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Medical Technology

Check out this month's focus section, which explores developments in 3-D imaging, dissolvable stents for heart patients and mobile health care apps.

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Helping our heroes

Physician launches program that provides surgical, medical services to veterans

By John Rumler
For The Scribe

Like many people in Oregon, **Richard Edelson, MD**, was disturbed by the recent widespread reports of mismanagement and poor treatment provided by Veterans Administration hospitals. In addition, medical documents were falsified by hospital personnel on a large scale to hide the extent of the problems.

VA hospitals in Portland and Roseburg were deemed among the nation's worst for wait times, with more than 6,600 veterans not able to be seen by a physician for three months.

During the blizzard of criticism, Edelson, an orthopedic surgeon at the **Oregon Outpatient Surgery Center** (OOSC) in Tigard and also chief medical officer of the Portland Timbers, didn't point any fingers. Instead, he created a program—one that shows signs of becoming a nationwide model—to help alleviate the situation.

Edelson founded the Save Our Veterans program on July 4 to provide needed surgical and medical services to local veterans.

Edelson's practice includes a wide range of orthopedic and sports injuries with a focus on arthroscopic knee and shoulder surgery. Besides serving as head team physician for the Timbers, he is also an orthopedic consultant for the Portland Thorns, and he provides orthopedic support for Nike Inc. and several local high schools.

Although it was always in the back of his mind to do something for veterans, Edelson said it was the VA scandal that jolted him into action. "A lot of people were upset about that and wanted to do something. We happen to be in a profession that allows us to help."

Three local Oregon military veterans were the first to benefit. **Justin Thomas**, 33, who lives in Salem and is in the Oregon Army National Guard and served in Afghanistan; **Robert Gustafson**, 63, of Beaverton, who served in Vietnam in the U.S. Army; and **Evan Johnson**, 32, from Tigard, who fought in Iraq in 2004 as an infantryman, all received surgeries at no charge.

Gustafson, who is the commander of the Veterans of Foreign Wars (VFW) chapter in Tualatin, received surgery to repair a torn shoulder rotator cuff. He was unable to raise his right elbow over his head for nearly a year. "It caused excruciating pain and limited what I was able to do," he said. Now with his arm in a sling, Gustafson will soon begin several months of physical therapy, also

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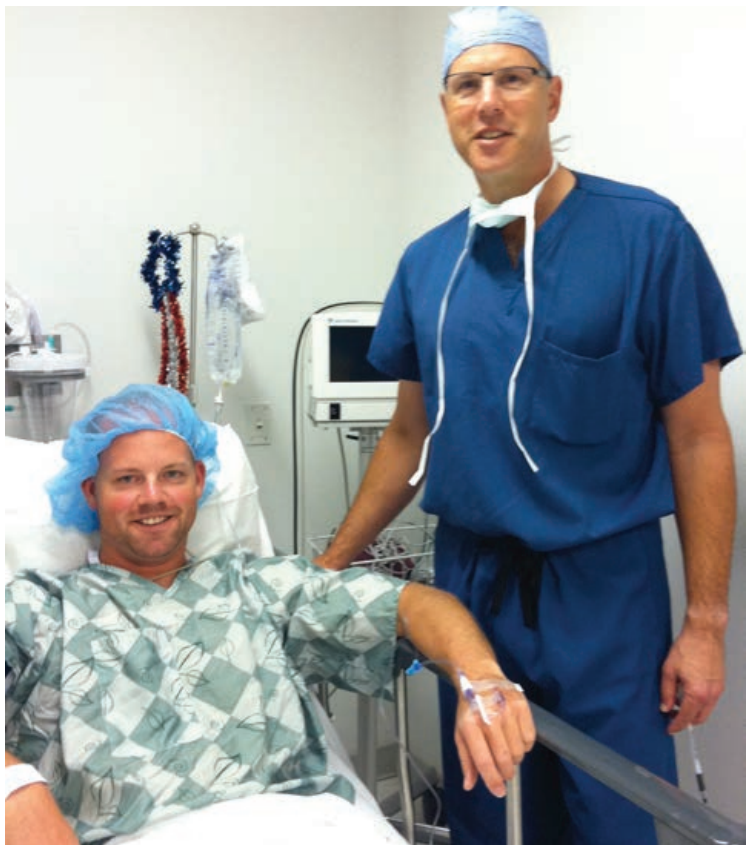

Justin Thomas is among the veterans who have received complimentary care from Richard Edelson, MD, through the Save Our Veterans program, which provides needed surgical and medical services to local veterans. Photo by Bela Friedman

Proponents: Medical scribes assuage EMR pains

Scribes enhance doctor-patient relationship, increase patient satisfaction, clinicians say

By Cliff Collins
For The Scribe

Electronic medical records constitute an integral component of health reform, but they also have introduced new challenges for physicians.

Many doctors dislike being tied to a computer in the exam room, feeling that it interferes with their interactions with patients. When Legacy Salmon Creek Medical Center opened nine years ago and simultaneously implemented EMRs, emergency physician **Kathleen M. Myers, MD**, founded an in-house medical scribe program within her emergency department physician group.

"I started getting inquiries about it," she said. "I realized it was a need." Her service spread to other Legacy hospitals, then took off so fast that she formed a company to take medical scribes nationally. Today, **Essia Health** employs 600 people and contracts out scribes to 20 different specialties in 14 states.

KATHLEEN M. MYERS, MD

Myers said the reason doctors need scribes is simple: Many physicians feel just as she did, that "I didn't want to be on a computer instead of at the patient's side. You're multitasking, and it's frustrating." She thinks EMRs—also called electronic health records, or EHRs—bring many advantages, including improved instant access

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Healing horses

Walter Buhl, MD, and his wife, Bonnie Rhynard-Buhl, run Trillium Creek Training and Rehabilitation Coalition, a nonprofit dedicated to healing sick or neglected horses and helping people build healthy and beneficial relationships with them.

