused on prevention and helping manage chronic conditions such as diabetes. The intention is to reduce unnecessary emergency room visits and provide people support to help them be healthy.

"It's fair to say that **everybody is a little tentative**. We don't know what the population (of patients signing up) will look like."

— Ralph M. Prows, MD
President and CEO of Oregon's Health CO-OP

The federal government is giving Oregon $1.9 billion over five years to show that by using CCOs, the Oregon Health Plan can reduce the rate of medical inflation by 2 percent, saving $11 billion during the next decade. If the state fails to achieve that percentage reduction, it will lose the federal money.

"CCOs have been in existence only about one year," said Hoffman, who emphasized that the opinions he expressed are his own and not Health Share of Oregon's. "Their timeline to get up and running has been extremely fast. I don't really think the majority of physicians understand the concept behind CCOs."

Most physicians haven't felt any effect yet from CCOs, he said, with two exceptions: doctors who are in a strategic planning role, and physicians who are treating patients who fall under Health Share of Oregon's federal CMMI Health Commons Grant.

Regarding the first, "Some of the larger clinics, both primary care and specialty, are busy making plans for expansion of the Medicaid population, as well as the exchange changes," he said. "We don't know how that will unfold."

The 2013 Legislature approved opening the Oregon Health Plan to more low-income Oregonians as allowed under federal health reform. The state projects that the number of people expected to qualify who currently don't have health coverage will total about 180,000 by 2015. Ultimately, 240,000 additional people could be covered through the Oregon Health Plan by 2016.

The second exception Hoffman noted, the Health Commons Grant, involves $17.3 million over three years that Health Share of Oregon receives from the Centers for Medicare & Medicaid Services. The money funds five complementary care interventions, including the hiring and training of new community health outreach workers, who identify patients with the highest needs and try to help keep them out of the ER, when appropriate. Doctors who work with that population affected by the grant necessarily are aware of the change, he said.

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—Retired dermatologist Robert Amon, MD, on course speakers for OHSU's Professionals Training in Global Health program

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2. Fritz JM, Childs JD, Wainner RS, Flynn TW. Primary care referral of patients with low back pain to physical therapy: impact on future health care utilization and costs. *Spine*. 2012;37:2114-2121.

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CCOs: bring doctors concern, confidence

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Dealing with expansion

One of the concerns doctors and others express about the health reform law is that a shortage of primary care providers already exists, and with the expansion of the Medicaid and insured populations, that problem could worsen.

Patrick Curran, chief executive of the health plan **CareOregon**, said one of the intentions of the CCOs—the patient-centered medical home—is to help alleviate this shortage of providers by allowing all providers involved with the care of a patient to practice at the top of their license, which enhances physicians' role.


PATRICK CURRAN

CareOregon, which is a member of Health Share of Oregon as well as four other CCOs across the state, worked for several years to help clinics create medical homes, which enable them to take a team-based approach to care. This model expands doctors' capability by involving physicians, nurses, medical assistants, behavioral health specialists and others, Curran said. Because many patients have multiple physical and behavioral needs, this team approach is thought to enhance care, as well as to help prevent people from getting sicker and needing more expensive treatments.

Still, there is "concern about access with expanded enrollment," said Oregon's Health CO-OP's Prows. "Particularly at the primary care level, we know access is tight." Even if the initial estimates turn out to be less than expected, the larger number of patients "could put additional tension on an already stressed environment," he said. "People are holding their breath."

Specialists are the wild card as the changes take effect. "We expect there's going to be a pent-up demand for those not (now) insured," Hoffman said. "Specialists will be on the receiving end of that pent-up demand."

The Oregon Clinic's Fausel said he is not sure what the CCOs' long-term plan will look like for contracting specialty services. "The business part, we don't know how that will work out," he said. He pointed out that a number of specialists in Oregon already limit or exclude Medicaid patients from their practice, but his group has no plans to change its own approach: "We've seen Medicaid patients forever. We will continue to as long as we can."


CRAIG S. FAUSEL, MD

Phil Armstrong, chief operating officer of **The Oregon Clinic**, said a key question remaining is how specialists can be more collaborative under the CCO plan, which focuses heavily on primary care even though patients will still need specialty care when they become ill.


PHIL ARMSTRONG

"The Oregon Clinic is ready to do that," to take a cooperative role, Armstrong said, noting that the group has a great deal of experience in measuring quality and meeting meaningful use requirements for electronic health records, attributes that are not reimbursed through fee-for-service. "Under CCOs, providers have an incentive for better cooperation and doing what's best for the patient," he added. "We want to collaborate."

"There's a lot of angst out there," conceded Fausel. "Change is always difficult." But facing financial and professional insecurity and uncertainty, specialists are finding it helpful to "retreat back to what we know how to do. We're trained to be physicians and to take care of patients, and we'll continue to do that."

Hoffman agreed. "Are physicians prepared? In a broad sense, Oregon physicians are better prepared than anybody," he said. With the widespread implementation here of electronic records and early adoption of medical homes—even faced with "the uncertainties of what is going to be happening in the next two years—Oregon physicians are very well-positioned for this." •

How will health reform affect you and your practice? What are its most significant advantages and challenges?
Visit the members forum section at msmp.org to respond.

