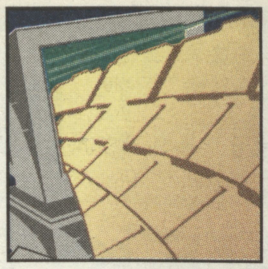
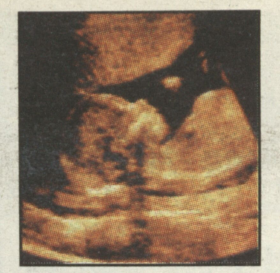


Are you really ready for HIPAA?

— Page 5



Focus on Technology: New help with infertility

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The Portland Physician SCRIBE

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M2FO investing in the community

By John Kendall, MD
M2FO Board Member

The Metropolitan Medical Foundation of Oregon (M2FO), the Medical Society's beneficent arm, has a very strong base in terms of numbers of donors for its badly needed work. However, its financial base is still very small, principally because almost every donor contributes $20 when renewing his or her membership in the Society. This is a suggested amount and we are very fortunate that so many choose to make a donation. It is truly appreciated.

Could more make a difference? You bet it could. The small grants program is a wonderful example of the uses that your contributions support. These have mainly gone to organizations that are engaged in health education. Larger contributions have been made to bolster immunization programs in Oregon. The Scribe has and will continue to report on these projects so that you can see where your money is going.

So why don't we contribute more? I believe it is partly explained by our own backgrounds. Many of us (physicians) learned to give only relatively late in life. We were students until age 30 or so and were forced to be very cautious about all expenditures. Then we had debts to pay off, mortgages to start up, families to feed and education to ensure. So by age 50 or 60 when we could be giving more, the habit of giving had, for many of us, never been developed or, if developed was still hypotrophic.

Can the giving muscle be exercised into a normotrophic state? I am convinced it can and would like to suggest a beginning step for all who have been reliable $20 donors these past years of M2FO's activities. As you write your membership dues, steady your hand, grimace slightly and then take the courageous step of adding a zero after the 20 and before the decimal on the donation line. See how easy it would be? I did it, and have given even more and it really makes me feel good. I feel it is an investment in the health of the community.

If you are bitten by the giving urge, consider talking with one of the board members about M2FO's activities. Perhaps you could help make it an even stronger foundation by participating in its activities. I can be reached at 503-494-6021.

Local participants contribute to Womens Health Initiative

By Cliff Collins

After two follow-up studies released in May and June, the case against combined hormone therapy for menopause looks stronger than ever.

"I think the tide is turning," said Cheryl Ritenbaugh, PhD, MPH, of Kaiser Permanente's Center for Health Research. The center was one of several nationally that studied the effects of combined estrogen and progestin hormone therapy. The Women's Health Initiative followed 16,000 post-menopausal women for a decade, until the Data Safety Monitoring Board halted the study in July 2002. The study was stopped after results showed the combined medications increased women's risk of breast cancer, heart attacks and stroke.

Before that, the drugs had been thought to provide protective effects for heart disease and osteoporosis, but a lot of the positive effects were construed only from "observational studies," said Ritenbaugh, principal investigator for the trials at Kaiser, which followed 348 women in Oregon and Southwest Washington. "We've been fooled by observational data."

New findings released at the end of June found that women who had been involved in the study had a significantly increased risk of breast cancer and an increase in breast density that made tumors harder to detect until they were more advanced. The combined therapy "created almost immediate changes in mammograms," said Ritenbaugh. "It absolutely increased the rate of breast cancer and simultaneously delayed diagnosis."

In May, researchers announced that estrogen-progestin doubled the risk of dementia in older women. Like the most recent findings, this discovery was the opposite of what the drug's maker, Wyeth, and researchers had expected. That's because there is "a lot of epidemiological evidence that estrogen helps cognitive functioning," she explained.

That study found that post-menopausal women age 65-79 who took estrogen plus progestin developed demntia at more than twice the rate of similar women who took placebos. The study also found that the two groups of women developed mild cognitive impairment at the same rates. A second finding, which looked at global cognitive function (concentration, language, memory, and abstract reasoning) among the two groups, showed that women taking the drugs had slightly lower cognitive function scores than did those on placebo.

A third finding of the May report showed that post-menopausal women aged 50-79 taking the combined hormones had a 31 percent greater risk of stroke than women who took placebos and that women in all age groups and health categories taking the drugs were at increased stroke risk.

"These new findings strengthen the view that women should not take the estrogen plus progestin combination long-term to prevent diseases," says Ritenbaugh. "At this point, the benefits of the hormone combination for osteoporosis and colon cancer are far outweighed by the increased risks of breast cancer, heart disease, stroke and dementia, and by the lack of benefit for maintaining or improving cognitive function."

In the findings released in June and published by the Journal of the American Medical Association, researchers found that even short-term use appeared much riskier than thought. The changes in breast tissue appeared within a year: About 30 percent of women who had been in the study had at least one questionable mammogram, a prevalence rate considered high, she said. The changes in breast density apparently both promote early tumors and make their detection harder. The difference in abnormal mammograms continued throughout the six years the women received mammograms.

Invasive breast cancers among women taking the drugs were larger and were diagnosed at a more advanced stage. After four years, women had a 45 percent greater risk of invasive breast cancer than the women who had taken placebos. "If a woman is on combination hormone therapy for relief of menopausal symptoms and gets even one abnormal mammogram, that should be a strong signal to seek alternatives," Ritenbaugh said.

The negative reports over the past two years have made both providers and patients re-examine the reasons women are taking the combined hormones. "I think that the average consumer is extremely confused about what to do," said Susan Cooksey, PhD, lead practitioner for the Kaiser center's Women's Health Initiative study. Their question, she said, is: "How does a 16,000-person national study relate to one person? How does it relate to me?"

