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Providence, OHSU researching new frontiers with Fortune 500 firms

Providence immunology trials part of international collaboration to treat cancer

By John Rumler
For The Scribe

In May 2012, **Providence Cancer Center** joined an exclusive team when Bristol-Myers Squibb formed the International Immuno-Oncology Network, a collaboration between industry, universities and research centers from around the world aimed at expanding knowledge of immuno-oncology.

Patients in the Providence Cancer Center are now involved in clinical trials using a combination of drugs that stimulate antibodies that affect the body's immune system.

"These drugs work better together than alone," said **Walter Urba, MD**, director of cancer research for the Robert. W. Franz Cancer Research Center in the Earle A. Chiles Research Institute at Providence Cancer Center. "We're still in the early phases of research. We're moving forward slowly and are closely monitoring any toxicity."

Providence and nine other research partners share the results and progress of their research through subcommittee satellite teleconferences. So far, there's been just one meeting, last May in Philadelphia, in which representatives of all 10 partners and Bristol-Myers Squibb attended in person.

Of the approximately 50 Providence personnel working

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Walter Urba, MD, with the Providence Cancer Center, is helping spearhead research Providence is involved with as part of a global network created to advance scientific understanding of immuno-oncology. Patients in the Providence Cancer Center are involved in clinical trials using drugs that stimulate antibodies that affect the body's immune system.
Photo courtesy of Providence Health & Services

Pioneering group keeps pushing for quality improvement

By Cliff Collins
For The Scribe

Five years ago, the pioneering nonprofit **Oregon Health Care Quality Corp.** boldly blazed a trail by publishing public scores for how primary care clinics across the state performed on certain quality measures.

At the time, many physicians greeted this development with trepidation. After all, doctors didn't participate by choice: Quality Corp. obtained claims data from the largest Oregon health insurers and managed Medicaid organizations, then based its evaluation on how clinics met or failed to meet nationally accepted measures for determining quality for preventive care, chronic disease care and appropriate use of services.

Since then, the push for increased public reporting has become routine as part of several local and national initiatives intended to improve care. A recent example is medical clinics that have sought and achieved recognition as patient-centered medical homes through the Oregon Health Authority, which gives clinics credit for participating in public reporting.

This year, Quality Corp. added a new category to its twice-annual scores: Ten clinics around Oregon volunteered to survey their patients' satisfaction with their care, and to publicly report those results (www.PartnerforQualityCare.org). The clinics ask patients about communications with their doctor, access to timely care when they need it, and whether they were treated with courtesy and respect by all staff at a doctor's office.

One of the participants, The Doctors' Clinic in Salem, weighed the pros and cons before deciding to share its patient satisfaction results.

"We felt we wanted to be transparent," said **Jim McKeon**, administrator of the clinic, which is comprised of 16 internal medicine and family physicians, one general surgeon

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Surgery…and much more

Thomas Albert, DMD, MD, focuses on procedures, support that help patients with cleft lip and palate deformities

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RESEARCH *from page 1*

in the cancer center, about one-half are involved in the research in some way, but the leadership team consists of four or five people. The point person is **Bernard Fox, Ph.D.**, chief of molecular and tumor immunology at Earl A. Chiles Research Institute. "Bernie plays an incredibly important role. He helped convince BMS (Bristol-Myers Squibb) that we should be on the research team," Urba said.

In addition to researchers, clinicians, laboratories and patients, Providence Cancer Center also offers internationally recognized expertise in flow cytometry, or cell sorting, and will provide flow cytometry support for every research institution in the network.

Flow cytometry allows researchers to track the development of specific anti-tumor immune responses in patients who are on the network clinical trials. "We can determine which cells were activated and which were suppressed, and that helps us understand how the therapy worked or didn't work," Urba said.

Collaborations between academic institutions, private research companies and Big Pharma are on the rise, as pharmaceutical companies scan the horizons outside their own walls to acquire promising new, early-stage treatments and to decrease both the risks and costs of developing such drugs.

With $21.2 billion in revenue in 2012, New York City-based Bristol-Myers Squibb—ranked sixth on Fortune 500's 2012 list of the largest U.S. pharmaceutical companies—has amassed a large oncology portfolio and has been aggressively pursuing immuno-oncology therapies.

The Earle A. Chiles Research Institute at Providence Cancer Center was one of 10 leading research institutions, and the only U.S. site west of the Mississippi River, selected by Bristol-Myers Squibb. The global partnership will allow substantially more patients at Providence Cancer Center to take part in clinical trials every year as new immunology-oncology drugs become approved and others move into clinical testing.

"We must continue advancing this important research, and this network is exactly what we need," Fox said. "These new drugs, many of which have never been used in people before, show great promise and that means seeing lots of big tumors go away."

Two major advances have occurred in this area in the last year, according to Urba: a new vaccine to treat patients with prostate cancer and a new antibody to treat patients with malignant melanomas.

"We consider immunotherapy as the fourth method of treatment of patients with cancer," Urba said. "People are used to chemotherapy, surgery and radiation, but those all have their limitations."

Immunotherapy is different, Urba explained, because it takes advantage of a patient's own immune system, activating it in a special way that allows it to target and eradicate cancer cells while minimizing damage to normal tissue.

The focus on researching immunology fits in with the recent shift towards personalized medicine, Urba said. "We haven't even scratched the surface of the potential. When this is combined with other forms of targeted treatments and therapies, the impact could be huge." •

International Immuno-Oncology Network

In addition to the Earle A. Chiles Research Institute at Providence Cancer Center, the other partnering institutions include:

- Clinica Universidad Navarra, Pamplona, Spain
- Dana-Farber Cancer Institute, Boston
- Institut Gustave Roussy, Villejuif, France
- Istituto Nazionale per lo Studio e la Cura dei Tumori Fondazione G. Pascale, Naples, Italy
- Johns Hopkins Kimmel Cancer Center, Baltimore
- Memorial Sloan-Kettering Cancer Center, New York
- The Royal Marsden NHS Foundation Trust and The Institute of Cancer Research, London
- The Netherlands Cancer Institute, Amsterdam
- The University of Chicago

OHSU, Intel merge medical research, computing expertise to address cancer

By John Rumler
For The Scribe

Earlier this year, OHSU began a partnership with Intel Corp. that aims to advance personalized medicine through the development of new computing technologies.

