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Making strides in HIV/AIDS research

Louis Picker, MD, and his team at OHSU have made huge progress toward an HIV vaccine by harnessing T-cells. Read about the advancements, Picker's background and the story behind his work focusing on HIV/AIDS vaccines.

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Oregon develops catastrophe response guidance

Document called 'profound step forward' in educating medical community

By Cliff Collins
For The Scribe

At a large health preparedness conference in fall 2008, attendees concluded that a regional, coordinated process needed to be developed to respond to disasters.

But it was H1N1, a strain of influenza that caused widespread illness in many parts of the world during 2009, that proved to be the catalyst in spurring people to action. Many health care workers asked for statewide guidance on how to respond effectively when a major threat occurs.

"It got close enough, for a lot of people, to become much less theoretical and a lot more real," said **Richard F. Leman, MD**, medical epidemiologist and chief medical officer of Health Security, Preparedness and Response at the Oregon Public Health Division.

The Institute of Medicine and the federal Agency for Healthcare Research and Quality had been urging states to develop catastrophe response plans to prepare to treat "large numbers of people who are sick or injured when resources are limited and there is a severe, sustained, pervasive surge in health care needs," Leman said.

RICHARD F. LEMAN, MD

Once the H1N1 flu pandemic struck, efforts shortly afterward got underway to develop a comprehensive strategy document, released earlier this year and called **"Crisis Care Guidance for the State of Oregon: A Framework for Healthcare Response in a Public Health Emergency."**

In response, the Public Health Division convened work groups to develop strategies to address two main types of disasters: severe outbreaks of infectious disease, such as an influenza pandemic; and mass trauma events, such as a major earthquake. Such recommendations would take effect if, after such an event or series of events, the need for resources exceeded supplies, equipment and staff.

The guidance applies to allocation decisions made at different levels of government, as well as in the nonprofit and private sectors, and encompassed work already done in several regions and health systems around the state. It outlines strategies that help standardize response, but also allow sufficient flexibility that they can be adapted to meet the needs of different facilities and communities.

Over three-plus years, the proposed guidance was developed through extensive collaboration involving experts from across Oregon representing many disciplines, including medicine, nursing, emergency medical services, hospitals, public health, medical ethics and others. Participants contributed time and ideas within six different work groups. Through a series of meetings and revision of drafts via email, the contributions from each group were combined into a comprehensive document.

One of the overriding objectives was "the idea of developing ethically grounded guidance" to respond to a health crisis, Leman said. An ethical framework, developed by members of an ethics work group, was intended to ensure that ethical principles were addressed in the development of all care strategies included in the document. "It also has provided work groups with a common ground to help assure that the guidance presented will not only help save lives, but will also be just and equitable," according to the document.

Health systems and medical professionals are preparing for natural disasters and manmade crises through drills such as this one staged at Providence Portland Medical Center, and an anthrax disaster drill last May. Crisis care guidelines, recently endorsed by MSMP, also aim to help health care workers across Oregon respond effectively when a major crisis occurs.
Photo courtesy of Providence Health & Services

"Further, emergency managers have a duty to promote ethical allocation of scarce resources in a public health emergency," the document reads. "Such guidance could help identify ways to provide efficient care in challenging circumstances and help save many people who might not otherwise survive."

Under the plan, hospitals would designate experienced providers to serve as triage officers who are responsible for making these decisions. Access would depend on which patients have the greatest medical need and the best chance of survival if they receive hospital support.

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Off Hours

From soaring to sowing, Sara Kristine Becker, MD, savors endless challenges.

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OMA leads statewide appropriate-care effort

Choosing Wisely
An initiative of the ABIM Foundation

Choosing Wisely campaign stresses 'shared responsibility' between physicians, patients

By Cliff Collins
For The Scribe

Perhaps the biggest message the Choosing Wisely campaign is trying to convey is that deciding on what constitutes the right care is a two-way street between physicians and their patients.

"Really, Choosing Wisely is about having these conversations, more than anything else," said **Cassandra Dictus**, program coordinator for the Oregon Medical Association. The OMA is one of 21 organizations nationally that were awarded a two-year grant from the American Board of Internal Medicine Foundation to promote its Choosing Wisely campaign.

"Both doctors and patients are involved here; this really is a shared responsibility," said **John Santa, MD, MPH**, director of the Health Ratings Center for Consumer Reports, an organization that is a key participant in the Choosing Wisely campaign. "You have patients asking for stuff they don't need," requests oftentimes inspired by advertising by drug companies, hospitals and doctors, he said.


JOHN SANTA, MD, MPH

Many physicians have heard about Choosing Wisely, but they may not know that Consumer Reports has created a host of materials to use when discussing potential treatments with patients, Dictus said. "It's a hard conversation to have," but being able to present evidence-based recommendations made by national specialty medical societies gives physicians a valuable resource, she said.

The OMA, as part of the campaign it is sponsoring in Oregon, also provides numerous other resources on a designated website, www.consumerhealthchoices.org/oma, to give doctors practical information about how to apply the specialty groups' recommendations. An example is a video that addresses how to incorporate decision discussions into short patient visits.

"It's impressive that in three or four minutes of good conversation, you can express concerns about overuse of tests," said Santa, formerly a trustee of the Medical Society of Metropolitan Portland and a former Portland internist and physician administrator in Oregon. "It takes focused and effective communication. Not to say it's easy to do, but our experience has been that the combination of (tests) being overdone *and* unsafe is very compelling to patients."

The concept of false positives is difficult to explain to patients, Santa acknowledged. Patients usually are aware that drugs or surgery involve risks, but they don't think the same about preventive or screening tests.

The campaign stresses that they should. According to a report from the Institute of Medicine, as much as 30 percent of health care spending is duplicative or unnecessary. Health reform places great emphasis on the overuse of health care resources, noting that some routine tests and procedures may provide little, if any, benefit to patients, and also can cause harms such as needless stress and unnecessary radiation exposure.

For Choosing Wisely, more than 50 contributing national specialty societies produced lists of "Five Things Physicians and Patients Should Question," covering more than 140 tests and procedures. The resulting lists for each medical specialty offer specific, evidence-based recommendations physicians and patients should discuss to help make decisions about appropriate care based on each patient's situation.

A prime example was supplied by the Society of General Internal Medicine. Like the other specialty groups, it made recommendations to educate patients and physicians about what practices are:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

Among the society's "Five Things Physicians and Patients Should Question," it listed this: "Don't perform routine general health checks for asymptomatic adults." The organization goes on to explain: "Routine general health checks are office visits between a health professional and a patient exclusively for preventive counseling and screening tests. In contrast to office visits for acute illness, specific evidence-based preventive strategies, or chronic care management such as treatment of high blood pressure, regularly scheduled general health checks without a specific cause, including the 'health maintenance' annual visit, have not shown to be effective in reducing morbidity, mortality or hospitalization, while creating a potential for harm from unnecessary testing."