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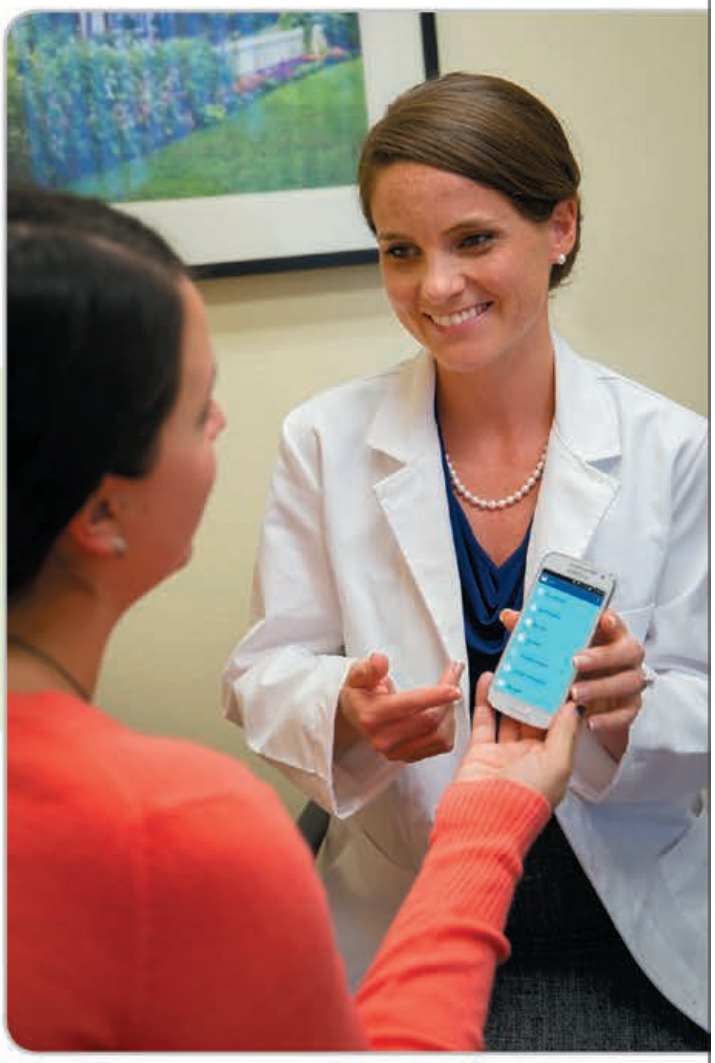

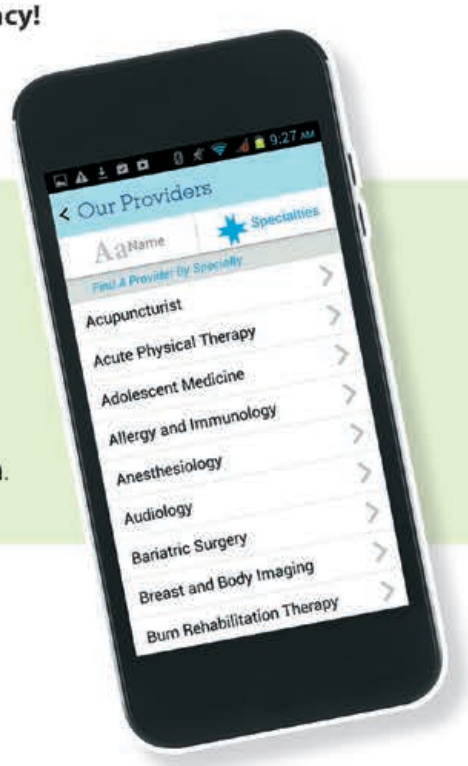

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Come join us at the PHAME Variety Show!

Aug. 24

PHAME

After viewing the heartwarming presentation by PHAME during our May Annual Meeting, we now invite you to enjoy a PHAME Variety Show with MSMP members. **MSMP has reserved a limited number of tickets at a group price of $15 a piece for the Aug. 24 PHAME Variety Show**. PHAME creates opportunities for adults with disabilities to experience the joy of artistic expression through lifelong arts education and performance. The PHAME Variety Show is an amped-up version of its popular annual cabaret night, with plenty of music and shtick for days.

Contact Amanda at 503-222-9977 or amanda@msmp.org to purchase tickets. •

OHSU Student Orientation

MSMP is excited to welcome OHSU's newest assembly of medical students and physician assistant students on Aug. 18. MSMP and the Oregon Medical Association will sponsor a luncheon for the students to introduce membership, and MSMP will hold a prize drawing for Netters Anatomy Flash Cards and Maxwell Quick Reference. •

Day of Community Service

MSMP is proud to participate in the Oregon Society of Association Management's Day of Community Service on Aug. 19. We will harvest vegetables to benefit Farmers Ending Hunger and Marion-Polk Food Share. Oregon currently ranks second in the country in terms of hungry citizens. MSMP is currently developing a Day of Community Service for its members—look for an announcement soon. •

The Bite of Oregon and Providence Bridge Pedal

Thank you to all who participated in the MSMP Bridge Pedal Team. What a ride! And thank you to all who supported our Battle of the Doctor Bands winner on the Garden Stage at the Bite of Oregon following the Bridge Pedal. We are looking forward to doing it all again next year! •

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Conferences to focus on clinician well-being, organizational professionalism

By Barry Finnemore
For The Scribe

Qualitative research during the past 18 months on the impact of coordinated care organizations on clinicians has found a renewed interest in and increasing need among medical professionals for programs that will help them thrive in an era of sweeping changes in health care delivery.

The research, conducted by **Ron Stock, MD**, the John Kitzhaber, M.D., Fellow in Health Policy at the Portland-based **Foundation for Medical Excellence**, isn't necessarily a surprise to foundation President **Ed Keenan, PhD**. Rather, it represents a critical acknowledgement by health care professionals about what they need to not just survive, but thrive amid reform and the uncertainties that accompany it.

"I see it as a healthy perspective, and it coincides with making sure the clinician workforce is healthy and thriving and achieving personal and professional balance and well-being," Keenan said. "They're realizing and appreciating that the way medicine is practiced, particularly in Oregon—with patient-centered medical homes and CCOs—is changing significantly over a short period of time. This is influencing the patient-physician relationship, and creating an integrated health care team with the physician as the team leader."

Promoting health and wellness among physicians has been a central focus of the foundation since the 1990s. As a part of that, the organization has held an annual conference on physician wellness.

This year, the Oct. 11 event is reframing its emphasis on wellness in two important ways, Keenan said. First, the program is focused on vitality in addition to well-being and resilience. In addition, the foundation has designed the event not just for physicians but, more broadly, clinicians.

Titled **"Thriving in an Era of Change: Promoting Clinician Vitality and Well-being,"** the conference in part will address:

- "Finding Meaning, Balance, and Personal Satisfaction in the Practice of Medicine." **Tait Shanafelt, MD**, will talk about how clinicians assess their well-being, identify personal and professional values, explore approaches to increase meaning in their work, and evaluate and refine their self-care strategy. Shanafelt, a medical oncologist and director of the Mayo Clinic of Medicine Program on Physician Well-being, is a leading researcher on physician well-being and its impact on patient care.
- "Developing Teamwork in the Clinical Setting." Stock will define teams and team-based care; describe the attributes of "teamness" and how practices can improve team care; and discuss the challenges related to teams and team-based care.
- "Thriving on Change & Transition." **Chris Edgelow**, who for nearly three decades has helped leaders build their capacity for leading and thriving on change, will help attendees understand the difference between change and transition; clarify the impacts of change and discuss ideas on how to increase personal resilience; and outline a transition plan for major changes.

