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Renowned Devers Eye Institute expands

By John Rumler
For The Scribe

Legacy Devers Eye Institute, widely recognized as an international leader in optic neuropathy and surgery, recently expanded its regional presence in two ways.

It opened the Legacy Devers Eye Institute Emanuel, which will provide Northeast Portland patients with a full range of eye care services, including treatment of glaucoma, cataract, diabetic retinopathy, macular degeneration and ophthalmic trauma.

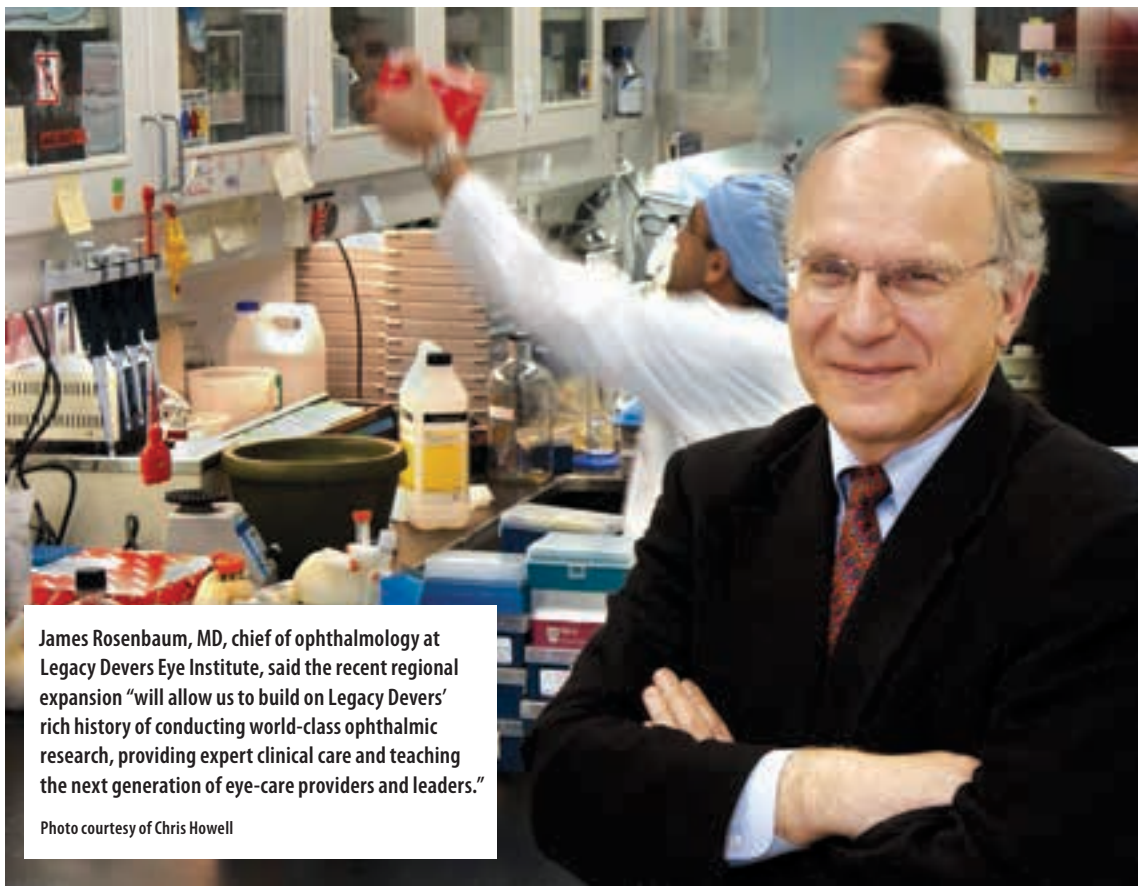
Legacy also completed a significant remodel and expansion of its flagship operation at the Good Samaritan Medical Center in Northwest Portland, adding 1,000 square feet of clinic and office space to make room for new providers and accommodate a new contact lens clinic.

Blake Acohido, MD, medical director of eye trauma for Legacy Health, will oversee the new Devers Emanuel clinic and also provide eye trauma care and work directly with the Legacy Emanuel's ER department and trauma staff. After graduating from Chicago Medical School's Rosalind Franklin University of Medicine & Science in 2009, Acohido completed his residency at OHSU's Casey Eye Institute in June 2013. As part of his rotation, he spent 10 weeks at the Good Samaritan Devers Eye Clinic.

Acohido—who staffs the clinic with **Jennifer Sinclair, OD, Dawn Brunelle**, ophthalmic technician, and **Rachel Collins**, customer service—started in time to help design the facility at 300 N. Graham St., Suite 300. Legacy expects to receive about 6,000 patient visits in the clinic's first calendar year.

James Rosenbaum, MD, chief of ophthalmology at Legacy Devers who joined the organization in 2012, said his priorities have been to retain the talented nucleus he inherited during a challenging time (complicated by the federal sequestration) for research grant funding and to develop Devers' presence at the Emanuel campus, which is located in an underserved area in North Portland.

Devers also recently hired two retina specialists, **Sirichai Pasadhika, MD**, and **Elizabeth Verner-Cole, MD**, and is planning a unique interdisciplinary clinic for children with arthritis and uveitis that will open sometime in 2014. Uveitis is an inflammation of the uvea, the middle layer of the eye, that causes blurry and spotty vision. It can occur by itself, affecting one or both eyes, or it can be triggered by many autoimmune disorders, particularly juvenile rheumatoid arthritis. Symptoms appear rapidly, and if untreated, uveitis can lead to cataracts, glaucoma, detached retina and loss of vision.



James Rosenbaum, MD, chief of ophthalmology at Legacy Devers Eye Institute, said the recent regional expansion "will allow us to build on Legacy Devers' rich history of conducting world-class ophthalmic research, providing expert clinical care and teaching the next generation of eye-care providers and leaders."

Photo courtesy of Chris Howell

"The significant growth on both sides of the Willamette River will allow us to build on Legacy Devers' rich history of conducting world-class ophthalmic research, providing expert clinical care and teaching the next generation of eye-care providers and leaders," said Rosenbaum, who is recognized for his expertise in eye inflammation and is among several experts at Devers.

Commitment to charitable work

The Devers Eye Institute opened nearly 55 years ago. It was funded by Arthur Devers, a successful Portland coffee merchant who developed an eye condition called retinitis pigmentosa, which eventually caused him to become blind.