Resources

The tri-county CCO **Health Share of Oregon** consists of these members: Adventist Health, CareOregon, Central City Concern, Clackamas County, Kaiser Permanente, Legacy Health, Multnomah County, Oregon Health & Science University, Providence Health & Services, Tuality Healthcare, and Washington County.

www.healthshareoregon.org

FamilyCare Health Plans is also running its own CCO.

www.familycareinc.org/index.php?/main/familycare-a-coordinated-care-organization

Cover Oregon—The state's insurance exchange

www.coveroregon.com

Oregon's website about CCOs

cco.health.oregon.gov

CCO Oregon—Supplies news and sponsors conferences about CCOs

www.ccooregon.org

Oregon Health Authority's Transformation Center—Provides resources to CCOs

www.transformationcenter.org

The **Oregon Coalition of Health Care Purchasers** is sponsoring a forum with nine health plan CEOs:

"A Look into Oregon's Health Insurance Landscape for 2014"
7– 9:30 a.m., Sept. 12, Multnomah Athletic Club

http://ochcp.org/default.asp?id=79

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Giving back abroad and at home

OHSU global health course helps professionals brush up on primary medicine skills and aid the underserved

By John Rumler
For The Scribe

A small, relatively new class at Oregon Health & Science University—and the only one of its kind in the nation—is making a huge difference in some of the most remote and farthest-flung places on the globe.

Professionals Training in Global Health is an 11-week program that helps medical professionals brush up on their primary medicine skills and covers a wide range of health care issues that are more prevalent in developing nations than in Western medical practices.

Steven Marks, MD, who has conducted medical camps in Uganda for several years, said the PTGH course was extremely useful in organizing the camps, assessing needs and treating thousands of people in remote villages.

"The topics were germane to the work we do and it created the necessary knowledge base to perform more confidently," he added.

nations, but realized that in the places he would visit, including Sierra Leone, Ethiopia, Sri Lanka and Moldova, he'd be called on to take on a wide range of medical problems.

Harris had spent years refining his skills in ophthalmology, but it had been decades since his primary medicine training. He also wanted some training on practicing medicine in the often challenging circumstances doctors find in remote areas and/or low-income countries.

Although he made an exhaustive search, Harris could find no clear pathway for medical professionals in the United States to acquire such assistance.

Feeling he was not alone in wanting this sort of training, he sent a letter to every physician in Oregon between ages 46 and 69, and about 400 responded positively.

So, in 2007, after cobbling together a unique curriculum—Harris, 70, created OHSU's Global Health Center and the 10-week PTGH course. Harris became the program's coordinator at the same time he was one of the first six students—all physicians—to complete the course. Four of the doctors went overseas on volunteer missions, including Harris, who went to Ethiopia.

Jim Peck, MD, former medical director of the Oregon Medical Board, enjoys a jog with some new friends during a trip to Africa. He completed the PTGH course in 2009 and says the information he learned has been invaluable during his trips abroad.

This fall, for the first time, the course will be offered through videoconferencing for people who live too far away to commute to Portland. University officials think this may expand the program's reach considerably.

PTGH, which is believed to be the nation's only global health course offering retraining in primary care medicine, is now in its sixth year. Twenty people are enrolled for the upcoming training, which begins Sept. 12 and is held on Thursdays and Fridays and lasts until Nov. 22. The basic course tuition is $3,800, which includes CME credits.

The idea for PTGH came about when **Andy Harris, MD**, was winding down a satisfying, 24-year career as an ophthalmologist in Salem, and statewide for another 10 years *locum tenens*. Harris was eager to share his medical skills with underserved populations in developing

'Exceptional idealism and commitment'

PTGH is gaining attention and respect nationwide. The national Purpose Prize, which recognizes people late in their careers who are creating new ways to solve social problems, named Harris as one of its Purpose Prize Fellows, citing his work with the Global Health Center course.

Harris said the Purpose Prize recognition is less important than how successful the course has become. "The course not only gives U.S. medical professionals a chance to provide care overseas, it also enables them to provide care locally—in

*See **GIVING BACK,** page 6*

Ophthalmologist Andy Harris, MD, created OHSU's Global Health Center and its 10-week PTGH course. Dr. Harris is pictured here with (from left) his ophthalmic assistant, Ayantu Tesfa, the daughter of the patient next to him and one of the patients he treated during a 2009 trip to Ethiopia.

Photos courtesy of the Professionals Training in Global Health program

BY THE NUMBERS

One-third—The estimated number of graduates of OHSU's Professionals Training in Global Health program who continue to volunteer at free medical clinics in the metro area and around the state.

***GIVING BACK** from page 5*

free medical clinics for the uninsured where course participants volunteer one evening per week."

The course employs about 35 instructors with overseas experience, and offers information and training on numerous diverse topics, including tropical diseases, childhood illness, trauma care, malnutrition, casting and splinting, breach deliveries and laboratory identification of parasites.

It covers essential medications in the field and how to set up a medical delivery system following a disaster. With help from Medical Teams International, it spends a full day on medical team safety and security, including a field exercise that features a simulated insurgent attack and hostage taking.

"Those who take the PTGH class are demonstrating exceptional idealism and commitment," said OHSU President **Joe Robertson**.

"The most practical application, of course, is for those who go overseas, but the focus of global health—improving the health of impoverished populations—is of increasing relevance here at home," Robertson added. "It's a wonderful course offering and we're very grateful for Andy Harris' vision and drive in establishing it."

A physician's assistant and doctoral student at OHSU, **Eric Holden** has provided medical services in Haiti on six separate occasions since 2009. He said PTGH provided him with a level of comfort practicing overseas that he did not expect to acquire from a one-semester course. "With the hands-on nature of the course covering issues like precipitous/difficult childbirth, surgical procedures in austere conditions and emergent procedures, I'd recommend it to anyone considering medical work in an underserved area, either domestic or international."

The former medical director of the Oregon Medical Board, **Jim Peck, MD**, completed the course in 2009. "Although several of us in my PTGH class had worked in developing nations before, the in-depth information received was invaluable for my subsequent missions to Nigeria and Haiti."

Photos courtesy of the Professionals Training in Global Health program

Mary Ellen Coulter, MD, examines a patient in Kenya. Along with encouraging physicians to volunteer overseas, the PTGH program has led many to provide medical services at free health clinics in the Portland metro area.