The Foundation for Medical Excellence's 2014 Physician Well-being Conference

"Thriving in an Era of Change"

Saturday, Oct. 11

Skamania Lodge, Stevenson, Wash.

For details: www.tfme.org

Building resiliency skills is critical given the statistics about physicians and burnout and its direct impact on patient care. Research suggests that nearly half experience burnout, which can negatively affect patient care, increase the risk of medical mistakes, lead to early retirement in a field that can't afford to lose practitioners, and lead to substance use and mental health problems.

Individual skill building is only part of the solution, however. Keenan stressed that a fundamental culture change is needed among health care organizations and practices that, as part of their responsibility to improve community health, ensures that clinicians are "well-supported to deliver high-quality care."

To that end, the Foundation for Medical Excellence has launched a program focused on organizational professionalism, forming a national working group to develop a charter that serves to define the term and promote the kind of cultural change that supports clinician well-being, improved care and a stronger organizational bottom line. Among the organizations involved in the working group are The Commonwealth Fund, the American Hospital Association, the American Board of Internal Medicine, Long Island North Shore Jewish Health System and the Federation of American Hospitals.

"A lot is talked about today about medical professionalism as it relates to the individual, but another way to think about it is the principles, behaviors and competencies at the organizational level. What are their core values, and how do individuals within complicated organizations relate? That is fundamental to how an organization supports its physicians and staff," Keenan said.

Dovetailing with the foundation's October event is a Nov. 14 conference in Portland about organizational professionalism that will address those and other topics. Keenan said part of the foundation's goal for the half-day conference, at Portland's RiverPlace Hotel, is to help set the stage for pilot projects with health care organizations that would demonstrate that such cultural change improves clinical and financial outcomes.

In fact, Keenan is optimistic that the time is now, in the midst of far-reaching changes in health care, to implement lasting changes that lead to clinician well-being and resilience and organizational professionalism.

"We believe that emerging coordinated care organizations are the new entities and the perfect places to consider introducing these principles in such an early stage of their development," he said. "I think we'll land on soil that will enrich the conversation." •

Note to readers: As a neutral forum for discussion, The Scribe welcomes guest commentaries on health care reform and other issues that impact the region's medical community. To respond to these opinion pieces, or to propose a commentary, please contact the editors at scribe@llm.com or 360-597-4909.

Failed ACA is not reform for patients, physicians or employers

By Samuel Metz, MD
For The Scribe

Is the Affordable Care Act a failure? After all, more Americans will own health insurance policies, government spending on health care will decrease, and the financial burden of Medicare patients with medical complications moves from the government onto providers caring for them.

The Affordable Care Act (ACA) is a failure because this is not reform. Not to patients, not to physicians, and not to employers.

The goals of reform for patients are simple: access when they need it, reduced costs and better outcomes.

The ACA achieves none of these.

Access for patients? The ACA will leave 10 to 30 million under-insured Americans at risk for bankruptcy or death if they get the wrong disease at the wrong time. For the 30 million Americans predicted by the Congressional Budget Office (CBO) to have no insurance at all, their care and possibly their lives end when their income ends.

Reduced patient costs? The CBO predicts a decrease of $100 billion annually in *government* health care spending. But it also predicts an increase of $100 billion in *total* health care spending. That means patients pay an additional $200 billion annually for health care.

Improved outcomes? Not according to the Massachusetts experience. In 2006, the state enacted its version of the ACA (Jonathan Gruber, the MIT economist who worked on both the Massachusetts program and the ACA, called them "the same [expletive deleted] bill"). Although 95 percent of Massachusetts residents now own insurance policies, outcomes are unchanged, medical bankruptcies are 30 percent higher, and health care costs are increasing faster than anywhere in the country. We should not expect the ACA, even working perfectly, to produce different results nationally.

For patients, the ACA is not reform. What do physicians want from reform?

First, payment for our work. It's a tragedy that Haitians need free medical care from our medical missions to prevent dying from easily treatable diseases. But it's a tragedy and an embarrassment that Oregonians also need our free care to avoid dying from easily treatable diseases.

The poor and sick Oregonians we serve should not be dependent upon us working for free.

Second, we want our payment to reflect the value of our services, not the value of the insurance policy owned by the patient receiving our services. Should reimbursement for our care be higher for patients who wear pearls than those who wear tattoos?

Lastly, we want easy billing and prompt payment.

The ACA addresses none of these needs.

What about Oregon's employers? In addition to being physicians and occasionally patients, many of us own or have an ownership stake in our practice. What do we want as employers?

First, we want healthy employees. When office staff call in sick, it doesn't matter if they are full time or part time—that's lost productivity.

Next, we want to get out of the health benefit management business. Employers providing health care benefits spend two percent of payroll on additional employees just to manage the health care benefits of everyone else. Can we rid ourselves of this added cost of doing business?

While we're talking reform, can we get health care benefits out of labor-management negotiations?

We also want whatever we pay toward health care to be no more than what our competitors pay. The flip side is we want the benefits our employees enjoy to be no worse than what our competitors offer.

Lastly, we want our health care costs to be predictable and consistent.

The ACA addresses none of these needs.

In summary, the ACA fails to address the needs of patients, providers or employers. This 900,000 word opus certainly qualifies as legislation, but it does not qualify as reform. •

Samuel Metz, MD, is a member of Physicians for a National Health Program and a founding member of Mad As Hell Doctors, both of which advocate for universal health care. He is a private practice anesthesiologist who lives and works in Portland.

Health reform results promising, but we have much left to achieve

By Sen. Laurie Monnes Anderson, RN
For The Scribe

Alongside the successes of the Affordable Care Act at enrolling millions more Americans in health insurance and protecting Americans from damaging insurance practices, significant health care reform is occurring in Oregon. We are making progress improving the health of Oregonians of all ages, managing and preventing chronic illness, and delivering health care more efficiently in the communities where Oregonians work and live. The first year of data is back on Oregon's innovative coordinated care organizations (CCOs), and it is clear that important progress is being made across the state.

In 2011, the Legislature created an innovative new system of CCOs, which are designed to better integrate physical, mental and dental health care and focus on preventative care. This system creates incentives for preventing disease, reducing emergency room visits and meeting other goals to provide better care at lower cost. These CCOs currently only serve the Medicaid population through the Oregon Health Plan (OHP), but will include some public employees soon. More than 353,000 Oregonians have signed up for the OHP so far this year.

In June, the Oregon Health Authority released a report on the first year of data on Oregon's new CCO model. These numbers demonstrate progress in both improving care and reducing health care costs. The report indicates that Oregon Health Plan members are using hospital emergency departments 17 percent less than in 2011, and associated costs are down 19 percent. They are also hospitalized significantly less often for chronic conditions such as

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to patient information; no lost charts; better legibility; and with some EMRs, easier compliance with evidence-based guidelines.

