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News & Events
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MSMP hosts Certified
Medical Insurance Specialist
program, Dec. 2, 3, 9 and 10.

A publication of the Medical Society of Metropolitan Portland

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Helping doctors make better decisions

Health care leader Mark Helfand, MD, to head Cochrane's new West Coast branch at OHSU

By Cliff Collins
For The Scribe

In the fields of evidence-based medicine and medical decision-making, **Oregon Health & Science University's Mark Helfand, MD, MS, MPH**, was present at the creation.

"I feel like I was there from the inception," he says. "I organized efforts to make systematic decisions," and early in his career he worked closely with individuals who later went on—as he did—to leadership positions in those fields, such as with the American College of Physicians, the Institute of Medicine and the international Cochrane Collaboration, considered the world's leading organization for conducting systematic reviews on what is effective in health care.

"I came early to it and got interested because I was trying to understand why we do things," he says.

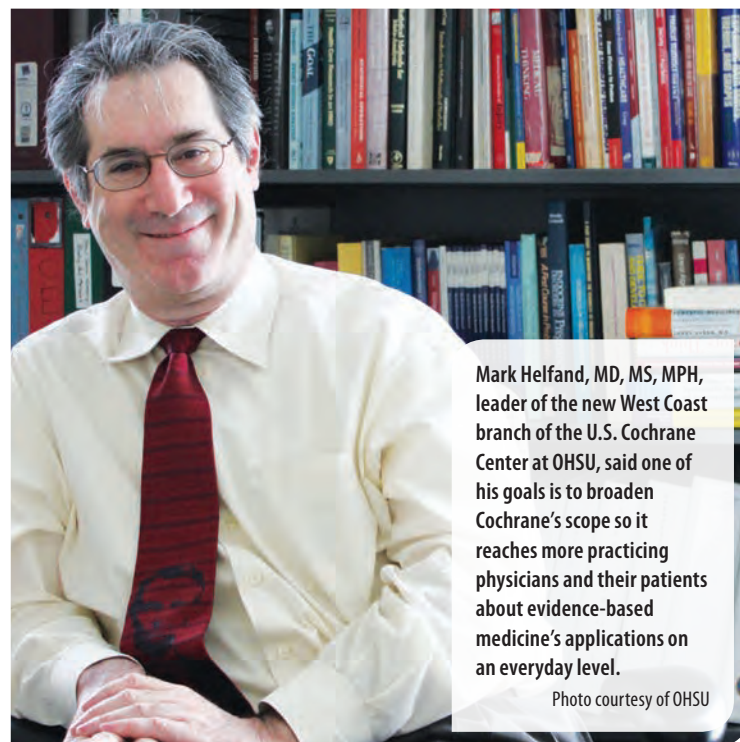
Helfand founded OHSU's Evidence-based Practice Center in 1997, when the federal Agency for Healthcare Research and Quality, or AHRQ, selected the university to serve as one of 10 evidence-based practice centers—known as EPCs—in the nation. The OHSU center plays a key role in research on which national practice guidelines are based.

Since 2002, the OHSU-based EPC—renamed and expanded in 2012 as the Pacific Northwest Evidence-based Practice Center—has held an exclusive contract with AHRQ to perform research

for the U.S. Preventive Services Task Force, which is responsible for setting national clinical guidelines. Most primary care physicians follow the task force's guidelines when treating their patients, and many insurers base their coverage decisions on what the task force recommends.

Now Helfand, a professor of medicine, medical informatics and clinical epidemiology at OHSU, adds to his legacy with the university's selection in September as the **Cochrane Collaboration's West Coast branch of the U.S. Cochrane Center**. The branch will work in concert with Cochrane's primary

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Mark Helfand, MD, MS, MPH, leader of the new West Coast branch of the U.S. Cochrane Center at OHSU, said one of his goals is to broaden Cochrane's scope so it reaches more practicing physicians and their patients about evidence-based medicine's applications on an everyday level.

Photo courtesy of OHSU

New quality report covers more clinics, patients

By Cliff Collins
For The Scribe

The **Oregon Health Care Quality Corp.**'s annual quality report on primary care in the state came with a twist: It included fee-for-service Medicare data.

That addition, courtesy of the Centers for Medicare & Medicaid Services (CMS), allowed Quality Corp. to expand the number of medical clinics about which it publicly reports quality scores. A result is that reporting now includes information on

92 percent of the state's Medicare population, up from 41 percent last year, according to **Mylia Christensen**, executive director of Quality Corp. "Prior to that, we had no fee-for-service data" derived from Medicare claims data, she said.

Posted last month on the nonprofit organization's Partner for Quality Care website, www.PartnerforQualityCare.org, the report, "Information for a Healthy Oregon," enables



MYLIA CHRISTENSEN

consumers and policymakers to compare how clinics perform in areas such as preventive care, chronic disease care, and use of services such as emergency rooms. Reporting quality scores publicly, which Quality Corp. pioneered in Oregon, has fit well into what has become "a national movement, a concerted effort to provide more data to help decision-making," Christensen said.

In 2008, Quality Corp. produced the first public reports of health care quality for primary care clinics across the state. That and its other achievements since then went a long way toward the organization's successfully winning designation from CMS as a "qualified entity," which permitted it to obtain fee-for-service claims data submitted by Oregon clinics to Medicare. That qualification allowed Quality Corp. to add an additional 350,000 patients, so that it now

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Safety first



Medical student David Liskey spearheads a bike safety project that brings together various organizations and benefits kids and families.

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MSMP News & Events

MSMP hosts class on how to improve front-desk skills

Tuesday, Oct. 28

Don't miss MSMP's three-hour course Tuesday, Oct. 28, designed to teach front-desk staff the critical thinking skills to appropriately manage front-line communication, data collection, privacy and compliance issues.

Sessions will be offered from 9 a.m. to noon and from 1 to 4 p.m. in the Medical Society of Metropolitan Portland's first-floor conference room, 4380 S.W. Macadam Ave. The cost is \$199 per session, including instructional materials.

For more information and to register, please visit msmp.org and click on the Education tab. •

Medical Society Staffing to offer medical assisting review course

Mondays in November

The Centers for Medicare & Medicaid Services recently issued its ruling allowing credentialed medical assistants to enter medication orders into a computerized provider entry system. MSS's four-week course will help professionals refine skills and get better prepared to take the Medical Assistant Examination to become a credentialed medical assistant. Our course graduates have had great success in passing their exam.

MSS's course, titled "The new CMS change: I am not certified, what do I do now?" begins Nov. 3 and will be held each Monday in November from 6:30 to 9 p.m. in the first-floor conference room at MSMP's office, 4380 S.W. Macadam Ave. The cost is \$75 per person, with one free staff attendee per MSMP physician member. For more information and to register, please visit msmp.org and click on the Education tab.

More information also is available by contacting Paula Purdy, CMA, MSMP operations director, at paula@msmp.org or 503-944-1128. •

Certified Medical Insurance Specialist (CMIS) class

Dec. 2, 3, 9 and 10

MSMP is hosting a program to get small to mid-sized provider practices, organizations and companies certified in medical insurance third-party reimbursement methods. The course includes four full days in a live classroom environment Dec. 2, 3, 9 and 10 and concludes with a certification exam.