She said patient reactions to the studies have varied. "Some people immediately take themselves off," without even consulting their health care provider, said Cooksey, a nurse practitioner. Many others asked for advice about how to proceed, often reeling from the news that what they thought they were taking the drugs to prevent might

Please see RESEARCH, page 4

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ON THE LEADING EDGE:

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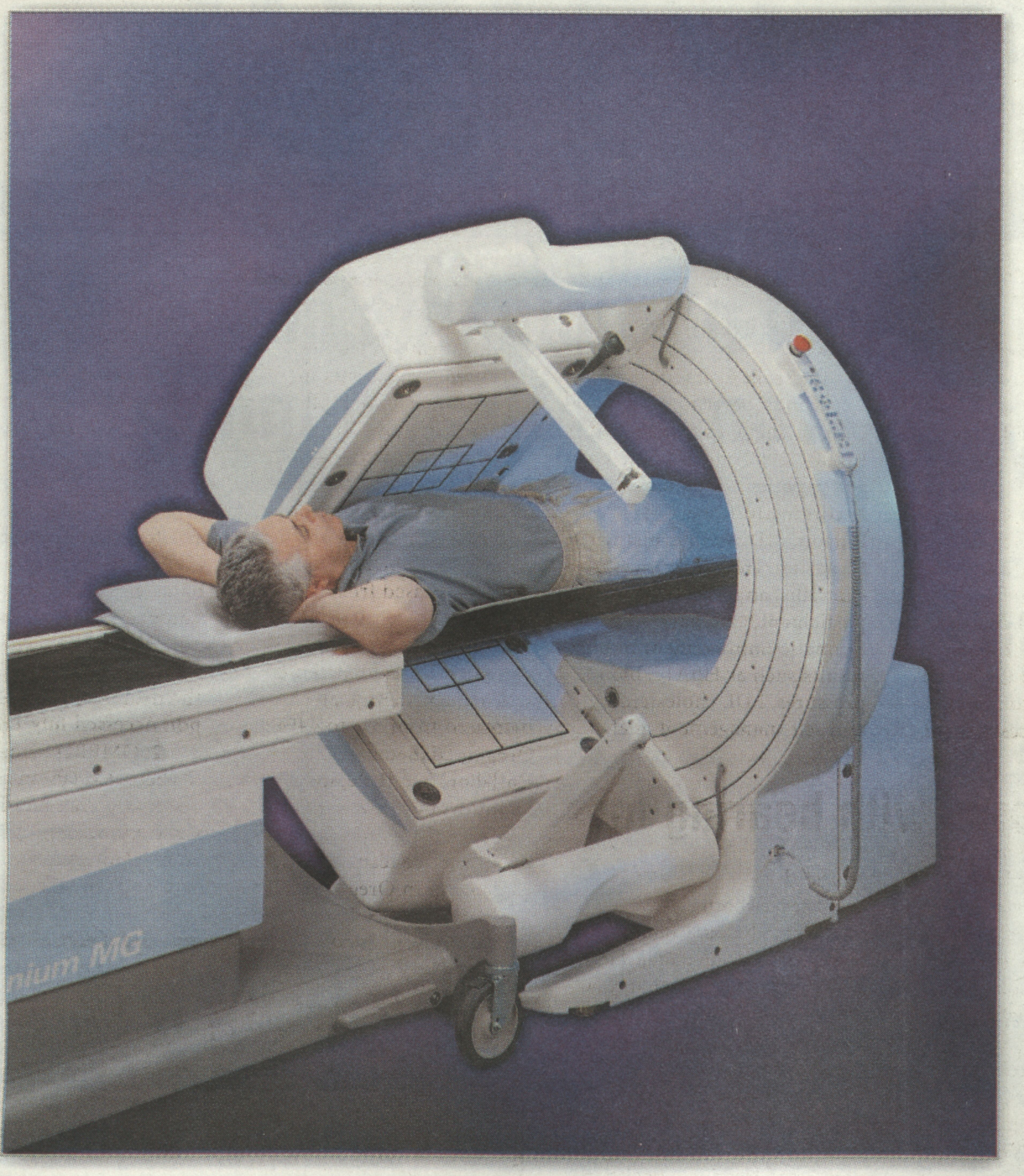

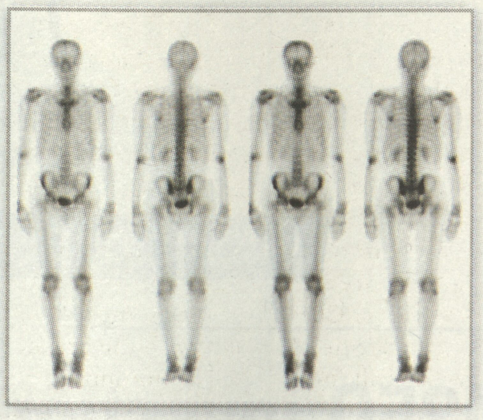

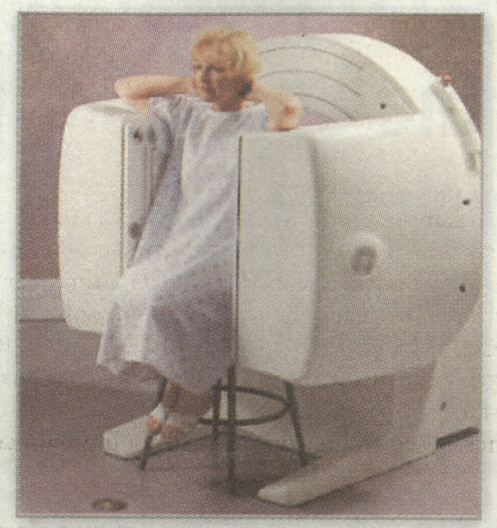

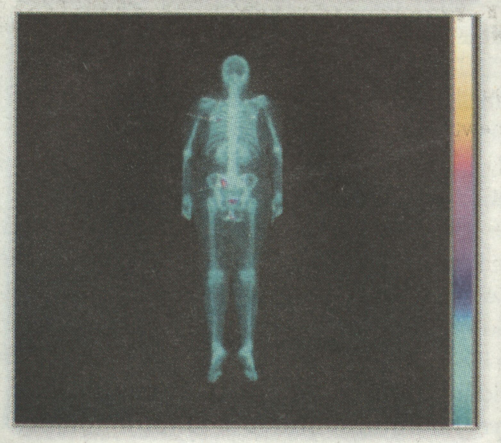

NUCLEAR MEDICINE SERVICES HAVE BEEN EXPANDED AT EPIC IMAGING

In response to requests by numerous referring offices, EPIC Imaging|West is pleased to announce the addition of nuclear medicine to our service offering. The Beaverton facility represents the only non-hospital based facility on the Westside currently providing nuclear medicine services. In a field that requires longer procedure times, the relaxed outpatient environment greatly enhances patient care.