But she and other proponents also know that electronic records have introduced an assortment of obstacles for physicians. EMRs were touted as a way to increase productivity, but they actually require more time than paper charts. For one thing, they were designed by engineers, not clinicians, to meet billing and coding needs rather than clinical needs, she pointed out. Connected with that, the government has imposed more coding requirements and documentation than ever before, which makes doctors have to capture an estimated three and a half times more data for each patient encounter, said Myers, who now is chief medical officer of her company.

'The future of medicine'

Claudia P. Taylor, MD, JD, a Portland dermatologist, thinks electronic records improve medicine, but she feared EMRs would force her to compromise the way she practices. She wanted to continue to spend sufficient time with each patient and document visits thoroughly, but the additional time required to enter data into a computer was daunting. That necessitated being more efficient, which was where scribes come in.

Before she began using scribes three years ago, Taylor often spent 90 minutes to two hours daily completing notes after she finished seeing patients. "For complex cases or very busy days, I sometimes spent up to three hours after the last patient went home. That time has been reduced dramatically—20 to 30 minutes for charting after the morning clinic, and the same after the afternoon clinic. (Scribes have brought me) huge time savings and much greater accuracy."

Using scribes enhances the doctor-patient relationship, especially for specialists who do a lot of hands-on examinations, Taylor said. "This is the future of medicine. It allows us to go back to being connected to the patient. Record-keeping is more difficult, (but) it doesn't have to be that way."


CLAUDIA TAYLOR, MD

Myers points to data showing that patient satisfaction increases when patients receive a physician's undivided attention, and that measured scores for satisfaction increase further when doctors use scribes. They also let physicians practice at the top of their license, another goal of health transformation.

The Vancouver Clinic brings in scribes for about 25 of its providers, said **Marcia J. Sparling, MD**, medical director for operations and IT. The 220-member clinic has been using EMRs since 2000, and the Epic system for four years. Nevertheless, she said, EMRs mean more time and work for the doctor than under paper records. So when the group added scribes, it required physicians who wanted to use them to cover the cost of scribes by seeing more patients.

"We only provide scribes for (physicians) who ask for it," said Sparling, a rheumatologist. "They need to have enough demand; their patient schedules have to be full. With that extra few patients, it covers the cost of the scribe. We've been able to prove that works. It's an important tool—it allows some physicians to take care of more patients," which helps in the face of the doctor shortage.

She noted that not all physicians want scribes. "Some really like the privacy of the exam room with patients."

And Myers added, "Some don't like to give up control of their chart." Sparling said patients at The Vancouver Clinic "always have the option to speak to the doctor alone, but most don't ask. Patients are very comfortable with it."

But Taylor sees having a scribe in the room as a double advantage: They record a narrative record of the visit, and their presence adds a "chaperone" effect that makes many patients feel more at ease when they have to disrobe or undergo invasive exams or procedures.

Having scribes also "allows you to see more patients and have a better work-life balance," she said. They're the antidote for burnout, which is mainly caused by administrative and record-keeping pressures, Taylor said. "They pay for themselves. It's made me a better doctor and a happier one, having scribes."

Myers agrees: "I did this simply for the quality of life, to be able to interact with my patients."

Part of a health care transition

A scribe accompanies the physician into the room, either carrying a laptop computer or pushing a computer on wheels. The doctor introduces the scribe to the patient, and then the scribe sets up on the side or back of the room, not interacting with patient or physician and fading into the background, Myers explained.

"They are typically bright, tech-savvy college students or recent graduates interested in pursuing a career in medicine and other health care disciplines," she said. Many become scribes to gain direct experience and to enhance their chances of acceptance into medical or related training. Candidates to become scribes for Essia Health must type at least 60 words a minute and possess a high grade point average, Myers said. They also "have to be committed to entering the medical field."

However, because they are not credentialed medical assistants or licensed professionals, scribes cannot enter orders into the EMR under federal rules if the office benefits from "meaningful use" incentive programs under Medicare and Medicaid. As of January 2013, only credentialed medical assistants have been permitted to enter medication, radiology and laboratory orders into electronic records. According to the Centers for Medicare & Medicaid Services, a scribe is not qualified to enter these orders into the computerized provider order entry, or CPOE.

Sparling said The Vancouver Clinic's scribes draft a record of the visit, which then is edited later by the physician. "Scribes don't enter orders," which the clinic treats as "a separate process," she said. "The physician does the order entry."

Sparling continues to be an advocate of using medical scribes, but "I don't think scribes will be around forever," she said. Instead, she views them as part of a transition in health care, one that eventually will be displaced as younger, "digitally oriented" doctors continue to fill the work force; easier-to-use EMRs come into being; and voice-recognition software improves.

The big contribution scribes make today is this, Sparling said: They listen "to conversation and turn it into a document." That's something voice-recognition software cannot do, she added.

"The scribe is taking down your thoughts," said Taylor. "You learn to think out loud as you think it and view it on the patient." The best part for her is that scribes allow her to practice the way she wanted.

"I can be hands-on in a way that I didn't use to be able to do," either with paper records or with EMRs without a scribe. "It just creates a much nicer relationship with the patient." •

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adult asthma and congestive heart failure. Hospital readmission rates for additional treatment are down as well.

The first year's data also show that Oregon is doing a better job at preventative care. Ten of the 15 CCOs met all 17 of their improvement targets over the past year. The report shows that Oregon's CCO model is starting to deliver improved preventive and primary care at a more sustainable cost, a promising result since primary care is much more cost effective than having Oregonians show up in the emergency room. Outpatient primary care visits for CCO members increased by 11 percent and spending for primary care and preventive services are up over 20 percent. Enrollment in patient-centered primary care homes has also increased by 52 percent since 2012.

While these results are promising, we have much left to achieve, such as improving screening for risky drug or alcohol behavior, ensuring adequate access to health care providers and improving mental health care. Each of these requires sustained attention and improvement if we are to reach our quality and cost goals. As chair of the Oregon Senate Committee on Health Care and Human Services, I will continue to work closely with the Oregon Health Authority and other stakeholders in the health care community to keep these promising reforms on track as the health care system continues to evolve in the coming years.

The Affordable Care Act and Oregon's innovative CCO model of integrating health care and incentivizing prevention are far from the end of health care reform, but are a promising start. Both take essential steps toward controlling costs and preventing costly conditions before they develop, but must be carefully monitored and adjusted as implementation continues during the coming years. The Legislature is up to this task and I look forward to sharing more progress in health care in Oregon in the future. •

Sen. Laurie Monnes Anderson, RN, a retired public health nurse and manager, represents Senate District 25, which encompasses the cities of Fairview, Gresham, Troutdale and Wood Village.