Upon his death, Devers bequeathed $1 million to Good Samaritan Hospital to develop an eye clinic for the underemployed and uninsured. Soon after the Arthur Devers Memorial Eye Clinic opened in 1959, it established an ophthalmic residency training program and it has been growing ever since. Today, through investments and

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Focus on Technology

This month we explore, in part, offerings touted as retail answers to some health system challenges, and mobile health monitoring's ability to make patients part of their care team.

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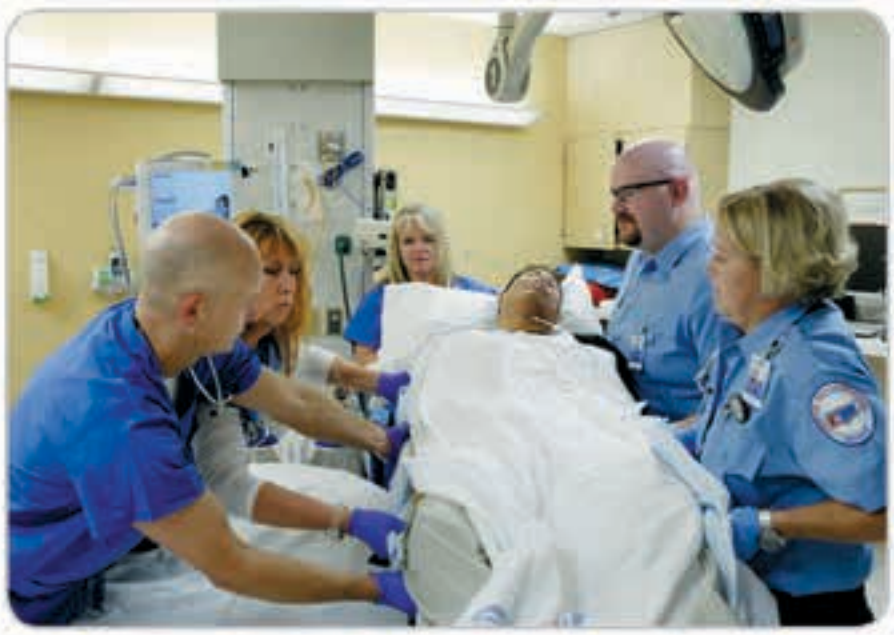
To refer, please visit **www.legacyhealth.org/healthprofessionals**.

Our legacy is yours.



LEGACY HEALTH

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RANDALL CHILDREN'S HOSPITAL Legacy Emanuel | LEGACY MEDICAL GROUP | LEGACY LABORATORY | LEGACY RESEARCH | LEGACY HOSPICE

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Services aim for quicker physician pay, less red tape

Read more about medical technology in the *Scribe's* Technology section, pgs 8–9.

Sprig Health taking steps to go national; Wellero designed to streamline billing

By Cliff Collins
For The Scribe

If slow or no pay and insurance hassles are the bane of your practice, the parent company of Regence BlueCross Blue Shield of Oregon thinks it offers solutions.

Two for-profit, wholly owned subsidiaries of Regence parent **Cambia Health Solutions** came into existence specifically to address these concerns of physicians and other providers. The companies' respective chief executives see what they are offering as a retail answer to some of the problems plaguing our health care system.

"We're targeting those providers who want a more retail type of business," said **Marcee Chmait**, president of **Sprig Health**, a direct-pay website where providers post their services and prices and consumers shop and pay cash for those services. A health care insurance company and startup veteran, Chmait views Sprig as an attraction both for doctors wanting to fill openings in their appointment books and patients who are uninsured or employed and carrying high-deductible coverage.


MARCEE CHMAIT

Not only that, but she adds that her company addresses health care costs by eliminating the middle man—the insurer and claims and billing that go with it—which can reduce costs by up to half. Getting rid of that portion of overhead allows providers who contract with Sprig to offer lower prices.

She points to the example of Sprig's contract with Epic Imaging. Having an MRI done by purchasing the scan through Sprig Health translates into a 50 percent lower cost than the contracted insurance rate for an MRI, she related. "They get paid, near real-time, with no claims to file," she said. "It takes a lot of inefficiencies out of the health care process."

Since its launch in fall 2011, Sprig has signed up 370 providers representing a wide variety of practices, and 2,500 consumers have used the program. The majority of providers are in the Portland area, as are 90 percent of patients seen by them through Sprig.

The next step is national. Since her arrival at the company this past April, Chmait has pushed toward attracting major employers, who often are self-insured and spread over several states. She's also teaming up with national PPO networks, which helps Sprig address the challenge of credentialing providers who sign up with Sprig. Such large networks already have credentialing in place, which means Sprig doesn't have to run a separate credentialing operation for those clients.

Sprig Health acts as a facilitator to connect patients to providers, at no upfront cost to providers. Doctors and other providers who sign up can decide what price to offer for services that patients pay for directly by credit card prior to the appointment or service. Sprig offers physicians what it labels a "standard market price," and the provider then selects a price to charge.

No prior authorization is required and no insurance forms need to be filled out, by either doctor or patient. Patients can make appointments online or by phone, and providers post their available appointment days and times for specific services, including for a new patient or for an existing patient.

Chmait observes that buying health care is the only purchase society makes without knowing what it's costing. "Price and quality transparency are missing. That's insane," she said. Although "the open-marketplace concept is still very new, and controversial at times," she said, taking the "noise" out of the health care system will lead to "happy providers and consumers."

Another Cambia spinoff with part of its aim to get physicians paid quickly is **Wellero** (accent on the second syllable). Debuting this past June, the company's product is a mobile application that allows consumers to pay for their care before they leave the provider's office. The app is set up so that both provider and patient can find out instantly what portion of their care their insurance covers and how much is left for them to pay.

This feature has obvious advantages for the doctor, but it was the additional pluses for the consumer that actually led to the idea to create Wellero, said **Hanny Freiwat**, president and co-founder.

"We've all left the doctor's office only to receive a surprise bill in the mail weeks later," he said. "As patients ourselves, we saw a need for the ability to check in, see the price of the service and calculate the cost of the visit based on our insurance coverage."


HANNY FREIWAT

*See **CAMBIA,** page 9*

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OAG is the premier Physician Anesthesia group in the Northwest for creating value for our patients and partners in operating rooms and beyond. Find our 240 Anesthesiologists at www.oagpc.com

From your MSMP **Student Member**

Agree to disagree

Differences of opinion far from a negative in the medical community

By Anushka Shenoy
For The Scribe

In many professions, "difference of opinion" is code for "all out conflict" or "war." When you "agree to disagree," you are often agreeing to part ways. This is the case in the political arena, where campaigns, interest groups and even research organizations are often partisan, and even in the corporate world, where boards of directors and executives are chosen because of a shared vision of leadership. In our medical school class, we often agree to disagree, and our differences of opinion lead to thought-provoking and lively conversations. The differences of opinion I have with my classmates will make me a better physician.