EPIC Imaging|West is now scheduling appointments for:

- **Bone Scans**
- **Biliary Imaging**
- **Thyroid Uptake**
- **Renal Scans**
- **Breast Scans**
- **Gastric Scans**

Services have also been enhanced at EPIC Imaging|East. We now feature a state-of-the-art, dual head GE Millennium MG gamma camera. The unit provides 180° positioning for uncompromised whole-body exams and superior image quality. The unique design places the detectors externally on the gantry improving patient comfort, enhancing patient positioning and greatly reducing claustrophobic reactions with reduced scanning time.

The new gamma camera is housed in the EPIC Portland PET Center at our Eastside campus. Studies are performed on the bones, breast, liver, gall bladder, kidneys, spleen, lungs, thyroid and lymph system. Please call the centers for services not listed. We will make every effort to accommodate you.

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OMPRO reports on Diabetes Collaborative II

By David Shute, MD

Patients with diabetes and other chronic conditions place growing demands on our healthcare system, and on primary care physicians in particular. Chronic conditions are now the leading cause of illness, disability, and death in the adult population. The systems we use work well for managing acute problems, but do not meet the needs of patients with chronic illnesses.

Many healthcare leaders-including the authors of Crossing the Quality Chasm, the significant Institute of Medicine report-call for a fundamental redesign of healthcare delivery to increase the effectiveness of chronic illness care. Oregon Diabetes Collaborative II is an opportunity to participate in and benefit from this redesign.

How the Collaborative Works

During the yearlong Collaborative, teams from Oregon clinics will learn the Chronic Care Model (CCM) and apply it to their own practice settings. The CCM is an evidence-based framework developed by Improving Chronic Illness Care, a program of The Robert Wood Johnson Foundation, to support more effective care for diabetes and other conditions.

The Collaborative brings the clinic teams together in a series of Learning Sessions to develop ideas for changes based on CCM concepts. Back at their clinics, they engage in small-scale tests of these changes. The teams observe what works and what doesn't, gradually implementing tested improvements. At the end of a year, they share their results with the broader healthcare community.

Oregon Diabetes Collaborative II provides expert support for this work through its clinical faculty, chaired by Melinda Muller, MD, Associate Medical Director of Legacy Clinics, Portland, and a participant in the first Collaborative. Participating teams also problem-solve and share ideas with each other. Between Learning Sessions, the teams stay in touch via conference calls, a limited-access e-mail list service, and progress reports.

Results from Collaborative I

Clinics participating in Oregon Diabetes Collaborative I (2001-2002) documented better patient outcomes.1 According to Robert M. Burton, MD, an internist with Samaritan Health Services, Corvallis, and a Collaborative participant, "We have seen a dramatic improvement in our results such as HbA1c, blood pressures, LDL cholesterol, and self-management goal setting."

Aggregate outcomes improved for patients in collaborative clinics' pilot groups: as follows:

- the proportion of patients with HbA1c <8.0% increased from 53% to 68%
- the proportion of patients with LDL-C <130 mg/dl increased from 39% to 57%
- the proportion of patients with a documented self-management goal increased from 3% to 44%

Oregon Diabetes Collaborative II Begins October 2003

We invite physicians and their practice teams to participate in Oregon Diabetes Collaborative II. Learning Sessions begin October 30-31, 2003, in Portland.

Oregon Diabetes Collaborative II is sponsored by OMPRO and the Oregon Diabetes Coalition. For more information about participating, contact Collaborative Director Donna Thatcher, RN, CPHQ, at 503-279-0185, or Collaborative Coordinator Margene Bortel, BS-HSA, CPHQ, at 503-425-1234, or visit www.ompro.org/diabcollab on the Web.

CME credit for system improvements in clinics

In addition to earning CME for attending Learning Sessions, physicians participating in the Collaborative qualify for up to 10 hours of Category 1/Prescribed CME for improvement work in their own offices. The CMS-sponsored CME program encompasses diabetes care, breast cancer screening, and adult immunizations. It is offered free of charge to physicians.

See www.ompro.org/office-care/natl-CME-overview.html for details.

David Shute, MD, is Medical Director of OMPRO, Oregon's Quality Improvement Organization, and Improvement Advisor of the Oregon Diabetes Collaborative II.

FOOTNOTES:

1. Oregon Department of Human Services. The cure for hamster health care. CD Summary 51(24), November 19, 2002. Available online at www.dhs.state.or.us/publichealth/cdsummary/2002/ohd5124.pdf. Accessed July 1, 2003.

2. OMPRO. Oregon Diabetes Collaborative I: results. Available online at www.ompro.org/diabcollab/results. Accessed July 7, 2003.

New law benefits newborns with hearing loss

In 1999, the state Legislature passed a newborn hearing screening law that assures 90 percent of Oregon infants are checked for hearing loss at birth. Now, legislators have authorized the Oregon Department of Human Services (DHS) to establish a federally financed tracking system for infants who do not pass the hearing screening and those who are found to have a hearing loss.