3-D technologies may improve disease research, detection

By Cliff Collins
For The Scribe

Physicians see patients in three dimensions, and now advances in technology are allowing doctors to detect patients' problems via 3-D.

Local examples include the increasing use of 3-D mammography and the potential health care-related benefits of 3-D bioprinting. The outlook for both types of technology is being called promising.

Three-dimensional mammography, also known as tomosynthesis, has been adopted by several Portland-area health systems since its approval by the federal government in 2011.

Karen Y. Oh, MD, an associate professor and director of breast imaging at **Oregon Health & Science University**, said studies done on the technology so far show that cancer can be detected earlier with 3-D, and false-positive rates are as much as 20 percent lower, but the technology has not been available long enough to know yet whether it will bring higher survival rates than digital 2-D mammography.

Tomosynthesis differs from regular mammography in that it moves around the breast, taking many X-rays at different angles to create a three-dimensional image.

The first metropolitan-area health system to jump on board was **Legacy Health**, which acquired tomosynthesis in October 2012 to replace its 2-D-only machines. Legacy now offers 3-D mammograms to all patients who have a mammogram at all four of its hospitals that contain breast centers: Legacy Good Samaritan, Meridian Park, Salmon Creek and Mount Hood medical centers.

Legacy also recently made two significant upgrades to advance its mammography capabilities: It added radiation- reduction software that lowers radiation levels to less than that of 2-D digital mammography; and introduced tomo-biopsies, which eliminate the need for a surgical biopsy when doctors see something on a 3-D that is not a calcification. Legacy describes these biopsies as less painful and much quicker than surgical ones.

"Ninety-eight percent of women survive breast cancer when it is found in the earliest stage," noted **Nathalie M. Johnson, MD**, medical director of Legacy Cancer Institute and of Legacy Breast Health Centers.

Tuality Healthcare's Breast Health Center in Hillsboro has been using the new 3-D mammogram technology since April. "It allows us to make very thin slices and look at them in 1-millimeter increments," said **Geoffrey M. Gullo, MD**, a Tuality radiologist. "By seeing through the overlapping tissue, it has been shown in big studies that we find more cancer. It has improved the detection of cancer by somewhere in the neighborhood of 30 percent."

Tuality's tomosynthesis also includes C-View technology, which reduces the radiation dose that patients receive, he said.

OHSU bought 3-D imaging 18 months ago to supplement its existing 2-D digital mammography, Oh said. 3-D is particularly helpful with patients who have dense tissue, which often is found in younger, pre-menopausal women.

"With 3-D, you get a better look through that tissue," she said. "It increases detection at all densities," and is better than 2-D for finding tumors when they are smaller. OHSU patients receive 2-D and also the option of an additional 3-D, Oh said.

Most insurers aren't paying any more for tomosynthesis than for regular digital, even though 3-D costs hospitals approximately double the expense of 2-D machines, or about $500,000, according to *The New York Times*.

"The insurance doesn't cover the fee over 2-D insurance, but Legacy had a commitment to go ahead and do it and not charge the patient for the difference," said Legacy's Johnson.

3-D printing may aid drug studies

Three-dimensional bioprinting can produce tissue in shapes such as tubes or patches, with exciting potential in tissue engineering, organ regeneration and wound control. According to an article on the website of the American Society of Mechanical Engineers, asme.org, applications such as cancer drug testing are taking off quickly in the biomedical laboratory world.

"In the field of cancer research, one of the first focus areas is the study of the chemical signals transmitted between cancer cells, how cancer growth is abetted by certain nearby cells, and how cancer might be vulnerable to drugs that manipulate these processes," the article reported.

As a local example, last year OHSU formed a collaboration with Organovo Holdings Inc., a small, San Diego-based biotech company that creates and manufactures functional, three-dimensional human tissues for medical research and therapeutic applications.

Joseph Carroll, PhD, director of business development for the **Knight Cancer**

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Trial at Providence sizes up dissolvable stents in coronary arteries

By Jon Bell
For The Scribe

Ethan Korngold, MD, has seen it many times before: the look of disappointment or disbelief on a patient's face when they realize that the metal stent that's been inserted into their coronary artery is going to be with them forever.

"In a way it's kind of a wakeup call for patients with heart disease or who've had heart attacks," said Korngold, medical director of cardiovascular research at the **Providence Heart and Vascular Institute**. "It gets them thinking more about diet and exercise and lifestyle changes when they realize that the stent is part of the package. It's never coming out."


ETHAN KORNGOLD, MD

Patients making improvements to their lifestyles is, of course, a good thing. There may, however, soon be another, possibly better, alternative to traditional metal stents that are never removed. Abbott Vascular, a California medical device company, first introduced a dissolvable stent, called the **Bioresorbable Vascular Scaffold**, during an initial trial in 2006. Eight years later, the third phase of the U.S. trial has kicked off, with Providence as the only health care organization in Oregon participating.

Unlike traditional metal stents, the Absorb BVS is made of a naturally dissolvable material called polylactide, which is used in other medical implants, including dissolvable sutures. The scaffold, about the size of the coiled spring in a retractable pen, is coated with medication and inserted through the femoral artery in a catheterization procedure. It is then guided to the blockage in the coronary artery to restore blood flow, essentially by propping open the artery. In the ensuing two years, a new artery lining develops and the scaffold dissolves, leaving nothing behind but a "potentially . . . more flexible vessel because it is free from a permanent metallic stent which cages the vessel," according to an April 2014 release from Abbott.

"Just on a more personal level, I'm excited about an implant that goes away completely and leaves no trace," Korngold said.

Personal enthusiasm aside, there may be some other benefits to the dissolvable scaffold as well. Ideally, the new stent will set the stage for a more naturally restored and healed artery. Metal stents can prevent arteries from contracting and flexing the way they would otherwise. Additionally, metal stents can sometimes re-narrow, which can require that another stent be inserted into the original one.

"We think that having the normal musculature of the artery, having it be able to flex and contract, could lead to long-term benefits," Korngold said, adding that the dissolvable scaffold might also reduce chest pain sometimes associated with metal stents. "There's also the benefit that the dissolvable stent would be better for keeping our options open for other procedures that might be necessary in the future."

As for potential complications or challenges with the new implant, Korngold said there really aren't any that are different from those associated with metal stents. At this stage, the dissolvable scaffold isn't available in as broad a range of sizes as other stents are. As a result, they can only be used on lesions of a certain size and shape.

The third phase of the nationwide trial, which aims to enroll more than 2,000 patients in the U.S., is randomized, so some patients get the new scaffold while others get metal stents. Korngold, who noted that Providence will also be involved in the fourth phase of the trial later this year, said several patients have been enrolled at Providence so far. Results should be available within the next two years. The Absorb BVS is already commercially available in Europe, the Middle East, and parts of Latin American and Asia.