Andy Harris, MD, provides an eye exam for a patient during one of his overseas trips. Through the PTGH program, 32 graduates have served on one or more medical missions, embarking on 82 trips to 32 different countries.

Retired dermatologist **Robert Amon, MD**, who practiced in Alaska and several Oregon communities including Lake Oswego until 2000, took the course in the fall of 2011. Having spent six years in the Peace Corps, Amon says he especially appreciated that each of the course's speakers had deep experience practicing medicine in challenging environments overseas.

"They weren't lecturing from a textbook; they were teaching based upon personal field experience," Amon said.

An unanticipated benefit

Besides providing desperately needed help overseas, there's also been a huge and unanticipated local and regional benefit of the PTGH course. Harris said graduates are becoming much more active in donating medical services at free health clinics in the Portland area and around the state.

About a third of the graduates continue to volunteer in local medical clinics, where they maintain their primary care skills while serving the poor and uninsured. Some of these patients are refugees and immigrants from overseas.

"That was not part of my vision, but specialists like getting back into primary care and find a real satisfaction in being able to treat people locally," Harris explained.

Amon says many physicians believe much more can be done to meet the health care and medical needs of underserved people both locally and globally.

"I think what this course does so well is to provide medical professionals, who are nearing the end of their careers, an opportunity to relearn forgotten skills and acquire updated knowledge. This focused training readies them to care for those underserved, both at home and abroad."

Since 2008, 60 health professionals have graduated from PTGH, including 45 physicians, seven nurses, two nurse practitioners, two physician assistants, one podiatrist, one certified nurse midwife, one paramedic and a psychologist. The average age of course participants is about 55, but has ranged from 37 to 75.

Thirty-two of the graduates have served on one or more medical missions, embarking on 82 trips to 32 different countries.

"We in the medical profession are privileged in many ways," Harris said. "The beauty of this course is that it broadens our skills, while enabling us to give back to the medically underserved, both locally and globally." •

To learn more, visit msmp.org and click the Events and Education tab.

Do you have a volunteer medical experience you'd like to share with colleagues?

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

After decades-long addiction battle and suicide attempt, sobriety and 'life-giving' job

Periods of serenity emerge

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.

In the first installment of this essay, the author described her battle with food addiction and alcohol abuse as she strived for a medical career she wasn't sure she wanted. To read it, please visit msmp.org and view The Scribe's *August edition.*

During one 24-hour shift in the second year of my residency, I binged and purged three or four times. Leaving the hospital at the end of my shift, I used the last of my money to buy a cookie, even though the thought of eating it made me sick. I planned to binge more by using my debit card at Dunkin Donuts on the ride home. I left the cookie on a table outside while I ran back inside to answer a page. When I came back, the cookie had disappeared. I was baffled, and then I saw a squirrel scampering around. That forced pause allowed for an intuitive thought to enter—I went directly to an Overeaters Anonymous meeting rather than stopping at Dunkin Donuts.

I had been in and out of OA, and I remember the speaker that day really captured my heart. She followed a meal plan called the "grey sheet," which completely eliminated sugar, grain and flour. I decided to give it a whirl; I also quit drinking because I couldn't have the sugar. I entered a five-year period of sobriety and serenity, during which my mind and body were returned to me beautifully.

During this period of clarity, I took a good look at my professional life and realized that my passion was in writing and doing creative things. I moved to California and tried to break into screenwriting while working per diem medical jobs that required long commutes. My year in California was stressful because I was isolated in a strange city. The evenings were particularly scary because I was alone. I would go out, but come home disappointed because I hadn't met that special someone. I didn't write a screenplay. I started drinking and binging again, along with using Xanax.

I moved back to Oregon feeling hopeless. I didn't see a future for myself. This feeling became more devastating when I couldn't find a job. Fueled by pills, binging and alcohol, and plagued by stress and insomnia, I had a nervous breakdown in June 2012.

Suicide beckoned. I resisted because of the scar it would leave on my family. However, I kept researching the best ways to die. In August, the pain became too great to bear and I acted. My parents were out of town. I set up a lawn chair in their backyard and laid in the sun to die after taking a lethal dose of Phenobarbital, 30 Xanax, 30 Ambien, all washed down with a fifth of vodka. What I didn't factor in was the lawn boy coming. He showed up, found me unconscious and called 911.

I spent six days in a coma. I remember waking up and being so angry that I was alive. But people came to visit me and were so happy to see me. My family offered amazing hope and support for rebuilding a future, and that is what ultimately pulled me through. A year later, no one in my family has ever said, "How could you have caused us so much pain?"

I went through treatment at Hazelden and left stronger than when I went in. I voluntarily joined the Health Professionals' Services Program and stayed sober for 90 days before stupidly drinking at a concert because I thought I could get away with it. That prompted entering an intensive outpatient program through Serenity Lane, and I'm still participating in weekly meetings. I've been sober for nearly a year.

A huge part of my recovery has been finding meaning in my life. Working in a bakery, playing with my niece and nephew, and getting a job with hospice have been the highlights of this last year. I reflect on how a year ago I was suicidal, and now I'm caring for dying patients, buoyed by the life force I experience in this work.

In hospice, the denial of death is gone, so peace can come. The person says, "I am dying, let me go well. Let me live well until I go." The focus is on healing relationships that have been disregarded or misunderstood, or enjoying an ice-cream cone on a sunny day. The gift of presence with these people can be life-changing—for them and for me. I'm not terminally ill and yet I relate to many of the fears that surface most starkly at death compared to other times in our lives—they are universal human ailments. I get to feel solidarity with these folks and be reminded of how I can address these fears in my own life. What better job could there be for me, a doctor who once felt so hopeless she planned her own death? To be caught up in bringing comfort to others is the best way to comfort myself. Death's rejection of my own premature offering is beginning to take shape; it looks like grace. I'll go with it. •

ICD-10, Big Data hold promise of better care at lower costs

MARY ELIZABETH MCLEAN

By Mary Elizabeth McLean
For The Scribe

In the midst of health care reform we address the uncomfortable question, *How can we improve quality of care and increase its availability if we are cutting costs?* It sounds impossible, and maybe it is. However, I argue that we have entered an era in which the answer becomes clear and simple: We must stop using data inadequately and money incorrectly.