Another example, from the American Academy of Family Physicians: "Don't routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam." This recommendation goes even beyond that of the U.S. Preventive Services Task Force, which doesn't endorse routine PSA screening but stops short of including the digital exam.

Santa pointed out that one of the most significant recommendations came from both the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists. The two concluded that doctors should cease doing elective deliveries before 39 weeks or inducing labor before signs appear that the cervix is ready.

Given that defensive medicine and liability concerns are major drivers of medical overuse, this recommendation should be eye-opening to ob-gyns, he said, because, statistically, babies delivered too early have poorer outcomes. Besides, discussing with patients risks and benefits is the best defensive medicine, he added.

Related to that, on the OMA's campaign site is a resource produced by the American College of Physicians, discussing liability concerns and noting that defensive medicine does not protect physicians from malpractice lawsuits.

The OMA is employing a broad strategy to spread the word to doctors and the public about Choosing Wisely, Dictus explained. Its monthly membership newsletter, *Stat*, will carry articles each issue for the next two years, and the association will produce news releases throughout the two-year campaign. Also in the works are emails targeted at OMA members by specialty that include their specialty society's recommendations and pamphlets for patients. Plus, "We're working to integrate Choosing

See ***CHOOSING WISELY,*** *page 11*

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Louis Picker, MD

OHSU researcher, focusing on T-cells, blazes promising trail in fight against HIV/AIDS

In the early 2000s, unlike most HIV vaccine researchers, Louis Picker, MD, focused on the potential of T-cells to fend off the virus that causes AIDS. Recently, the journal *Nature* published research results showing that the vaccine candidate developed at Picker's lab, which has so far only been tested on monkeys, is capable of entirely wiping out AIDS-causing viruses in the body. Photo by Oregon Health & Science University

By Jon Bell
For The Scribe

For a long time, people thought **Louis Picker, MD**, was crazy.

Not because of any wild behavior or odd habits, but because of the way he was thinking about a vaccine for HIV. In the early 2000s, when most HIV vaccine researchers were looking toward antibodies as the only answer, Picker turned instead toward T-cells and how they might be harnessed to fend off HIV the way they do some other infections.

"There were a lot of challenges because people thought I was nuts to pursue that," said Picker, associate director of the Oregon Health & Science University Vaccine and Gene Therapy Institute.

During the past 13 or 14 years, however, those thoughts have slowly dissolved as Picker and his research team at OHSU have made huge progress toward an HIV vaccine based off the T-cell theory. In September, the journal *Nature* published research results showing that the vaccine candidate developed at OHSU, which has so far only been tested on monkeys, is capable of entirely wiping out AIDS-causing viruses in the body.

"The world is desperate for something that will work," said **Klaus Früh**, a senior scientist and professor of molecular microbiology and immunology at OHSU's Vaccine and Gene Therapy Institute. "What Louis has done is spectacular. There's never been a vaccine as effective as his."

Drawn to science

Raised in California near UCLA, Picker was always naturally drawn toward science.

"I found it easier than English, so that's what I moved toward," he said.

Picker started taking microbiology classes in college at UCLA and became fascinated with the world of viruses, fungi and protozoa. He also got interested in the immune system and realized that medical school would be the best way to pursue that path. After graduating from UCLA in 1978 with a bachelor's in bacteriology, Picker went to medical school at the University of California at San Francisco. His residency was at Beth Israel Hospital in Boston, and he did four years of postdoctoral training at Stanford before landing a faculty position at the University of Texas Southwestern Medical Center in 1990.

All along, Picker had been interested in HIV/AIDS. During his studies in the 1990s, Picker began to wonder if there would be a way to trigger an immune response to HIV similar to those that kick in for other infections. HIV does in fact trigger an immune response from the body, Picker said, but because of the way HIV works, the response is too slow. By the time the response kicks in, the virus has already replicated so fast that the immune system can't catch up.

"We needed a fundamentally different kind of vaccine that would be there from the beginning," he said, "something that keeps the soldiers always armed and ready to go."

Picker's idea was to create a vaccine that would trigger the same kind of immune response that the common virus cytomegalovirus (CMV) does. To achieve that would require creating a vaccine vector that combined CMV and HIV.

Testing such a hypothesis is not exactly easy, however, especially on humans. But Picker had another option: monkeys, like those at the Oregon National Primate Research Center at OHSU. He joined OHSU in 1999.

'Extremely focused'

Since then, Picker's work has been largely focused on HIV/AIDS vaccines, including the creation of a vaccine vector that combines CMV with simian immunodeficiency virus (SIV), which causes AIDS in monkeys. Through Picker's experiments, monkeys were given the vaccine and then infected with highly pathogenic SIV. Half of those monkeys became infected with SIV but, over time, all traces of the virus in those monkeys were eliminated by "effector memory" T-cells. The lab is now trying to understand why the vaccine only worked in half the cases so that it can be improved.

"The **world is desperate** for something that will work. What Louis has done is spectacular. There's **never been a vaccine as effective** as his."

—Klaus Früh, *OHSU's Vaccine and Gene Therapy Institute*

Once researchers answer those final questions and finish up some fine-tuning, Picker said work will turn toward safety and clinical trials. The very first clinical trials are still probably three years out, and it could in theory be another 10 before a vaccine could be available. The ultimate goal, Picker said, is a vaccine that could be used both preventatively—in adolescents before they become sexually active, for example—and in a therapeutic setting that would help people already infected with the virus. Picker's approach to vaccines could also likely transfer to other infectious diseases like malaria and tuberculosis.

One of the biggest hurdles now is funding. The work and trials from here on out will easily cost millions, if not hundreds of millions, of dollars.

"My primary job right now is fundraising," Picker said. "We could shave years off of this if someone would just hand me the money, but that's not how it works."

According to Früh, if there's anyone who will be able to see this project through to fruition, it will be Picker. The two have worked together closely at OHSU since 2000, and Früh and his team will play a big role in transitioning the vaccine from monkeys to humans in the coming years.

"Louis is extremely focused. He's the kind of person who has a goal and then follows it and makes it happen," Früh said. "I've always admired that in him."

Though Picker's work in HIV/AIDS vaccines seems all-consuming, it's not, entirely. A married father of six, Picker stays busy with his children, four of whom live with him, including a 3-year old. Picker also loves to mountain bike, even though he recently fractured his hip after a crash. Undeterred, Picker said he'll be back on his bike as soon as he can be.

"All the beautiful trails that are so close by," he said, "it's one of the pleasures of living in Portland." •

Flexible benefit makes MSMP members' long-term care insurance plan unique

Editors' note: This article is part of a series profiling MSMP partner organizations. To read the previous Partner Profile, highlighting The Doctors Company and its liability insurance, visit www.msmp.org, click on the News and Publications tab and view the November 2013 Scribe.