"We will be able to make sure these babies have their hearing-loss diagnosis confirmed and are connected with medical and educational services right away," said Donalda Dodson, manager of child health programs in DHS. "Hospitals are doing a good job of screening infants, but some babies with abnormal results have fallen through the cracks."

Getting an infant into these services during the first six months of life is critical for the proper development of speech and language centers in the baby's brain and for future academic, vocational and social success, according to Dodson.

"This law represents hope for a bright future for children with hearing loss. It also means we'll be able to support families who are going through a difficult time," Dodson said. "And it has potential to reduce costs for long-term special education services."

Currently, 44 Oregon hospitals have screening programs, but DHS data show that fewer than half of babies with abnormal results receive the necessary follow-up diagnosis, Dodson said.

"Furthermore, 40 percent of those who are diagnosed with hearing loss are not enrolled in early intervention services," Dodson said. "For those who are enrolled the average age is 13 months, which is far beyond the goal of 6 months or less."

Under the new law, hospitals and diagnostic centers will be required to report screening results to DHS as well as early intervention data, both for follow-up purposes. Dodson said that all family privacy and choice decisions will be respected and protected.

The Newborn Hearing Screening Advisory Committee, a broad-based group that includes parent advocates and adults who are deaf, sponsored the bill. It was championed by the Oregon Academy of Audiology and supported by many groups including the Oregon Pediatric Society, Oregon Grange, Oregon Speech and Hearing Association and March of Dimes.

Dodson said the law goes into effect Jan. 1, 2004. Funding comes from the federal Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) through grants amounting to $400,000 per year. Although no state dollars will be used, the DHS did need to gain legislative approval to accept the federal funds.

More information about the current newborn hearing screening program is available on the Web at http://www.dhs.state.or.us/publichealth/pch/hearing/index.cfm or by calling (503) 731-4021.

High cardiac arrest rate brings study to Oregon

Oregon Health & Science University cardiology researchers have received $1.2 million to join a national consortium studying sudden cardiac arrest. The four-year grant from the Donald W. Reynolds Foundation will support the work of Sumeet Chugh, MD, director of OHSU's Heart Rhythm Research Laboratory and a member of the Medical Society. Through this lab he leads a multidisciplinary team studying the causes of sudden cardiac arrest.

The grant will fund a project that hopes to combine clinical information gathered from actual sudden cardiac arrests in the community with genetic information to help investigators create therapies to prevent this deadly disease. Investigators will look for new ways to identify and treat patients with coronary heart disease who are at risk for sudden cardiac arrest.

"At present the outlook for managing and treating sudden cardiac arrest is dismal," said Chugh, cardiologist and associate professor of medicine in the OHSU School of Medicine.

"If someone collapses with a terminal heart rhythm disorder, they only have a 5 to10 percent chance of survival, so advancing prevention and prediction of this condition is critical. If we can do that, we will have a significant impact on the fight against heart disease."

Sudden cardiac arrest results from a heart rhythm disorder that strikes some 400,000 Americans every year, according to the Centers for Disease Control and Prevention. The CDC also reports that more than 70 percent of cardiac deaths in Oregon are sudden, one of the highest percentages in the country. The overwhelming majority of these patients have associated coronary heart disease.

The consortium is led by the Reynolds Cardiovascular Center at Johns Hopkins University, which is affiliated with three other Reynolds Centers at the Harvard Medical School, the University of Texas Southwestern Medical Center and Stanford University. OHSU's team was asked by Johns Hopkins researchers to participate in this effort because of its proven track record of investigating cardiac arrests that take place in people's homes or in public settings, where most of them occur.

"We know the most effective way to solve a complex problem is to understand the individual parts that make up the whole, which is what we are doing to find the answers to why people suffer cardiac arrests without warning," said Chugh.

This new project will complement an ongoing project, the Oregon Sudden Unexplained Death Study, or SUDS, in which Chugh and colleagues are focusing on the discovery of novel mechanisms of sudden cardiac arrest in patients who do not have coronary heart disease or other known cardiac disorders. In the process, these investigators identify and study all instances of sudden cardiac arrest in Multnomah County, thereby gathering critical community-based data.

Though OHSU scientists are conducting their research in Oregon, several Reynolds' investigators nationwide will have access to their study results. The availability of a wide array of researchers and their research tools will greatly improve the power of the investigative approach. The information gained in this ongoing study will be directly applicable to the Reynolds Foundation investigation.

Oregon SUDS is funded by the Centers for Disease Control and Prevention. The multidisciplinary team includes Jonathan Jui, MD, director of Multnomah County Emergency Medical Services and American Medical Response; Karen Gunson, MD, the State Medical Examiner and investigators from the OHSU School of Medicine's Departments of Cardiology, Emergency Medicine, Pathology, Medical Informatics and Clinical Epidemiology, and Molecular Genetics as well as 16 Portland-area hospitals.

"For a long time the hope has been that a large consortium of scientists would come together under one umbrella to study the phenomenon of sudden cardiac arrest in coronary heart disease. If they all study the same population of patients, the resultant findings are rendered much more comparable and relevant," said Chugh.

"Through the Reynolds grants, this coordinated effort is happening for the first time. It's very exciting and very promising."

RESEARCH

(Continued from page 1)

actually cause those diseases.

Clinically, Cooksey looks at the individual's risk profile. She said the primary reason women use estrogen-progestin is for "symptom management," because the drugs have been "extremely effective in decreasing hot flashes," night sweats and similar problems. Menopausal symptoms affect some women profoundly – symptoms can be disruptive or debilitating for months or even years – while other women are minimally affected, she said.

Cooksey suggests patients analyze what events or actions seem to set off symptoms. These can be of a wide variety, she said, naming the food additive monosodium glutamate (MSG), red wine, caffeine, stress, spicy food, hot drinks, and sleeping in a hot room as examples that can affect some individuals. Some herbal products and some prescriptions other than hormones can be beneficial as alternatives, she said.