We recently discussed motivation interviewing in our clinical medicine class. As a classmate and I walked out of Richard Jones Hall, I expressed an opinion on the lecture, and was surprised that he passionately and coherently expressed a different point of view. Should doctors confront their patients about harmful behaviors? What are the risks of doing so, and what should the practical and ethical considerations be? As we talked, several classmates joined us. Some contributed their perspectives, and many just listened. After a recent exam, a few of us discussed the best ways for scholarship monies to be divided amongst medical students. Should financial aid be merit based, need based, both or neither? What other factors should be considered? Not only were we able to agree to disagree over this potentially contentious issue, the conversation continued within our class and with the administration. In fact, the administration has joined our conversation several times, when members of our class expressed strong opinions about our curriculum and its evolution. What say should we have in the changes to our curriculum? How accountable is the administration to its students?

At a recent student-run clinic, a resident and I visited a patient together. Her case seemed straightforward and our encounter was brief. Later, I asked the resident a few follow-up questions about the patient's care. I worried I might sound silly, but I had a few lingering concerns. The resident carefully explained the case to me, and during our conversation, we realized that we might have missed something important. We reviewed her chart, discussed it with the attending physician, and ordered more labs and a comprehensive follow up. Had I not been empowered to voice my concerns, or had the resident not welcomed an open conversation, the patient may not have received the best quality care. When my classmates and I vehemently disagree one moment, then joke around or bemoan our workload, we practice skills of openness, humility and professional discourse that will lead to better clinical outcomes.

If people glance at photographs of our class, they could easily conclude that we are not very "diverse." In many ways, they would be right. This paucity of diversity was a real concern for me when I decided to join this community, and it still is as a community member. However, I must say that I am pleasantly surprised by the diversity of background, opinion, belief and knowledge bases represented in my class, and more importantly, by the courage and eloquence my peers demonstrate by expressing their opinions vocally and articulately. We put pressure on our administration, on our teachers and on each other. I think that this will make us better doctors and better people, and I am proud to be part of a community that encourages disagreement and discourse. •

Anushka Shenoy is a first-year medical student at Oregon Health & Science University. She can be reached at shenoya@ohsu.edu. This piece first appeared on the OHSU StudentSpeak blog.

Welcome New Members

Drs. Takacs and Schmitt
5909 SE Division St, Portland, OR 97206
503-234-1531
Becky Hatch, Administrator
Susan Schmitt, MD
John Takacs, DO

Susan Schmitt, MD
Specialty: Physical Medicine and Rehabilitation
Graduated: Hahnemann University, Drexel University College of Medicine, '94

John Takacs, DO
Specialty: Family Medicine
Graduated: Kirksville College of Osteopathic Medicine, '86

MSMP Board of Trustees invites recommendations and welcomes self-nominations for new board

The MSMP Board of Trustees will consider recommendations for positions on the new board, commencing May 6, 2014. We invite your recommendations and welcome self-nominations:

The Board of Trustees is the policy-making body of the society. The purpose of the board is to see to it that the Medical Society of Metropolitan Portland:

1) accurately and reasonably represents the needs and desires of the members of the organization;
2) oversees cost and expenditures;
3) initiates appropriate actions to achieve excellent results; and
4) continues to generate creative, new ideas and ways to enhance the practice of medicine and the community of medicine.

The board represents the members of MSMP and the profession in determining and assuring exceptional organizational performance. Toward that end in recent past sessions of the board, a grant was approved for the enhancement of humanities in medicine. The intent of the grant is to bring art, literature, music, and the international culture of medicine to the members. Ultimately the leadership success of the board is a direct result of the imaginative and productive input of individuals and the collective participation of its members. These are exciting and changing times in medicine. Involvement on the board of the medical society will allow exceptional individuals to be a part of shaping the future. The board meets monthly except July and August. Conversations are lively, direct, diverse, and important.

The board will consider all recommendations and present its list of nominees in March. If you have an interest in serving on the MSMP Board of Trustees or know of a colleague who has expressed an interest in serving, please contact **Amanda Borges** at **503-944-1129** or **amanda@msmp.org** by **February 6, 2014**. •

Partner Profile

MSMP members receive privileged discounts, rates with OnPoint

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

By Cliff Collins
For The Scribe

Among the multiple benefits for Medical Society of Metropolitan Portland members is MSMP's partnership with Oregon's largest credit union.

OnPoint Community Credit Union, founded locally in 1932, offers MSMP members not just the many free services and competitive interest rates all OnPoint members receive, but also significant additional privileges, as well.

These include (for MSMP members and all their associated medical office personnel who wish to join the credit union):

- Free interest checking, with free bill pay
- $175 discount on a home equity loan or line
- $250 discount on closing costs for a first mortgage
- 0.25 percent discount on standard consumer loan rates
- 0.25 percent extra on any standard published CD rates
- No membership fees

In addition, MSMP members can receive personal help from "skilled relationship officers" to assist with any aspect of their banking needs, said Kelle Summerfield, an OnPoint vice president and branch manager. This benefit also extends to providing "customized small-business needs," she said.

KELLE SUMMERFIELD

"Group banking benefits are better and general rate and fee structure are usually much less than our competitors," she explained. "Most services we offer are free."

Special benefits for group practices include:

- $150 discount on website portal payment
- Savings of as much as 30 percent for banking
- No set-up fees or annual fees
- Special group banking offers

MSMP medical group members also have access to assistance in lowering their overhead costs with electronic billing, card processing and check processing through OnPoint's vendor partnership with NXGEN, a merchant services company. "They have advantageous pricing" and will send people out to medical offices to advise them on these services, Summerfield said.

These partnerships technology solutions include:

- Single deposit of all card types as one
- Payment portal on the group's own website to reduce receivables
- Automated recurring payments
- E-checks and remote deposit

Maximum security for financial transactions:

- Fully PCE-DSS compliant
- Full range of consulting and support
- $100K data-breach coverage

Savings and support:

- A local team in Portland with 24/7 availability
- Multilingual support available
- Guaranteed rates without long-term contracts
- Processing costs reduced 15 percent to 20 percent

OnPoint recognizes that the process of changing financial institutions is hard, and the credit union tries to accommodate, Summerfield said. "It's challenging for individuals and businesses to switch banks. We do what we can to make it easier."

Just the fact that the credit union offers history and stability—with 250,000 members, 22 branches and access to 50,000 ATMs nationally—provides some extra comfort, she said.