Korngold said he's optimistic that this new technology will be a nice improvement in the world of stents. The range of sizes and shapes of the Absorb BVS will likely expand in the future, and the design could potentially be transferred to other applications, such as stents for other arteries elsewhere in the body, including the legs.

There's also the likelihood that patients won't be as deflated about having a stent implanted if they know it won't be inside them forever. The hope, though, is that they'll still make the changes they need to make to keep their hearts healthier in the time it takes their dissolvable stent to disappear.

"Absolutely that's the hope," Korngold said. •

Mobile health apps wave hasn't crested

By John Rumler
For The Scribe

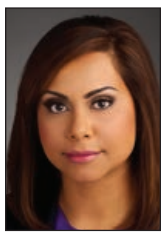
With 40,000 devices flooding the markets on Apple and Google, the $290 billion global medical device market (in 2009), shows no signs of abating. From fitness trackers to cardiac monitors and diabetes devices, Portland is just as gaga over these gadgets as the rest of the U.S.

More local physicians are becoming aware of the practicality and convenience of health apps, said **Beenish Khwaja, DO**, a neurologist and director of the **Legacy Mt. Hood Sleep Center**.

Khwaja, who uses apps for general as well as for specific purposes in her neurology and sleep practices, separates health apps into five major categories:

Clinical Reference Apps give providers easy access to clinical information, medical alerts and diagnostic tools. Examples include Epocrates or PubMed Mobile, frequently used by medical students and clinicians to access real-time information on medical tests, drugs and diseases.

Diagnostic Apps use algorithms to help physicians make treatment decisions. For example, a breast cancer risk assessment app consolidates the common formulas, guidelines and values used to assess a woman's risk for developing breast cancer, and can help a caregiver decide whether to pursue aggressive monitoring using magnetic resonance imaging.


BEENISH KHWAJA, DO

Public Health Apps aggregate information from multiple sources to monitor population health, for example, by tracking disease clusters in real time and giving the providers information about disease outbreaks such as strep, whooping cough, and bacterial meningitis in their community, relying on bio-surveillance data from the Centers for Disease Control and Prevention.

Telehealth Apps incorporate biometric sensors which capture and transmit data that can be used to adjust treatment regimens such as an app that allows users to hook up an EEG scanner to their smartphones and share the recorded images with their physician(s). These are often used by those suffering from chronic conditions.

Disease Management Apps use interactive tools to engage and support patients and specialize in helping providers manage conditions such as diabetes, hypertension and asthma.

Khwaja frequently uses the following clinical reference apps: **Epocrates**, which, she said, "has replaced many a copy of the Physician's Desk Reference," **UpToDate**, for the latest reference materials, and **Medical Calculator**, for calculating everything from kidney function to stroke risk and bleeding risk in patients with certain arrhythmias.

Benefits of health apps, Khwaja said, include the storage of data and clinical tools on one device, immediate real-time access, teleconference and telehealth options, improved convenience and efficiency, improved communications between patient and physician, and potentially reduced healthcare costs. "The market for mobile health apps has overtaken downloads of other apps and will only continue to grow," she said.


SARAH GRALL, PHD

Director of Health Engagement and Wellness Services at **Kaiser Permanente Northwest**, **Sarah Grall**, PhD, also uses a variety of apps and describes them, from a health coaching point of view, as an engagement tool. "Not everyone will want to use one, but for some, the interactive technology can be a tipping point for behavior change."

Many health apps have a social network that appeals to some people, Grall says, and mobile technology will become routinely used to self-gather health data such as blood pressure, blood sugar and other biometrics. "The key will be the simplicity of the user interface and personalization, and although there's still some gaps, smartphone technology will soon close them."

However Grall sees the proliferation of apps hitting a saturation point in the not-too-distant future. "The novelty will wear off and the apps of the future will be much more personalizeable—you'll be able to pick and choose which metrics to track.

"The upside," according to Grall, "is the self-monitoring opportunities apps afford which facilitates behavior change, along with the self-efficacy and social support. The downside is the lack of regulation and the privacy and security concerns."

Another avid proponent of apps and a cardiologist at **Providence Portland, Ty Gluckman, MD**, saw an opportunity to create a new mobile app when lipid guidelines were revised late last year. Gluckman—who serves on the editorial board of the American College of Cardiology's website, CardioSource—was lead developer for the ASCVD Risk Estimator, an app that helps calculate risk for atherosclerotic cardiovascular disease.

"We had algorithms on everything from who may need their risk estimated to what does the risk mean and what should be done," Gluckman said. "We needed an app that was usable for patients and providers." His app was produced by the American College of Cardiology and the American Heart Association and, after just five months, it is already being used by upwards of 60,000 physicians, an average use rate of 6,000 times per day.

Users enter their age, gender, race, cholesterol levels, and systolic blood pressure and other info. Depending on their score, the app may suggest varying intensity of statin therapy on top of risk-reducing lifestyle changes. "It doesn't replace clinical judgment," Gluckman said, "but it can help guide conversations between patients and their care providers."

TY GLUCKMAN, MD

Part of Gluckman's motivation came from his desire to make caregivers aware of the new guidelines and the fact that many physicians were still relying on wall charts or pocket guides and guideline documents up to 100 pages long.

"Almost anyone can build an app now," Gluckman said. "They will continue to grow, grow, grow. The biggest challenge will be separating the wheat from the chaff." •

Wearable medical technology: the next big wave?

Behind the tidal wave of mobile medical apps, another health trend tsunami is building. In the past few years, the popularity of wearable medical technology has exploded. While the origin was primarily fitness applications, it is shifting to medical and wellness.

From continuous glucose monitoring devices to wearable drug delivery devices, wearable patches and sleep monitors, smart watches and smart clothing—this technology will soon play a more critical role in managing and monitoring a wide variety of chronic diseases.

Skeptical? Consider the following:

A column in the *Huffington Post* states that the number of wearable devices shipped to consumers in 2018 is projected to reach 130 million while another source puts the figure at 171 million.

At the 2014 Consumer Electronics Show, upwards of 300 exhibitors showcased wearable health devices of every type imaginable.

TechNavio estimates the global wearable technology market to grow at a compounded annual growth rate of 49.4 percent from 2012 to 2016.

IMS Research said the wearable technology market will triple from $2 billion to $6 billion during the same period.

Driving this phenomena is a perfect storm of technological innovation, increasing health/wellness/fitness consciousness and a globally rising aging population. •

Despite ICD-10 delay, don't wait to get ready

Earlier this year, physician practices were granted a reprieve in the implementation timeline for the industry's new and expanded ICD-10 codes when the government delayed the deadline to Oct. 1, 2015. However, practices shouldn't see this delay as a time to rest; rather, the additional year should be used as an opportunity to become better prepared to smoothly—and seamlessly—adopt the more detailed codes, which will impact your practice's bottom line.


