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www.MSMP.org

MSMP's Battle of the Doctor Bands

Learn details about the live music event, which will benefit Project Access NOW. Tickets on sale now. Space is limited!

—Pages 2 and 6

Youth mental health consult line shows results as year anniversary approaches

By John Rumler
For The Scribe

A severe shortage of mental health specialists in rural areas, particularly child psychiatrists and psychologists, means many Oregon children with serious mental health problems experience long delays before treatments are started, or worse, do not receive treatment at all.

Many of the youth with unidentified and/or untreated mental illnesses drop out of school, fail to develop friendships and social skills, and have an increased risk of entering the juvenile justice system.

Mental illnesses are implicated in 90 percent of youth suicides, which are the third-leading cause of youth fatalities in the nation and are the second-leading cause of death in Oregon youth ages 12–18, according to the Oregon Health Authority.

Fortunately, a pilot program, **Oregon Psychiatric Access Line about Kids**, launched in June 2014, offers help. OPAL-K provides statewide psychiatric consults to medical practitioners who work with children and adolescents.

The state-funded, no-cost program, which operates Monday through Friday, 9 a.m. to 5 p.m., provides:

- Same-day phone consultation to medical practitioners with psychiatric questions
- Evidence-based practice data to medical practitioners who need more information on psychiatric treatment(s)
- Practical advice to support medical practitioners providing mental health care in the medical home of coordinated care organizations (CCOs)

"Our team has traveled to dozens of primary care sites over the past eight months and enrolled about 900 providers who now access our services. When a provider calls, they are connected to a child psychiatrist almost immediately," said **Keith Cheng, MD**, medical director of OPAL-K.

Cheng moved to Oregon in 1990 after completing his post doctoral fellowship in child and adolescent psychiatry at the Yale University Child Study Center.

KEITH CHENG, MD

He is also chief medical officer of Trillium Family Services, the state's largest provider of child/adolescent inpatient treatment.

OPAL-K strives to promote clinical teamwork through a "biopsychosocial" understanding of children and knowledge of evidence-based treatments, and not just prescribe medications or refer kids to inpatient care, Cheng said.

So far, OPAL-K has handled upwards of 400 calls, and is averaging about eight calls a day, while providing consultations

*See **OPAL-K,** page 4*

OPAL-K

The Oregon Psychiatric Access Line about Kids (OPAL-K) is a telephone consult line for medical practitioners in Oregon who serve children and adolescents.

Pediatricians or primary care practitioners who have questions about the line, or who treat children and are interested in enrolling in OPAL-K, may register at www.ohsu.edu/opalk, or call 855-966-7255 or 503-346-1000.

Transformative power of friendships

Providence team's service trip to Guatemala makes all kinds of impacts

By Jon Bell
For The Scribe

In addition to wanting to help out less fortunate folks, one of the reasons that **Maggie Mellon** wanted to join a **Providence Health International** trip to Guatemala was to put the Spanish she'd been learning to the test.

She got to do that in a bigger way than expected during the February trip, which found Providence volunteers working with locals in the tiny village of El Soch to build more sanitary latrines. When a minor medical incident left the team down one interpreter, Mellon had to step up and act as the third link in a communication chain that flowed from native Mayan to Spanish to English.

"I was nervous, but I had to do it and I got it done," said Mellon,

*See **PROVIDENCE,** page 14*

Providence's Maggie Mellon, right, **and Lisa Helderop,** center, **build a latrine with a "mother counselor" who is a health care leader in a Guatemalan village Providence volunteers visited earlier this year.**

Photo courtesy of Providence Health & Services

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Physician Wellness

Leslie Ruminski, MSW, encourages providers to take a new approach to patient care by "defining difficult differently."