Members "see the value in banking locally with a local, large credit union. You're going to be dealing with someone right here in town, whether it's a business or personal need. I just really believe in what we offer, and it's safe, providing value as well as safety and soundness." •

For more information about OnPoint, or to join, contact Kelle Summerfield at kelle.summerfield@onpointcu.com or 503-525-8748.

OnPoint COMMUNITY CREDIT UNION

For information about becoming an MSMP member, call 503-222-9977, or visit msmp.org and click on the Membership tab.

When prescribing drugs, physicians have primary duty to warn patients

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

Prescribing physicians have a primary duty to warn patients about the risks and complications of prescribed medications. While legal arguments have been made that the drug manufacturer should be responsible for this duty to warn, courts continue to hold physicians accountable.

In a recent lawsuit, a patient claimed a prescribed medication caused lupus-like symptoms and that the manufacturing company, along with three physicians, failed to adequately warn of the drug's risks and, in fact, overemphasized its benefits. Two physician defendants settled with the patient, while the third physician was dismissed. The trial resulted in a $4.7 million jury verdict against the manufacturer.

The company appealed, claiming it had no duty to directly warn the patient after providing the patient's prescribing physician with adequate warning. Based on the legal doctrine of "learned intermediary," the court ruled in favor of the manufacturer. The doctrine states that a prescribing physician acts as a "learned intermediary" between manufacturer and patient: the manufacturer has a duty to inform the physician about drug uses and hazards, and in turn the physician has a duty to relay to each patient the dangers of using the prescribed medication. As such, the prescribing physician has the responsibility or "duty to warn" a patient of a prescription drug's side effects.

Review these tips to ensure you fulfill your duty to warn:

- Stay abreast of FDA prescription drug warnings and recalls.
- Use PDR Network as a reference for FDA-approved drug labeling and as a source for drug safety information.
- Be aware of prescription drug manufacturer product disclosures and warnings.
- Determine if additional information about the drug is available, including studies suggesting dangers that the FDA has yet to act on.
- Require that patients provide a list of all prescription and over-the-counter drugs being taken.
- Advise patients of other available medications and the medical rationale for the one being prescribed.
- Counsel patients about the difference between brand-name and generic drugs.
- Inform patients of potential drug-food and drug-drug interactions.
- Document all disclosures and warnings made to patients.
- Instruct patients to read drug labels.
- Provide patients with written, simplified dosing instructions.
- Obtain written informed consent when prescribing for off-label use.
- Date and archive product manufacturer disclosures and warnings.
- Seek legal or risk management guidance when uncertainty arises.

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

THE DOCTORS COMPANY

For 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.

Does your practice take additional steps to warn patients about the risks and complications of prescribed medications? Visit the Members Forum section at msmp.org to respond.

Going mobile

New technology, devices help physicians and patients monitor their health

By Jon Bell
For The Scribe

Ty Gluckman, MD, is the first to admit that he's not the earliest adopter of new technology; no smartphone, no blog, just the basics so far.

But Gluckman, a cardiologist and the regional director of the **Providence Heart and Vascular Institute**, does see a lot of promise in technology's ability to improve care for patients in many different ways. One in particular: mobile health monitoring.

"Some of this new technology can really make people an integral part of their own health care team," Gluckman said. "It gives people a sense of their ability to interact with their providers in their care. There's been a barrier to this kind of interactivity. Technology has brought down that barrier."

TY GLUCKMAN, MD

While still in its relatively early stages, mobile health monitoring technology is becoming a reality in large part due to the rise of the smartphone and wireless networking. Mobile devices have been developed to help people measure their blood pressure, listen to heartbeats, monitor blood sugar levels and even track electrocardiogram tracings. Some of the devices attach to smartphones or tablets and sync up with software applications that record and share data.

"This equipment is arming patients with information in ways that they have not had before," Gluckman said.

In December, Providence was finalizing terms on a mobile monitoring technology grant from a telecommunications company. If the deal comes to fruition, Providence would have mobile monitoring devices that it could issue to, say, residents of a skilled nursing facility when they are discharged. They would use them to monitor blood pressure and weight levels; the devices would then send that information to care providers at Providence.

A quick scan of the Apple App Store came up with scores of health monitoring apps. Some let people monitor their heart rates and blood pressure; others work for diet, exercise and even sleep cycles. And still others work with larger software programs that hospitals may purchase, which then give doctors access to patients' real-time data. One app, called AirStrip, lets clinicians log in securely to see everything from lab results and prescription medication lists to cardiac waveforms and vital signs.

Gluckman and other providers at Providence and elsewhere already use a similar approach with some patients through electronic health records. Gluckman said the EHR at Providence allows him to send patients blood pressure flow sheets for home use and based around specific parameters. If data comes in outside of those parameters, Gluckman gets a notification and can work with patients to adjust therapies and get them back on track.

"It really improves the connectivity with the patient," he said.

In a more advanced example, physicians at Ohio State University have conducted trials of implantable medical devices that monitor conditions inside the body and transmit the data to physicians. In one trial, doctors implanted small catheters with sensors on the end of them inside the pulmonary artery or the left atrium of the heart in patients who have had heart failure. The catheters monitor the pressure inside the heart and send the data to doctors—valuable information to have, since an increase in pressure in the left atrium can be a sign of impending heart failure.

"If it ends up reducing heart failure, you could see more and more patients jumping on board," Gluckman said. "I believe there are a number of other areas where this kind of information will be helpful."

Others in health care are turning to mobile technology as well. **Housecall Providers**, a Portland nonprofit that provides primary medical care to homebound seniors and disabled patients, uses a "virtual clinic" model to deliver their services. Clinicians out in the field connect remotely with care coordinators back in a physical office to make sure patients are getting the treatment and care they need. The clinicians use Droid smartphones with wireless Internet hot spots to stay connected; they can also tap into electronic health records remotely. Additionally, they use mobile devices for blood draws, and they can order X-rays, ultrasounds and EKGs to be done in the home.

"There are applications for us that work really well," said Terri Hobbs, Housecall Providers' executive director. "We're always exploring whether something would work for us, like iPads."

One of the reasons Housecall Providers doesn't use even more technology than it already does is plain and simple: the cost.

"For us as a nonprofit, it's very expensive," Hobbs said. "Unless we get grants or other funding, we can't always afford it. But there are definitely things that are happening and ways we are moving forward."

Another challenge with mobile technology is that it can give patients vast amounts of information and pretty much instant contact with their providers. Yet while there may have been some worry that patients would be forever emailing or texting their doctors and poring over their EHRs with the advent of technology, Gluckman said that hasn't really happened so far. And though some older patients might not be comfortable with new technology, Gluckman said it's not rare to see an 80-year-old swiping away on an iPhone.