Detailed lectures, course materials and examples teach participants how to effectively expedite claims, secure timely, correct reimbursement and protect the financial interests of the practice. To register, visit msmp.org and click on the Education tab. •

2015 Innovative Lecture Series begins with workplace assessment and workflow problem solving

MSMP will hold a 2015 Innovative Lecture Series, with the first lecture titled "Developing transferable skills to optimize your office workplace assessment and workflow problem solving."

The medical society's organizational readiness expert will facilitate the monthly cohort courses. Areas of study include how to be a leader when you aren't the boss; FaceTime or face time—communicating across the generations; and defining difficult differently—working with "difficult" patients and families. A benefit option for Lecture Series participants is having the expert provide a personalized onsite assessment of your office and help optimize workflow.

Look for more information on the Lecture Series soon at msmp.org, or email sarah@msmp.org for more details. •

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The Portland Physician Scribe is published monthly by the Medical Society of Metropolitan Portland, 4380 SW Macadam Ave, Portland, OR 97239.

Subscriptions are available upon request. For enrollment, please email Sarah@MSMP.org

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American center at the Johns Hopkins Bloomberg School of Public Health in Baltimore.

"Cochrane is a very respected, important and largely volunteer organization that, over the years, has collected and produced thousands of reviews on clinical topics," Helfand says. "Most clinicians know it as a library. Clinicians rely on it directly, and also indirectly: Any source they are familiar with relies heavily on Cochrane, as well."

Asked why Cochrane selected OHSU as one of only two sites, along with Johns Hopkins, in the continental United States, **Kay Dickersin, PhD**, director of the U.S. Cochrane Center, exclaims: "Mark Helfand is the reason! He has a fantastic mix of skills, knowledge, and professional connections."

She cites his leadership of an EPC and his understanding of systematic reviews. She also notes that Helfand is director of the Scientific Resource Center for AHRQ's Effective Health Care Program, which provides services to all EPCs.

"So he understands the informatics side of things, as well as other aspects of the science, and he is a physician and has professional links such as professional societies and guidelines groups that are key to using the Cochrane products. Mark is also a person who contributes to the thinking that is needed to move Cochrane forward in the U.S. Although he has kept up with Cochrane activities over the years, his perspective is fresh and his ideas are new and modern."

Dickersin adds that OHSU itself has been an up-and-coming player in biomedical research over the past decade and has firmly established itself as a home for scientific expertise and a hub for important work in science and medicine.

Helfand says individuals affiliated with the EPCs and Cochrane have cooperated and collaborated on research and reviews for years, and he views the Cochrane designation as a natural step that will enhance OHSU's and Portland's EPC work. In 2012, the Kaiser Permanente Center for Health Research also was named an EPC.

"Portland is a very logical place to do this because of the two EPCs, the scientific center I run," and the presence of the Portland Veterans Affairs Medical Center, he says. "We think particularly here in Oregon and the Northwest, there's a great amount of interest in the Cochrane Collaboration."

Helfand also was selected by the U.S. Government Accountability Office to serve on the Methodology Committee of the Patient-Centered Outcomes Research Institute, a nongovernmental organization established in the Affordable Care Act to perform clinical comparative-effectiveness research.

Interest sparked early

When Helfand, an internist, was beginning a clinical rotation in his second year at the University of Illinois Medical School, electronic fetal monitoring was fairly new, and there wasn't a lot of evidence about its effectiveness.

One day when he was on rounds, he asked an attending physician: "What does fetal monitoring do? Does this work?" The doctor shot back, "Don't you know that it has eliminated cerebral palsy in this country?"

Helfand was stunned and skeptical of the doctor's response. He thought, "What's going on here? What's behind the beliefs we have? What is the evidence behind it?" He wrote to a professor, "I need to know what we base decisions on." The professor then accepted him for a clerkship.

"That got me started in medical decision-making, later and now called evidence-based medicine," Helfand says. When Helfand returned for his internship, residency and fellowship

on to do clinical research in addition to performing reviews of medical literature for the ACP, and from 1995–96 did reviews on thyroid cancer for the Institute of Medicine.

Shortly afterward, the EPC concept was created, and OHSU applied and was accepted as a center. Many of the original EPC leaders—now including Helfand—went on to become part of the leadership of the Cochrane Collaboration. Some of the leaders of EPCs also have become involved in medical decision-making, including Helfand, who this month becomes president-elect of the Society for Medical Decision Making. The international, multidisciplinary organization explores how physicians and patients make decisions, identifies barriers

"Mark is also a person who contributes to the thinking that is needed to move Cochrane forward in the U.S. Although he has kept up with Cochrane activities over the years, his perspective is fresh and his ideas are new and modern."

—Kay Dickersin, PhD, director of the U.S. Cochrane Center, on OHSU's Mark Helfand, MD

at Stanford University, where he had received his undergraduate degrees, "It just happened that there was a concentration of people there with an interest in this topic," some of whom went on to leadership positions with the American College of Physicians and other organizations.

At Stanford, Helfand earned a master's degree in health services research.

He began writing systematic reviews of screening, diagnosis and treatment of thyroid disease, and the ACP developed guidelines out of those. "This was one of the first to use evidence to create guidelines," he explains. He went

to good decision-making, and develops tools that doctors and patients can use to make better decisions.

One of Helfand's goals with Cochrane is to broaden its scope to make it reach more practicing physicians and their patients about evidence-based medicine's applications on an everyday level. He says evidence-based medicine sometimes is perceived by doctors as too rigid. But he emphasizes that judgment, clinical decisions and values also play a role: Systematic review is "based on the best available evidence, but we're not trying to substitute for good clinical decision-making." •

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David Liskey

Safety first

David Liskey's volunteer project promotes bike safety for youngsters

By Barry Finnemore
For The Scribe

For a good portion of the night, the queue stretched across the gymnasium floor, with scores of families interested in obtaining a new child's bicycle helmet and learning a bit more about bike safety.

The helmets and information, distributed during a recent open house at Alder Elementary School, came courtesy of a project spearheaded by David Liskey, an Oregon Health & Science University medical student.

For Angie Briles, the open house couldn't have come at a better time for her and her 10-year-old daughter, Allyson, an Alder student who loves to ride her bike.

"Her helmet was getting too small, so to have one is a nice surprise," said Briles, who also appreciated that the helmets were free. "Every little bit helps."

The Briles received one of 60 helmets handed out at the Southeast Portland school as part of a project Liskey developed with the nonprofit "I Have A Dream" Oregon and funded by a nearly \$500 grant from the Metropolitan Medical Foundation of Oregon, the nonprofit that supports activities that improve health education and health care delivery to communities in the Portland metro region. The helmets were purchased through Doernbecher Children's Hospital's Tom Sargent Safety Center. As a nonprofit, the safety center obtained the helmets at a significant discount from the nonprofit Helmets R Us, Liskey said.