The United States relies too heavily on reactive medicine, rather than on prevention and maintenance. Oregon is obviously a pioneer with coordinated care organizations and the Oregon Health Plan, but these programs are still insufficiently proactive and we have yet to dig out the true epidemiological roots of our problems. We finally are developing the means to collect and examine billions of gigabytes of health statistics in ways we never have before (a concept deemed Big Data), but there is little public awareness and considerable resistance to movements that could make this introspection possible. One such movement is ICD-10 (the 10th revision of the International Classification of Diseases), the implementation deadline for which is October 2014 for *all* HIPAA-covered entities.

Providers, coders, billers and payor organizations have used the outdated ICD-9 system for decades to assign codes to medical diagnoses and procedures for easier communication between parties involved in health care, particularly regarding reimbursement. The overhaul of the system is a huge change. It will come at significant monetary and productivity cost to providers and health care facilities.

What makes the switch worth the trouble? Between medical diagnoses and procedures, ICD-10 increases the code bank tenfold. It improves specificity, incorporates laterality and room for new code additions, and reflects advancements in medical terminology, procedures and devices. It is an essential systems change.

Incorrect money usage will decline with ICD-10. The copious detail signified by each ICD-10 code will improve information flow between provider and payor, thereby promoting more accurate reimbursement rates for services incurred. Fraud, abuse and upcoding (choosing a higher-paying diagnosis than the most accurate one) will be easier to catch because diagnoses and procedures indicated are cross-checked against clinical documentation, and discrepancies will be more apparent. This will save billions of dollars annually.

The **incorporation** of this **public health data** into studies and clinical practice would allow **better care at lower cost** due to **fewer expected complications**, which is the purpose of evidence-based medicine.

Big data can be better collected and utilized with ICD-10 coding, again due to increased coding detail. For example, if a patient presented with a fractured patella, there would be only two possible ICD-9 codes (open versus closed patella fracture). However, there are 480 possible codes in ICD-10 because it accounts for right versus left, displaced versus non-displaced, transverse versus longitudinal, etc. Big Data analytics can use the ICD-10 diagnosis to find correlates

*See **ICD-10,** page 9*

ICD-10 *from page 8*

between these parameters and efficacy of treatments, thereby improving evidence-based medicine and providing an enormous statistical population from which to draw conclusions. In other words, we could use ICD-10 to show that a specific procedure works best for longitudinal patella fractures, but we could not do this with ICD-9. The incorporation of this public health data into studies and clinical practice would allow better care at lower cost due to fewer expected complications, which is the purpose of evidence-based medicine.

Nobody could better explain health care costs than Atul Gawande in his 2011 commencement address to the Harvard Medical School. He describes differences in health care facilities:

"The places that get the best results are not the most expensive places. Indeed, many are among the least expensive. This means there is hope—for if the best results required the highest costs, then rationing care would be the only choice. Instead, however, we can look to the top performers—the positive deviants—to understand how to provide what society most needs: better care at lower cost."

Where do you stand on the impending ICD-10 switchover? Do you agree that ICD-10, combined with Big Data, will improve care and lower costs? Visit the members forum section at msmp.org to respond.

Our health care system is inadequate for the general population due to cost, quality and availability. We can help fuel the reform by promoting movements like ICD-10 and Big Data analytics. In my schooling at Oregon Health & Science University, I have already encountered the theme of big data in conversations with our faculty and leaders. I am proud to be a part of the OHSU community because it sincerely represents Oregon's prevailing progressive viewpoint, and I am excited to see how we will use these concepts as medical students, future physicians and future surgeons. •

Mary McLean is a first-year medical student at Oregon Health & Science University and aspires to be an orthopaedic trauma surgeon. She also practices Bikram yoga and works as a medical scribe at the Portland Adventist Medical Center Emergency Department. She was born and raised in Portland, and considers it her forever home. Mary can be reached at mcleama@ohsu.edu.

Charles M. Grossman, MD: Physician, scientist, activist

Maija Anderson, head of Historical Collections & Archives, OHSU Library
For The Scribe

One could not live life more fully than did **Charles M. Grossman, MD**. When he passed away, this past July, at age 98, he left a rich legacy characterized by tireless dedication to causes that moved him; alignment of professional integrity and personal values; and rich friendships that bridged generations, professions and nations.

Charles Milton Grossman was born on Dec. 23, 1914, in Harristown, N.J. His family was large and, as he described them in a 2008 oral history interview, "very poor." His parents had emigrated to the United States from Jerusalem, and his father traveled long distances as a teacher of Hebrew. With typical humor and candor, Charlie remembered the day he decided to study medicine: "When I started high school…people who wanted to go to college had to take ancient history… the teacher outlined about twenty books we were going to have to read. And I just shook my head in despair. I'm never going to read all that. And I looked in the catalog, and it had an asterisk under the requirement to take ancient history in the first year. And it said, 'Premedical students should substitute biology.'"

After graduating high school, he lacked the financial means to continue his education. He spent a term at Temple University with the help of his brother, but then moved to New York to work in his aunt's store in Harlem. He attended the City College of New York, which at

Charles M. Grossman, MD, circa 1940

that time was free. He then worked at Emerson Radio for a year, saving money for his first year of medical school at New York University. Poverty was still a reality in his life; he borrowed bedrooms from family and friends during the week, and hitchhiked home to New Jersey on the weekends. He also became interested in politics, and would identify with progressive and left-wing movements for the rest of his life.