By Cliff Collins
For The Scribe

Because of what they witness in their day-to-day professional lives, physicians tend to be more aware than many other people of the need for and value of having long-term care insurance.

And that's a good thing, suggests **Courtney Rogers**, a broker with **EZDIquote**, the Medical Society of Metropolitan Portland's partner company for long-term care insurance, one of several individual member benefits MSMP offers. Most folks have no conception of the cost of care for those who become unable to take care of themselves. That figure currently averages $6,000 a month, he says.

Rogers points out that regular health insurance is not designed to pay for long-term care expenses, and Medicare covers only limited long-term care services, not the largest part of services or personal care. In addition, disability insurance will replace only a portion of the income you need for living expenses, not the added expense of long-term care.

Further, Medicaid will cover long-term care, but to qualify, individuals must meet federal and state guidelines for income and assets. Many people end up having to pay for care out of their own pocket and spend down their income until they are eligible for Medicaid.

In addition, if you needed such care, you would want it to be in a setting that promotes your independence, such as your own home, if possible. Yet the high cost of care could make that much more difficult to obtain.

Rogers, whose office is in Tigard, says EZDIquote has the solution: a flexible plan that pays based on setting. The majority of long-term care services are provided in the individual's home, an adult day care center or an assisted living facility, he explains.


COURTNEY ROGERS

Under this plan, these options pay a cash benefit, which differs greatly from standard, traditional long-term insurance plans. With those, the insured must pay upfront costs for care and submit receipts for actual expenses, then is reimbursed only for those direct costs. But with the EZDIquote plan, the insured receives a set lump sum monthly. The cash benefit may be used for care provided by family members, friends or other individuals you may choose.

If the enrollee later needs to move to a certified nursing home, the insured then receives reimbursement for actual expenses he or she incurs.

"The real advantage to this plan is the flexibility of how you get paid and where you can receive care," says Rogers. "With this plan, if you are receiving in-home care, they just send you a check and you can have anyone you want provide the care. When it comes time to need care, if someone has the choice to stay in their own home, most people take it."

The best part: MSMP members receive a 5 percent professional association discount on total premiums. If both member and spouse or domestic partner apply together for coverage and are issued coverage, each of them receives a 30 percent discount. When only one applies or is issued coverage, he or she receives a 15 percent discount.

EZDIquote's plan can complement current income protection plans or cover individuals who cannot obtain disability insurance. And you can structure the plan for the number of years for which you want to buy coverage, he says. The plan provides cash that will pay for home health care, home modification, durable medical equipment, transportation and anything else you choose for yourself—including new long-term care services that don't exist today but may in the future—at the time you need them.

Here is how it works when you need the benefits: A health care practitioner will determine the need for such care. You submit a simple request each month, and cash benefits are paid to you. There are no bills or reports required; just send the request and the cash is yours.

EZDIquote uses a simple online quote-request system, and a long-term care specialist can review the quotes in person or over the phone to help you decide what type of plan is best for your needs. Once you have decided on a plan, the EZDIquote team will help you through the streamlined application and enrollment process.

As a testament to the value his company sees in the program, Rogers adds, "Out of all the plans that the agency offers, even some of its own employees and owners choose to go with the plan for their own coverage." •

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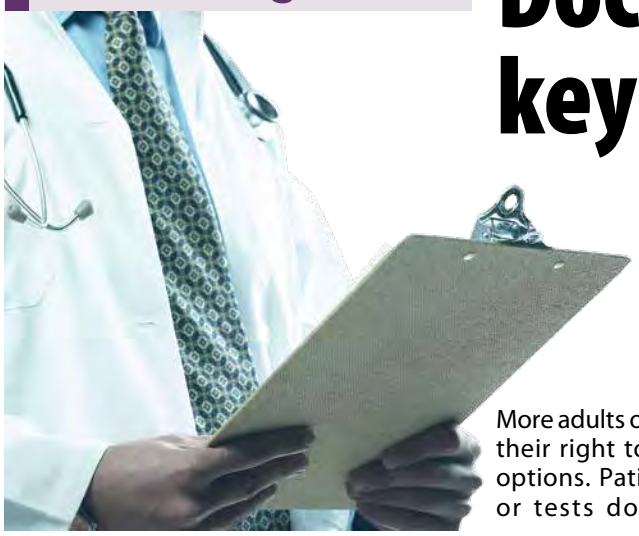
Documentation of patient's refusal key to minimizing risk exposure



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

More adults of sound mind are exercising their right to refuse test or treatment options. Patient refusal of procedures or tests doesn't equate with their incompetence. Refusal to comply, however, can be an important cautionary flag. Physicians should take a close look at their recommendations and at the reasoning behind the patient's refusal to follow them.

In *Truman v. Thomas*, 27 Cal.3d 285 (1980), the California Supreme Court held that physicians are responsible for making sure patients are aware of all significant risks that could result from noncompliance. Physicians' obligations apply equally to all tests and procedures, whether simple and routine or unusually complex. The obligation also applies to a recommendation that a patient see a specialist, holding that physicians must inform patients of the possible consequences of not getting a consultation.

Documentation in a patient's medical record of a refusal should include the following notations:

- Information that the physician gave the patient concerning his or her condition and the proposed treatment or test. Reasons for the treatment or test should be noted.
- Patient was advised of the possible risks and consequences, including the loss of life or limb, of failing to undergo treatment or a test.
- Physician's referral of the patient to a specialist, including the reasons for the referral and possible risks of not seeing the specialist.
- Patient's refusal of the physician's treatment/testing plan or advice. In this circumstance, consider asking the patient to sign a specific refusal of treatment form (available in the "Miscellaneous" category of The Doctors Company informed-consent form resource center at www.thedoctors.com/consent). Although such a form is optional, it offers physicians the strongest protection against claims alleging a lack of informed consent. •

This article is courtesy of The Doctors Company, the nation's largest insurer of physician and surgeon medical liability.

THE DOCTORS COMPANY

For more information, contact Sarah Wolfenbarger or Christopher Clark at 800-243-3503, or visit www.thedoctors.com/patientsafety.

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.

What strategies has your practice implemented to document patients' refusal of test or treatment options? Visit the Members Forum section at www.msmp.org to respond.

From soaring to sowing, Sara Kristine Becker, MD, savors endless challenges

By John Rumler
For The Scribe

Currently on staff at Providence Milwaukie Hospital and on the courtesy staff at Adventist Medical Center, **Sara Kristine Becker, MD**, also volunteers at the not-for-profit Oregon City Founders Clinic.

Amazingly, in addition to keeping up with her professional demands and raising a family, Becker's carved out time for a mind-boggling array of hobbies, including piloting aircrafts; playing the piano, organ and classical guitar; horticulture; walking; and writing.