In addition to fitting and distributing helmets, Liskey and fellow fourth-year OHSU medical students Amy Anderton, Corey Costantino and Eunice Ko shared tips for safe bike riding. They also provided the school with bike-safety posters.

Liskey said he developed the project based on research showing effective bike safety programs encompass educational presentations, informational materials and helmet giveaways.

Cathy Krieger, MMFO board president, said Liskey's project met a need at Alder, and his leadership led to a highly successful collaboration.

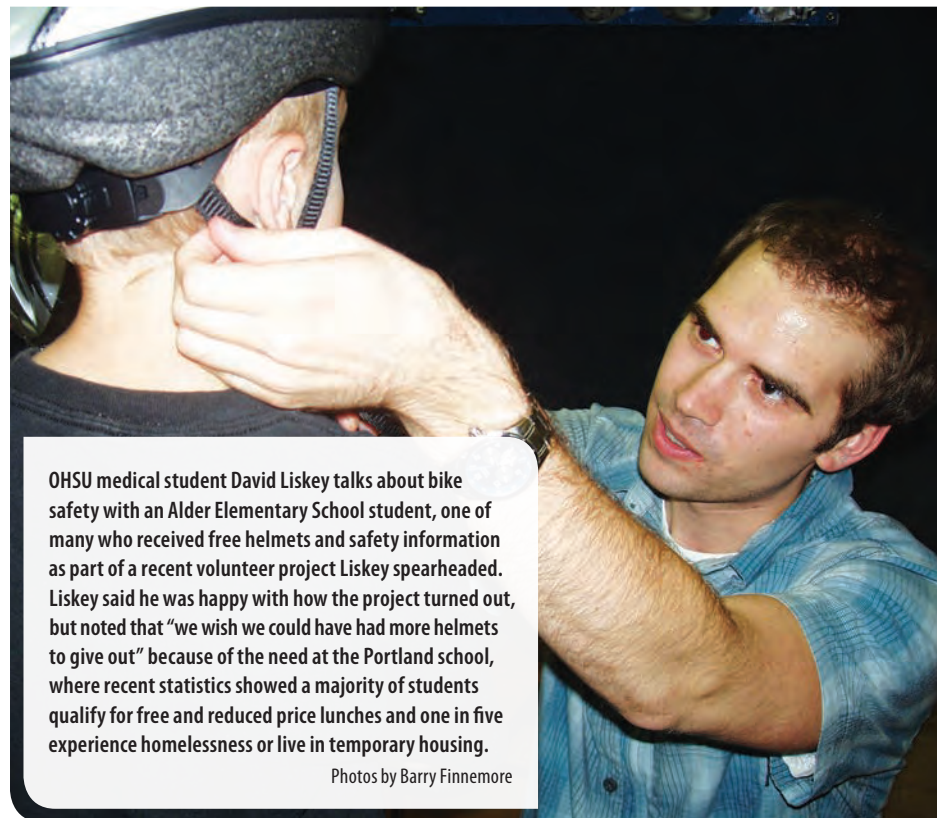
"His efforts to raise awareness about bike safety are just one of many examples that effective health education improves lives in our community," Krieger said.

A bike commuter himself, Liskey has a natural interest in bicycling safety, particularly among kids. The project built on "I Have a Dream" Oregon and OHSU med students' involvement with the school, which has included classroom presentations to students about careers in medicine.

"Starting in middle school, I had a big family of other students and community members pushing me toward volunteering, and I loved it."

The bike-safety project is just the latest in Liskey's volunteerism, which started when he was young. He was invited to be a part of College Dreams, a nonprofit based in his hometown of Grants Pass that promotes healthy youth development, academic excellence, and college preparation for students, especially those who face life challenges.

"Starting in middle school, I had a big family of other students and community members pushing me toward volunteering, and I loved it," he said.



OHSU medical student David Liskey talks about bike safety with an Alder Elementary School student, one of many who received free helmets and safety information as part of a recent volunteer project Liskey spearheaded. Liskey said he was happy with how the project turned out, but noted that "we wish we could have had more helmets to give out" because of the need at the Portland school, where recent statistics showed a majority of students qualify for free and reduced price lunches and one in five experience homelessness or live in temporary housing.

Photos by Barry Finnemore

As an Oregon State University undergrad, he was involved in the University Honors College, leading its service committee and helping organize student events.

Liskey's interest in medicine took root in high school, and it didn't take long to learn what he appreciated about it. As a

doctors and nurses who were visiting from around the world. Experiencing the teamwork displayed by the medical professionals, sometimes with only the most basic of equipment and supplies, had a profound effect on him.

"Those were strong messages for me," he said.

After graduating with a biology degree from OSU, Liskey earned a certified nursing certificate and worked for a year and a half on the night shift at Good Samaritan Regional Medical Center in Corvallis. The experience gave him a taste for work inside a hospital at a time when he knew he wanted to become a doctor but was unsure about a specialty.

These days, Liskey is doing rotations and serving as vice president for the OHSU medical school class of 2015. He's poised to begin applying for residency programs in internal medicine and eyeing a career as a hospitalist or ICU doctor. He also continues to carve out time to volunteer with "I Have a Dream" Oregon.

And thanks to his efforts and those of his classmates, Alder Elementary students are better equipped to bike safely.

Rob Stewart, Alder's principal, said the bike-safety project dovetailed well with the school's approach to family outreach, noting that the helmet giveaway helped serve as an effective platform to engage children and parents in conversations about student safety and success.

"We want to make sure everything we do is looking at that bigger picture," he said. •



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Five strategies to lower taxes before year's end

By **Karla Dennis**
For *The Scribe*

Although you may not be thinking about tax season preparation just yet, fall is the perfect opportunity to get ahead and organized. All business owners, including private medical practice owners, can improve their tax position with the right prep work. There are simple, yet effective strategies that owners can take to reduce taxes before the end of the year.

Start with the 12x12 system. For 12 consecutive days, one day at a time, go over each month of the year to review bank accounts, gather receipts and find canceled checks if you don't currently have financial statements, and go through checking accounts to find tax deductible items. Then, place each month's records in an organized folder for either your tax preparer or accountant. This approach presents 12 opportunities to

analyze your tax situation and make adjustments prior to the end of the year and also gives you an idea of your tax liability.

Find easy steps to reduce liability. Now that you have a benchmark number, face it, and find ways to reduce it. Put your fixed expenses on paper and seek out opportunities to have a better tax position. Determine the items that can become tax benefits and those that



Karla Dennis

can be written off—but don't write off items just for the sake of it. Do so for the beneficial reasons to get money back in your pocket, and then determine where to invest it, such as contributing to a retirement account.

Give the gift of marketing. The holidays are approaching, which means gift giving is underway. As you may or may not know, gifting clients has a write-off limit of \$25 per person, and many business owners often exceed the limit. However, if business owners include marketing materials and business information with their gift, the items are considered a marketing ploy rather than a gift and do not have a write-off limit. These items can therefore be written off for the entire expense.