If women are so affected by symptoms that they want to continue on the combined hormones – which Cooksey noted is no longer properly called "hormone replacement therapy" but simply "hormone therapy" – she advises them to take the lowest possible dose for the least amount of time, operating on the assumption that "half the dose theoretically should have less risks."

The findings do not apply to estrogen-only therapy, and a separate part of the Women's Health Initiative study, examining use of estrogen alone, for women who have had a hysterectomy, continues and is scheduled to end in 2005.

Kaiser's Center for Health Research is involved with about 250 studies conducted by about 35 investigators. In one such study, the U.S. Preventive Services Task Force concluded that there was insufficient scientific evidence to recommend vitamin supplements as a way to prevent cancer or heart disease. It also advised against the use of beta carotene supplements in smokers because of a possible increased risk of lung cancer and death.

The task force based its conclusion on a report created by the Agency for Healthcare Research and Quality by a team of researchers at the Oregon Evidence-based Practice Center collaboration among Kaiser's Center for Health Research, Oregon Health & Science University and the Portland Veterans Affairs Medical Center. The report was published in the July 1 issue of the Annals of Internal Medicine.

Another recent study co-authored by a Kaiser researcher found that people who make multiple changes in their health behavior can significantly reduce their blood pressure and lower their risk of heart disease and stroke. The study demonstrated that people who made the greatest number of lifestyle changes – including losing weight, adopting a healthful eating plan, reducing salt and other forms of sodium, increasing physical activity, and limiting alcohol consumption – reaped the greatest benefits.

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Checklist of common HIPAA compliance shortfalls

By Tom Speers

To get an idea of the real risks of HIPAA, take a look at this government Web site: http://www.hhs.gov/ocr/privacyhowtofile.htm.

Any patient – or even a relative or friend of a patient – can download this complaint form and send it in. You're just one whistle-blower away from a compliance review that could cost you dozens of hours and thousands of dollars – unless you've prepared in advance.

Is your practice really ready? Maybe. But if you're like the majority of physicians and health care professionals I've met over the past few months, you may have significant gaps in your HIPAA plan and documentation that could cost you plenty.

Most likely, you've taken the obvious steps: distributing the newly required Notice of Privacy Practices and having patients sign HIPAA-compliant authorizations for releasing protected information. But many health care professionals haven't met many of the less-visible, but equally important, HIPAA requirements, particularly in areas involving staff and physician training, dealings with outside vendors, data and record security arrangements, and maintaining compliance over time.

Documentation is another common challenge. In the event of a compliance review, you'll not only have to BE compliant, you'll have to PROVE you're compliant. That means documenting every step you take to meet HIPAA standards.

The following questions identify some of the more common compliance problems. Answering them will give you a pretty good idea of how your practice will look to an HHS inspector.

1. Has your organization designated a Privacy Official?

The office manager or other senior staffer usually takes this role. Keep in mind, though, that as the proprietor of a health care practice or business, you're the one on the hook for non-compliance. Make sure your privacy officer understands the entire scope of your HIPAA obligations.

2. Have you assigned the responsibility for maintaining the security of information systems that contain Protected Health Information to an individual or an organization?

This position also is typically held by someone other than the organization head, perhaps even an outside consultant. Once again, you're responsible for their mistakes, so make sure you know what they're doing.

3. Do you have a policy and procedure for limiting the uses and disclosures of Protected Health Information to the minimum necessary information required to accomplish the purpose of the use or disclosure?

This is a basic tenet of HIPAA that many practices fail to document, even as they comply in daily operations. However, if you don't commit your policies and procedures to writing, inspectors will assume you haven't complied.

4. Do you have a policy and procedure requiring verification of identity and authority of individuals and entities requesting disclosures of Protected Health Information?

This is another area where many practices comply in practice, but fail to adequately document a policy and process.

5. Do you provide and document HIPAA Privacy training for all members of your workforce?

HIPAA is intended to change the way health care workers handle information. That happens through training. Don't forget to include physicians and other practitioners. - they're the ones who communicate most with patients. Most doctors I've met have overlooked their own training needs.

6. Have you identified all of your Business Associates and do you have written Business Associate Contracts as required by the Privacy Rule?

Billing services, suppliers, transcription services, ancillary service providers - everyone to whom you provide patient information may be a HIPAA business associate. You must develop agreements with all of them on how you will work together to protect patient privacy.

7. Do you have a formal, documented process for receiving, acting on and documenting the disposition of privacy complaints?

An inspector is going to want to know all the details of how you handled every complaint. A formal process ensures you've got the information in one place and that you've responded to every complaint.

8. Do you have policies and procedures that address safeguards and mitigation of harm due to violations of an individual's privacy on the part of your workforce or business associates?

In the event of a violation, you have a responsibility to minimize potential harm, such as asking for the return of records mistakenly sent to the wrong address. Your compliance plan is not complete without policies on limiting damages.

9. Do you have a policy and procedure that describes how you modify existing privacy policies and procedures, and how you add new policies and procedures, so you can accommodate changes in the law, or changes you make in your privacy practices?

Compliance is a moving target. Your plan needs a review and update process built in to keep it on the mark.

10. Have you completed a risk analysis to identify and assess the potential risks to electronic Protected Health Information created, received, maintained or transmitted by your organization and taken the appropriate steps to reduce risk and maintain it at an acceptable level?

This is an area that many practices have neglected, in part because it requires sophisticated IT skills. But it is an integral part of protecting patient privacy.

Despite all the confusing information you've seen about HIPAA, developing a comprehensive compliance program doesn't have to be overwhelming. Interactive software packages, similar to popular income tax programs, are available to guide you through a complete practice assessment in about two hours and provide plans, sample forms and policies you need to develop a comprehensive compliance program. Such programs also help document all your HIPAA activities.

Implementing an effective HIPAA compliance plan does take time and effort, and it will change the way you and your staff operate. But if one of your patients files a complaint, you'll be ready.