She grew up in Michigan where her mother was a homemaker and her father sold abrasives to the automotive industry. Neither completed high school. "I visited many auto plants with my dad and realized the value of an education early on," she says.

As a youngster, during summer vacations, Becker guided people fishing for northern pike and it happened that one of the individuals was a neurologist for the Mayo Clinic. "He noticed that I was skillful at filleting fish, so he suggested I become a doctor," she recalls. "I was nine and had no idea what I wanted to do, although I'd thought about becoming a pilot."

After graduating from the University of Michigan Medical School in 1977 and completing her residency in family medicine in 1980, Becker opened her practice in Milwaukie. Now, during the span of three decades as a physician, her roles have ranged from being an assistant professor at Oregon Health & Science University to serving on the staff of the Old Town Clinic for 12 years.

Flying a passionate pastime

Music has been a part of her life almost as long as Becker can remember. She taught herself to play the organ starting at age 10, and years later studied piano with her daughter. She took up the classical guitar in 2006 and still takes weekly lessons from William Jenks of Portland Classical Guitar. Almost all the music she plays is from the 16th to 19th century.

She owns several valuable, handmade guitars as well as an old Wurlitzer organ and a reconditioned 1921 Chickering Grand Piano. "During its time it was considered the equivalent of a Steinway," Becker says. "Although it does not have the range, it does have a beautiful mellow tone." She plays the keyboards weekly to maintain her skills.

Photos courtesy of Sara Kristine Becker, MD

Jenks said learning classical guitar, which requires playing individual strings and chords, takes great determination, patience and discipline. He describes Becker as a devoted intermediary player who is constantly improving.

"Sara has a fabulous attitude and incredible tenacity, passion and commitment. She takes a guitar almost everywhere she goes and practices whenever she can, 15 minutes here or a half hour there."

Although Becker dreamed of becoming a pilot since childhood, one of her early preceptors in family medicine, Gordon Willoughby, MD, of Frankfort, Mich., was an accomplished pilot. Tragically, he took his entire family into an aircraft and then somehow flew head-on into a telephone pole. No one survived.

"Doctors are notorious for killing themselves in airplanes," Becker says.

The disturbing experience left an indelible impression and prompted Becker not to give up her dream of flying, but rather to get as much professional pilot's training as possible and to be extra safe.

Becker started flying in 1991 and by 1995 became a licensed multi-engine, instrument-rated commercial pilot. She was fully qualified to fly for commercial airlines and although the temptation was strong, she was unwilling to give up medicine or to be separated from her family, so flying remained a pastime, albeit a passionate one.

She's flown a variety of aircraft, from a two-person, ultralight, hang glider to a Boeing 737 (with a 215-passenger capacity) simulator at the Federal Aviation Administration center in Oklahoma City. Her favorite is the Piper Apache with the Geronimo conversion, a twin-engine, retractable-gear, high-performance aircraft that cruises at 165 miles per hour.

But with the advent of electronic records and their accompanying strain, when Becker reached her day off, she usually was too mentally exhausted to fly.

'A wonderful perspective on the world'

Becker also is one of only about 3,300 aviation medical examiners in the world. To qualify, a doctor has to earn special certification and complete training from the Civil Aerospace Medical Institute, the medical arm of the Federal Aviation Administration.

Although Becker has not flown in nearly four years, she is excited about having more time to sit in the pilot's seat again next summer. The most wonderful thing about flying, she says, is banking and flying over mountains and ocean.

"Feeling the wings lift you up and see the ground fall away gives a wonderful perspective on the world, and executing a smooth landing using instruments in cloudy conditions brings about a tremendous feeling of accomplishment."

A prolific writer, Becker has three websites, lectures on hormone therapy and aviation medicine, and helps care for several transgendered persons. "Some doctors are reluctant to care for these individuals so it has been fun to teach others how to care for them," she says.

She goes for long walks near her home on the Clackamas River and at her home in Puerto Vallarta when she is there. She frequently listens to continuing education or history course audio books when she walks and also at night before sleeping.

Becker designed and built a 12-foot by 50-foot greenhouse that is self-maintaining in terms of heat, water and light. It houses koi and many tropical plants, including cymbidium orchids, four types of bananas, Bird of Paradise, and about 30 varieties of orchid cacti.

"I select plants that will thrive in the climate established in the greenhouse. If one chooses the right plants and provides the right conditions, it is not that difficult to grow them."

Her daughter, Alena Foresman, a psychologist in Charleston, S.C., says her mom becomes so engaged in hobbies she practically reinvents herself. Foresman served unofficially as Becker's co-pilot more than a dozen times as they whale-watched along the Oregon Coast.

"She doesn't do anything halfway. Whatever she does, medicine or music or growing rare, practically extinct orchids, she gives it her all."

Asked how she finds time for her diverse hobbies, Becker replies, "I always had a number of dreams that I wanted to pursue and I just sort of kept working at them. I am not that much of a social creature, so I actually have time for my hobbies, though not as much as I'd like."

Oh, and Becker also coaches her pet Amazon parrots to sing opera. "So far I've not had much success with it, but it is a lot of fun." •

Kaiser Permanente opens unique health plan info center in Washington Square

By John Rumler
For The Scribe

Kaiser Permanente Northwest launched the first, and so far only, retail health plan information center in the region at the Washington Square Mall in conjunction with the Obamacare rollout on Oct. 1.

The retail entry is a natural progression for Kaiser as Oregon, Washington and the rest of the nation embrace more consumer involvement in health plan decision making, said **Dan Woodard**, retail marketing lead at Kaiser.

"People who are not currently insured or who are looking to make a change have a lot of choices. Many folks might not feel entirely comfortable making these important decisions without expert guidance and face-to-face assistance," Woodard said.

Kaiser officials would not divulge specific data but report that they are pleased so far and have seen steady growth in the number of overall visitors at the Washington Square location.

Interest has no doubt been spurred by public confusion surrounding the Affordable Care Act and the delays in fully launching the Cover Oregon website.

Paul O'Mara, a sales executive for ID Experts, an Internet security firm, works across the street from Washington Square and walked to the mall for lunch. He discovered the Kaiser kiosk and instead ended up purchasing an insurance plan for his son, who is turning 26 and will no longer be covered under his current policy.

O'Mara, 57, is normally an avid online shopper, but he described the Obamacare rollout as "a colossal snafu."

Although his expectations were initially low, O'Mara was surprised and impressed with the service and the information he received. "We sat down in front of a computer and I got a fast, efficient and authoritative walk-through explaining our options. After only about 10 minutes, I walked out of there very satisfied."