Track all charitable donations. Many business owners do not take advantage of the ability to set up their own charitable organization. At the end of the year, if you determine that your taxes are very high, you can make a donation to your own organization and receive a tax deduction. This positions the company favorably, as people like to conduct business with organizations that serve the community.

Open separate companies. Business owners can open a separate company for sellable content or products and have two entities. This provides a multitude of benefits, but from a tax perspective, you have the option to invoice one entity based on services rendered, ultimately lowering your tax bill.

As a business owner looking to do what is best for your business, taking the time and effort to prepare your taxes will help you capitalize on opportunities than can lower your tax bill. Even though it is not tax season yet, a lack of planning can put your tax position at a disadvantage. Taking these strategies into consideration and being proactive about your taxes is the key to finding ways to lower your tax bill before the end of the year and fuel success for the year to come. •

The "practical tax strategist," Karla Dennis is founder and CEO of Cohesive Tax, a comprehensive tax and accounting firm based in Southern California.

"When my colon cancer was first diagnosed, I had a thousand questions."

"My doctor always gave me the time I needed to understand my choices. It's been a tough road but having that support keeps me going."

Actual patient testimonial. Representative photo.

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Area physicians help improve outcomes for women through cancer research, treatment advances

By John Rumler
For The Scribe

It's been 43 years and more than \$120 billion since President Richard Nixon launched the war on cancer. Although the disease has not been conquered, 2002 marked a huge milestone as the first time the United States noted an overall decline in the number of cancer-related deaths.

While upwards of 40 percent of Americans will contract some form of cancer in their lifetime, much progress is being made globally, nationally and regionally. Portland-area health systems and clinics are doing their part to not only find the silver bullet to forever eliminate cancer, but also to improve research, screening, and cancer treatments and surgery methods. These efforts include improving outcomes for women with cancer.

Legacy Health, for example, is now offering breast cancer patients who have undergone a mastectomy a new breast reconstruction option: Deep Inferior Epigastric Perforator or DIEP flap breast

reconstruction. Microsurgeons **Shane Kim, MD**, and **Hema Thakar, MD**, perform the highly specialized procedure, which involves transplanting a patient's own tissue and blood vessels to recreate a breast that contains no foreign bodies, has a more natural-looking anatomy and is able to age, gain and lose weight with the patient throughout her life.

After the mastectomy, fat and skin from the patient's abdomen is used to create a new breast. Zero or very little abdominal muscle is removed, and blood vessels are relocated to supply the transplanted tissue with blood. DIEP flaps have better longevity than implants as there is no chance of leaks or ruptures and only one surgery is required.

Just a few U.S. surgeons are trained to perform the procedure, and Kim and Thakar are the only Oregon physicians who perform the surgery as a team. DIEP flap requires highly developed microsurgery skills (few plastic surgeons are also microsurgeons), and the procedure typically takes about five and a half hours. The team approach allows for decreased operative time, less anesthetic,

increased patient safety and a quicker healing process.

"DIEP flap is the most advanced form of breast reconstruction available today; unfortunately, many women don't even know it exists," said Kim, who is fellowship-trained in the surgery. "As the gold standard for breast reconstruction for women who have undergone radiation, we want to raise awareness of this option."

Vaccine clinical trial shows promising results

Legacy Cancer Institute (LCI) is participating in a promising new vaccine clinical trial targeting breast cancer that could reduce by half recurrence in survivors, even those diagnosed with the most aggressive subtypes. The trial aims to prevent or delay recurrence in women who have survived triple negative breast cancer, or who have had lymph node involvement, and achieve remission after surgery, radiation and chemotherapy. The clinical trial combines Herceptin, a drug used to treat other types of breast cancer, and E75, a peptide-based vaccine.

The study is entering Phase II after results from Phase I showed a 50 percent reduction in recurrence for patients with triple negative breast cancer. Phase II trials, which have 96 patients enrolled so far nationwide, are placebo-controlled studies conducted to determine the effectiveness, side effects and potential risks of a new drug that is in development. If it is successful, Phase III trials would involve a much larger group of patients.

"The biggest fear of most cancer survivors is that their cancer will return," said **Nathalie Johnson, MD**, medical director of Legacy Cancer Institute and principal investigator.

"The ultimate goal of this research is to apply the science of this vaccine to other cancers and eventually one day prevent cancer from occurring in the first place. Vaccines are the next frontier in the fight against cancer."



NATHALIE JOHNSON, MD

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LCI was one of 20 hospitals across the United States selected to take part in the study and the only one in the Pacific Northwest.

LCI also is offering nipple sparing mastectomy surgery, a revolutionary technique that leaves all of the breast's skin in place, including the nipple and areola. The mastectomy is performed through an incision that is closed primarily, which bolsters cosmetic outcomes and avoids additional scarring.

Early follow up of nipple sparing mastectomy in selected patients has shown low rates of nipple tumor recurrence and decreased rates of nipple necrosis. Immediate reconstruction is now available, lessening some of the emotional effects associated with undergoing a mastectomy. Women are able to have a tissue expander, implant, or autologous tissue placed at their initial operation rather than in a delayed approach. These options allow a more cosmetically appealing result with skin sparing techniques and a shorter recovery process.

Female cancer patients frequently experience a host of symptoms, including sleeping problems, increased anxiety, and decreased appetite, that can be easily managed if properly addressed. LCI recently started utilizing the Edmonton Symptom Assessment System (ESAS) to systematically improve patient/provider communication and help patients manage a wide range of symptoms, including pain, nausea, depression, anxiety, fatigue, appetite changes, and shortness of breath. ESAS tracks symptoms on a numeric scale and is projected onto a graph so the progression of symptoms is better understood by patients, physicians and caretakers and care plans can be adjusted as needed.

LCI is also participating in a clinical trial for postmenopausal women who have estrogen receptor positive breast cancer. The trial, which is being sponsored by the Alliance for Clinical Trials in Oncology, is to help gauge the effectiveness of promising new drugs. The specific purpose is to determine if fulvestrant or fulvestrant combined with anastrozole is superior to administering anastrozole alone in shrinking tumors before surgery. Fulvestrant degrades estrogen receptor in the cancer cell and anastrozole lowers estrogen in postmenopausal women and is the standard of care for pre-surgery. Both are considered endocrine therapy drugs and do not cause the same side effects as chemotherapy.

Nationwide enrollment for the trial began in December 2013, and Legacy started the trial in January. About 2,820 women will take part in the study.

Compass Oncology physician boosts cancer risk assessment tool

An oncologist/hematologist with Compass Oncology in Portland, **Lucy Langer, MD**, recently presented findings at the American Society of Clinical Oncology's 50th annual meeting in Chicago that shined a spotlight on a valuable new tool—a genetic test—that can dramati-



LUCY LANGER, MD

cally improve assessments of a person's risk of developing several forms of cancer.

Langer worked to further review and interpret a test by Myriad Genetic Laboratories using aggregate data. The initial study involved 648 ovarian cancer

patients who underwent a screening, between September and December 2013, using a panel of 25 different genes. Normally, genetic cancer screening utilizes only one hand-selected gene at a time to test one syndrome at a time.