Tom Speers is a consultant with HealthCare Information Solutions, Kalamazoo, Mich., and a developer of HIPAASays, produced by SaysSuite, Lincolnshire, Ill.

Correction

The July 5, 2003 issue of The Scribe incorrectly identified the medical degree of Jennifer Lyons, MD. Lyons received her medical degree from Indiana Universtity School of Medicine, graduating in 1992; she did a transitional internship at Emanual Hospital from 1992-93, and her residency at the Casey Eye Institute at OHSU from 1993-96. She has been with Oregon Eye Specialists since then, working in the Gresham, Providence Portland and Seaside offices.

Electronic data management a new career opportunity

With health care organizations relying more on information technology as the solution to data management, the demand for health care professionals in medical informatics continues to increase.

To help meet this demand, Oregon Health & Science University has formed separate agreements with two national organizations for medical informatics professionals. These organizations, the Healthcare Information and Management Systems Society (HIMSS) and the Association of Medical Directors of Information Systems (AMDIS), will help promote OHSU's medical informatics distance learning graduate certificate program and will provide their members with tuition discounts. Medical informatics is the field concerned with the acquisition, storage and use of health care information.

"Until recently most medical informatics education programs have focused on preparing researchers at the cutting edge of the field," said William Hersh, MD, professor and chairman of medical informatics and clinical epidemiology (DMICE) in the OHSU School of Medicine. "However, a growing number of programs like the graduate certificate program offered by OHSU are focusing on the much larger number of applied or professional informaticians who work in operational as opposed to research settings."

HIMSS will promote the OHSU certificate program by providing information to its m than 13,000 individual membe and 125 corporate members through its Web site, newsletter and other outlets. AMDIS also will promote the program to its physician members, associates a foundation. Members of both groups who enroll in the progra will receive a 5 percent tuition discount.

"The graduate certificate program in medical informatic from OHSU offers HIMSS members an opportunity to expand their knowledge in heal care information technology, bu at a pace that fits their schedule and locations," said Becky Mancuso, PhD, manager of HIMSS distance learning. "We look forward to working with OHSU and are pleased to offer this program to our members a way to further their education a enhance their careers."

OHSU's DMICE has an international reputation in medical informatics. It develop the graduate certificate program and enrolls more students than any other similar program in th world. The department also is a leader in medical informatics research, developing new approaches to electronic medica records, computerized physician order entry, and access to online knowledge resources. These research opportunities enrich students' educational experience

"AMDIS is pleased to be working with OHSU in increasi opportunities for health care professionals interested in learning more about medical informatics and expanding the awareness of its distance learnin program," said Richard Rydell, MD, executive director of AMDI "OHSU's distance learning program is a good fit for AMDI members interested in medical informatics."

The distance-learning program comprises eight online courses. Most students finish the 24 hours of coursework in two years. The certificate curriculum subset of OHSU's on-site and distance learning master's degree programs in medical informatics includes coursework in electroni medical records, information retrieval, outcomes research, organizational behavior and management, and bioinformatic

OHSU was among the first

Please see DATA, page

Imaging brings better diagnosis, treatment of infertility

By Cliff Collins

Technological advances increasingly are allowing radiologists to detect women's diseases and disorders using minimally invasive techniques.

The result often is same-day, same-site detection, a vast improvement over the waiting and sweating it out for women who undergo procedures such as breast biopsies, according to Amy S. Thurmond, MD, a nationally known expert on infertility and other women's health issues.

After spending "15 years in the field, I have a strong opinion about how people should be treated," said Thurmond, a Portland-area radiologist who joined Epic Imaging this year. When a patient presents with a problem, caregivers should be organized enough to take care of the patient's problem as efficiently, and as soon, as possible, she said.

"There are several different tools we can use. Instead of sending (patients) for a test and having them come back, we try to have everything taken care of as much as possible in one day," Thurmond said. "Most symptoms that patients experience are not (caused by) something awful," and it is a relief to their mind if they do not have to wait days or weeks to find that out.

Using digital mammography and needle biopsy, physicians often can deliver a diagnosis on the same day the patient is seen, and in the same location. "I'm proud of that; I think it's good," she said. "The surgeons in town have become increasingly supportive of that," she said of needle biopsy. "It's been shown to be reliable and it gets impressive results."

Studies now are under way comparing digital mammography to regular mammography, Thurmond said. "I think they're (digital) easier to read." The technology uses less radiation and no film; instead, it is read using a computer, which can call up different views and enhance areas without having to take additional pictures.

Thurmond first made her mark while a faculty member at Oregon Health & Science University, where she practiced until 1993. At OHSU, she helped develop Fallopian tube recanilization, a procedure modeled after the pioneering work of OHSU's Charles Dotter, MD. The technique, patented as the "Thurmond Rosch Hysterocath," now is being done all over the world, Thurmond said.

The university owns the patent. And though she receives no royalties herself, Thurmond said she derives satisfaction from the many pregnancies that have resulted from opening blocked Fallopian tubes using recanilization. "That's been rewarding: participating with these couples," she said. "Some have ended up with babies they would not have had."

In the procedure, doctors guide micro-catheters through the uterus and into the Fallopian tubes, she explained. Using digital fluoroscopy, physicians can find the blockage and flush it out. "Roughly 80 percent of the time we're able to open the blockage, offering a reasonable chance for conception," Thurmond said.

Focusing on women's needs is a major theme for health care these days. But this is a fairly recent trend. Thurmond points out that not so long ago, a lot of women's health problems weren't even discussed — by patients or even among physicians. A graduate of UCLA medical school, Thurmond remembers that during her first year in residency, she noticed almost an "abhorrence" among medical staff to deal with women's fertility issues. "That's when I started to get involved," she said.