Washington Square was chosen for the retail site because it is the premier shopping destination in the area with nearly twice the number of annual customer visits as its closest competitor. Also, with Kaiser's opening of its Westside Medical Center earlier this year, the Hillsboro neighborhood medical office and renovations to several nearby facilities, officials felt it would be an ideal location.

Kaiser's 180-square-foot satellite, next to Microsoft and Nordstrom, includes customized iPad stands for shoppers to access tailored health care information, literature on healthy lifestyles, a biometric screening device to assess body mass index, and a private area for shoppers to evaluate and enroll in health plans.

Colin Blyth, manager of retail sales and marketing for Kaiser Permanente Northwest, oversees the location, which is open the same hours as the mall (10 a.m. to 9 p.m., Monday–Saturday and 10 a.m. to 7 p.m. on Sunday), and has a staff of as many as four.

Kaiser Permanente Northwest opened the first, and so far only, retail health plan information center in the region at the Washington Square Mall. Kaiser's Dan Woodard said the center is a natural progression for the health system as Oregon, Washington and the rest of the nation embrace more consumer involvement in health plan decision making.

Photo courtesy of Kaiser Permanente

So far, the center closely mirrors the mall in terms of demographics and activity, which Blyth describes as a "steady flow, which peaks on weekends." Kaiser will maintain the kiosk not only through the enrollment period, but through 2014, he said. "We're anticipating that our number of visitors will surge with the holidays. It'll be a fun challenge for us."

Since the kiosk opened two months ago, some recurring themes in public concerns and questions have emerged, including many people who are skeptical about health-care reform in general, especially as the rollout of the health insurance exchanges were delayed.

"We're fielding many general questions about the Affordable Care Act, such as who is required to purchase coverage and a good number of folks who are uninsured that are eager to find out how much financial assistance they may qualify for to offset monthly premiums or cost sharing for themselves and their families," Woodard explained. "We're also talking to a lot of seniors, many of whom want to know if and how they are affected by the ACA."

Other frequent question topics include Cover Oregon and when the website will be bug free and ready for online enrollment. In addition, although almost everyone is aware of the Affordable Care Act, a good portion of the general public, including those who are currently insured, don't understand how specific portions of the ACA will affect them.

Sylvia Warren, 61, of Hillsboro, stopped by during the last week of October to ask several what ifs? Warren said her health insurance premiums recently spiked $400 annually—an increase she could not afford—but she wanted to keep her same doctor, clinic and health services.

Warren, who retired a few years ago but is several years away from qualifying for Medicare, is wary of buying online or over the phone. After getting her questions answered and her options clarified, she ended up purchasing a new, more affordable insurance policy in about 15 minutes.

Warren rated her experience as extremely favorable and said she'd like to see other health-care information services become similarly accessible and user-friendly. "The biggest thing was getting all my questions answered one-on-one by a real person. That was a huge factor, plus it is a convenient location."

So far, no other local health-care giants engage in similar direct-to-consumer retail sales strategies, but Woodard said he would not be surprised to see competitors entering the space within the next 12 months.

Kaiser also utilizes an outreach van, or Mobile Information Center, to access communities and lower-income population clusters that would not typically find their way to Washington Square.

"We'll visit lower-income communities on Portland's east side as well as our service areas outside of the Portland metro area, such as Salem, and meet people where they live, work, play and shop," Woodard said.

"We want to make sure that everyone, particularly those individuals and families whose incomes fall within the range of the federal poverty levels, knows about the financial assistance that is available to purchase high-quality health care." •

Second of two parts *To read the first installment, visit the MSMP website and view the November 2013* Scribe.

This article is among a series of personal essays exploring life challenges of 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, visit the Forum section of MSMP's website at www.msmp.org.

Medical community must allow doctors to speak openly about stresses

By David Hanscom, MD

Physicians are conditioned to be really tough. From the first day we walk into the anatomy lab of medical school, it's understood that we are essentially in boot camp. The intention is to quickly weed out those who cannot cut it. The ones who can suppress their anxiety are the ones who survive.

Early in my practice, I always thought I was in control. It didn't matter what I encountered—angry patients, billing problems, even a malpractice suit—I remember thinking, "I can take it. Bring it on." All physicians are used to being in control, especially when it comes to anxiety.

Anxiety cannot be suppressed forever. Research has shown that the more one tries not to think about something, the higher the chance it is thought about.[1] Many physicians find themselves in a state of chronic anxiety. When this happens, surgeons may quit doing the bigger cases or stop doing surgery altogether. Addictions begin to surface. Other dysfunctional coping mechanisms, such as aggressive behavior toward staff and residents, are common. And then there is suicide.

Doctors hold up perfectionism as one of the highest virtues of their profession. Most physicians would agree that "perfect" is the standard for our medical culture. It's both implicitly and explicitly taught from the time they enter medical school. Unfortunately, many mentors react severely to their underlings when a given task is performed in a less-than-perfect manner.

> "As doctors, **our goal is 100 percent** success for every patient. But **that's not humanly possible**."

But what does perfectionism really accomplish? Nothing. It's a destructive trait. As doctors, our goal is 100 percent success for every patient. But that's not humanly possible. If you torture yourself over every case that doesn't turn out perfectly, you can't do your job well. The energy burned up by judging yourself negatively is the energy you need to perform at the highest level.

Since there's no such thing as perfection in the human experience, the difference between reality and expectation will determine the degree of your unhappiness. For many physicians, failure to meet the standard of perfection engenders growing anxiety, anger and guilt that facilitate suicide.

I was able to escape the perfectionist trap by using a technique known as neuro-cognitive reprogramming, which involves writing down your thoughts to create new, alternate neurological pathways. These pathways connect the thoughts with sight and feel. In David Burns' book, *Feeling Good*,[2] one of his tools is to write down negative thoughts and then categorize them. By using Burns' writing methods and facing my anger, I was able to work myself out of the abyss. For me, it has been life altering.

There are other reprogramming methods. They include mindfulness/meditation, awareness, group dialogue, auditory methods, art, role playing, music and many other techniques. Broken down, each follows a pattern of three parts: (1) awareness; (2) detachment; (3) reprogramming. Each person's journey will be unique.

As a medical community, we must recognize that *anxiety* is not a dirty word and that it's not a sign of weakness to admit that you have anxiety. Members of the medical community must engage in a dialogue about allowing doctors to speak openly about their stresses. Each of us is so good with our façade that we couldn't imagine that the other physician is anything less than completely together. We are human, too, however, and we are suffering—badly. With an open dialogue, the medical community can start to heal its own members. •

David Hanscom, MD, is a board-certified orthopedic surgeon practicing in Seattle.