Langer's follow-up study confirmed that by using a panel of genes up front, rather than testing one gene at a time, researchers can more quickly and accurately identify genetic changes or mutations. "The panel testing increased the hit rate in finding deleterious mutations, over and above the previous system, by 48 percent," she said.

By identifying patients with an increased genetic risk, doctors hope to be able to detect cancer earlier by stepping up screening efforts. For example, patients with ovarian cancer are also at increased risk of breast cancer and a form of colorectal cancer called Lynch syndrome.

As the director of Compass Oncology's Genetic Risk Evaluation & Testing Program (GREAT) and medical director of cancer genetics for US Oncology, Langer had a huge interest in how panel testing could change the way scientists screen for genetic syndromes and manage cancer risks.

"This is an exciting time for hereditary cancer genetics because the science and the economics have brought us to a place where we can accurately evaluate a large number of genes with a single test," she said. •



Legacy Health offers breast cancer patients who have undergone a mastectomy a new breast reconstruction option: Deep Inferior Epigastric Perforator or DIEP flap breast reconstruction. Microsurgeons Hema Thakar, MD, and Shane Kim, MD, perform the highly specialized procedure, which involves transplanting a patient's own tissue and blood vessels to recreate a breast that contains no foreign bodies, has a more natural-looking anatomy and is able to age, gain and lose weight with the patient throughout her life.

Photo courtesy of Legacy Health

Three questions with Anupama Kurup Acheson, MD, an oncologist with Providence Cancer Center

The Scribe: Lung cancer, breast cancer, and colorectal cancers are the most common cancers among women, according to the Centers for Disease Control and Prevention. Are there new tools for diagnosing these cancers?

Acheson: There is now evidence that screening high-risk people (aged 55 to 74 years who have cigarette-smoking histories of 30 or more pack-years and who, if they are former smokers, have quit within the last 15 years) with a low-dose helical CT scan can reduce lung cancer mortality by 20 percent.

Breast cancer diagnosis has now been aided with the use of digital mammography. Breast MRIs can also be helpful in specific populations, and there are developing technologies such as 3-D mammography and breast-specific gamma imaging that may be helpful in certain groups of women.

For colorectal cancer, although careful use of fecal occult blood testing, sigmoidoscopy, and/or colonoscopy remain the mainstay, there are developing technologies such as stool DNA mutation tests and immunohistochemical fecal occult blood testing that are being studied for their roles in screening and diagnosis.



ANUPAMA KURUP ACHESON, MD

The Scribe: Has treatment changed dramatically in recent years?

Acheson: Most exciting in the field of oncology are studies that have shown translation of research from labs into use in our clinics for the care of patients with cancer. Specifically, there is much ongoing research that seeks to better target treatment to specific tumor subtypes. This is changing our approach to cancer patients. We are not only interested in whether a person has cancer, but with whether we can specifically understand the tumor biology such that we can better understand the prognosis and more effectively tailor treatments in populations that can derive benefit. One such example is the common use of the breast cancer gene assay Oncotype DX, in early stage patients, to determine whether or not adjuvant chemotherapy is necessary in their treatment plan. Another example is selecting specific targeted biologic agents in patients with metastatic lung cancer and metastatic colorectal cancer that have a specific mutation (ALK, EGFR, KRAS mutations) for better response to therapy.

The Scribe: What is new with research in treatment?

Acheson: There is a lot of excitement regarding research at the Providence Cancer Center, and there has been a long history at the cancer center in the field of immunotherapy and targeted therapies, including vaccine therapy, anti-PD (Programmed Cell Death) directed therapy, and OX40 monoclonal antibody. •

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Gender differences play a big role in heart disease, medical research

By Jon Bell
For The Scribe

Lori Tam, MD, a cardiologist with **Providence Heart and Vascular Institute**, once had a patient come in because she was having chest pain. The woman, who was in her mid 50s with cholesterol that was a touch high, but otherwise in good health, had been experiencing the

pain for a few days. But because it was the week of Thanksgiving and she had a meal to plan, she worked her way through it.

When she got to Tam's office, it became clear that she'd been having a heart attack for several days.

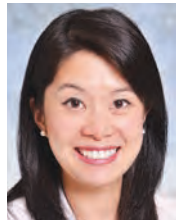
"She thought it was heartburn and didn't realize that things were that bad," said Tam, who's been with Providence a little over a year.

While it's not unusual for both men and women to underestimate the severity of chest pain and other signs of heart attacks, Tam said there's a tendency for women to perceive the symptoms differently—i.e. as pressure instead of pain—that can delay proper treatment. Similarly, many women who get heart disease don't realize they have it. That's due, in part, to a long-held perception

that heart disease is a disease for older men.

"People have always thought of that as a man's disease," Tam said. "You think of an old man with a beer belly who's popping nitroglycerine."

In reality, however, more women die of heart disease each year than men. Women are also more likely than men to die within a year of having a heart attack. The disease is the leading killer of both men and women, and while awareness about breast



LORI TAM, MD

cancer is high, the same is not as true for heart disease despite the fact that about one in three women die from it. The death rate for breast cancer is approximately one in 31.

Research in recent years has made some headway into how heart disease differs in men and women. For example, researchers have found that estrogen provides a natural protection against heart disease by increasing good cholesterol and lowering the bad. After menopause, however, women lost that protection. Diabetes also seems to increase the risk of heart disease in women more than it does in men, as does metabolic syndrome, a group of risks such as high blood pressure and a large waist that increase the chances of heart disease, stroke and diabetes.

Another concern for women is polycystic ovary syndrome (PCOS), an endocrine system disorder in women that can increase the likelihood of heart disease and diabetes.

Tam's patient who'd been having a heart attack for several days had PCOS, but was unaware of it.

"She said nobody had ever mentioned it to her or that it could increase her risk," Tam said. "I think there's still a lot to be done in terms of education and prevention, and educating both providers and the community."

Another factor behind the disparity in knowledge and perception when it comes to heart disease and other illness in men and women is the fact that, for decades, medical research has been skewed largely toward men. Research has shown that studies are almost always geared toward men.


"Women continue to be fairly underrepresented in research," said **Brenda Olson, MD**, a primary care doctor at **Legacy Health's** new Raleigh Hills location. "Unless it's something related to cervical cancer or breast cancer, for the most part the majority of medical research is always done on men."

Tam noted that the results of such studies tend to get generalized for both genders.

"It's a big shortcoming, but I do think the pharmaceutical companies are coming around and realigning that and trying to include more women," she said.

Olson, too, said she thinks the trend will continue to involve not only more women, but more minorities as well.

"I'm optimistic," she said. •


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Research impacts area practices, patients

Medicine is an ever-evolving field that generates a robust body of research studies each year. The *Portland Physician Scribe* caught up with a few area physicians specializing in women's health and wellness, who touched on some of the ways research and other advancements are impacting their practice.