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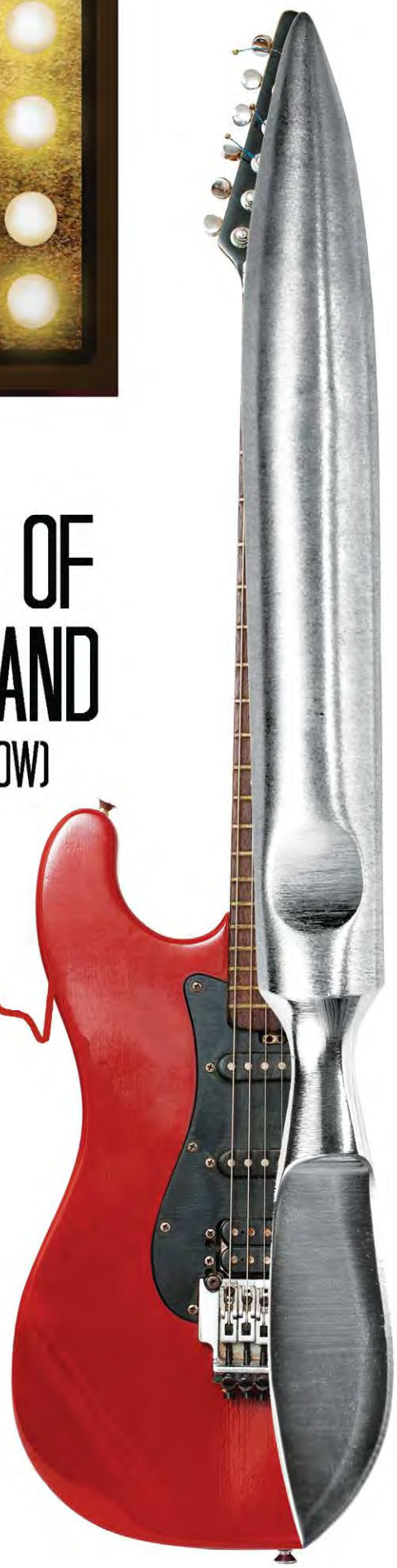

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MEDICAL SOCIETY OF METROPOLITAN PORTLAND

Physician Wellness Program

The Medical Society of Metropolitan Portland's Physician Wellness Program is tailored specifically to physicians, creating a safe harbor to obtain help through confidential counseling. We are pleased to announce contributions toward the program from the following organizations: Ater Wynne Attorneys at Law, Metropolitan Medical Foundation of Oregon and Hart Wagner Trial Attorneys, each contributing $5,000. *To make a donation, please go to www.mmfo.org.* •

Women's Circle

May 14, 6–8 p.m., MSMP Conference Room

The Women's Circle is a women physicians group facilitated by certified physician development coach Deborah Munhoz, MS. Not only does she address leadership issues important to women physicians, such as how to have your voice heard and competently influence quality of care, but she also builds a unique sense of community that has become extraordinarily valued. *See details at msmp.org.* •

Final Advance HIPAA Compliance Training Class of 2015

May 15, 9–11 a.m., MSMP Conference Room

Don't miss MSMP's Final Advance HIPAA Compliance Training of 2015.
As recommended by ONC, OCR and AHIMA, HIPAA compliance training should be done annually. This class will offer updated Oregon Privacy Laws, discussion on how privacy laws apply to your role, and interactive case studies. Certificate of participation is included in this event and able to be used for employees' compliance files. *See details and register at msmp.org.* •

Battle of the Doctor Bands 2015

June 25, 7 p.m., in Lola's Room at the Crystal Ballroom

The bands have been chosen! This year's Battle of the Doctor Bands will feature Crimson, Wolf Meetings and Ojos Feos! Buy your tickets now! The Battle of the Doctor Bands is sponsored by The Doctors Company and KGON. The event benefits Project Access NOW. *See details and buy tickets at msmp.org.* •

Risk Prevention Tips for E-mail, Texting, and Social Media in the Workplace Seminar

July 14, 7–8 a.m., MSMP Conference Room

Electronic communication is not a trend or a fad—it is a revolution that is changing the world. This seminar will address the evolving risks and benefits associated with social media and electronic communication, and will provide risk tips to mitigate potential liability. Offered to office managers and administrators. *Register at msmp.org.* •

The Scrub Run 5K presented by MSMP & Uberthons

Aug. 15, St. Josef's Winery in Canby

MSMP's First Annual Scrub Run will start with a 5k run through the country roads of Clackamas County into the vineyards of St. Josef's Winery. Following the run, join us for dinner from Qdoba Mexican Grill and a concert overlooking the lake featuring the winner of the Battle of the Doctor Bands. Bring the whole family! *See details and register at msmp.org.* •

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***OPAL-K** from page 1*

to primary care providers, Federally Qualified Health Centers and school-based health centers. Callers receive an e-mail with a summary of the call, a copy of care guidelines and an invitation to call back, as needed.