This article originally appeared in The Doctor's Advocate*, 4th quarter 2011 (www.thedoctors.com/advocate), and is courtesy of The Doctors Company.*

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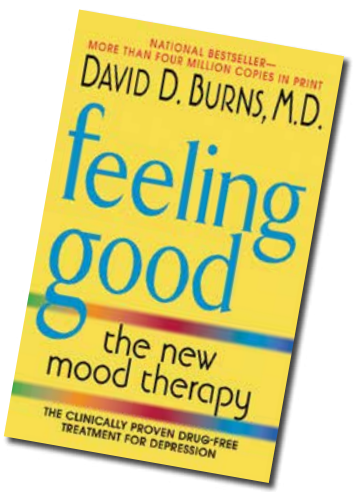


The guidelines suggested here are not rules, do not constitute legal advice and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in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

Ask the Expert

The **American Medical Association** recently shared with *The Scribe* some of the biggest practice management hurdles physicians face and how to overcome them.

Practice management changes can enhance patient, physician satisfaction and boost the bottom line

The Scribe: **What are some of the most significant challenges physicians and other medical professionals encounter with respect to practice management?**

AMA: The administrative burden of being a physician continues to fuel discontent among doctors. The unfulfilling interface with the bureaucracy of managed care is a major factor associated with a sense of physician dissatisfaction. A recent survey by the RAND Corporation, sponsored by the AMA, shows that the professional satisfaction of physicians is affected by the burdens of overlapping rules and regulations. The AMA estimates that $12 billion a year could be saved if insurers eliminated unnecessary administrative tasks with automated systems for processing and paying medical claims. This savings represents 21 percent of total administrative costs that physicians spend to ensure accurate payments from insurers.

The Scribe: **What strategies can physicians implement to improve operational efficiencies, devote more time to patient care and strengthen financial performance?**

AMA: New federal standards governing how health insurers conduct electronic transactions with physicians should help reduce administrative hassles, cut paperwork burdens and free up time to spend with patients. The Centers for Medicare & Medicaid Services estimates that approximately one-third of claim payments across the industry currently are transferred electronically, and insurers' reliance on electronic funds transfers is expected to increase. Medicare rules already require physicians who are new to the program or who update their enrollment information to be paid via electronic funds transfer.

The new rules, called for under the Affordable Care Act, require health insurers to standardize business practices for electronic funds transfers and electronic remittance advice. Set to take effect Jan. 1, the rules will make it possible for medical practices to automate the time-consuming process of manually matching payments from insurers with claims that have been submitted. Free toolkits from the AMA can help physicians take advantage of the changes.

The Scribe: **How do these strategies ultimately improve the health care system overall?**

AMA: Physicians too often feel disconnected from what really matters—their patients—yet it's providing patients with high-quality care that drives a physician's professional satisfaction. A physician's professional satisfaction is important to both increase the quality of care for patients and better recruit and retain physicians in health care today.

The Rand Corporation study shows that being able to provide high-quality health care is a primary driver of job satisfaction among physicians, and obstacles to quality patient care are a source of stress for doctors. During its Interim Meeting in November, the AMA adopted policy to study current tools and develop metrics to measure physician satisfaction.

The RAND study is a significant step in one of the AMA's three ambitious focus areas—Care Delivery and Payment: Professional Satisfaction/Sustainability. The study findings are important and they will become transformative as the AMA builds on them. By analyzing this data from a wide variety of physician practices, the AMA will be able to provide the information, tools and environment physicians need to succeed in providing the best possible care at an affordable cost.

Over the coming months, the AMA will continue identifying effective models of care delivery and payment that achieve high-quality patient care, greater professional satisfaction and long-term sustainability within our evolving health care system. We will then share our insights to help physicians make informed decisions about their practices, equipping them with practice-level solutions to help them to adopt models that meet their needs and the needs of their patients.

But we won't stop there. We'll also continue our work to change the health care environment to support these models—including removing regulatory barriers, altering how hospitals view success and leveling the playing field with health insurers. That means using our influence and leadership to protect the integrity of medicine and medical practices of all sizes, whether in pushing back against regulations that require physicians to use inadequate technology in a way that detracts from patient care, illuminating the pathway for physicians to reconfigure how they deliver care to patients with debilitating chronic diseases or providing resources for implementing more patient-centric payment models.

This study is only the start. Expect to see dramatic results as we shape the nation's health care system for the 21st century. •

For more information about how to improve practice management, please visit the AMA's website at: www.ama-assn.org/go/simplify

CHOOSING WISELY *from page 3*

Wisely into CME," as well as into the curricula for medical and PA schools, she said.

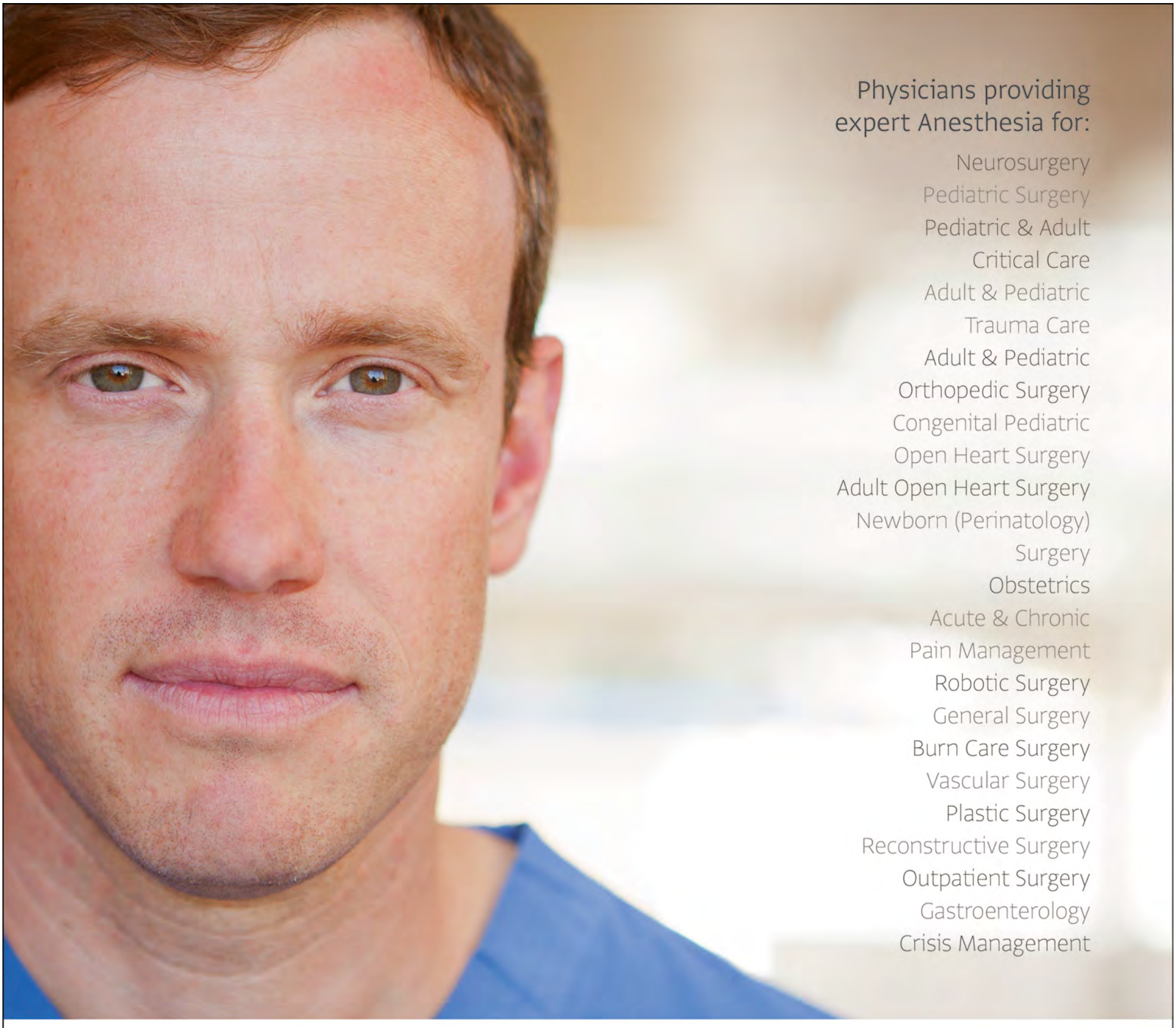
"Our major concern is that we want the public and doctors to trust this information," Santa said. The fact that the recommendations come directly and voluntarily from the specialty societies themselves "has truly been remarkable," he emphasized.