"And now," he said, "I think as we have a younger generation that has been raised on smartphones and tablets, this will be the norm for decades to come." •

In what ways is your practice using mobile monitoring devices? How are they improving health outcomes, and what feedback have patients provided about the technology? Visit the Members Forum section at msmp.org to respond.

Prominence of mobile devices, social media in health care prompts international focus, local training

By Melody Finnemore
For The Scribe

Although legal guidance and regulations may differ from one country to another, concern about physicians' use of mobile devices, social media, health care apps and similar technologies as part of their practice—and potential legal pitfalls—is widely shared across the developed world, according to a Portland health care attorney.

Indeed, health information privacy and security are global issues, Paul DeMuro says.

A focus is being placed on these issues right here in River City. As physicians' on-the-job use of personal laptops, smartphones, tablets and other devices grew, Oregon Health & Science University began offering a course titled "Health Information Privacy and Security." DeMuro co-teaches the course with Justin Fletcher, an assistant professor in OHSU's Department of Medical Informatics and Clinical Epidemiology. DeMuro's portion of the course focuses on issues he has seen firsthand through his legal practice at Schwabe, Williamson & Wyatt.

Among them is the legal quagmire that can occur when a physician uses their own electronic device for their practice, commonly referred to as BYOD for bring your own device. The issues involved range from who owns the data stored on the device, whether that data is properly encrypted, how to protect patients if the device is stolen or lost, and how the data is managed if a physician leaves the practice to work elsewhere.

"Those privacy and security issues extend to what kind of policies a medical group may have about physicians using their own devices," DeMuro said. "Some don't have a policy and they passively let physicians do things on their iPads. Others have policies against using iPads because of security, but they may know their physicians are doing it and turn a blind eye."

Interaction with patients through social media is another subject DeMuro frequently encounters in his legal practice and discusses during the OHSU course. Potential problems within this realm include whether a patient-physician relationship is inadvertently established if a new patient contacts a physician through their social media site. The type of social media presence a physician establishes is critical from the start, DeMuro noted.

"The American Medical Association and state medical societies suggest that physicians should keep their personal social media presence separate from their professional presence," he said. "This is a big area that people coming out of medical school and residencies are more familiar with because they use social media for personal reasons, and that can create a ton of problems."

On the flip side, physicians also need to think twice about viewing a patient's social media presence. DeMuro illustrated this point with an example of a doctor, curious about whether a patient was being honest about their lifestyle choices, going online and finding photos of the patient smoking, drinking or doing drugs.

"If the patient has previously denied doing any of those things, does that change the way the physician treats the patient after knowing these things?" DeMuro said. "How will that snooping be viewed by the medical board, and how does the physician get themselves out of the fix?"

The use of health care apps can be another potential minefield, particularly when it comes to the regulation guidelines the U.S. Food and Drug Administration recently issued in its Final Guidance on Mobile Medical Applications. DeMuro said the FDA's "murky" rules include regulating apps that are used for diagnoses or treatment but not regulating those that are purely informational.

"In between is the gray area that the FDA has decided not to regulate and therein lies, in my opinion, where most of the issues will be," he said, adding that with so many apps available online and at medical conferences, physicians may unsuspectingly step into a problem area without knowing it.

"A clinician generally would have no clue, so they can be using an app and maybe they should be using one that is approved by the FDA," DeMuro said. "Whether it's FDA approved or not, you need to be careful about any app you're going to use that has anything to do with health care." •

CAMBIA *from page 3*

By way of encouraging physicians to sign up, Freiwat notes that once the exam is over, the consumer walks out the door and the billing process begins—with coding, claims filing, benefit coordinating, billing, adjusting and collecting payments from insurance companies and consumers. This can drag on for months and be a resource drain on a physician's practice. Doctors in small to midsize practices told him that chasing down the patient's portion of a bill is not cost-effective, so they often just let it go.

Wellero is an attempt to solve that problem, as well as to shorten the entire collection experience and collect the consumer's responsibility immediately. It's free to join, for both provider and consumer, and offered as an iOS and Android mobile app.

To use Wellero, providers don't need to purchase new software or equipment. Instead, the patient's smartphone can access the Wellero system directly, and at check-in, and lets the office staff instantly validate insurance eligibility.

Freiwat summarized other benefits to the physicians:

- Consumer co-pay and coinsurance are collected at the time of the service. Wellero compensates the provider within two to three business days instead of the typical 60 to 90 days that the insurance and patient payment cycle takes.
- Wellero checks the consumer's insurance eligibility at the time of service, saving the provider administrative time and effort. The app is HIPAA compliant.
- Wellero also reduces claims paperwork and billing errors for medical providers by applying health plan clinical editing rules at the time of the service, which can increase administrative efficiencies and reduce lost revenue from rejected claims.
- There are no monthly subscription fees or software integration costs. Wellero gets paid only when payments are collected from the consumer.

"The response has been extremely positive," Freiwat said. "We've received resounding feedback from the provider community that the app is easy to use and streamlines their office staff processing." •

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Training, travel and time to recharge

Medical professionals share plans for maintaining health, wellness in 2014

"Variety is my spice of life! As a triathlete, I rotate through running, biking and swimming on a regular basis. It keeps me mentally fresh and is very effective cross training. For 2014, I'm helping a friend prepare for her first triathlon; I love to introduce friends and family to the sport! Recently, I've taken up salsa dancing and this year hope to improve my dancing ability. Not only is it a great workout, I love the music and the fun social community."

—Christine Cha, MD, *radiation oncologist, The Oregon Clinic*

"I am an avid mountaineer with the goal of climbing all the high peaks in the Pacific Northwest and Colorado. I volunteer uncountable hours with a local hiking/climbing organization called the Mazamas. I am working towards a diploma in mountain medicine so that I may provide expert care to other high-altitude seekers. In addition to mountaineering, I plan to continue running, traveling and reading to maintain my health and wellness in 2014."

—Ann Marie McCartney, MD, *internal medicine, The Portland Clinic*

"I thoroughly enjoy practicing sports medicine and plan to help my patients reach their personal physical health goals. I also plan to play more guitar to help maintain my own wellness in 2014."

—Jonathan Crist, MD, *sports medicine, The Portland Clinic*

"I turn 60 this year, and I've always wanted to see the northern lights. I've booked a trip for my husband and me to Alaska with a Mazamas group to see them. Also, I do yoga and go to the gym, but my goals in 2014 are more about keeping my mind active and learning new things. There's a song on YouTube kids have been telling me about called "Cups," where you sing a song a cappella while doing a drum routine on a paper cup. I've told my husband that by my birthday in August I'll be able to do that. Also, I plan to start playing a video game, which I've shunned for 40 years, to improve my hand-eye coordination."