Charlie earned his M.D. in 1941. He completed his internship and residency at Yale University, where he made his first major contribution to medicine. In 1942, as acting assistant resident at Yale-New Haven Hospital, he and a colleague administered a dose of penicillin to a patient dying of septicemia. The patient survived, making the event the first successful use of penicillin in the United States. It was also at Yale that he met Helen "Frosty" Frost, who would become his wife. She shared his passion for social justice, and the two were lifelong partners, collaborators and friends.

An ad in *JAMA* brought Charlie to the Northwest: Internists were needed to staff a new hospital in Vancouver, Wash., that would serve workers in the Kaiser shipyards. He responded and was hired, becoming one of the first doctors to work at Northern Permanente. In 1950, Charlie opened a private medical practice in Portland, and many of his Kaiser patients followed. Frosty worked as the office manager. He also worked on grant-funded research projects at the University of Oregon Medical School and University of Portland.

*See **GROSSMAN,** page 11*

***GROSSMAN** from page 10*

In the 1940s and 1950s, Charlie's political beliefs had professional consequences. In the McCarthy era, he faced opposition from medical societies who did not wish to admit leftists to their ranks, as well as university administrators who feared investigation by the House Un-American Activities Committee. However, in the 1960s and '70s, Charlie was part of a powerful movement for change. He was a co-founder of organizations that advocated for social justice and public health in the region, including the Interagency Welfare Crisis Committee, and the Oregon chapter of Physicians for Social Responsibility. He also applied his scientific background to activism, researching and publishing on the health effects of radiation released from the Hanford Nuclear Reservation.

Charlie and Frosty were world travelers. China, however, held a special place in Charlie's heart. He began traveling to China in the 1970s and was soon leading tour groups on a regular basis. He was a leader in China–U.S. friendship associations, culminating in his 2010 designation as a Friendship Ambassador by the Chinese People's Association for Friendship with Foreign Countries.

Charlie practiced medicine until he was in his early 90s—even after that time, he kept to a busy schedule of activism, travel, family activities and socializing. He wrote narrative essays about his life, and was engaged in archiving his personal papers at OHSU Historical Collections & Archives. Charles Grossman passed away July 16. His wife preceded him in 2002. He is survived by his son Peter Grossman and daughter Lindsay Johnson, along with four grandchildren. •

Charlie **practiced medicine** until he was **in his early 90s**—even after that time, he **kept to a busy schedule** of activism, travel, family activities and socializing.

Therapist sees MDT Method playing important role for patients, physicians

By Jon Bell
For The Scribe

When **Nick Rinard** first started his physical therapy practice in Portland in 1999, he needed a niche. He found it in patients who area physicians had referred for physical therapy elsewhere, but who'd never gotten any better.

"I would go to a physician and say you have some examples of patients who didn't get better. Send them to me," said Rinard, whose practice is now called Nick Rinard Physical Therapy. "I got all the bad cases."

But that didn't matter to Rinard, who looked forward to helping those patients through an approach to physical therapy that, at the time, was much less well-known than it is these days.

Called the **Mechanical Diagnosis and Therapy Method** or the **McKenzie Method** after New Zealand physical therapist Robin McKenzie, the approach treats mechanical pain caused by problems in the body's structure or movement. It employs a series of tests to diagnose if a patient's back, neck or extremity pain is indeed mechanical and, if so, addresses that pain through custom treatment plans of simple exercises that the patients perform themselves. More severe cases require more hands-on treatment from the therapist.

Fast-forward nearly 14 years and Rinard's patient base has expanded. He's got a clinic in Southwest Portland and one in northeast, a satellite clinic in Government Camp and roughly 40 percent of his patients are now self-referred.

"I think the Portland patient community is becoming very savvy about how insurance works," Rinard said. "That 40 percent, I think, is a reflection on patient dissatisfaction."

Rinard first heard of the MDT Method while earning his master's degree in physical therapy at the University of Puget Sound. He graduated in 1996, and at the time, the method wasn't very mainstream and he'd not gotten much training in it at all.

"I would like physicians to **use us as a sorting tool** to help them out. I see us **working together as a health care team**."

—Physical Therapist Nick Rinard

"I got the impression that it doesn't work on everybody, and that's true, but then no system works on everybody," Rinard said. "Since it didn't work on everybody, though, I kept pursuing other areas like manual therapy."

But Rinard found he wasn't getting the results he wanted. So he took a course on the MDT Method in 1998 and found what he'd been looking for.

"They were getting results like I wanted to get," he said, "so I took every course that I could find and I have been doing it ever since."

Certified in the MDT Method, Rinard said that many times patients following a more traditional regimen of physical therapy can go for weeks and weeks and never really respond to the treatment or get any better. The MDT Method starts with a thorough mechanical assessment to ensure that the pain is, indeed, a mechanical problem and not caused by something else.

"If they can be diagnosed and respond to treatment, they have a pretty good outcome that is fairly rapid," Rinard said.

If it isn't a mechanical problem, then Rinard refers patients back to physicians for further testing, diagnosis and treatment. He said he would like to see more physicians utilize him or therapists like him as a "first line approach" to help classify their patients. Once a physician ensures that a patient's pain is not a serious medical issue, a referral for a mechanical assessment can help determine if the issue is a mechanical one.

"I would like physicians to use us as a sorting tool to help them out," he said. "I see us working together as a health care team."

Rinard noted that it usually takes about three to four visits over a one- to two-week period to determine if a patient is responding to MDT treatment. If a patient is responding, it can often take six to eight visits for completion. According to Rinard, a 2003 survey by CareConnections found that in Portland, the average physical therapy patient required roughly 11 visits to see an improvement of 74 percent; for Rinard's patients, it took just 6.5 visits to achieve an improvement of more than 92 percent.