BRIAN O'NEILL

The new codes are not simply expanded and renumbered; rather, they reflect fundamental differences such as changes in terminology and more diagnosis detail to appropriately represent advances in medical knowledge. And there are more of them: up from "only" 14,000 codes in ICD-9 to more than 69,000 codes in ICD-10. Codes are up to seven digits, in part because they include more detailed and information about the type of encounter data and laterality of the condition. That is a significant change from the three- to five-digit codes that have been used for the last 35 or so years.

Brian O'Neill is president and CEO of Office Ally, which serves 330,000 providers in all 50 states and is the only organization in the country offering health care providers a full suite of revenue-cycle management services. O'Neill took time recently to offer advice about how practices can make the most of the delay.

In essence, he said, practices should use this delay as an opportunity to test the new codes, as it will be vital to ensure that coding is administered correctly. A one-digit mistake can cause insurance companies to delay or deny claims, which will greatly impact cash flow and profitability.

The Scribe: **Why should practices start preparing now for the ICD-10 transition?**

O'Neill: It can't be underestimated how important the transition to ICD-10 will be for all involved. From providers to payers to vendors, it is a huge and complicated undertaking. Since these new codes are being both expanded and changed, it's especially important for practices to take the time now to become familiar with the specific changes to ensure a successful and much less stressful transition.

The Scribe: **Since it's difficult to imagine how far-reaching the impact of these changes will be, is there a way to experience what the new ICD-10 codes will be like for businesses?**

O'Neill: It's a great idea for practices to try out how the new codes will affect them. One of the best ways is to start "code mapping." By mapping your most commonly used ICD-9 codes to their ICD-10 equivalents, you can familiarize yourself and your staff with the new codes before the transition, which also will improve the accuracy and precision of billing.

The Scribe: **What should practices do to ensure that the new codes work with existing practice management software?**

O'Neill: Now is the time to ensure that your practice management software will be able to accommodate the much higher data management demands of the larger procedure and diagnosis code sets. If your EHR and billing applications allow for it, you should begin dual coding, a process of entering both ICD-9 and the equivalent ICD-10 codes for visits, charts and claims. By incorporating ICD-10 into your daily processes now, you can reduce—if not eliminate—issues with ICD-10 once the transition occurs.

The Scribe: **Will staff need training to work with the new codes? If so, what type of training is best?**

O'Neill: Since the codes have been expanded and increased, ICD-10 training is vital and should be started as soon as possible. Types of training will vary for different organizations, but expect it to take approximately 16 hours for outpatient and 50 hours for inpatient coders. Look for specialty-specific training offered by specialty societies and other professional organizations. Take into account that ICD-10 training will be integrated into the CEUs that certified coders must take to maintain their credentials. Resources and training materials will be available through CMS, professional associations and societies, and software/system vendors. Visit www.cms.gov/ICD10 regularly throughout the transition to access the latest information on training opportunities.

The Scribe: **If a practice has not yet started to transition to ICD-10, what action should they take now?**

O'Neill: There are five things I suggest practices start doing right away.

- Develop an implementation plan and communicate the system changes to your organization to ensure that everyone understands what's involved in the transition.
- When budgeting, account for software upgrades/license costs, hardware procurement, staff training costs, workflow changes during and after implementation, and contingency planning.
- Talk with your payers, billing and IT staff, and vendors to confirm their readiness.
- Coordinate your transition plans among your partners and evaluate contracts with payers and vendors for policy revisions, testing timelines and costs related to the transition.
- Create and maintain a timeline that identifies tasks to be completed and crucial milestones/relationships, task owners, resources needed, and estimated start and end dates. •

3-D *from page 8*

Institute, said animal models and cancer cell lines present challenges in predicting clinical outcomes and testing potential cancer drugs. The hope is that OHSU's pairing with Organovo for 3-D bioprinting will give scientists more accurate and representative human disease models and potentially improve drug discovery and development for a number of diseases, including cancer.

By applying bioprinting technology, Organovo develops three-dimensional, architecturally correct, human disease models to improve the understanding of drug toxicity and efficacy earlier in the drug development process, enabling safer, more effective therapies, he said.

In clinical use, bioprinting technology someday could allow doctors to use a patient's own cancer cells in a laboratory setting to find and test the most favorable combination of drugs for a particular tumor in time to stop cancer at an earlier, more treatable stage, according to the asme.org article. But the first step is to develop laboratory models of bioprinted tissues that let drug researchers study the complex interactions of cancer cells and surrounding healthy cells in a representative micro-environment.

Carroll explained that mouse models can't accurately represent human physiology, and cell lines don't provide information on "how cells act in a three-dimensional, native architecture. Ideally, you want a system that is wholly human and can capture the architecture," he said. Using Organovo's bioprinting technologies, OHSU wants to create new models to understand cancer disease mechanisms and metastatic progression, which can be used to discover and test new targeted therapies.

Better research models lead to a richer understanding of disease mechanisms and more accurate information in the preclinical drug discovery and development process, added Knight Cancer Institute Director **Brian J. Druker, MD**. "We believe new technologies like bioprinting are important for producing more relevant models of cancer and metastasis to ultimately support the discovery of new therapeutics." •

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Healing horses

Couple finds many benefits in equine friends

By Jon Bell
For The Scribe

Walter Buhl, MD, has been around horses his entire life, but it's only been within the last six months or so that the real equine light bulb has turned on for him.

Born in Hillsboro but raised a farm boy in Minnesota, Buhl grew up with horses, but they were always in the background, out in the fields. He'd chase them around until they got tired enough that he could climb on and ride, then turn them back out into the fields when he was done.

Horses came into his life even more when, 14 years ago, Buhl met Bonnie Rhynard, a lifelong friend of horses whose earliest recollections center around the animals on a Montana ranch. She learned to ride and take care of horses at a young age, stroking and grooming them to gain their trust. She'd tire them out on long rides into the mountains and was known among the cowboys for riding bareback during cattle drives since there weren't any saddles that fit her. According to Buhl, she has always been a natural.

"Whereas Bonnie was flying down the mountainside like 'The Man from Snowy River,' I was sort of the rodeo clown," he said.

Within six months of meeting each other, the two married—she now goes by **Bonnie Rhynard-Buhl**—and moved to a small farm in rural Wilsonville in 2001. That farm has since become home to the **Trillium Creek Training and Rehabilitation Coalition** (TCTC), a nonprofit dedicated to healing sick or neglected horses while also helping people build healthy and beneficial relationships with them.

Buhl, a family practice physician at Northwest Primary Care, said that only once he and Rhynard-Buhl were together did he begin to see a side of horses that he'd never really picked up on before. And only in the past six months did that side really come into the light for him.