The program's eight consulting child and adolescent psychiatrists are MDs and average 20 years of clinical experience. The OPAL-K office is managed by **Marie Timbreza, MAT**, who also manages the outreach and education components of the program. The call center is staffed by **Behjat Sedighi, QMHP**, and **Elisa Ross**, who register callers, collect intake information, and return timely summaries to medical practitioners from the OPAL-K consulting psychiatrists.

Last November, OPAL-K reached out to medical practitioners identified by the DHS foster-care psychopharmacology review program and has provided consultation for 18 foster-care cases concerning polypharmacy, off-label prescribing and excessive dosage. They anticipate doing many more.

"OPAL-K is absolutely making a difference for the primary care physicians and the children and families who receive the consultation," said **Amy Baker**, child and family mental health manager for the OHA Addictions and Mental Health Division. "There is increased access to child psychiatric consultation in regions of the state where they need it the most."

OPAL-K arose out of a collaboration between the Oregon Pediatric Society and the Oregon Council of Child and Adolescent Psychiatry, which began in 2006. At that time, both groups recognized the need for better mental health access in the medical home.

The groups investigated several programs, including the Massachusetts Child Psychiatric Access Program (MCPAP) and the Pediatric Access Line (PAL) in Washington state. Both of these state-funded programs improved the primary care provider's ability to provide psychiatric care in the medical home through the use of child psychiatry consultants through phone consultations, education and direct telemedical evaluations.

Following consultations with the medical directors of the MCPAP and PAL programs, and with $30,000 in seed money from Clackamas County MHO and the Marion County Independent Physicians' Association during the first two years, the basic OPAL-K pilot was developed. The 2013 Oregon Legislature authorized new investments in children's mental health (under the advice of Addictions and Mental Health), designating $1.5 million for OPAL-K.

Oregon Health Authority AMH signed a contract with Oregon Health & Science University's Division of Child and Adolescent Psychiatry in January 2014, the OPAL-K program was formed over the ensuing six months and it started taking calls in June 2014.

The OPAL-K program is delivered by OHSU Child Psychiatry in collaboration with the Oregon Pediatric Society, Oregon Council of Child and Adolescent Psychiatry, Psychiatric Access Line at the University of Washington and with oversight by the OHA's Addictions and Mental Health Division.

The shortage of children's mental health specialists is not unique to Oregon. According to the U.S. Surgeon General, nearly 20 percent of children and adolescents nationwide have a mental disorder with functional impairment, yet only one-fifth who need treatment for mental illnesses receive it. Students with untreated mental health problems contribute to increased special education costs, school violence, bullying behavior and can be victims of bullying, OHSU notes on the OPAL-K website.

"It is too early to determine what overall impact OPAL-K will have on mental health care in Oregon." Baker said. "Increasing access to behavioral health services is a critical component of our efforts to transform our health care system and we expect a continued increase in demand for OPAL-K's services." •

OPAL-K case vignette

'Should I add another medication?'

A primary care doctor inherits a patient who has ADHD, anxiety and high functioning autism. The patient was receiving a complex regimen of multiple medications. The consult question was about whether to add another medication. After careful review of the differential diagnosis and sorting out which symptoms were related to psychosocial factors, it became clear that adding another medication was not necessary. OPAL-K consultants are trained to help primary care medical practitioners look at more than a diagnosis and medications. Frequently, environmental, family, school and peer relationships play a larger role in presenting symptoms than a psychiatric diagnosis. By helping PCPs review their cases using a "biopsychosocial" approach in case formulation, each new psychiatric symptom does not necessarily need another medication added to the regimen. OPAL-K consultations can help PCPs avoid taking the road down the polypharmacy route.

From OPAL-K Quarterly Report Outline, April 2015

What a sampling of medical providers say about their experience with OPAL-K:

"Thanks. Good to bounce off tough situations with your staff!"

"Fantastic service! Timely, useful, clinically very helpful."

"The consultation confirmed that my decisions were sound choices, and I was very thankful for the contact."