An elite team of scientists—researchers from OHSU's Knight Cancer Institute partnering with Intel engineers—has set its sights on cancer as their first disease target.

The objective, according to **Joe Gray, Ph.D.**, associate director for translational research at the Knight Cancer Institute, is to drive scientific progress in understanding the genetic origins of illness, starting with cancer, at an individual-patient level and, ultimately, to make precision medicine a more routine model of patient care.

"By combining Intel's computing expertise with what we know about how to analyze genomes and to create images of how cells change over time, we believe we have the capability to develop the right tools to make significant progress in making the promise of personalized cancer medicine a reality for more patients," Gray said.

One of the primary computing challenges—and what the research team hopes to address—is the need to analyze enough disease-causing malfunctions in a sufficiently large population of patients to detect statistically valid patterns in

See ***OSHU/INTEL,*** *page 7*

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Challenging the challenges of medical school

By Dani Babbel
For The Scribe

Having transitioned from the first two didactic years to clerkships as a third year, I have been able to reflect on the variety of challenges being a medical student entails. Though it is tempting to complain, upon deeper reflection there are actually many positive aspects to what some might consider the downsides of medical training:

Sleep deprivation

Perhaps the most formidable challenge of doctorhood, as it goes against all health and wellness advice that we as health care providers give. However, the late nights and early mornings allow us to provide a real-life demonstration of the terrifying outcomes that result from lack of sleep so that our patients may see in our faces the importance of sleep hygiene. They say that neuronal death results from sleep deprivation, and to think that we can operate with parts of our brain dying for each hour of sleep lost just makes us utilize more efficiently those parts that survive. Additionally, who else is fortunate enough to see both sunrise and sunset from one of the grand vistas of the university hospital? Who else gets to bike on quiet streets at 3 in the morning and beat traffic? Thankfully, we as medical students are not subject to intern work-hour restrictions, and can fully appreciate the joys of >80 hour workweeks.

Lack of exercise

Similar to how we are seemingly hypocritical when counseling patients on the importance of sleep, our advice on exercise might also be called into question. Though exercise might become increasingly deprioritized the busier our schedules get as we move through clerkships, I would argue that it only makes us more creative in the ways we reach our daily target heart rate. Additionally, it seems to only get easier and easier to achieve that target heart rate as we prematurely age throughout medical school. Walking five flights of stairs with clunky Danskos and rounding for hours on the floor while supporting white coats full of medical accessories probably equal out roughly to running a half marathon each day.

Long hours of standing

Continuing thoughts on exercise, some students complain of long hours on their feet without realizing how strong their ankles as well as one-way venous valves are becoming. Standing in the OR for a day while retracting a body wall is a great exercise in Buddhism (mind over matter) and being as still as a praying mantis while surgeons beside you slice around vital organs. Enduring a long case with a full bladder from your morning coffee is an even better way to develop meditative skills.

Long hours of sitting

On the flip side, long hours of standing are often followed by even more hours of sitting while studying for some sort of nationally administered exam. If uncomfortable while seated during a 10-hour stretch of studying, remember how badly you wanted a chair in the OR.

Standardized tests

They enable us to enhance our skills in filling bubbles with a pencil or clicking small buttons with a mouse, talents that will inevitably be valuable in the future. Taking daylong tests is also a great way to build camaraderie with students across the nation who also suffer through the same paragraph-long vignettes full of red herrings.

Tuition and fees

Spending exorbitant amounts of money each year on tuition and fees forces us to become expert financial planners as we come out of medical school with a six-figure debt statement that looks almost mythical. It is also great motivation to keep working despite a desire to go part time immediately and make up for four-plus years of lost sleep.

Endless grilling

Great preparation for an appearance on a televised game show. Alex Trebek will look like a saint compared to some attendings, and an unseen audience of millions will be far less intimidating than a small group of cranky residents who don't have time to hear you fumble your way through some kind of question on the sensitivity and specificity of a screening test.

Photo courtesy of Dani Babbel

"Long **hours of standing** are often followed by even **more hours of sitting** while studying for some sort of nationally administered exam. If uncomfortable while seated during a **10-hour stretch of studying**, remember how badly you wanted a chair in the OR."

— Dani Babbel

Screen time

Whether you're typing electronic progress notes that won't be read, or doing U-World questions online, copious amounts of time in front of the glow of an electronic screen enables you to be able to get a new style of glasses every year to keep up with the latest eyewear fashion.

Bottom of the totem pole

Arrogance is the foe of good teamwork and strong patient rapport. Feeling worthless for the majority of time that you are a medical student is the best way to instill humility from the very beginning. The more a scrub nurse yells at you, the more doors you open for people and the more chairs you offer to standing attendings at a weekly conference, the better you will be able to relate to your patients and work as a team in the future. •

Dani Babbel is a third-year medical student who is considering a career in internal or family medicine. She tries to spend all her free time outdoors, mostly rock climbing, and doing as little sitting as possible. She hails from Corvallis and will always consider the Pacific Northwest home.

If you are a student member of MSMP and would like to contribute an essay to *The Scribe*, please contact Melody and Barry Finnemore at scribe@llm.com.

Thomas Albert, DMD, MD

Surgery ... and much more

Thomas Albert, DMD, MD, focuses on procedures, support that help patients with cleft lip and palate deformities

By Jon Bell
For The Scribe

For **Thomas Albert, DMD, MD**, the initial surgical procedure that fixes a child's cleft palate is only part of a bigger solution. There are often follow-up surgeries, speech therapy and all kinds of family and community support that needs to go along with it.

That comprehensive approach has been a focus of Albert's since he joined Oregon Health & Science University in 1977. He's now a professor at OHSU and a surgeon specializing in orthognathic, reconstructive and cleft surgery. He's also the founder of the Foundation for the Advancement of Cleft Education Services (FACES), a nonprofit that provides care to medically isolated patients with cleft lip and palate deformities.