—Anna Jimenez, MD, *medical director, The Wallace Medical Concern*

"Traveling to new places is how I thrive and recharge. I plan to travel and discover several new places in 2014."

—Michael Hwang, MD, *orthopedics, The Portland Clinic*

"In 2014, I plan to continue doing the things that help me thrive in mind, body and spirit—my daily morning run, eating healthy, spending adequate time with family and friends, and stopping to smell the sweet Portland roses every once and a while."

—Ron Allen, DO, *ophthalmology, The Portland Clinic*

"I strongly believe in living my life with the same focus on balance as I share with patients. This starts with a healthy diet, a varied and regular exercise regimen, time for sleep, meditation and quality social time with friends and family. I plan to replenish my soul by exploring nature through cycling, kayaking and hiking through new areas of this beautiful state, in addition to working in the yard and cooking meals with my wife. I also believe that providing a quality service to those that I serve gives me a purpose and direction that keeps me healthy and happy on many levels, so I plan to continue this in 2014."

—Miles Holland, ANP, *cardiology, The Portland Clinic*

"I think it is important to set obtainable goals—the more realistic they are, the more likely you will be able to achieve them. My general goals are to exercise four times per week, and drink more water on a daily basis. Like most women, I am always trying to have more self-control, especially when it comes to desserts. I have learned that the key is moderation and depriving myself of something I love will eventually backfire. It is also crucial to love your body, no matter what shape or size as women tend to be especially hard on themselves and constantly find physical flaws."

—Melissa Pendergrass, MD, *women's specialties (gynecology), Legacy Medical Group*

"Exercise is key to feeling and being healthy. I plan to focus on exercising more regularly in the morning, even for just 15 minutes. It energizes me and helps me feel good the rest of the day as well as sleep better at night. I also plan on taking advantage of the wonderful fresh produce in this region and will incorporate more fruits and vegetables into my diet."

—Jody Tate, MD, *pulmonary, critical care and sleep specialist, Legacy Medical Group*

How do you plan to improve or maintain your health and wellness in the new year? Share your thoughts in the Members Forum section at msmp.org.

Reinschmidt key figure in Oregon's rural health care transformation

By Maija Anderson, OHSU Library
For The Scribe

Oregon's health care providers have addressed the challenges of rural medical practice since the 19th century. The picturesque ideal of the country doctor on horseback was the reality for many early physicians. Oregon's pioneer doctors described long journeys to call on patients in remote areas, bartering for food in exchange for their services, and isolation from their colleagues. By and large, these practitioners were generalists, and accepted the expectation of being all things to all patients. Medical education programs in Oregon also accepted the challenge, seeing the development of a strong, statewide medical profession as part of their mission.

However, as Oregon's urban centers grew, the needs of rural patients remained distinct and became underserved. Medical schools and major hospitals were in cities. Few of Oregon's medical students returned to rural communities to establish a practice. Physicians who remained in those communities had fewer resources than their urban counterparts, and little continuing education or professional support. Oregon was soon experiencing a crisis in rural health care.

Oregon was not alone. In the early and mid-20th century, as medical education became lengthy and scientifically rigorous, the number of physicians—especially primary care providers—dropped nationwide. The social concerns of the 1960s–1970s brought attention to disparities in health care, including the shortage of providers in rural communities. In a 1970 report, the Carnegie Commission recommended that academic health centers partner with rural communities to develop a network of health education centers across the country. Congress provided funding for the first Area Health Education Centers in 1971. Oregon, however, would not have an AHEC until 20 years later.

The key figure in the transformation of rural health care in Oregon is **Julian S. "Dutch" Reinschmidt, MD**. Originally from Florida, Reinschmidt was educated at Vanderbilt School of Medicine, and completed a residency at University of Colorado Medical Center. His experience practicing in the small Eastern Washington town of Tekoa influenced his commitment to rural medical education. In a 1997 interview with **John Benson, MD**, Reinschmidt said, "You have to understand I really enjoyed the general practice I was in. But the isolation, the lack of any real resources for help made one work out of one's own salvation."

Reinschmidt joined OHSU's School of Medicine in 1976. As associate dean of Continuing Medical Education, he developed a model program that served rural practitioners. His interest in AHECs did not at first attract institutional interest, but his efforts created a strong network of supporters across the state. When **Peter Kohler** became OHSU president in 1988, he prioritized statewide rural medical education. Kohler appointed Reinschmidt to develop and direct an AHEC program for Oregon.

A 1988 conference in Joseph, Oregon, brought academic leaders together with legislators and rural health care providers. It culminated with the appointment of a task force, directed by Reinschmidt, to establish an AHEC program. The proposed program was based on Reinschmidt's vision of how and where students would be educated; how continuing education would be supported; how postgraduate residents would be trained; and how to communicate that OHSU, as Oregon's only medical school, understood rural problems and could be part of the solution. In 1990, the proposal for federal funding of Oregon's AHEC program was approved. The first AHEC was established in LaGrande in 1991. Today there are also centers in Bend, Lincoln City and Roseburg, as well as a workforce development center in Lake Oswego.

Reinschmidt later became the architect of a radical curriculum transformation in the medical school. The new curriculum required students to spend six weeks working alongside rural primary care doctors. Reinschmidt saw this as an opportunity to improve the students' education, while encouraging them to consider rural practice themselves.

In 1979, the Oregon Legislature created the Office of Rural Health and its advisory body, the Rural Health Coordinating Council. The office was charged with coordinating and improving health care for rural Oregonians. The late 1980s and 1990s brought other state programs and incentives that sought to improve the shortage of rural health care providers. In 1989, the Office of Rural Health partnered with OHSU to improve rural access to statewide health resources.

Technology emerged as a critical tool for rural medical education. In the 1980s, early telephone conferencing made it possible for rural physicians to call in to lectures given by distant presenters. Telephone conferences paved the way for videoconferencing, and a new generation of virtual presentations.

Today, Oregon is still challenged to overcome disparities in rural health care, and to develop and support a strong workforce of rural health care professionals. Current efforts, including the recent establishment of an OHSU satellite campus for rural medicine in Klamath Falls, build on Reinschmidt's original vision of supporting health care practitioners through strong academic-community partnerships. •

Julian S. "Dutch" Reinschmidt, MD, circa 1980s

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Clinic: Upwards of 250,000 Oregonians have received care

DEVERS, FROM *page 1*

fundraising, Devers' seed money has grown to an endowment of more than $20 million. The institute has an annual budget of $1.5 million for the patient clinic and a staff of 100, including 20 ophthalmologists.