Now Thurmond and her colleagues are doing cutting-edge work — and talking about it with each other and with patients — in identifying a myriad of issues women still find embarrassing to discuss, such as pelvic-support disorders, chronic pelvic pain and bleeding, and pelvic prolapse. The newest MRIs have made a world of difference for both diagnosis and treatment. "Surgery for those conditions has improved, totally because of improvement in imaging," Thurmond said. "MRI now can be applied to many things in gynecology."

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Many women, especially those who have had several children, will experience some kind of pelvic-support problems with age. The primary parts affected are the bladder, small intestine, rectum, uterus and vagina. Symptoms may be relatively minor or severe, such as urinary or fecal incontinence, prolapse of the uterus and bladder, bulging of the intestines into the vagina or a combination of these problems. Successful treatment depends on pinpointing where the weakened structures are that are causing the symptoms.

"Many women undergo surgeries, many (of) which don't work particularly well," Thurmond said. "Perhaps half of those women say they are unhappy with the results or that they experience new symptoms."

Using short-bore, shorter-tube MRIs, physicians can obtain highly detailed images that are used to construct a videotape capture of what is occurring with the pelvic prolapse. This information is essential in optimizing the best surgical strategy, according to Thurmond.

One in seven American women suffers from pelvic pain. Conditions such as endometriosis, pelvic inflammatory disease, adhesions and fibroid tumors all can cause chronic pain.

With abnormal bleeding, the standard procedure in the past has been to give the patient an ultrasound, possibly a biopsy, then manage her with hormones. Thurmond and her colleagues are having patients first undergo a pelvic ultrasound. If indicated, this would be followed by a sonohysterogram, an imaging procedure that can detect fibroid tumors and polyps in the uterus.

"Many women are embarrassed to discuss these issues, even with their own doctors. Our goal at Epic Imaging is to take care of women, give them accurate results and make the process as comfortable as possible," Thurmond said.

DATA MANAGEMENT

(Continued from page 6)

offer a medical informatics distance-learning program. About 200 students from around the world currently take the distance-learning classes. While more than half of the enrollees have been physicians, others have had backgrounds in nursing, pharmacy, librarianship, health care administration and other fields.

OHSU has more than 40 master's degrees in the field since 1998 and has 60 students currently enrolled. A doctoral program will begin this fall, and a postdoctoral fellowship has existed since 1992. Graduates find work with hospitals and clinics, health product vendors and manufacturers, and other universities. For more information, contact the OHSU program administrator via e-mail at informat@ohsu.edu or call (503) 494-4563.

HIMSS provides leadership in health care for the advancement and management of information technology and management systems. Visit www.himss.org for more information.

AMDIS is a physician membership organization dedicated to advance the field of applied medical informatics. For more information, contact AMDIS via e-mail at info@amdis.org or visit www.amdis.org.

Oregon Burn Center helps set product safety standards

The Oregon Burn Center at Legacy Emanuel Hospital has joined the U.S. Consumer Product Safety Commission and over 100 burn centers nationwide in an initiative aimed at collecting data about serious clothing-related burns to children under age 15.

The Consumer Product Safety Commission's new national Burn Center Reporting System is a cooperative effort of the Oregon Burn Center, the American Burn Association, Shriners Hospitals for Children and the National Association of State Fire Marshals.

Under the new system, the Oregon Burn Center will report any incidents in which a child's clothing is believed to play a part in a burn injury. "We will be reporting incidents that include the ignition, melting or smoldering of any apparel worn by children," said Nathan Kemalyan, MD, Medical Director of the Oregon Burn Center.

"One of our top priorities is to keep families safe from fires," said Hal Stratton, chairman of the Consumer Product Safety Commission. "We want sound science and solid data to be the basis for decisions we make on regulatory strategies. The National Burn Center Reporting System will give us a more complete picture of the most serious clothing-related burns to children and help us prevent or reduce burn incidents in the future," he said."We're grateful for Oregon's involvement."

When a participating burn center reports an incident to the Consumer Product Safety Commission, the commission assigns an investigator to the case to conduct an in-depth investigation into the circumstances surrounding the burn injury. The information is logged into the commission's epidemiological databases.

"This tool will give safety experts information that hasn't previously been available, allowing them to better document and understand the nature and cause of clothing-related burn injuries to children" said Kemalyan. "We share the Consumer Product Safety Commission's goal to keep families safe from fires"

The National Association of State Fire Marshals also is participating by retrieving and preserving for the commission children's clothing involved in burn injuries.

For more than a quarter of a century, the Oregon Burn Center has met the challenges of caring for more than 5,500 seriously burned patients from Oregon and Southwest Washington. In recent years, the number of patients has swelled to almost 300 annually, approximately one third of which are children.

Guidelines for brain injuries get unusual attention

Health care providers around the world recently gained the first scientific guidelines for the best way to treat children who have suffered traumatic brain injuries (TBI). Researchers from Oregon Health & Science University joined forces with other national experts to create the most effective guidelines based on the review of more than 700 peer-reviewed journal articles.

In an unusual cooperative effort, three journals – Pediatric Critical Care Medicine, Critical Care Medicine and the Journal of Trauma – simultaneously published "Guidelines for the Acute Medical Management of Severe Traumatic Brain Injury in Infants, Children, and Adolescents" on June 6 as special supplements . This unique tri-publication put the guidelines in the hands of more than 30,000 health care experts across multiple disciplines.

"There's an enormous amount of information out there about what works and what doesn't in treating pediatric brain injury," said Randy Chesnut, MD, associate professor of neurological surgery in the OHSU School of Medicine and the principal investigator on the guidelines project. "We not only want to publish guidelines that bring together all the best practices, we want to remove obstacles to putting those guidelines to work saving lives."

In the past, a child's treatment for a brain injury could vary depending on what country they lived in, how they got to the hospital, what hospital they went to and what kind of equipment was there, who her/his doctor was and dozens of other variables. And if his/her injury was severe, variations in any of these factors could make the difference between full recovery, a lifetime of disability or death. These new guidelines will allow all hospitals and clinicians, no matter where you take your child, to consistently provide the best treatment available.