He talked with *The Scribe* recently about how he got into this area of medicine, what's changed over the past three-plus decades and how the FACES Foundation makes a difference in people's lives.

The Scribe: **How did you get into medicine and your area of focus?**

Thomas Albert: I was always interested in the sciences, and actually in college I had done some research over the summer that got me really interested in the bigger idea of dentistry as a specialty area. At Harvard, the medical and dental programs are together, so I got to see how you could combine the backgrounds. I also worked at a children's hospital and got interested in craniofacial surgery, which combines medicine and dentistry. A lot of it is interrelated with the face and head, and so it's really helpful to be able to look at the bigger picture. There was a position in the oral surgery department at OHSU, so I came out here in 1977 and have been here ever since.

The Scribe: **What kept you in Oregon?**

Albert: I love to fish a lot. I'm actually hoping to go later today and tomorrow. But I was also greatly influenced by the multidisciplinary approach at OHSU's Cleft/Craniofacial Clinic. It's a comprehensive clinic, which allows us to look at the comprehensive management of these problems, not just as isolated surgical procedures. That was really led by **Dr. Robert Blakeley**, who was a speech pathologist and head of the cleft/craniofacial team for 30 years.

The Scribe: **You've been in this field for a long time. What's changed over the years?**

Albert: There have really been some great technical advances in technique and in helping with diagnosis and management. There is also the need to step back and see the bigger picture of how this requires a comprehensive approach from multiple disciplines so that the patient is not isolated, and not just in a medical sense. Patients are part of families and communities, and you need to be aware of that in order to try and help them be a functional part of their community. That's very important, particularly for patients with cleft lip and palate deformities, which you find all over the world.

The Scribe: **Can you talk a little about the FACES Foundation?**

Albert: The issue for most people is access to care. In a developed society, access to medical care is more readily available. But people without money or insurance and physical access to care, that's the group that I've been most interested in helping.

Photo courtesy of Thomas Albert, DMD, MD

That was the impetus for starting FACES. We wanted to concentrate on the most difficult to reach. FACES was founded on September 11, 2001, but it grew out of the work that I had done for many years with a hard-to-reach population in China. What I had seen was that most of the emphasis for the care of a child with a cleft issue was just surgery related. But in order to make them functional, so they can play with their friends, go to school, find a job, get married, you also need to help them with other things that are equally as important, like learning how to speak. Most patients after their surgery need help.

The Scribe: **Where is the foundation working now?**

Albert: We are currently very focused in northern Peru, up along the coast. It's a very needy area. We look for local community groups that help find and service these families, and we get the local ministry of health and medical facilities to help make the care delivery available. It's always an educational process for us.

For me, the most interesting part is reaching out and getting people involved. The thing that's really changed the world is, of course, the Internet and the connectivity we have now. People are not as isolated as they were before. We can do a lot of speech therapy over the Internet. We have been developing ways to get people from poor areas to an Internet site, and I get speech therapists who sit in my kitchen and do therapy on Skype or FaceTime, whatever. It's very interactive and the screen just kind of disappears. The results can be quite impressive.

The Scribe: **So advances in technology have been pretty helpful for this kind of work?**

Albert: The idea of staying connected is incredibly helpful. It's allowed us to follow patients before and after we go down, delivering care even though we're not there.

The Scribe: **Is the FACES Foundation all-volunteer?**

Albert: We are totally volunteer, just a small team mostly from OHSU and Kaiser. It takes people who are passionate about this. I've been really fortunate to find people who are good at what they do and are passionate.

The Scribe: **You've been doing this for more than 35 years now. Do you see yourself winding down anytime soon?**

Albert: I hope not. It's a privilege to take care of people. •

OHSU/INTEL *from page 3*

cellular circuitry linked to the progression of disease.

It still takes weeks and many thousands of dollars to analyze just a single patient's cancer profile. The team of scientists in the OHSU/Intel collaboration is focused on developing systems to accomplish that task in a matter of hours at a cost that is feasible for clinical applications.

OHSU's genomic analysis and imaging technologies, combined with adequate computing power, have the potential to illuminate how billions of genetic mutations interact in an individual's body over time to create tumors. The power of Intel's extreme-scale, high-performance computing solutions provides the capability to analyze this data at a cost that will eventually allow for clinical applications, and with lower power consumption than alternative technologies.

> "By combining Intel's computing expertise with what we know about how to analyze genomes and to create images of how cells change over time, **we believe we have the capability to develop** the right tools to make significant progress in making the promise of **personalized cancer medicine a reality** for more patients."
>
> —Joe Gray, Ph.D., associate director for translational research, OHSU's Knight Cancer Institute

A clearer, more detailed understanding of how this circuitry works may enable medical researchers to develop tools that detect cancer at earlier and more treatable stages, to create diagnosis and staging methods that more precisely guide treatment decisions, and to devise new treatments that more effectively inhibit the molecular triggers of the illness.

In the next phase, this data will then feed the team's more complex work of developing computer systems capable of analyzing how genomic abnormalities cause changes in the molecular architecture of cells and tissues in individual patients. This could help accelerate drug development and also lead to more precise, clinical diagnostic tests.

To process this unprecedented volume of complex biomedical data, and to ultimately increase the speed, precision and cost-effectiveness of analyzing a patient's genetic profile, requires a new level of computational horsepower.

An OHSU/Intel team of computer scientists, biophysicists, genomicists, bioinformaticists, biologists and other experts is developing a research data center equipped with an Intel supercomputing cluster that will demystify the root causes of cancer through genetic profiling of patients' tumors, identify patterns in how the disease progresses and use this information to find out how tumors will respond to treatment.

"This collaboration combines Intel's strengths in developing energy-efficient, extreme-scale computing solutions with OHSU's lead in visualizing and understanding complex biological information," said **Stephen Pawlowski**, Intel senior fellow and chief technology officer. •

Clarification—In the August *Scribe*, the Page One article about the Comprehensive Primary Care Initiative listed four representative payers participating in the CPCI initiative. Besides the four payers listed, Tuality Health Alliance and Teamsters Multi-Employer Taft Hartley Funds also are participating payers in CPCI.