The national campaign has teamed up with numerous other organizations such as AARP and reached 100 million people about Choosing Wisely, as well as produced more than 100 peer-reviewed articles, according to Santa.

"We've shown you can wage a campaign to change a culture," he said. "The question is whether we can win a campaign." •

For more information, consult OMA's Choosing Wisely website at: www.consumerhealthchoices.org/oma, or contact program coordinator, Cassandra Dictus, at 503-619-8000, or cassandra@theOMA.org.

Do you have thoughts on the Choosing Wisely campaign or about issues such as the overuse of medical tests? Visit the Members Forum section at www.msmp.org to share them.



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Portland IPA's Tom Gragnola, MD, addresses patient engagement, physician shortage and health care reform

TOM GRAGNOLA, MD

The Scribe: **Patient engagement is a very important and resonating topic among providers. What are some of your thoughts about it?**

Tom Gragnola: The assumption is that engaged patients make better health care choices, have better outcomes and spend less of the health care dollar. There are a proliferation of consultants, programs and technology to promote patient engagement. However, while the health care industry and government programs are promoting and making substantial investments developing and implementing the various tools such as patient portals, online calendars and communications mechanisms, the concern is that there isn't good evidence supporting that patients value it and use it.

Practices are often—and rightly so—timid about jumping into the deep end of this pool. There is the concern of cost and time potentially spent managing and tracking additional channels of communications with patients, concerns of potential liability, and complying with HIPAA protections. These are very real concerns.

Practices can take heart that there are simple but positive ways to engage patients, and help them learn more about their individual accountability for their own health. Successful methods that have worked in and outside the Patient Centered Primary Care Home Model include support and focus group visits, health and prevention classes, secure messaging with patients, and generally taking the proactive approach by providing printouts for patients at the end of a visit, so he/she has clear information and instructions about the next steps in their treatment. I also depend on the good, old-fashioned telephone. Direct conversations can often take the place of an office visit and create that one-on-one relationship that encourages trust and transparency.

The Scribe: **Is there still a concern about physician shortages?**

Gragnola: Yes. And, in fact, the concern is more acute than ever. While this is a national problem, the concern is that the shortages will disproportionately affect Oregon. There are several factors precipitating the predicted shortage, including, but not limited to, fewer students pursuing primary care; a growing aging population; decline in reimbursements; and increases in liability and insurance coverage costs.

The Oregon Healthcare Workforce Institute predicts that Oregon will contend with a "major" workforce shortage, citing the number of licensed physicians in the state dropping as much as 15 percent from 2010 to 2012. We must ask ourselves what can we implement to incentivize more incoming providers to choose the primary care path? From a systematic perspective, it would be to increase reimbursements for primary care services and loan forgiveness opportunities. Currently, the debt load of most newly minted physicians is well north of $100,000.

The solutions proposed include the use of allied providers. Many primary care clinics have or are looking at ways to incorporate nurse practitioners and physician assistants. For primary care providers, especially, the key to providing more efficient and effective care is utilizing all the opportunities available for all practitioners to practice at the top of their license. Also important are effective triage and care management efforts.

Also, the Patient Centered Primary Care Home model aims to make the best and highest use of each practitioner's training, skill set and discipline.

The Scribe: **What are some of the most common concerns that physicians are expressing about the coming changes in health care?**

Gragnola: I'm hearing more and more uncertainty from physicians. The most salient topic is that of declining payments. Both Medicaid and Medicare fee-for-service reimbursements are at all-time lows. Many Oregon physicians have stopped accepting Medicare assignments. The global budgeting models proposed for coordinated care organizations and "value-based" contract strategies leave disbursement methodologies unclear. Many of our members are unsure how the reimbursement methods work and are looking for help in understanding the new rules.

Another concern is that the health insurance exchange plans are new plan designs that might be confusing for patients and difficult to integrate into their current practice management systems. Additionally, reporting requirements continue to grow; thus, administrative functions have greatly increased but without the reimbursement to underwrite staff or technology. The IPA works closely with members and their practices to implement tracking and reporting systems; advise on implementing tools and practice management systems; assist with creating patient-centered medical home and specialty partnering protocols; and knowledge sharing that helps providers improve their practices and effectively manage the changing requirements.

Physicians must recognize that it isn't going to be enough to just react to the changes. They must help drive the changes that will benefit their patients and their practice. •

Tom Gragnola, MD, practices at Greenfield Health and is medical director of the Portland InterHospital Physicians Association.

***CRISIS CARE** from page 1*

When medical resources are overwhelmed, access to critical care would be limited for those with medical conditions associated with low likelihood of long-term survival. These include recurrent cardiac arrest and severe illnesses or injuries with an average life expectancy of less than 6 to 12 months. Age, non-life threatening disability and social standing were not used as exclusion criteria.

LEARN MORE: "Crisis Care Guidance for the State of Oregon: A Framework for Healthcare Response in a Public Health Emergency" can be found at: public.health.oregon.gov/Preparedness/Documents/CrisisCareGuidance.pdf

MSMP endorses document

John Evans, MD, who represented the **Medical Society of Metropolitan Portland** in serving on the General Review Work Group that developed the document, said the concept of maximizing survival of members of the community is hard for medical personnel to embrace, but it is even harder for society at large.