About 20 percent of uninsured patients receive direct funding from the Devers Memorial Fund, while the percentage of underinsured patients (Medicare and Medicaid) being served is between 60 percent and 70 percent. In the wake of the Affordable Care Act (ACA), it is likely that both clinics will see more patients with some degree of insurance, but it is also likely that Medicaid plans will not cover their expenses, Rosenbaum explained.

"The EHBP (Essential Health Benefit Plan), which is a part of the ACA, only mandates vision coverage for children, so unfortunately there will still be a great many people without covered vision care," he said.

Upwards of 250,000 Oregonians have received care from the Arthur Devers Memorial Eye Clinic since it opened, including 15,000 patients last year. This figure does not include many patients who were treated by sub-specialists.

Devers is unique not only because of its commitment to charitable work, but also because almost all other highly regarded eye research institutes are affiliated with university medical schools.

Modern corneal transplantation was born at Devers. **Richard Chenoweth, MD**, Devers' first full-time director, also was the first Pacific Northwest retinal surgeon. His trainees included **Joe Robertson, MD**, now president of OHSU.

Innovations bring international prestige

Devers has carved out an international reputation with cutting-edge research and a series of surgical innovations. It is the mecca of modern corneal transplant surgery because of the work of **Mark Terry, MD**, whose innovations include techniques such as deep lamellar endothelial keratoplasty, Descemet membrane endothelial keratoplasty and refinements in Descemet's stripping endothelial keratoplasty.

Devers spends about $4.2 million annually on research, $2.2 million coming from National Institutes of Health grants. It invests an additional $2.1 million from its endowment to support research and to fund care for the indigent.

Last year, the Institute for Scientific Information, which tracks research on the basis of article citations, ranked Devers number one in the world for the study of eye biomechanics.

Some leaders of the Devers "Discoveries in Sight" research team include **Claude Burgoyne, MD**, who leads glaucoma research and has won the Lewis Rudin Glaucoma Prize, the $200,000 Alcon Research Institute award and the Association of International Glaucoma Societies Award. Burgoyne serves on the board of the Association for Research in Vision and Ophthalmology (ARVO), the world's largest eye research organization.

The section editor of the *American Journal of Ophthalmology* for epidemiology and the author of more than 175 scientific papers, **Steve Mansberger, MD, MPH**, serves on the boards of Prevent Blindness America and the Glaucoma Research Foundation. Mansberger has received upwards of $11 million in federal funding for his groundbreaking work on the epidemiology of eye diseases.

Because of his international reputation and unique surgical skills, patients from all around the world come to see Terry for corneal transplants. In addition, visiting scientists and fellows from South Africa, Australia, Japan, China, and some of the farthest-flung places on the globe come to learn new surgical techniques from Terry and other Devers physicians (see sidebar).

Rosenbaum has received the Friedenwald Award (the highest award from ARVO), the Distinguished Clinician Scholar Award from the American College of Rheumatology, and the Gold Medal given once every four years by the International Uveitis Study Group Foundation. The author of more than 400 scientific papers, Rosenbaum is a past president of the American Uveitis Society.

Devers is also recognized for tracking the characterization of structural changes near the optic nerve from glaucoma; innovative clinical trials; studies on ocular blood flow; and devising techniques to detect and measure early changes in glaucoma.

Currently, Devers is conducting clinical trials to determine if a single injection can obviate the need to use glaucoma drops for six months. It is also studying a new technique called "corneal cross-linking" to better treat the visual distortion from a condition known as keratoconus, a thinning disorder of the cornea that occurs in one out of 2,000 people. •

MSMP welcomes nominations for the Rob Delf Honorary Award

The Board of Trustees of the Medical Society of Metropolitan Portland has created an annual award in honor of Rob Delf's long service to the organization. This award is to be given to a person or persons who exemplify the ideals of the Medical Society within the community where members practice.

This can be demonstrated by work projects or activities that improve the health of the community or the practice of medicine in arenas including but not limited to the practice of medicine; education of new members of the medical community; education of the public about health, medicine and health public policy; improving public health and emergency preparedness; advocacy in health public policy; or other community activities relating to healthcare and policy. This award may be given to members of the medical community, the health education community, or the general public.

The Board of Trustees is interested in receiving nominations for this award, to be presented at our annual meeting in May. We welcome nominations until the **deadline of Feb. 28, 2014.**

Please send your nominations to amanda@msmp.org.

Harvard doctor among many who receive training at Devers

Like many accomplished medical professionals, **Peter Veldman, MD**, himself from an acclaimed teaching hospital, came to Legacy Devers Eye Institute for additional training.

PETER VELDMAN, MD

Veldman, from the Massachusetts Eye and Ear Infirmary, a Harvard Medical School teaching hospital, is specializing in corneal surgery and spending a year at Devers. He moved to Portland last July with his wife and two-month-old daughter to learn new surgical techniques and is focusing on corneal transplantation, particularly the lamellar or partial thickness corneal procedures including DSAEK, DALK, ALK and DMEK.

Veldman is far from alone in training at Devers, which, because of its accomplished specialists and leading position in the field, attracts many visiting doctors. *The Scribe* spoke recently with Veldman about his experience at Devers, among other topics.

The Scribe: **How did you happen to come to Devers?**

Veldman: I came to Devers to work with Drs. (Mark) Terry and (Michael D.) Straiko because they offered training that I couldn't get back in Boston. They are on the absolute cutting edge of corneal transplantation, particularly with their continued advancement of DMEK (the thinnest possible corneal transplant). In fact, currently there is no one at Harvard, or in Boston for that matter, doing this new form of transplantation. After interviewing at many of the most renowned eye centers in the country, I was convinced that Devers offered the best cornea training available anywhere. I was ecstatic to come here.

What makes Devers stand out in ophthalmology?

Many things, but especially the cornea service at Devers, which excels at every type of corneal transplantation. By providing these various transplantation techniques, they are able to replace exactly the tissue that is deficient and leave the healthy tissue in place. This allows people to minimize the amount of surgery needed, recover faster and have better vision when they are done. There are very few places in the country that excel at all of these types of surgery.

What are the highlights of your time at Devers and in Portland?

I have been honored to contribute in the care of many patients. It is very exciting to be able to offer patients the best possible treatment for their diseases. Also, my family has enjoyed Portland and the greater Pacific Northwest. There is so much natural beauty here, and the culinary experience has been great as well.

How do you spend your workdays?