Increase in sleep disorders leads to expanded services

By John Rumler
For The Scribe

If you are having difficulty sleeping, you have lots of company. And if you are not, the odds are that someone close to you is.

The National Heart, Lung, and Blood Institute estimates that 70 million people in the United States have some form of sleep disorder and about 30 percent of these are chronic conditions.

Nearly 40 percent of adults report falling asleep, without wanting to, at least once a month. Nationwide, 70 percent of adults report not getting sufficient sleep at least once a month, and 11 percent report insufficient sleep on a regular basis.

Area specialists agree that the numbers are rising—for a wide variety of reasons. Some of the major factors include the nation's burgeoning aging population and an obesity epidemic, while contributing causes of sleep loss include psychological issues, life changes, stress, illness, genetic factors and diet. And as the numbers increase, so have area services available to address these disorders.

If you think being a little short of sleep isn't a big deal, consider that sleep deprivation is associated with a two-fold increase in obesity, diabetes, hypertension, heart attacks, strokes, depression and substance abuse. In the elderly, sleep deficiency is linked to an increase in falls and broken bones.

Vivek Dogra, MD, medical director of Somnique Health, a sleep disorder clinic that opened earlier this summer in Southwest Portland, points out that, historically, loss of sleep has frequently played a role in human errors related to tragic events, such as ship groundings, nuclear reactor meltdowns and aviation accidents.

"Many poor sleepers believe they can get by with little or no sleep with no negative effects, but studies show this is not true," Dogra said. "Getting enough quality sleep is vital for mental and physical health, quality of life and also safety."

'Education is the key'

The causes of sleep loss are as many and varied as the disorders themselves. Some sources list more than 100 varieties of sleep disorders. However, there are six major categories: sleep-related breathing disorders, insomnias, hypersomnias, circadian rhythm disorders, parasomnias and sleep-related movement disorders. The health problems associated with sleep disorders can range from mild and minor to severe and even life threatening.

Unfortunately, many people with sleep problems do not seek medical help.

"Anyone of any age can be affected by sleep disorders," said **Chad Hagen, MD**, director of Oregon Health & Science University's Sleep Disorders Program, which gets upwards of 3,500 clinic visits yearly and conducts about 1,800 laboratory sleep tests and another 400 in-home tests annually.

The Portland metro area now has several sleep clinics, and the technology and treatments are becoming more advanced and effective. Vivek Dogra, MD, says patients treated for sleep disorders can see dramatic improvements.

Photo courtesy of Somnique Health

Hagen, who completed a sleep medicine fellowship at Stanford University, said about 40 percent of people who suffer from sleep apnea are undiagnosed. As Hagen explains, many people still don't think of a sleeping disturbance as a medical problem. Even if a person sees a doctor on a regular basis for an illness or condition, they often do not mention their sleeping difficulties.

CHAD HAGEN, MD

"Education is the key," he said. "Besides the health costs, sleep disorders affect a person's performance at work and at school and all areas of their lives."

Youngsters may be particularly vulnerable to sleep problems, as 25 percent of children between ages 1 and 5 and more than 40 percent of children ages 8 to 10 experience some sort of sleep disturbance.

"In pediatric sleep medicine, the entire family's well-being may be at stake," said **Teng Ji, MD**, a pediatric neurologist and pediatric sleep specialist at Randall Children's Hospital Sleep Center, which opened in April. "If a child can't sleep, it can keep everyone else in the house awake as well."

TENG JI, MD

The two-bed facility, designed for children and young adults as well as their parents, is located on the Legacy Emanuel Medical Center campus.

"As a fourth-year neurology resident, by chance, I took a rotation in sleep medicine and became fascinated," Ji said. "I realized that pediatric sleep medicine is a much-needed service in the community."

The diagnosis and treatment of sleep disorders have come a long way. After a detailed medical/sleep history, including medications and diet, is obtained, a treatment may include a polysomnograph, which examines REM and sleep cycles (sleep-study-graph similar to an EEG), continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP). While much progress is being made in the non-pharmacological treatment of sleep disorders, options often include a variety of medical and surgical remedies.

In late September, the National Sleep Foundation unveiled the latest weapon in the battle against sleep disorders: an anatomical model of a human head that helps primary physicians and sleep specialists educate patients about sleep disorders. The model opens in two halves, one to show normal sleeping patterns and another to show the disruption caused by sleep disorders. Sleep disturbances and apnea are often difficult for patients to understand, said **Meir Kryger, MD**, the model's designer.

"The model clearly, simply and visually demonstrates what is happening with the tongue and throat," said Kryger, the first to diagnose and report obstructive sleep apnea in North America. "It's a win-win for everyone."

A public health epidemic

As sleep disorders continue to increase in the United States, so do the problems and hazards they bring. A loss of sleep can lead to diminished alertness along with a slower reaction time, a dangerous combination.

Between 20 percent and 25 percent of serious vehicular accidents involve a sleep-deprived driver. A significant number of household and work accidents involve men and women with sleeping problems. Sleep disorders and the related accidents, loss of productivity and work costs billions of dollars annually.

*See **SLEEP,** page 12*

Medical office market healthy; retail locations continue their popularity among tenants

By Alexandra Ionescu
For The Scribe

Alexandra Ionescu, a Real Estate Broker with NAI Norris, Beggs & Simpson, recently shared with *The Scribe* her perspectives on the area's medical office market.

The Scribe: **What is the current state of the medical office market in the Portland metro area, and what trends are affecting the local market?**

Ionescu: Portland's medical office market is healthy, with steady demand, vacancy slowly falling and rental rates rising. During the recession, landlords were more likely to provide concessions, such as generous tenant improvement packages and free rent, to attract tenants, but landlords today have regained leverage. New construction of medical office space is also a positive sign.