"This may be the greatest benefit of this document and why we at the MSMP Board encourage the active discussion of this document," he said. "Our society needs to hear and understand the actions we may have to take in the face of an emergency, where we will not have enough equipment, medicines or medical personnel to take care of everybody as we do in a non-crisis environment. This education of our community needs to be forthright and make very clear the justice and ethical guidelines that were the basis of the development of this plan. It will confer on our community patience and a social solidarity that will carry us through the crisis."

Evans, a past president of MSMP as well as of the Oregon Medical Association, said the MSMP Board of Trustees "commends the creation" of and endorses "Crisis Care Guidance for the State of Oregon," adding that "a number of the members of the board and staff of MSMP have participated in the development of the document, and its contents have been discussed with the board."

"We feel it represents a profound step forward in educating our medical community about the ethically difficult challenges we will face in an overwhelming crisis," he said. "It gives, as much as possible, evidence-based decision pathways for critically ill patients when our resources are overwhelmed. Physicians and medical providers will be given the maximum support in making triage and scarce resource utilization by a weaving together of a group across multiple sites not directly caring for the individual."

Leman concurred. He said that in normal situations, medical care is provided on a first-come, first-served basis. "But in a situation where there is a severe limitation on resources, some people will not make it; and in a challenging, difficult setting," caregivers must use their "skill and resources to save as many people as possible, and do it in a way that is fair and just, and based on the condition of the person."

Leman is certain the document will be used, because of how it originated. "I think the beauty of this is, this is not implemented by the Public Health Division. The community and the state developed this as they moved forward in their emergency services planning. We just need to implement the parts that make sense for individual communities."

Moreover, Leman called the guidance "a living document," one that already is being employed by several health systems in order to improve their response plans.

"We're seeing a number of health systems and communities using the guidance for just what it's intended to do," he said. "One advantage we had: This was not done in a vacuum. Having emergency managers who regularly have to deal with situations out of the ordinary put us in a better position to be ready," and to have guidance that is "usable and practical."

He added that it's important for medical providers to become familiar with the guidance in order to prepare their offices and clinics to respond. •

For more information about health preparedness, please visit www.msmp.org and click on the Resources tab. To read a recent Scribe *article about regional efforts to prepare for large-scale health emergencies, log on to the MSMP website and open the July 2013 issue, which featured an article by anesthesiologist John Evans, MD, an at-large member of MSMP's Board of Trustees, about the lessons learned from an anthrax attack exercise.*

How has your organization prepared for a natural disaster or other crisis? Do you feel the crisis care guidance document will be useful in your planning? Visit the Members Forum section at www.msmp.org to respond.

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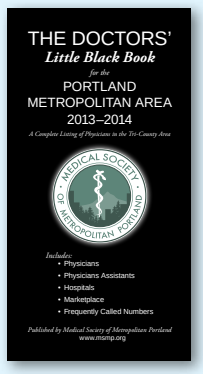

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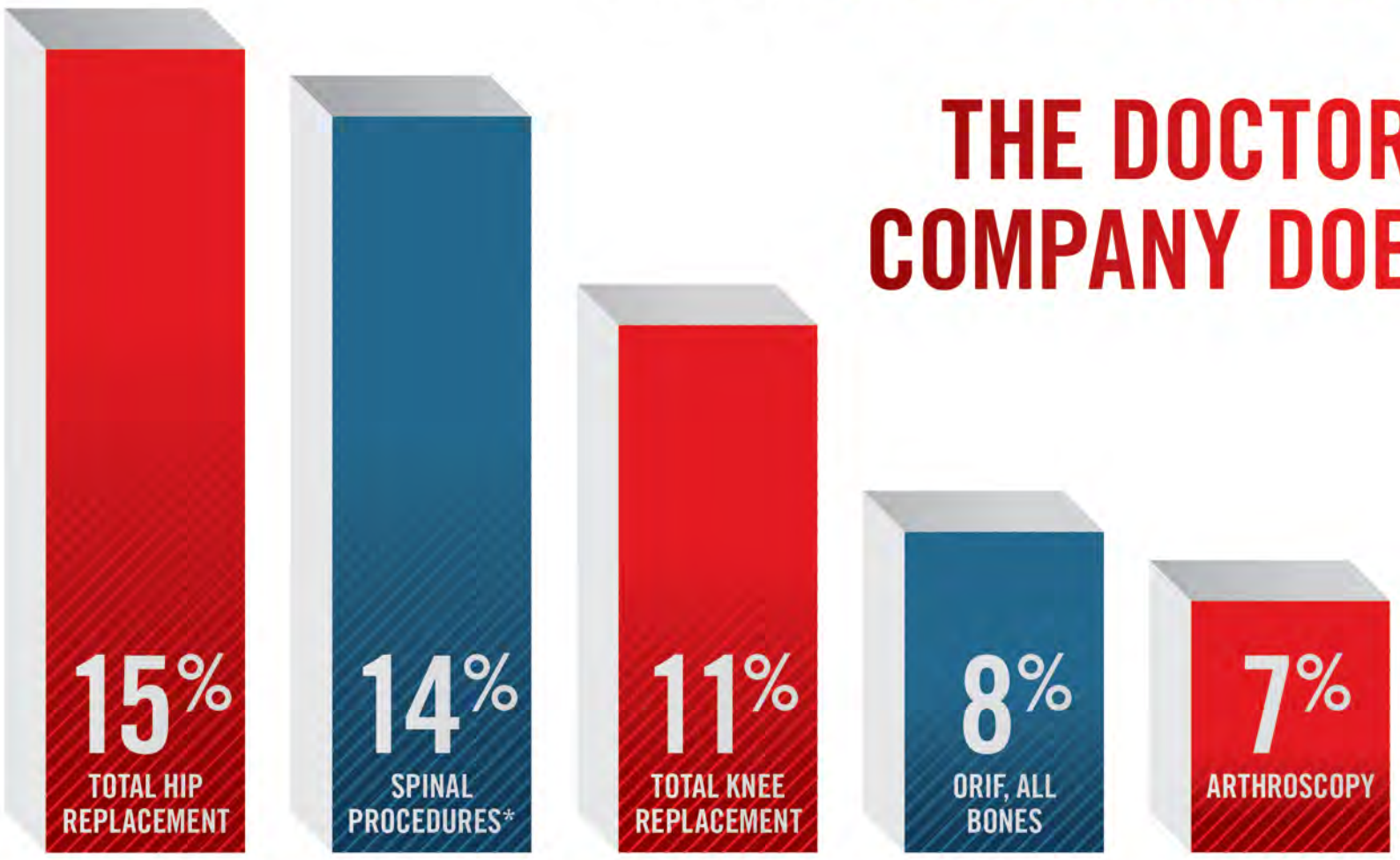

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