I spend the majority of my week seeing patients in clinic or in the operating room. I do have some research time on Wednesdays that has allowed me to do additional work both in the lab and at the eye bank (Lions VisionGift). This work is being presented at a number of meetings this year, including our national Cornea Society meeting and at the American Society of Cataract and Refractive Surgeons meeting in April (in Boston).

Is Devers a smaller institution than you are accustomed to?

Devers is much smaller than Mass. Eye and Ear. There are approximately 80 ophthalmologists on staff at Mass. E & E alone and well over 200 in the Harvard system. One of the biggest advantages of being in a smaller facility is the one-on-one mentoring that is possible.

What do you hope to accomplish in 2014?

I will be joining the Cornea Service at Harvard in the fall of 2014. I am looking forward to bringing the advanced transplantation techniques that I have learned at Devers, particularly DMEK, back to Boston. •

—John Rumler

Ambulatory surgery center association sees progress through discussions with CareOregon

By Melody Finnemore
For The Scribe

Members of the Oregon Ambulatory Surgery Center Association, concerned about initially being left out of the coordinated care organizations (CCOs) formed as part of the state's health care reform, are now seeing some positive results from collaboration between the association and CareOregon.

CareOregon provides plan services to five CCOs and Oregon's Health CO-OP, and offers two Medicare plans that support the state's coordinated care system. The association represents the approximately 85 ambulatory surgery centers that provide same-day surgical, diagnostic and preventive procedures. In 2012, the total statewide economic impact of ambulatory surgery centers in Oregon was nearly $612 million.

Rob Schwartz, the association's executive director, specifically praised Rose Englert, senior manager of regulatory affairs at CareOregon, for her efforts to provide ambulatory surgery centers with contact information and other resources to improve their chances of contracting with the CCOs.

Schwartz had previously expressed frustration that ambulatory surgery centers were not part of the conversation about which medical providers would be allowed to contract with the CCOs. He noted that research about ambulatory surgery centers shows them to be a successful, low-cost option with proven outcomes.

"We feel that surgery centers should be at the table," he said during a November interview. "If one of the major purposes of CCOs is to drive costs down, then it would seem to be logical that lower-cost providers would contribute to achieving that goal. If you're going to keep sending patients to the highest-cost providers, how to you hope to achieve a different outcome?

"Another area of concern we're hearing about is what we're calling a two-tier approach where CCOs create a structure and then the surgery centers are invited to participate as out-of-network participants," Schwartz noted during the November interview. "That marginalizes the surgery centers, and that is not the spirit of what Governor Kitzhaber was trying to achieve."

In a second interview following meetings with CareOregon, Schwartz said he was pleased with the results and the association's members look forward to being included in future conversations about how to improve the state's health care system. •

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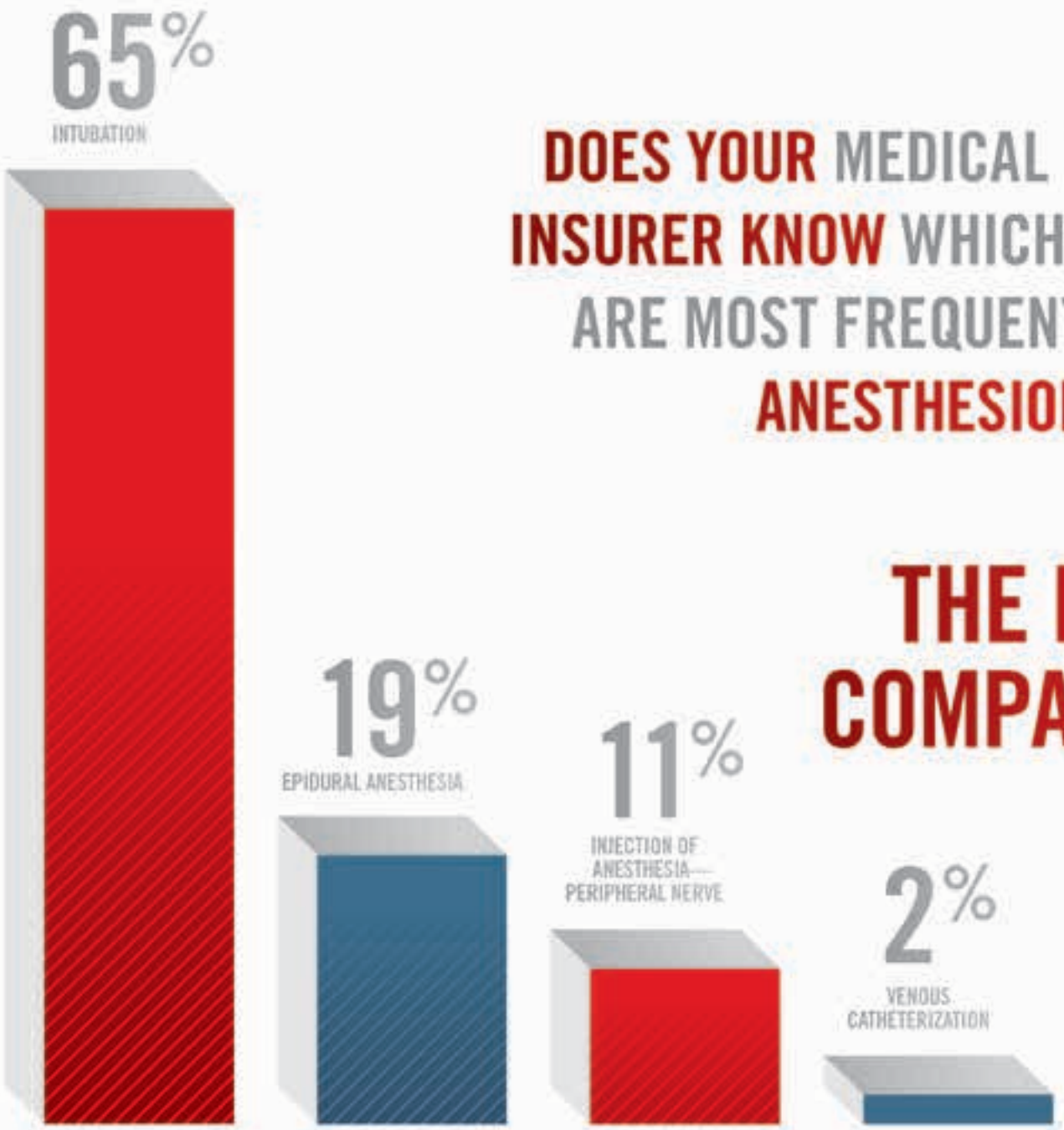

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