One of the major trends in the market is medical tenants leasing retail space, rather than traditional office space. This trend started during the recession, as medical tenants who wouldn't have traditionally been able to afford more expensive retail rates were able to because of landlord concessions. But even as rates have risen, medical tenants continue to be interested in retail. They want to be in locations that are convenient to their patients and have high visibility, such as on busy retail corridors.

Certain submarkets are performing better than others in terms of medical space. The Sunset Corridor, for instance, has seen strong demand and absorption. This strength can be attributed partially to Nike's and Intel's expansions, which have triggered an increase in optimism and other tenants feeling a little more confident when considering expansion in these areas.

The Scribe: **What advice would you give medical providers before they start their search for office space and when considering a particular space, and what considerations should they keep in mind before and when signing a lease?**

Ionescu: The first step for a medical provider that I would recommend would be enlisting the services of a qualified commercial real estate broker who has plenty of experience with medical leasing. A broker can represent the tenant's interests and facilitate the transaction throughout the process, saving tenants time, and often, money. In the Portland market, it's typical for a landlord to pay the tenant's representative, so it is truly a great benefit.

I also recommend getting several construction bids for tenant improvements. Working with space planners that are experienced in the medical arena is a great idea as well, as they can help guide in planning decisions and reduce costs where possible.

The Scribe: **For medical providers who are landlords, what factors should they keep in mind in this current market regarding leases and working with tenants?**

Ionescu: Landlords should know that tenants are becoming increasingly sophisticated and are often shopping around in the market to compare and contrast

*See **ASK THE EXPERT,** page 13*

Risk Management

Frequently asked questions: The Americans with Disabilities Act

This article, courtesy of The Doctors Company, is part of a series focusing on patient safety/risk management issues.

By Laura A. Dixon, BS, JD, RN
For The Scribe

The Americans with Disabilities Act, or ADA, evolved from the Civil Rights Act of 1964 and the Federal Rehabilitation Act of 1973. The ADA's goal is to eliminate discrimination against persons with disabilities and provide enforceable standards to address such discrimination.[1]

The ADA protects individuals with a disability, which is defined as an individual with a physical or mental impairment that substantially limits one or more of the major life activities, a record of such impairment, or being regarded as having such impairment.[2] A major life activity includes caring for oneself, breathing, learning and working.[3] Not everything that restricts a person's major life activities is an impairment.[4] Examples include obesity (unless there is a physiological disorder), hepatitis A and side effects from certain drugs. A similar provision is the Department of Health and Human Services (HHS) Guidance Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Person. The policy is a guide, not a regulation. The purpose behind the guide is to provide limited English proficient (LEP) persons with meaningful opportunity to participate in HHS-funded programs by requiring recipients of federal financial assistance from HHS to take reasonable steps to ensure LEP persons have access to such services.[5] Recipients of HHS assistance do not include providers who only receive Medicare Part B payments.[6] The following questions and answers are designed to assist a physician when presented with a disabled or LEP person in his or her clinic.

Question: **I occasionally see HIV-positive patients, including some who require minor surgery that can be completed in my office. May I require that these patients be treated as an in-patient for enhanced infection control purposes?**

Dixon: No. HIV-infected individuals are protected under the ADA. Because you would be providing disparate treatment from that given to noninfected individuals, requiring a hospital admission and stay for minor surgery that can be completed in your office is prohibited. Universal precautions, designed to reduce the possibility of transmission of the HIV virus, are to be implemented and utilized for all patients.

Question: **May I terminate a disabled patient from my practice?**

Dixon: Yes, but only for appropriate reasons. Termination due to the patient's disability is prohibited. However, termination for reasons other than the disability, such as the patient's failure to pay the bill or his or her disruptive behavior unrelated to the disability, is permitted.

Question: **One of my patients has fibromyalgia and is demanding pain medication in amounts in excess of what I feel comfortable providing. I sent a termination letter, but he responded by saying that I could not terminate him because he is disabled. Is the patient correct?**

Dixon: Possibly. As with any ADA issue, there must be a careful examination of the conduct at issue and the reasons for the termination. If you terminated the physician-patient relationship based upon the patient's disability, the patient is correct. However, if the termination was due to an appropriate reason (such as learning that the patient had forged a prescription to obtain medication), then you are correct. In this situation, it may be best to refer the patient to a pain management provider to address the chronic pain issues.

Question: **One of my patients was recently diagnosed with multiple sclerosis. I am a family medicine physician with very limited experience with this condition. Her symptoms are minimal now but are rapidly progressing to a point that will be beyond my expertise. I have explained to the patient that she will need to seek care elsewhere, but she stated I am required to care for her and her MS. Is this true?**

Dixon: No. Although courts have held that ADA requires physicians to treat patients with disabilities, cases involving this issue are very fact-specific. For this situation, it could be deemed an undue burden for you to provide care for the patient's multiple sclerosis. Additionally, you may refer the patient as she is seeking care outside of your specialty (and if in the normal course of operations, you would make a similar referral for a patient who requires the same treatment).[7] As this patient's disease process will reach a point outside your expertise, prudent practice and standard of care suggest that her care should be transferred to a physician with such expertise.

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.

Question: **I have a deaf patient with whom I exchange handwritten notes during examinations as a form of communication. Though it is time consuming, effective communication occurs. The patient is demanding that I provide and pay for a sign language interpreter as it is now too cumbersome for her to write notes. Am I required to pay for the interpreter?**

Dixon: Yes. To be in compliance with ADA, the patient can select the method of communication that serves his or her needs, including an interpreter, unless you can demonstrate that providing the interpreter would result in an undue burden; i.e., significant difficulty or expense.[8] No charge can be made back to the patient or family for the service.[9]

Question: **As a solo practitioner who accepts Medicare/Medicaid patients, am I required to comply with the LEP requirement for interpreters?**

Dixon: Yes. The exception is if you only receive Medicare Part B payments. To determine the extent of your obligation, analyze the following four factors:

a. The number or proportion of LEP persons served or encountered by your clinic. The greater the number the more likely language services will be needed.
b. The frequency with which LEP persons come into contact with your clinic. Even if unpredictable or infrequent, there must be a plan for obtaining interpretive services.
c. The nature and importance of your services. The more important the services or greater the consequences, the more likely interpreter services will be needed. Also, determine if a delay in accessing your services could have serious or life-threatening implications.
d. The resources available to you and the cost. As a solo provider, you are not expected to provide the same level of service as a large, multi-specialty group, but you are nonetheless still required to take reasonable steps to provide the service. Investigate technological services or sharing resources with other providers.