In this day and age of high deductibles and rising health care costs—and efforts to keep them contained—Rinard said the MDT approach can make a noticeable difference.

"Effective physical therapy is really in the patient's best interest," he said. •

Health reform challenges PTs to show accountability

By Cliff Collins
For The Scribe

An overarching emphasis of health reform and the Affordable Care Act is value: Providers of all stripes must demonstrate that they can improve outcomes at a lower cost.

"Value equals quality, divided by cost," points out **Richard Katz**, director of contracting and business development for Therapeutic Associates, the oldest and largest privately owned physical therapy group of clinics in Oregon and Washington, with 65 locations.


RICHARD KATZ

Like other providers, physical therapists are finding they have to prove that what they offer patients brings that equation to the fore. With the advent of the state health insurance exchange, PTs who are in private practice and not part of an integrated health system are especially feeling the pressure to show they are meeting the so-called Triple Aim: improved care and patient satisfaction and reduced costs.

Of the **Oregon Physical Therapy Association**'s 1,200 members, about half work in PT clinics that are privately owned or run by physical therapists, according to **Chris Murphy, PT**, president of the association. Those private practice members are "wary" about what could happen in the future if coordinated care organizations, or CCOs, expand beyond serving Medicaid patients, he said.


CHRIS MURPHY, PT

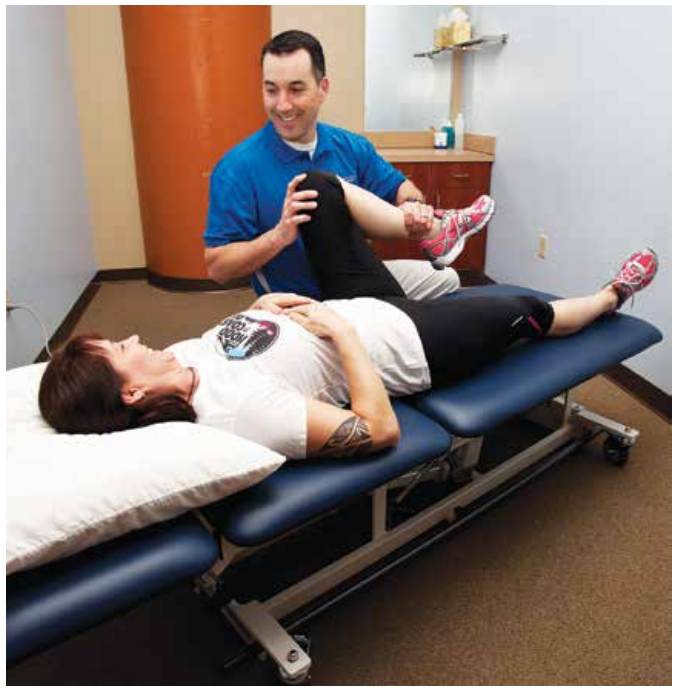
"I think there will be a place for private practice within the CCOs, to contract (with them)," Murphy said. "There are not enough therapists now to take care of the number of patients within the integrated systems."

PTs have been proactive in treatment areas such as lower-back pain, and if they can continue to demonstrate evidence of successful outcomes, there will be a need for them in the CCO scheme of things.

"I think that's our opportunity to jump in to provide better care at a lower cost," Murphy said. "We're actually looking forward to being involved with the CCOs."

Katz said the insurance exchange, Cover Oregon, an online marketplace for comparing costs, is long overdue.

Since 1996—years before the term "Triple Aim" came about—Therapeutic Associates has been able to demonstrate the value of the care it provides, he said. The company has been collecting patient outcome and satisfaction data all during that time. Its IPA, Northwest Rehab Alliance, for which Katz serves as executive director, provides management services and negotiates contracts for more than 370 IPA member practices with 1,100 therapists in Oregon, Washington and Idaho. Northwest Rehab contracts with 25 of the region's major health plans, CCOs and PPOs.



Photos courtesy of Therapeutic Associates

"We are actually continuing a process of developing the tools necessary to meet the challenges of this new era," Katz said. A prime way Therapeutic Associates is doing that is through its CareConnections online suite of rehabilitation medical management services. All member clinics employ these evidence-based clinical practice guidelines as standards for their evaluations and interventions.

"I represent, in my contract negotiation to payers, a one-stop shop using these CareConnections tools (that demonstrate to) those payers access, quality and cost," he explained. "There's strength in numbers, and that's what Northwest Rehab provides: a convoy, a flotilla of independent practices all using the same treatment guidelines and contracting as one unit."

Small PT clinics "have a much better chance within the Northwest Rehab umbrella, but Northwest Rehab cannot guarantee (their) success," Katz said. Those that don't deliver or prove quality and costs savings will struggle, he predicted. "I think there is a significant level of trepidation. There will be casualties."

Already he is starting to see physical therapy clinic consolidation taking place: mergers and acquisitions, particularly among smaller clinics with older owners, who either sell out or close shop. Slightly larger groups will coalesce. Katz also expects Wall Street money to come in and try to buy smaller practices, then bundle and sell them or go into an initial public offering.

Physical therapists "are happy at this point with how things are going with the (insurance) exchange," said the Oregon Physical Therapy Association's Murphy. "It's nice to see standardization of benefits. The plans offered on the exchange

*See **REFORM,** page 14*

REFORM *from page 13*

are required to include rehab. We are considered an essential health benefit from the (Affordable Care Act) perspective. It's going to be good to see that."