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Gina Allison, MD, and fellow obstetricians/gynecologists at **Women's Healthcare Associates (WHA)** are embracing the new guidelines for cervical cancer screening. The 2012 guidelines, from the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology, advise that women be tested less during their life to better ensure they derive testing's benefits while minimizing the harms.

The new guidelines advise that cervical cancer screening not begin until age 21, except for special populations including women with a history of cervical cancer or whose immune systems are compromised. For those 21–29, the guidelines recommend screening with cytology alone every three years. In addition, HPV testing is not recommended, as a stand-alone test or as a co-test with cytology, to screen women 21–29. The guidelines also include a preference for co-testing using the Pap test and HPV test for women 30–65.

Allison said that while Pap tests for many years had been performed in younger populations, such screening can lead to more invasive yet unnecessary testing and procedures given that the dysplasia older teens and young women can experience often goes away with time.

"We're not intervening as much, screening less aggressively with younger populations and watching and waiting with some minor abnormalities," she said. We're "respecting the use of the screening test for what it is" but realizing that "just because you can test doesn't mean you should."

As WHA puts into practice the evidence-based guidelines, it also is developing educational materials for patients, Allison said.

For her, the guidelines represent a great example of the need as a clinician to "embrace being a student forever." •

Michelle Berlin, MD, MPH, co-director of **Oregon Health & Science University's Center for Women's Health** and vice chair of the Department of Obstetrics & Gynecology, pointed by way of example to a couple areas where women's health and wellness is evolving: improvements in screening and tracking women for cardiovascular disease and diabetes if they had certain conditions during pregnancy.

According to the National Institutes of Health, gestational diabetes—which occurs when the body can't make enough insulin during pregnancy—may increase a woman's chances of developing type 2 diabetes during her lifetime. In addition, high blood pressure and other conditions during pregnancy also may increase the chances of high blood pressure and cardiovascular disease later in life.

Berlin said it's been known for years that women who have gestational diabetes should be re-tested six weeks after delivery to ensure their blood sugar has returned to normal. But the challenge has been tracking women after those initial weeks for both diabetes and high blood pressure because "so many women don't have a primary care provider," she added.

"With the renewed interest in the primary care model, CCOs and other mechanisms, there will be better tracking overall," Berlin said, adding that use of electronic medical records can help ensure such vital information is shared over time between specialists and primary care doctors.

"We're now asking women more and more, 'How were things during your pregnancy?' Berlin said. "There's a heightened awareness." •

Statistics indicate that as many as half of women who have given birth can experience pelvic organ prolapse. Incontinence impacts a large number of women as well. Yet, in **Audrey Curtis'** experience, those who have the conditions can feel like they are all alone.

"When I tell them how common it is, their mouths drop," said Curtis, MD, a urogynecologist with **Legacy Medical Group**.

Thanks to research, less-invasive treatments have been emphasized for both conditions. With respect to prolapse, Curtis said studies show more than 80 percent of patients can benefit from pelvic floor physical therapy, which rehabilitates the muscles.

In fact, the Portland area, with its community of skilled physical therapists and specialists in urogynecology, was an early adopter of the treatment, Curtis noted, adding that, in many cases, insurers now require that therapy be pursued first.

A significant shift has also occurred in the research during the past five to 10 years away from objective outcome measures and toward subjective, yet statistically reliable, measures after such therapy, she said.

"Now we want to know, has their quality of life improved, how higher functioning are they and are they back to an exercise program, rather than simply the degree of prolapse," Curtis added.

In many instances, clinicians are sidestepping invasive testing in favor of offering prophylactic incontinence surgical procedures based on research. Curtis said that a large recent study showed that outcomes at one year after surgery were just as good among women who did not undergo invasive preoperative bladder testing as those who did.

"It's a great example where we're seeing that testing doesn't change outcomes, so we don't need it in the straightforward cases, which, in truth, are many," she said. •

Cristina De Castro-Dela Cruz, MD, with **Providence Medical Group** in West Linn, also sees many patients with urinary incontinence and highlighted a recent article from the American College of Physicians that reviewed different nonsurgical management options for treatment of incontinence.

De Castro-Dela Cruz explained that there are two kinds of urinary incontinence, although both can occur at the same time. Stress incontinence is secondary to urethral failure under increased abdominal pressure. Urge incontinence is loss of urine with the sudden urge to void.

The recommended treatment is pelvic floor muscle training for women with stress incontinence, and bladder training in women with urge incontinence. If a woman has mixed incontinence she should do both pelvic floor muscle exercises and bladder training. If bladder training does not work in urge incontinence, then medication may be used, she said.

Medications for urge incontinence include anti-muscarinics such as Darifenacin, Oxybutynin and Fesoterodine. Some side effects of these medications include dizziness, blurring, dry mouth, and constipation. These should be used with caution, especially in older women who are already taking a lot more medication. Weight loss and moderate activity will also help women with stress incontinence, De Castro-Dela Cruz said.

"It is nice to know that pelvic floor muscle training is now readily available in several physical therapy offices in Portland. There are therapists who are educated on this and are great allies in the treatment of urine incontinence," she said. "When conservative measures fail to treat urinary incontinence, a referral to a surgeon may be warranted." •

Amy Miller, MD, an OB/GYN physician and surgeon with **Bridgeview Women's Health**, said her practice has been impacted by a recent Canadian study about the value of mammograms. A subsequent article in the *New York Times* last February garnered publicity about the study. It also created confusion for many women.

"Now I've got women coming in every day saying, 'I was told mammograms aren't needed anymore' or that they are not valuable," she said. "I think, unfortunately, the editorial put doubt in a lot of people's minds."

Miller said similar information from the U.S. Preventative Task Force regarding mammograms further exacerbated the problem. And, with multiple cancer-related associations issuing different opinions on the issue, it's no wonder women don't know what to believe right now, she noted.

"Everyone knows someone with breast cancer, so I think it's very emotional for some women and the data is very confusing," Miller said, adding research has consistently shown a reduction in breast cancer deaths for women 40–49 who have mammograms. "Mammograms are the one thing that has shown early screening significantly reduces mortality, and that is huge."

"It's a little bit disheartening to have to have this conversation with women. I just feel like it's undermining the recommendations we have and that's very difficult," she said. •



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Health care teams turn out for the **Komen Race for the Cure**

By Jon Bell
For The Scribe

The Portland Marathon attracts about 10,000 runners every year. An estimated 35,000 turn out for the annual Shamrock Run around St. Patrick's Day. But one of the biggest foot-traffic events of the year in the Rose City usually comes close to 40,000 people: the Susan G. Komen Race for the Cure.

Held every year in September, the walk and run draws tens of thousands of people to Waterfront Park in an effort to raise funds for Susan G. Komen, the nonprofit whose mission is to save lives and end breast cancer forever. This year, the Race for the Cure hoped to raise at least \$2.5 million, largely through participants who solicit donations from friends, family and coworkers. As of Sept. 26, the event had raised more than \$2.3 million and still had four days to meet its goal.