Question: **May a family member act as an interpreter for a hearing-impaired or non-English speaking patient?**

Dixon: Yes, but it is recommended only as a last resort. Lay personnel are rarely familiar with medical terminology and its nuances. Additionally, the patient may not want a family member to have access to his or her health information. If care is needed on an urgent or emergent basis and an interpreter is not available, a family member can be utilized. Also, if the patient

*See **RISK MANAGEMENT,** page 12*

Physicians experience a fine blend in medical practice, wine

By Jon Bell
For The Scribe

Oregon's wine scene includes a colorful blend of farmers, aficionados, entrepreneurs and epicures. There are more than a few physicians who dabble in fermented grapes, as well. Here's a look at two who have done more than dabble.

Joe Campbell
Elk Cove Vineyards

Joe Campbell, MD, and his wife, Pat, founded Elk Cove Vineyards in 1974 and produced their first wines three years later after a trip to France inspired them. Today, their son, Adam, runs the vineyard full time, producing 50,000 cases a year that are sold in nearly every U.S. state and at least 10 foreign countries.

Photo courtesy of Anna M. Campbell

Three years into his history degree at Harvard University, **Joe Campbell, MD**, decided he wanted to change course.

Inspired by a Hood River doctor who had basically saved Campbell's brother, who had polio, Campbell switched gears and went into medicine instead.

"That was really one of the instigating factors," said Campbell, who considered himself lucky to have had a full ride to Harvard and also to medical school after that at Stanford. His medical career eventually led him into internal and emergency medicine, and he ended up in the emergency department at Providence Portland.

While at Stanford, Campbell would spend his weekends traveling to wineries in the Napa and Sonoma valleys and sampling wines. His wife, Pat, had grown up on an orchard in Hood River. When the two appreciations mixed together, it seemed only natural that they might try their own hands at growing grapes.

After a visit to Oregon in 1971, the couple purchased some land in the Willamette Valley near Gaston. They planted their first vines and founded Elk Cove Vineyards in 1974, a time when Campbell would put in long hours in the emergency department and then come home and hop on the tractor.

"I was in my early 30s then and I've always been physically active," said Campbell, now 75, "so I was able to balance both."

It was also a time when the words "Oregon" and "wine" were unlikely to be found in the same sentence. Campbell said he and seven or eight others—pioneering vineyards with now-familiar names such as Eyrie, Sokol Blosser, Erath, Ponzi and Adelsheim—were about all that made up the burgeoning scene.

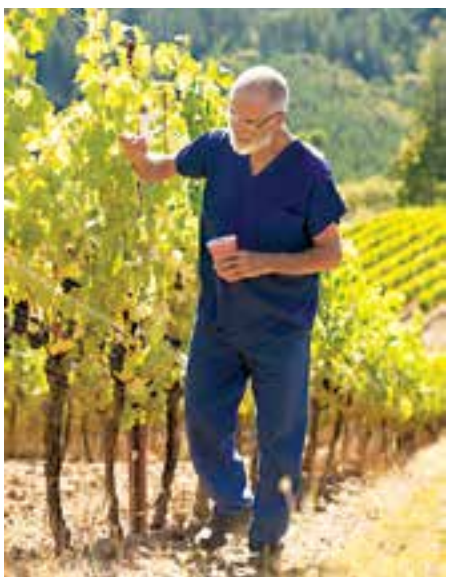
"There were just a handful of us, so there was a lot of information sharing and working together," he said. "I don't think any of us anticipated the scale of what would happen."

Though the Campbells' initial plan was to start out growing grapes, after a trip to France they got inspired and began reading everything they could get their hands on about making wine. Elk Cove's first wines came out in 1977.

Campbell continued to make wine and work in medicine for the next 20-plus years, growing Elk Cove into a renowned winery producing more than 15,000 cases a year. In 1999, Campbell and his wife began to step back from the day-to-day operations of the winery, and their son, Adam, took over as winemaker. He's grown the winery into a 50,000-case-per-year operation that sells its wines in nearly every state and at least 10 foreign countries.

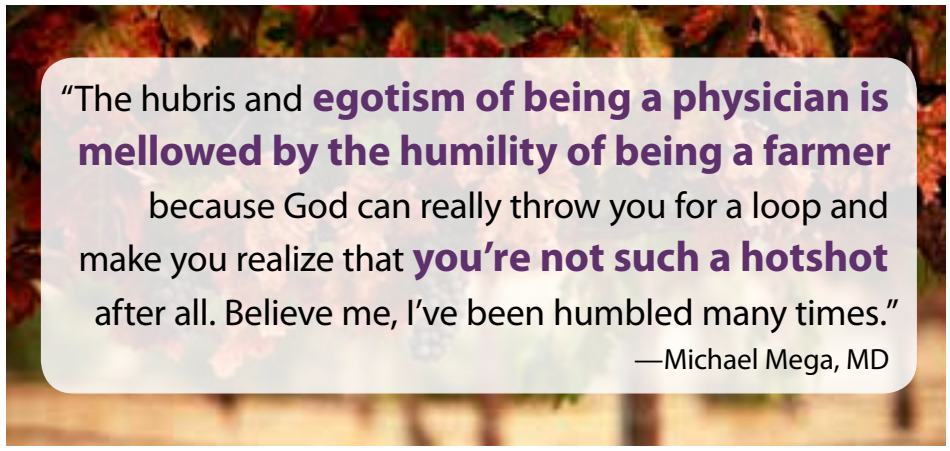
Campbell has also stepped out of the emergency room, but only recently. His final shift was last December, though he still works a few days a month in a nursing care clinic in McMinnville. In the years leading up to his retirement, Campbell had also begun to focus more on medical missions. Working with Medical Teams International, he has helped out in Guatemala, Nicaragua, Sri Lanka, South Sudan and in New Orleans after Hurricane Katrina. This fall, he's heading to Uganda to work in a refugee camp.