"With Bonnie, I realized there was this whole world I had no clue about," he said. "The power of horses as communicators. That's what I didn't know. It's quite an interesting phenomenon."

There's much more to horses even than that, plenty of which has come out at Trillium Creek over the past 14 years. Rhynard-Buhl has had horses come to her who've been seemingly at the end of their roads. She doesn't buy them, but she takes them in and, along with a host of volunteers and with the support of sponsors, rehabilitates them and finds ways to restore meaning to their lives.

A few years into Trillium Creek, Buhl called his wife from the office one day to see if she'd consider letting an 11-year-old girl come out to the farm and spend some time with the horses. The girl had become depressed after losing her best friend, her grandmother and her ability to play sports due to health reasons.

Walter Buhl, MD, and his wife, Bonnie Rhynard-Buhl, run Trillium Creek Training and Rehabilitation Coalition, a nonprofit dedicated to healing sick or neglected horses while also helping people build healthy and beneficial relationships with them.
Photo by Bonnie Rhynard-Buhl

"There's a confidence that the horses offer, a curiosity that they have. **They're very interested in connecting,** and some of these people have lost connections. Very often **the horses find it for them."**

—Walter Buhl, MD

"This child was really alone in the world and had no connection to life," Buhl said. "We had a horse, Kumba, who had barely survived an awful disease and yet, he wanted life. We thought that maybe he could get this idea over to this girl who'd been choosing the opposite."

The girl and the horse did indeed form a relationship and the approach worked to get them both back on track.

"That young lady was saved by one of our horses," Rhynard-Buhl said, "and is now in college studying vet tech, as she wants to work in equestrian rehab."

'Magic and miraculous'

Similar stories abound from over the years at Trillium Creek. Rhynard-Buhl said volunteers come out to help with all kinds of horse-related jobs, from mucking and grooming to feeding and riding. Kids and adults come for riding lessons on older horses who make good trainers, and adults who have been battling

*See **OFF HOURS,** page 14*

VETERANS *from page 1*

provided at no cost, and his prognosis is a complete recovery.

Through Save Our Veterans, OOSC is pledging to donate at least one day a quarter to local veterans who have pressing medical problems and are good candidates for outpatient surgery.

Thomas, who coaches youth baseball in his spare time, had an anterior cruciate ligament (ACL) repair on his knee, while Johnson, who was on a long wait list to get operated on at the VA, had ankle surgery.

In addition to surgery, veterans receive pre- and post-treatment, medical services, physical therapy, prescriptions and supplies at no cost.

Save Our Veterans receives medical support from the **Columbia Anesthesia Group**, while numerous corporations are donating resources, materials and/or financial help.

Bart Bracy is a vice president with **Parcus Medical LLC**, which is donating suture anchors, implants and other surgical supplies to Save Our Veterans. "We're extremely proud to be a part of Dr. Edelson's service to veterans," Bracy said. "I can't think of a single group that is more deserving."

Tim Ryan is a franchise owner of **ImageFIRST Laundry**, which is donating linens and scrubs. "We're very happy to help out with such a worthy cause. It was great of Dr. Edelson to start this service for our veterans," Ryan said.

Edelson and his colleagues are grateful for and heartened by all the support they're receiving. "We thank everyone who is helping us acknowledge the extreme debt we owe our vets. We've benefited greatly from their sacrifices and now it's our turn to make some sacrifices for them."

It appears that Save Our Veterans could be catching on. **Jesseye Arrambide**, OOSC administrator, has received calls from surgery centers around the nation who are starting programs to help veterans, and several other calls asking how to get started.

"The idea of Save Our Vets is starting to take hold with other clinics across the country, but we'd like to hear from more local veterans. Not enough of them know about us," Arrambide said.

Many veterans are suspicious and skeptical by nature, said Gustafson. "To some of them, Save Our Veterans might sound too good to be true. I'm proof it's for real and I'm going to do all I can to inform my fellow vets so they can get help too." •

For more information about Save Our Veterans contact Jesseye Arrambide at saveourvets@oosconline.com, or call 503-207-5369.

OMGMA to host fall conference

By default or plan, some practice managers assume the administrative duties of a practice without the tools or resources they need in a rapidly changing health care environment. The Oregon Medical Group Management Association (OMGMA) is an educational resource available for medical practice managers to help practices succeed. OMGMA is an organization offering networking, local conferences with national speakers, publications specific to practice management, and connections with other practice managers for best practice ideas.

OMGMA will host its fall conference, themed "Are We There Yet?," at the Jantzen Beach Red Lion Inn Sept. 7–9. This year's conference promises to be another exciting opportunity for managers and supervisors to hear from a lineup of excellent speakers while learning and networking with colleagues and friends. For more information or questions, please contact Debra Hansen at dhansen@everywomanshealth.org or visit www.OMGMA.com.

OMGMA is affiliated with the National MGMA, which has a board certification process for managers. Major testing areas included in the certification process are business operations, financial management, human resources, information management and quality management. Certification also enables clinic managers to go on to earn Fellow status in The American College of Medical Practice Executives.

A growing and vital organization, OMGMA has more than 300 members engaged in health care administration, representing over 5,400 physicians. •

OFF HOURS *from page 13*

various traumas have come out and found solace among the horses.

"People don't have to be on the horse to benefit from the relationship," Buhl said. "There's a confidence that the horses offer, a curiosity that they have. They're very interested in connecting, and some of these people have lost connections. Very often the horses find it for them."

"Little miracles happen as people's lives, as well as the horses', are changed for the good," Rhynard-Buhl said. "I think people come to TCTC to help the horses, but I find that the horses appear to help the people."

TCTC has also welcomed scores of kids, both at-risk and healthy, inner city and suburban, to experience the farm and learn from the animals. Buhl said horses are fine teachers when it comes to things like awareness, communication, empathy, leadership and trust. And it's not just children who can learn from horses. The animals — in general, not those at TCTC — have been used in sensitivity training sessions to help physicians improve their bedside manner and be more sensitive to patients. The Stanford School of Medicine even offers a course called "Medicine and Horsemanship," which has similar aims.

TCTC currently houses 15 horses total. In addition to volunteer help, Rhynard-Buhl said she tries to get two sponsors for each horse to help ensure the animals can live out their lives at the farm. TCTC also hosts pony camps for kids and has an art studio and educational opportunities around its gardens, an orchard and an undisturbed ravine that edges the property.

"It's magic and it's miraculous every day," Rhynard-Buhl said. "I don't know of any place like it on Earth, and I've never seen a place do so much for people from the moment they step on the property. There appears to be a universal benefit here." •

To find out more about Trillium Creek Training and Rehabilitation Coalition, visit www.tctchorsecare.org.

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