The actual Race for the Cure was held on Sept. 21. Among the hundreds, if not thousands, of teams who turned out were more than a few from health care-related organizations. Everyone from Oregon Health & Science University and Kaiser Permanente to Planned Parenthood and Gresham Women's Healthcare had teams participating.

The Scribe caught up with a few of those teams after the event to see how it went, why they participated and what it meant to them.

Moda Health

When Rick Love joined Team Moda for this year's Race for the Cure, he decided to up the ante on his fund-raising efforts. He made it known that if he raised at least \$500, he'd wear a pink tutu on race day.

He ended up raising \$672. "Amazingly, I had an awful lot of people who wanted to see that," said Love, a security specialist for the health insurance company.

True to his word, Love donned the pink tutu that his wife made for him and wore it with pride on the day of event.

Love said he was motivated to participate in the Race for the Cure in part because of Moda's employee wellness program, which encourages people to participate in health and wellness events. Moda also matches employees' charitable contributions as well. Love said he also simply enjoys those kinds of events as a way to support a good cause and the company.

On race day, Love said the weather was fabulous. While Love got a white T-shirt from Komen to wear during the event, he said he couldn't help but notice how many of the participants were wearing bright pink T-shirts. Those shirts, also given out by Komen, were for cancer survivors.

"It makes it very noticeable when you look around and see all those pink shirts,"

he said. "It's in a good way. I think the race really recognizes the survivors in a positive way."

In addition to noticing all the pink shirts, Love saw plenty of participants wearing badges, buttons and signs honoring loved ones who were either battling cancer or who had lost their battles with it.

"I've done other walks where you're there to support a cause," Love said, "but this one seemed like there was much more personal attachment and support for specific individuals."

Back at work after the race, it didn't take long for a picture of Love to appear on the company's intranet system. Though he had fun with the tutu, Love said he's not sure he'll get much more outlandish than that in the future.

"I enjoy doing that stuff and I'm game for anything," he said, "but I don't think the bar's going to get raised any higher than that."

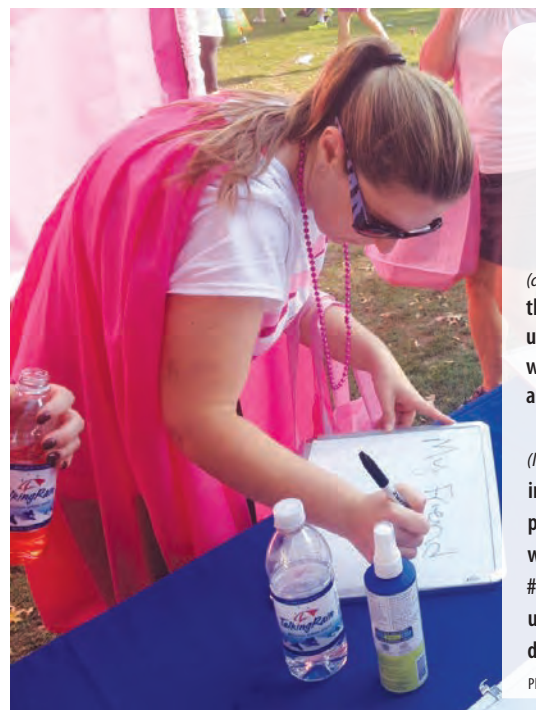
Providence Health & Services

Beth Ruml, an oncology social worker at **Providence Health & Services**, sees cancer patients in the hospital all the time. The talk, of course, is largely about cancer.

But during the Komen Race for the Cure, Ruml and her coworkers team up with patients and survivors outside of the hospital setting and talk about the lighter subjects of daily life.

"It's a great reminder that this is really bigger than breast cancer," Ruml said. "People come back and walk with the team. We catch up with them and talk about how their families are, how things have changed. Those kinds of conversations are just lovely."

Forty-two people joined the Providence Ruth J. Spear Breast Center team for this year's race, including one male breast cancer survivor. He'd walked up



(above) When Rick Love joined Team Moda for this year's Susan G. Komen Race for the Cure, he upped the ante on his fundraising, agreeing to wear a pink tutu if he raised at least \$500. Love, a security specialist for Moda Health, raised \$672.

(left) Providence Health & Services gave back in myriad ways, including a booth where participants honored people with cancer by writing "I race for..." and taking photos with #iracefor in the background. Each time someone used the hashtag on social media, Providence donated \$1 to the Komen organization.

Photo courtesy of Providence Health & Services

to the registration table and, when he was given a white shirt, asked what the difference was between the white and pink ones. Told the pink ones were for survivors, he said, "I'm a survivor."

"He wore his pink shirt proudly," Ruml said.

The team walked and ran in honor of Paula Zeller, a 15-year cancer survivor and a senior coordinator and fitter at the transitions/appearance center at Providence St. Vincent Medical Center. They carried a big wooden cutout of Providence's signature pink gloves, which were made famous though a dance video that employees did in 2009. The video went viral and has since neared 14 million views.

Sue Cook, cancer program manager at Providence and a member of the team,

said the day of the event saw a mix of emotions.

"For some folks, it's a party atmosphere, for those who look at this as a milestone," she said. "Others are bald or in a wheelchair and maybe a little more serious. It's got all those different atmospheres."

Ruml said there are always people who walk in the event a year after their treatment, as they've set that as a goal for themselves. The determination, joy and other emotions present at the race are palpable all around, she added.

"You think about 40,000 people, the street as far as you can see in front and back of you filled with people that are holding the same mission and purpose in their hearts," Ruml said. "It's pretty incredible." •

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Quality Corp.'s public reports on quality and utilization are based on claims data contributed by 12 of Oregon's largest health plans, plus the Oregon Health Authority's Division of Medical Assistance Programs and CMS. Decisions about what to measure and which measures to report are guided by Quality Corp.'s Measurement and Reporting Committee, said **Resa Bradeen, MD**, a member of the committee and medical director of children's services for Providence in Oregon.



"The quality measures show doctors where they are and how they compare. If a clinic wants to talk to another, people are happy to share what they did to get people healthier."

—Resa Bradeen, MD, a member of Quality Corp.'s Measurement and Reporting Committee

Quality Corp. tracks 3,453 primary care providers and 778 clinics across the state, up from 3,394 providers in 741 clinics a year ago. But for its statistics to be used in public reporting, a clinic must

include at least three primary care providers who see at least 30 patients who meet the criteria for the particular area of care being measured, explained spokeswoman Katrina Kahl. For example, for diabetes care, thanks to the addition of the Medicare fee-for-service data, 342 clinics met the thresholds for public reporting, up from 250 clinics in the 2013 report.

Bradeen, a pediatrician and former medical director of the Children's Health Alliance, helped Quality Corp. expand reporting to include pediatric patients. Being able to separate statistics for kids and adults for, say, potentially avoidable ER use, provides a more accurate picture of utilization, she pointed out. "Because Quality Corp. has such a breadth of data, it allows us to look at that," and the information showed that even though many times more adults than children are treated in the ER, nearly twice as many children as adults were being seen in the ER under the measure called "potentially avoidable ER visits per 100,000."