Campbell has put his winemaking history to work to help people in Peru, as well. After working in a clinic in Arequipa, Campbell began sending



In 2007, Joe Campbell, MD, launched Condor Wines Northwest and sells its top-tier wines to raise money for a hunger relief program in Peru. To date, the effort has raised more than $100,000, which helps feed at least 600 people one meal a day, 365 days a year.

Photo courtesy of Anna M. Campbell



annual financial donations. Then in 2007, he launched Condor Wines Northwest, which produces limited-edition, top-tier wines—only 100 cases per vintage—and sells them to raise money for a hunger relief program in Arequipa. To date, the effort has raised more than $100,000, which helps feed at least 600 people one meal a day, 365 days a year.

Michael Mega
Nysa Vineyards

If not for a promise he'd made to himself, **Michael Mega, MD**, may have gone straight into the world of wine and never become a neurologist.

A Midwesterner who majored in philosophy and neuroscience at the University of California, Santa Barbara, Mega promised himself that if he didn't make it into medical school on the first try, he'd head straight for the enology program at U.C. Davis. He never had to make that move since he got into George Washington University on his first attempt.

But Mega never lost his love for winemaking, particularly French-style pinot noir, something he'd fallen hard for after falling equally hard for a Parisian girl while he was an undergrad. Mega later toured wine cellars in Paris with the girl's father, who introduced him to wines from Burgundy.

"He developed my pallet for the best pinot noir grown in the world," Mega said.

Not a fan of the heavy and rich pinot noirs of California, Mega caught wind of pinot's promised land in 1986—Oregon—and spent his free time flying from medical school in Washington, D.C., to Portland to scour the Willamette Valley for land. He found 40 acres in 1989 while he was in residency at Boston University, and planted the first 10 acres on a hilltop property in Dundee the next year. Mega also completed a fellowship in brain mapping at UCLA and joined the staff of the neurology department there, moonlighting in emergency rooms to help pay for his growing vineyard. He moved to Oregon in 2003 and joined the Providence Brain and Spine Institute, where he directs the Cognitive Assessment Clinic.

He's very focused on his vineyard, named Nysa Vineyard after the mythical land where nymphs taught the Greek god of wine, Dionysus, his craft. Mega dry farms his vineyard, which means no irrigation for the vines. The practice forces the strongest vine roots to seek water and nutrients much farther below the ground, thus producing more complex characteristics in the fruit.

For the first few years Mega learned from other winemakers at Panther Creek, Bethel Heights and Ken Wright Cellars, who made their versions of Nysa. Since 2004, he has been making wine from a small portion of the vineyard himself—about 500 cases a year—selling it to high-end restaurants and wine shops, while still providing Nysa's fruit to other producers.

In addition to his passion for wine, Mega said getting his hands dirty farming is a welcome counterbalance to his focus on research and neurology. The hard reality of Mother Nature keeps his ego in check, he said.

"The hubris and egotism of being a physician is mellowed by the humility of being a farmer," Mega said, "because God can really throw you for a loop and make you realize that you're not such a hotshot after all. Believe me, I've been humbled many times."

Nysa has done quite well so far—so well, in fact, that Mega is approaching a crossroads in his medical career. He is currently building a winery and tasting room at the vineyard, which should be completed within the next year.

"I love helping patients," Mega said. "Making wine and cultivating the vineyard is my artistic outlet, but it has started to exceed my expectations."

He said there is one possibility that could solidify his choice between medicine and vino in the not-too-distant future: a cure for Alzheimer's. Mega said he's optimistic that there will be a breakthrough drug on the market within the next five years. In addition, the Food and Drug Administration's approval of an early Alzheimer's brain scan last spring could render the cognitive evaluations that Mega specializes in unnecessary.

"So I may be out of a job anyway," he said, "but with Nysa, I've got a very satisfying fallback option." •

What hobby or activity do you enjoy in your off hours? Visit the Members Forum section at msmp.org to respond.

SLEEP from page 8

But the hidden costs may be almost inestimable, said Dogra, who completed his internal medicine residency at Kingsbrook Jewish Medical Center in Brooklyn, NY, before his two-year research fellowship in cardiology at OHSU. He also completed a critical care fellowship and a sleep fellowship at OHSU.

"There's all of that, plus the added costs of treating other health problems people get from not sleeping well, such as heart and kidney diseases, high blood pressure, diabetes, strokes, obesity and depression."

A lack of sleep is related to numerous ailments including headaches, painful joints and stomach troubles, Dogra explained, and sleep disorders can contribute to heart complications, lung conditions and diabetes.

"It can also erode the mental well-being of persons stricken and may lead to mood changes, anxiety, eating disorders and depression," he added.

The Centers for Disease Control and Prevention states that insufficient sleep is a public health epidemic and has collaborated with the National Center on Sleep Disorder Research on two major studies that provide further evidence that insufficient sleep is an important public health problem.

Fortunately, the awareness of the serious toll of sleep disorders is gradually increasing. The Portland metro area alone now has in the neighborhood of a dozen sleep clinics, and the technology and treatments are becoming more advanced and effective.

Even though sleep medicine is still a relatively new field, many people are finding relief, Dogra said.

"Being a sleep medicine physician is gratifying because the results can be almost immediate. Patients really appreciate the fact that they are sleeping better and sometimes it changes their lives dramatically and that is a great feeling for me as a physician." •

Teng Ji, MD, is hosting a talk, "My Big Kid Can't Sleep," about sleep issues in children ages 7–12, on Nov. 5 at McMenamins Cornelius Pass Roadhouse, Hillsboro. For information, please call 503-413-5240 or register at legacyhealth.org/classes.