The fact that the CCOs, at least initially, will handle only the Medicaid population means that the CCOs' emergence will have little direct effect on physical therapists, Murphy said. The reason is that the Oregon Health Plan does not cover many PT services now, and the plan's priority list that has been in place for a long time will continue. What PTs would like to see down the road is for the Oregon Health Plan to move beyond its current priority list. If that occurs, "we're going to need more people to take care of the patients who are (treated) in private practice."

As health reform advances, the services of all practicing PTs—both those employed by health systems and those in independent practice—will be necessary to take care of the expanded population, Murphy said.

"I'm optimistic that the profession is going to be able to help control costs and reach that Triple Aim," he said. "If we're successful in using providers at the top of their license, I believe our physical therapists not in these integrated systems will be successful." •

Photo courtesy of Therapeutic Associates

September 23 HIPAA deadline approaches

From *PT in Motion* (formerly *PT Magazine*), the professional magazine of the American Physical Therapy Association

Practitioners have until Sept. 23 to comply with provisions of the final rule that earlier this year extensively modified the privacy, security and enforcement regulations established under the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

The final rule expanded many of the requirements to business associates of covered entities that receive protected health information, such as contractors and subcontractors. If a covered entity did **not** have a business associate agreement in place by Jan. 25 this year that was compliant with the previous HIPAA regulations, it must enter into one by Sept. 23. However, entities that **did** have HIPAA-compliant business agreements place as of Jan. 25 may get a one-year extension to revise their agreements, as long as they did not or do not renew those agreements between March 26 (the date the new rule took effect) and Sept. 23. Any agreement that is renewed after Sept. 23 must comply with the new rule, which also increases the penalties for noncompliance to a maximum of $1.5 million per violation.

The changes also strengthen the Health Information Technology for Economic and Clinical Health Breach Notification requirements by clarifying when breaches of unsecured health information must be reported to HHS.

The new rule also expands individual rights under HIPAA, and by Sept. 23 these rights must be added to the Notice of Privacy Practices (NPP) that providers give to new patients. For example, patients can ask for a copy of their electronic medical record in an electronic form, and they can instruct their provider to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full. The rule also sets new limits on how information is used and disclosed for marketing and fundraising purposes and prohibits the sale of individuals' health information without their permission. •

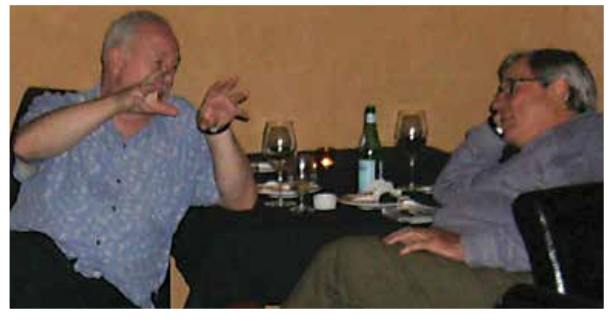
Seminar equips physicians with greater knowledge about prescription drug abuse, pain management strategies

An estimated 40 physicians came together in late August for a free seminar, sponsored by **The Doctors Company** and the Medical Society of Metropolitan Portland, that delved into the prescription drug abuse epidemic and strategies to recognize abuse and educate patients about pain management.

The event, titled "Prescription Drug Abuse—An Epidemic," was timely because of the immense scope of the problem. Although prescription medicines play a key role in improving health, they can be dangerous and even deadly when abused or misused. The U.S. Centers for Disease Control and Prevention has called prescription drug abuse the fastest-growing drug problem in the nation, noting in 2011 that "more people die in America every year from prescription drug abuse than die from heroin and cocaine combined."

The seminar's presenter, **Sonny Nguyen**, JD, RRT, CPHRM, described the extent of the problem and the risk factors that may lead to abuse; walked attendees through a comprehensive pain examination and plan; and outlined strategies to educate patients about pain management.

The seminar, designed for physicians of all specialties, was held at Thirst Wine Bar and Bistro in Portland. It was part of the organizations' Risk Management Series and provided 1.5 CME credits. •



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Keys to patient safety: To text or not to text

By Julie Song, MPH, Patient Safety/Risk Management Account Executive; and **Susan Shepard, MSN, RN, Director, Patient Safety Education, The Doctors Company**
For The Scribe

Texting is instantaneous, convenient and direct. It makes pagers seem as outdated as carrier pigeons. Without appropriate safeguards, however, texting can lead to violations of the Health Insurance Portability and Accountability Act (HIPAA).

Physicians are smart phone "super-users." According to Manhattan Research, more than 81 percent of physicians use a smart phone to communicate and access medical information. The attractions are obvious: Phone applications put libraries full of information at your fingertips, and drug alerts (such as PDR.net) are just a click away. Texting reduces the time waiting for colleagues to call back and may expedite patient care by sending and receiving critical lab results and other necessary patient data.

Safeguard against HIPAA violations

The very convenience that makes texting so inviting may create privacy and security violations if messages containing protected health information (PHI) are not properly safeguarded. Text messages among colleagues should be encrypted and exchanged in a closed, secure network.

However, according to a member survey conducted by the College of Healthcare Information Management Executives, 96.7 percent of those surveyed allowed physicians to text, and 57.6 percent of those surveyed did not use encryption software. The underlying reasons for poor compliance with encryption could be due to lack of technical knowledge or to avoid the inconvenience of sending a message to someone who may not be able to decrypt it.

With penalties starting at $50,000 per HIPAA violation, safeguarding texts should be of utmost priority.

In addition to encrypting texts, consider installing autolock and remote wiping programs. Autolock will lock the device when it is not in use, and it requires a password to unlock it. Wiping programs can erase data, texts, and e-mail remotely. Both types of safeguards provide additional protection in the event a device is lost or stolen.