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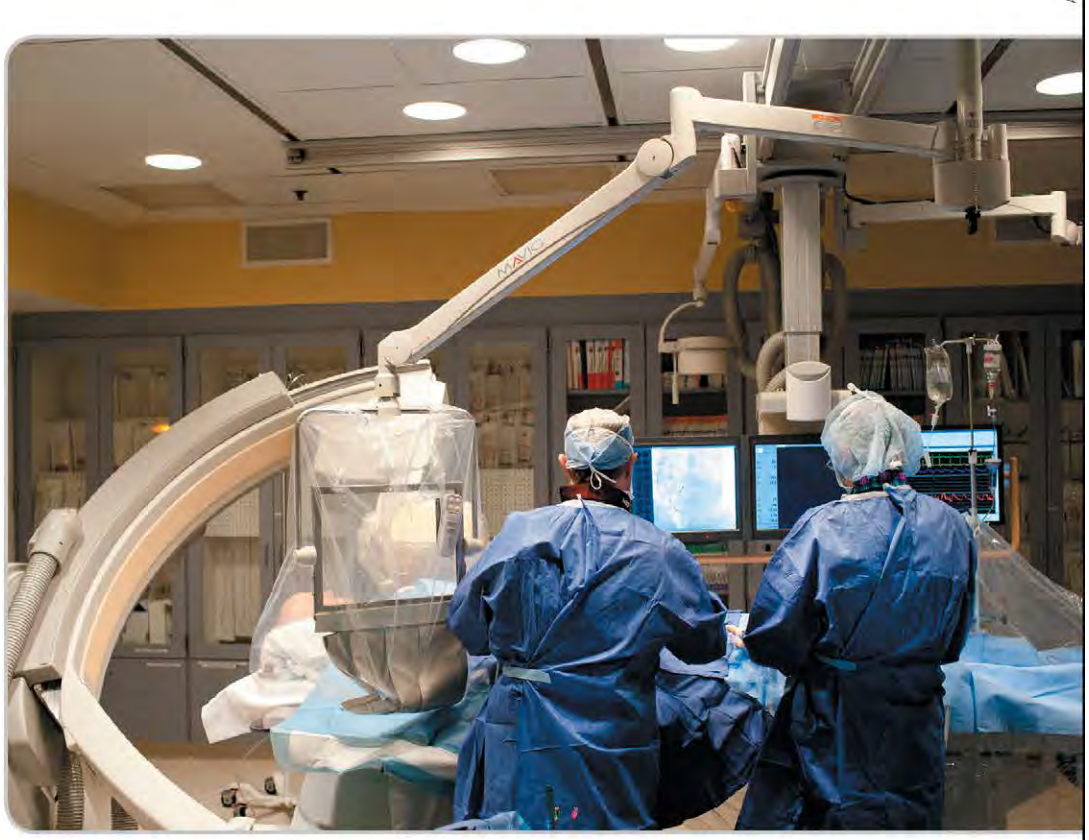

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Let the battle begin

Three groups to compete in MSMP's live music charitable event, now in its second year

By Jon Bell
For The Scribe

Classic and indie rock will meld with blues, Latin and African music at one of the more unique medically-minded fundraisers in the metro region this summer.

The **Medical Society of Metropolitan Portland's** annual **Battle of the Doctor Bands** will be back for an encore performance at **7 p.m. Thursday, June 25**. The event will bring three bands featuring MSMP members to **Lola's Room at the Crystal Ballroom** to compete for top act of the night and raise funds for Project Access NOW, which connects low-income people with donated care across the region. The winner also will headline MSMP's first annual 5K Scrub Run in August. **Battle tickets are $10 and available at msmp.org**.

The *Scribe* profiled each of the bands for a preview of this year's bout.

Wolf Meetings

Srini Mukundan, MD, was 12 or 13 when he first got a copy of Led Zeppelin's third album, which contains one of the band's classic blues tracks, "Since I've Been Loving You." Now 30, Mukundan still recalls first hearing the song's opening, which wails to life with a sorrowful Jimmy Page guitar riff and a steady groove from John Bonham's drums.

"I remember hearing that drum beat and thinking, man, that sounds so cool," he said.

Though his parents had introduced him to classical music through piano, violin and viola, Mukundan's mother hadn't been all that keen on adding a drum set to the mix. His father, however, was a little less averse and gave him the go-ahead to buy a kit of his own. He taught himself how to play and jammed his way through high school and college in several different bands.