Chesnut convened a group of investigators to help develop the guidelines that included neurosurgery, emergency medicine and pediatric experts from schools of medicine at OHSU, University of Pittsburgh, the University of Michigan and Emory University.

In 1997 Chesnut lead another multidisciplinary team that published the first comprehensive guidelines for treating adult brain injury. In several countries in Eastern Europe such as Poland, Hungary and the Czech Republic, socialized health care systems adopted the guidelines nationwide all at once. In those countries, documented adult deaths from traumatic brain injury have dropped by as much as 50 percent in the past five years. Chesnut and his OHSU team have helped develop all seven sets of treatment guidelines for TBI, including the adult guidelines.

"It was natural for us to look next at developing pediatric guidelines," said Chesnut.

The team started the project in March 2000. They reviewed thousands of abstracts and more than 700 journal articles, thanks to the administrative management of this project by OHSU's Evidence Based Practice Center. The resulting pediatric guidelines cover 18 topic areas (compared with 14 in the adult guidelines) ranging from managing a patient's airway on the way to the hospital to monitoring brain pressure in the hospital to surgical options and nutrition.

In addition to the three scientific journals publishing the guidelines nationwide, several professional societies have reviewed and endorsed the document, including the American Association for the Surgery of Trauma, International Society for Pediatric Neurosurgery, World Federation of Pediatric Intensive and Critical Care Societies, Society of Critical Care Medicine, Child Neurology Society, and International Trauma Anesthesia and Critical Care Society

"All this speaks to the widespread recognition of the importance of this work," said Nancy Carney, PhD, assistant professor of medical informatics and clinical epidemiology in the OHSU School of Medicine and a fellow investigator on the guidelines. "People are willing to cross boundaries in order to accomplish the widest possible dissemination of these guidelines."

They're also willing to cross borders. Rather than simply publishing the guidelines and hoping clinicians use them, the OHSU team will follow their progress in the United States and abroad for years, continually adjusting them based on how they work in the real world. The U.S. researchers will team up with Cuba's Ministry of Public Health and the Argentine Society for Intensive Therapy to observe different implementation systems.

In Cuba, with its socialized (and relatively sophisticated) health system, the researchers will study how outcomes for young brain injury patients change before and after adoption of the guidelines in a country where the guidelines can be implemented nationwide.

"It's a great opportunity to conduct a well-controlled, population-based implementation study that could not be carried out in the U.S.," said Carney.

"Here in the U.S., the biggest obstacle to implementation isn't technology, it's that our health care delivery system is so scattered," said Chesnut. "Many hospitals don't have equipment called for in the guidelines, such as intracranial pressure monitors or CT scanners." A follow-up study in Argentina will allow researchers to work with local facilities to recraft the guidelines based on locally available technology and expertise. This knowledge can then be applied to the United States.

Walta receives Master Endoscopist award

Douglas Walta, MD, has been named a recipient of the 2003 Master Endoscopist Award from the American Society for Gastrointestinal Endoscopy (ASGE). The award recognizes expertise and contributions to the practice of gastrointestinal endoscopy.

Walta, a member of the Medical Society of Metropolitan Portland, is the first physician from the Northwest to receive this award.

Walta is president and chief executive officer of The Oregon Clinic and practices at Providence Portland Medical Center. He completed his medical degree, residency and a gastroenterology fellowship at the University of Minnesota, Minneapolis. He has been a member of the American Society for Gastrointestinal Endoscopy since 1990.

Rotary honors Achterman for "Service Above Self"

Chris Achterman, MD, an orthopedic surgeon with Portland Bone and Joint, was presented the prestigious Kenyon T. Bement Award last week by the Rotary Club of Portland. The Club presents the Award each year to the club member who most exemplifies Rotary's "Service Above Self" motto.

Achterman was honored for the wide range of selfless work he does on behalf of the Portland Club and its many public service activities. In his 20 years as a club member, he has served on many Rotary Committees, including: Past Chair of the Wheels of Power Committee, The Long Range Planning Committee, Youth Exchange, Preserve Planet Earth, World Community Service, and the International Committee. He has participated in Charitable Trust Campaigns and currently serves on the Charitable Trust Board.

In recent years, Achterman has concentrated his efforts on Rotary's World Community Service activities. In this role, he has been responsible for securing and performing much needed surgeries for Guatemalan wheelchair-users brought to the United States through the Transitions Foundation of Guatemala, a non-profit directed by American John Bell. Since 1999, the Portland Rotary Club, with help from Achterman and others, has helped Transitions to secure medical treatment, supplie and rehabilitation for five severel disabled Guatemalans who otherwise would have had no hope for treatment.

The work has been a joint effort by Providence St. Vincent Medical Center and Medical Foundation, their Beverly Cross Guest Housing Center, Legacy Emanuel Hospital and Health Center, Legacy Emanuel Children's Hospital, Ronald McDonald House, CARE Medica Stryker Medical, Oregon Orthotics and Bill Carr, MD, along with Achterman. The Rotary Club of Portland and American Airlines have supplied funding for travel as well as volunteer coordination to help make the surgeries and rehabilitations happen.

Currently under Achterman' care as part of the program is a 3 year-old Guatemalan boy who is undergoing extensive assessment, rehabilitation and possible surgeries after a cement mixer accident left him with broken limbs and wheelchair-bound for life.

Livingston joins Metro Pediatric

Metropolitan Pediatrics announces the addition of Joseph Livingston, MD, to its Westside location on August 4, 2003. Livingston graduated from Oregon Health and Science University in 1999 and completed his pediatric residency training in 2002 and a pediatric primary care fellowship in 2003 at the University of Texas/Houston. He earned a master's degree in publi health from the University of Texas School of Public Health.

He has additional training in the medical and forensic evaluation of children who are victims of child abuse. Livingston is married and has a daughter an son. He enjoys spending time wit his family, running, computers and cooking.

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