RISK MANAGEMENT from page 10

consents and you believe translation or interpretation is adequate and correct, a family member can be used. The family member should be an adult unless such a person is not available and immediate care is necessary to prevent further harm or injury to the patient. Otherwise, it is recommended that you have a clinical staff member trained to provide interpretation or utilize certified interpreter services to ensure proper translation of medical information. The local hospital should have a list of qualified interpreters.

Other resources include a local nationality society, the national Registry of Interpreters for the Deaf at 703-838-0030 or the local center for the deaf.

Additionally, it is recommended you have consent forms, especially those for invasive procedures, translated into the applicable non-English languages by a certified translator for proper interpretation. •

Laura A. Dixon is patient safety/risk management account executive with the Rocky Mountain and Northwest Regional Office. The Doctors Company is the nation's largest insurer of physician and surgeon medical liability. For information on its innovative patient safety products and services, please call 800-421-2368, x1243, or visit thedoctors.com/patientsafety.

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2. Ibid.
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Have you experienced a situation involving a patient and the Americans with Disabilities Act?

Visit the Members Forum section at msmp.org to respond.

ASK THE EXPERT *from page 9*

various space options available to them. It is critical that landlords respond in a timely manner and offer competitive market terms in order to gain the advantage.

During the recession, more landlords of traditional office buildings were willing to compete for medical tenants and accommodate the larger tenant improvement requirements needed, in an effort to gain a long-term credit tenant. While this is not typically common and medical tenants like to be a part of a community of health care providers, it is important for landlords to be aware of this trend, and of the other options in the market.

The Scribe: **What is the outlook for the medical office market in the metro area, what factors (health reform, patient demographics, for example) will affect the market going forward, and how can tenants and prospective tenants best be prepared?**

Ionescu: The outlook for the medical office market in the Portland metro area is strong, as the area's population continues to grow and the overall economy and commercial real estate market improve. The Affordable Care Act will certainly have an impact on the market, and many experts predict that it may lead to an increase in demand for medical office space. When the health insurance mandate takes effect in 2014, for instance, millions of previously uninsured Americans will have insurance and may seek care, increasing space needs. The aging baby boom generation's mounting health care needs are also expected to boost demand.

Tenants and prospective tenants can best be prepared by enlisting the services of a knowledgeable real estate broker, and starting the leasing process early to ensure that they can educate themselves about the market and have plenty of time to explore their options. •

Alexandra Ionescu is a Real Estate Broker specializing in medical and conventional office leasing and sales with NAI Norris, Beggs & Simpson. She can be reached at 503-273-0314 or aionescu@nai-nbs.com.

Scores: Viewed as "a resource, a tool"

IMPROVEMENT *from page 1*

and two physician assistants. "In today's world, people are looking for feedback as to good and bad and how other patients view the doctor. This isn't information you can hide from; it should be public knowledge. Patients feel, 'You could do better on this. What do you plan to do to improve?'"

McKeon said the group views its voluntary participation in Quality Corp.'s patient satisfaction scores as "a resource, a tool" to help the physicians learn what they are doing well and where they could improve. The measure allows The Doctors' Clinic to compare how it did with other clinics of similar type and size in the Salem area, as well as in Oregon generally, he said.

'Pioneering spirit'

The dissemination of public scores for primary care clinics is just one of several initiatives in which Quality Corp. continues to make waves on the Oregon health care scene.

Since its founding in 2000, the organization has focused on producing unbiased information and leading community collaborations toward improving quality and making care more affordable.

In its earliest years, Quality Corp. focused on developing, measuring and reporting health care quality, said **Mylia Christensen**, executive director. "We provided that information for the first time in Oregon," she said.

MYLIA CHRISTENSEN

For the past seven years, Quality Corp. has produced its annual "Statewide Report on Health Care Quality, Information for a Healthy Oregon." The report (www.Q-Corp.org) assesses measures for preventive health screenings, hospital use, pediatric care and diabetes and other chronic disease care.

"We are unique compared with others, with the largest comprehensive database in the state" that tracks quality over a period of years and covers 2 million Oregonians, even when they change health plans or coverage, Christensen said. The effort has become a national model for translating data from multiple health plans into information consumers can use to make decisions about their care, she said.

An important new project this year for Quality Corp. is participation in the Patient-Centered Primary Care Institute (www.pcpci.org). It is a public-private partnership among Quality Corp., the Oregon Health Authority and Northwest Health Foundation. The purpose of the institute is to serve as a central resource for medical groups that want to become recognized medical homes, as well as ones that already have achieved that status but want to advance to higher levels of recognition, said **E. Dawn Creach**, a policy analyst with the Oregon Health Authority.

The institute offers free resources to doctors and medical group managers, such as webinars and learning collaboratives. Twenty-five clinics participate in learning collaboratives around the state, working together to share their experiences with primary care home transformation, Creach explained. They meet face to face three times a year and are paired with technical assistance experts to help clinics achieve their goals. The 25 clinics are organized under four groups, some geographically based and others by practice emphasis, such as pediatrics.

E. DAWN CREACH

Creach has observed a variety of motivations for medical clinics—425 of them so far in Oregon—to become a medical home, including marketing advantages, payment incentives by payers, encouragement of public employees to seek care from certified clinics, and recognition that the process of obtaining recognition leads to better care for their patients. Also, clinics "are very competitive with each other—they all want to say, 'We are a patient-centered medical home.' A lot of them are incredibly proud."

Kate Elliott, program manager at Quality Corp. responsible for organizing the webinars and learning collaboratives, said subject matter is selected based on what information clinics say they need and want. An example of a webinar title offered was "Engaging Patients in Quality Improvement Initiatives."

"People like to hear stories about how other clinics do things and how others in the same specialties do things," Elliott said. One topic recently added is a program about behavioral health, which has drawn a lot of interest from clinics seeking to learn how to integrate that into their primary care setting.

Executive Director Christensen said the fact that Quality Corp.'s measurement and reporting of quality data have been imitated or followed by other groups demonstrates her organization's "pioneering spirit." Such reporting now is recognized by the public as important, and it "allows purchasers to be more informed," she said. •

Do you believe public reporting is improving the quality of health care in Oregon?
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