Then came medical school in Chicago—"A black hole for me in terms of music," Mukundan said—followed by a move to Portland with his wife three years ago. He landed a residency in internal medicine at OHSU and, soon after, met other medically-minded musicians.

That matchup melded during the past year into Wolf Meetings, a relatively new band that plays all original tunes. The current lineup—Mukundan on rhythm guitar; **David Harmon, MD**, on keyboards and guitar; **Noah Beadell, MD**, on bass; **Sean Sanford** on lead guitar; and, for the upcoming battle, **Yascha Noonberg** on drums—all enjoy the Beatles but also 1990s alternative music and indie rock.

"For us, playing and writing music is really a chance to do something different than medicine, a way to be more creative," Mukundan said.

Crimson

Wolf Meetings

Ojos Feos

The band, whose name comes from early Oregon pioneer gatherings convened to address community issues, just played their first gig, an open mic, in late April, but Mukundan said they are confident about playing in the battle.

"We've been reading about some of the other bands and doctors who have been part of it before," he said. "For us, we are kind of new pups in the medical world, and our band is kind of the same way, so we're all excited."

Ojos Feos

The runner-up band from last year's event, Ojos Feos (Ugly Eyes) is back for another go-round, this time with a varied lineup of folks committed to both the music of the band and its causes.

"We are still focusing on presenting our music as being all about human rights and social justice," said **Scott Brown, MD**, an anesthesiologist and medical director at OAG Interventional Pain Consultants.

Brown, a multi-instrumentalist who plays under the stage name Robbie Cree, said the band is as serious as ever about bringing its music and its messages to a diverse array of audiences. Many of Ojos Feos' songs, which largely address human rights and political issues, are not in English but in Spanish and several African languages. Their style fuses blues and jazz with African and Latin elements. In addition to Brown, the updated lineup includes **El Caminante, Evan Carroll, Giovani Cruz, Kameron Cregar, Ivett Almaguer** and **Miranda Crystal**.

Part of the reason for the new lineup is that Ojos Feos has stepped up its game. The band practices once a week and plays out two or three times each month. It's also started playing outside of Portland, and band members have begun work on a studio album. Last year, Ojos Feos also recorded some music for a documentary filmed in Africa about Brown's nonprofit, Surg+Restore, an organization working to establish a plastic and reconstructive surgery and burn unit in Sierra Leone.

Brown said he's looking forward to playing the Battle of the Doctor Bands gig again to continue broadening Ojos Feos' reach and spreading its music and message.

"I'm not sure the medical community is in tune with what we're doing as a band," he said, "so this is a way to bring us some exposure in that community. Anytime we can play to another crowd and share our music and ideas with people, we do it."

Crimson

Alan Savoy's medical career almost cost him his spot as the drummer for his current band, Crimson.

A gastroenterologist at the Oregon Clinic, Savoy, MD, first connected with the group through an ad on Craigslist. Concerned that his on-call schedule might interfere with rehearsals and gigs, the band passed at first. But three months later, after another drummer didn't pan out, Crimson called Savoy and offered him the spot.

"I'm able to manipulate my schedule pretty much how I want to," Savoy said, "so it has worked out beautifully."

A classical percussionist starting at about age 10, Savoy also played in his high school marching band. He picked up his first drum kit back in 1999 and taught himself how to play. A father of three teenagers, Savoy eventually ended up in a Tom Petty cover band called Petty Thieves with another physician. That band still plays out a few times a year, but Savoy said he'd been looking for a more creative musical outlet, which led him to Crimson about a year ago.

The four-piece band—Savoy, **Tim Current, Brandon Cobb** and **Tracy Johnston**—plays all original tunes that Savoy described as melodic rock. The band's Reverb Nation page compares their sound to bands such as the Red Hot Chili Peppers, Foo Fighters and Foreigner. They practice weekly and try to play at least one gig a month.

"We're kind of gaining some steam locally," Savoy said. "I think our goal is to be one of those local bands who can open for traveling bands that come to Portland." •

Success with 'difficult' patients lies in shift in provider perspective

By Melody Finnemore
For The Scribe

Leslie Ruminski, MSW, often hears health care providers discuss the challenges of dealing with difficult patients and their families. And, while she empathizes with the stress providers encounter in their work, she suggests that perhaps the patients and their families aren't entirely the cause.