One of the objectives of the Measurement and Reporting Committee is to find as many ways as possible to make Quality Corp.'s reporting data "useful and actionable," Bradeen said. She added that the organization has done a good job of working with clinics to help them understand the data. She praised Quality Corp. for sharing information with clinics and allowing them to review and comment on it months before it is released publicly. Physicians' overall response to public

reporting has been positive, in Bradeen's view. They have become more and more accustomed to being measured by government and private entities, and to payers wanting to reimburse based on outcomes rather than services performed, she said. If clinics perform well, it can be a source of pride for the doctors, not to mention giving them an opportunity to use those results to market their clinic.

"I think physicians are somewhat competitive, and the neat thing about large sets of data like this: It can really help you see what you're doing well, and if you're not doing as well on certain things, you can ask" clinics that performed better how they did it, Bradeen said. "Physicians also are collaborative," and are very willing to ask others questions such as, "How did you improve your well-child rates?"

"I see that every day," she said. "It's one of the really good reasons to do this. The quality measures show doctors where they are and how they compare. If a clinic wants to talk to another, people are happy to share what they did to get people healthier."

Referring to physicians, Bradeen added: "It's basically what we're about. They want everyone in their population to get healthier and get good health care. I think this data assists them in doing that." •

An article on the Oregon Health Care Quality Corp. was featured in the October 2013 Portland Physician Scribe.

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Information helps identify barriers to care

Despite an increase in chlamydia screening rates, confidentiality and access issues for adolescents remain barriers to receiving screenings for the most common reportable illness in Oregon.

Primary care clinics across Oregon show wide variation in screening practices for chlamydia, according to a new report from Oregon Health Care Quality Corp. It reveals that screening rates for female patients 18 and younger is significantly lower than the rate for women older than 18. Some clinics didn't screen any patients 16 to 18, other clinics screened more than 80 percent. Chlamydia disproportionately affects younger people, with 69 percent of cases occurring in those who are 15 to 24. For young women, early diagnosis and treatment can help avoid serious complications such as infertility.

In Quality Corp.'s 2009 statewide report, Oregon's chlamydia screening rate was 28.8 percent. In the current report, screening increased to 45.5 percent of eligible women, though Oregon's chlamydia screening rate remains below the national average of 49.1 percent.

The data showed that the highest-performing clinics were those seeing mainly Medicaid patients, where no bills are issued showing what services were performed. That translates into a confidentiality factor missing with commercially insured patients and serves as an example of how examining large data sets permits Quality Corp. to identify barriers to care, said pediatrician Resa Bradeen, MD, who serves on the organization's Measurement and Reporting Committee.

The clinics that had high rates of screening offered ideas about how they accomplished this. One method was to assess all patients for sexual activity, regardless of the reason for the visit. If the assessment confirms that the patient is sexually active, he or she is screened for chlamydia. •

—Cliff Collins

Energized employees

Health systems and clinics find teamwork, incentives key to success of employee health and wellness programs

By Melody Finnemore
For The Scribe

Erica Heagy, a family nurse practitioner with **The Oregon Clinic's** Gastroenterology East practice, is a triathlete who frequently competes in Ironman events. She recently excelled in a different kind of competition that, while not an Ironman, still focused on peak physical fitness.

Heagy and her team of colleagues placed fifth in The Oregon Clinic's Summer Fitness Challenge, which marked its 20th anniversary this year. More than 300 employees participated in the eight-week challenge, and about 230 of them reached the goal of 20 minutes of daily fitness activity. Overall, employees logged nearly 800,000 minutes of exercise during the challenge.

"It seemed very motivating for my nursing staff to be recognized for the exercise they are doing, and it really helped the team to encourage each other to exercise and rack up those minutes," Heagy said, adding small incentives such as water bottles and gift cards were good motivators as well.

To continue to foster employee participation in corporate health and wellness programs, health systems and medical clinics also are taking a holistic approach that includes both physical fitness and mental and emotional well being.

Such programs have proven to help employees in myriad sectors of the workforce lose weight, quit smoking and exercise more, among other benefits. The programs also reduce medical costs, absenteeism and health-related productivity losses for employers, according to a 2013 report from the U.S. Department of Labor.

Melissa Savala, The Oregon Clinic's benefits and compensation specialist and fitness challenge organizer, said the Summer Fitness Challenge previously centered on walking, with pedometers offered to staff to track their activity. The clinic decided to change it up to include any form of fitness activity and make it a team challenge.

"We hoped the team aspect would create camaraderie and support and a little healthy competition among co-workers," Savala said.

Several local health systems and clinics have well-established employee health and wellness programs, and are continuously seeking ways to keep the programs motivating for employees. In addition to its Summer Fitness Challenge, The Oregon Clinic encourages its physicians to get involved with local causes that combine their medical focus with health and fitness. This includes joining the clinic's teams in the annual Ride to Defeat ALS and Walk to Defeat ALS.

Northwest Permanente Medical Group enlisted many of its 1,300 physicians in implementing its employee health and wellness program, not just as participants in improving their own

overall fitness, but in providing information for colleagues and staff members who are participating, too.

Among the program's offerings are brown-bag presentations about topics ranging from treatments for food allergies from an alternative medicine perspective and how to improve mindfulness to conquering addiction and managing stress. The program also features yoga and other fitness classes, opportunities to volunteer in the community, and incentives to take mass transit or bike to work. Its Rewards of Wellness initiative provides incentives for employees who participate.

Richard Odell, Northwest Permanente's chief of staff, developed the program with Dave McKay, health and wellness manager, and said the medical group's philosophy is that health occurs below the shoulders and wellness happens

above, and both are needed for optimum well-being.

"They go hand in hand," Odell said. He noted that evidence shows the most effective health and wellness programs are voluntary rather than mandatory, and they motivate employees with positive reinforcement instead of negative consequences. Northwest Permanente's program is a scientific, evidenced-based model with a behavioral component that begins with a total health assessment and understanding of preventive measures as a foundation, Odell said.

"Our goal is to improve awareness and provide opportunities for people to find their own solutions," said Odell, adding Northwest Permanente Medical Group was among the top nominees for the *Portland Business Journal's* Healthiest Employers of Oregon Awards. The awards were scheduled to be announced Oct. 11.

Adventist Health recently was recognized among the Healthiest 100 Workplaces in America for its commitment to employee health and wellness. Healthiest Employers, a national specialist in employee health analytics, best practices and benchmark data, ranked Adventist Health as the 12th healthiest company in the country.

Adventist's corporate wellness program, called LivingWell, includes discounts for gym memberships, culinary challenges that focus on healthy foods, fitness and weight management competitions, and other initiatives designed to improve and maintain both physical and mental health and wellness. In addition to the national accolades, the program has been honored by the *Portland Business Journal*.

"Our employees understand that healthy caregivers provide better care to patients. The organization believes that providing employees tools for their wellness journey enables them to pay it forward by creating healthy communities," Tom Russell, former president and CEO of Adventist Medical Center and now corporate vice president of population health innovations for Adventist Health's 19 hospitals, said in a statement. •



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