Do not text orders

On Nov. 10, 2011, The Joint Commission noted that texting is not the same as a verbal order. Texting provides no method for recipients to verify the sender's identity and no reasonable method for preserving or incorporating the original message into the medical record.

Ensure accuracy to avoid liability concerns

A cavalier attitude when composing a text message can also pose a legal risk. The informal nature of text messages may at times lead to using shorthand, which can increase miscommunication. Additionally, a deleted text is never fully deleted, and metadata (the "data behind the data") is also producible in a lawsuit. It's important to ensure accuracy, particularly when patient information is exchanged over text.

Finally, texting cannot substitute for a dialogue with a colleague concerning a patient. If there is a critical matter or any doubt about the communication, pick up the phone.

MSMP is placing a focus on social media etiquette for physicians. To learn more, please visit msmp.org and click on the Resources tab. To read *Scribe* writer Jon Bell's June 2013 article about how social media is finding its way into medicine, visit msmp.org and click on the News and Publications tab.

Take steps to protect your practice

Consider the following safeguarding steps:

- Enable encryption on your mobile device.
- Have a texting policy that outlines the acceptable types of text communication and situations when a phone call is warranted.
- Report to the practice's privacy officer any incidents of lost devices or data breaches.
- Install autolock and remote wiping programs to prevent lost devices from becoming data breaches.
- Know your recipient, and double check the "send" field to prevent sending confidential information to the wrong person.
- Avoid identifying patient details in texts.
- Assume that your text can be viewed by anyone in close proximity to you.
- Ensure the metadata retention policy of the device is consistent with the medical record retention policy, and/or in accordance with a legal preservation order.
- Ensure that your system has a secure method to verify provider authorization.
- When conducting your HIPAA risk analysis, include text message content and capability. •

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

According to Manhattan Research, more than 81 percent of physicians use a smart phone to communicate and access medical information. The attractions are obvious: Phone applications put libraries full of information at your fingertips, and drug alerts (such as PDR.net) are just a click away. Texting reduces the time waiting for colleagues to call back and may expedite patient care by sending and receiving critical lab results and other necessary patient data.

News briefs

Legacy expands primary care services in East County

Legacy Health is expanding primary care services for residents in Gresham and surrounding East County communities. Legacy Medical Group–Gresham began offering adult primary care services Sept. 1 at its clinic on the Legacy Mount Hood campus, 24900 S.E. Stark St. in Gresham.

The new clinic addresses the need for greater access to quality primary care services in East County. Internal medicine physicians **Robert Bailey, MD,** and **Jon Hobson, MD**, have joined the practice. The LMG–Gresham clinic provides routine services including annual wellness visits, health screenings, women's health screenings (pap smears, mammogram referrals, bone density testing), wellness evaluations and specialist referrals. The clinic also addresses specialized health concerns including immunizations, joint injections, skin procedures, nebulizer treatments, and treatment for chronic conditions such as diabetes, hypertension, asthma, depression, arthritis and heart disease.

In related news, a new community-based primary care clinic, Legacy Medical Group–Powell Butte, is set to open this month as well, providing greater convenience and access for mid-county and East Portland residents. That clinic is located at 17332 S.E. Powell Blvd. Legacy also offers primary care services through Legacy Medical Group–Mount Hood located on the Mount Hood Medical Center campus. Legacy Health's primary care clinics are managed as medical homes where the focus is on the health of the whole person in all stages of life, for acute and chronic care as well as preventive care. •

'Bio-partnering,' investing and bioscience's economic innovations focus of conference

This month's **Oregon Bioscience Association** annual conference will feature renowned thought leaders in the innovation economy, product and therapeutic development, industry funding, scientific breakthrough research and health reform.

The event, which will be held Sept. 16–18 at Marylhurst University, is themed "The Economics of Life Sciences." Speakers include William Brody, MD, president of The Salk Institute for Biological Studies; Michael Crowley, PhD, director of business development, Genentech; Colin Hill, CEO and founder, GNS Healthcare; Rob Coppedge, senior vice president, Strategic Investments at Cambia Health Solutions; Joel V. Brill, MD, gastroenterologist and reimbursement expert; David Sanders, MD, founder, Zoomcare Inc.; and Elena Taggart Medo, chairman and CEO of Neolac.

On Sept. 17, the conference will focus on bio-partnering and investing. The next day will focus on how shifting economic winds are changing the bioscience industry. The new **Oregon Bio Women** special interest group will feature its first-ever pre-conference workshop Sept. 16. Opening speakers and hosted interactive roundtables on leadership and social media topics will be featured.

For more information, and to register, please visit www.oregonbio.org. •

Poll: Physicians split over making Medicare payment data public

Making health care data available to the public is becoming an increasingly important government priority. But should that transparency also extend to the payments physicians receive from Medicare?

It's a question that provokes deeply divided opinions among the physician leadership community, according to a new poll conducted by the American College of Physician Executives (ACPE). When asked if they thought data about Medicare payments to physicians should be made public, the response was almost evenly split, with 46 percent of responding ACPE members saying no and 42 percent saying yes. Twelve percent were unsure.

The question was prompted by a federal court judge's decision to overturn a long-standing injunction that prevented the Centers for Medicare and Medicaid Services (CMS) from releasing information about payments to individual physicians. CMS is soliciting feedback on whether physicians have a right to privacy regarding the reimbursement information and if that privacy interest outweighs the benefit to the public. For complete poll results, go to acpe.org. •

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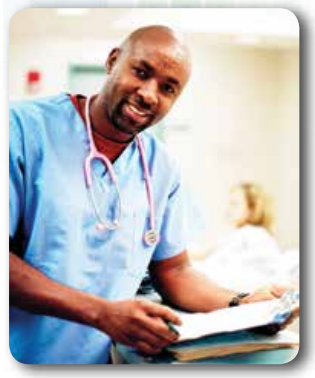

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