Ruminski, with **Operational Excellence for Providence Health & Services**, said she has seen two significant changes impact patient care in recent years.

The first involves the "Center of the Universe Patient" who may come across as demanding, impatient and controlling. They may even try to tell the provider how to do their job after conducting research about their health symptoms and possible conditions before getting an exam.

"Patients are being asked to be more involved in their care and the Internet is a big part of that," Ruminski said. "It's a sign of our times and our culture—searching online and getting information from the Internet—and it's not always accurate."

The second change involves the "Communication Concerns Patient," who often times has a lower educational level and lacks experience in dealing with the health care system. These patients may speak English as a second language, have cognitive impairments, or sensory deficits such as hearing or visual impairment.

Ruminski noted these patients and their families many times are older than the care provider, which can add to the complexity of communication.

"Providers may be caring for up to four generations of the workforce, and I really see the generations playing a huge role in our communication concerns right now," she said. "We have to be more conscious of how people learn and how they like to receive their information."

In addition, environmental factors such as a patient's hygiene, culture, illness, and emotional or behavioral disruption also can add to the stress providers encounter during their workday.

In presentations to the medical community, Ruminski encourages care providers to define "difficult" differently, which requires a distinct shift in perspective.

"When we experience any resistance or response that is out of the norm, we as health care providers tend to define that as difficult when resistance should actually be expected," she said. "Resistance is natural in the face of change."

"Defining people as 'difficult' is more about our discomfort than it is about them. So how do we change the way we deal with that?"

Ruminski recommends that providers recognize that, while they see patients and provide services repetitively, visiting the doctor may not be routine for a patient and their family. The patient may be feeling worried, nervous, or vulnerable. In addition, the patient may be experiencing a myriad of concerns beyond the exam room.

By pausing to think about these individual considerations before entering the exam room, providers can enhance their compassion and intentionality during the exam, she said.

For patients where communication is a concern, it is helpful for providers to speak more clearly, practice patience, take more time, explain more of what they are doing during the exam, and recognize that people have different learning styles.

Ruminski also suggested a team approach in clinical care and acute care settings because providers have the resources for this approach and can enlist ancillary services to support the care they provide.

"The team model exists, so we need to use it and seek support from colleagues," she said.

For situations in which environmental factors such as hygiene, culture, illness and behavior play a role, she advises health care providers to room the patient as soon as it's convenient, and consider their own bias and tolerance toward different cultures, influences and lifestyle choices.

At the same time, it's important to note when "difficult" becomes dangerous and to call the clinic manager if a patient becomes a danger to themselves or others, is verbally or physically threatening, or in any way makes the provider feel uncomfortable, she said.

*See **WELLNESS,** page 8*

Legal aspects of telemedicine inspire cautionary advice

By Cliff Collins
For The Scribe

The ways telemedicine is being employed continue to grow, while at the same time the legal considerations connected with its use bring new risks to providers.

Virtual office visits present potential benefits to patients, but for doctors pose new challenges, many of which were not even a factor before video consultations and electronic medical records became part of the medical armamentarium, legal experts say.

"From a treatment standpoint, it raises a lot of questions," said **Troy S. Bundy**, an attorney with the Portland office of the law firm **Hart Wagner** who specializes in health law and defending physicians.


TROY S. BUNDY

Among the potential legal pitfalls listed by the national **Center for Connected Health Policy** are liability, licensing and credentialing, online prescribing and informed consent. Physicians also must take into account that "numerous federal and state statutes have been enacted that pose significant risks to medical practitioners who engage in any form of telemedicine," among those being security and privacy issues, according to **Richard Cahill**, vice president and associate general counsel with **The Doctors Company**.

Telemedicine's developments have been concurrent with, and dependent on, the emergence of electronic medical records. As the transmission of personal health information between patients and providers, between providers and payers, and among providers has increased, medical "practices that engage in any form of electronic data transfers, including telemedicine, must strictly comply with the various statutory requirements of HIPAA and HITECH" laws, or risk an investigation and potentially hefty fines by the U.S. Department of Justice's Office of Civil Rights, Cahill said.

Bundy points out to physicians that the EMR companies and vendors with whom they deal are business associates of the medical practice, and that the doctor is ultimately responsible for HIPAA compliance. "What I have suggested my clients do is have business associates confirm in writing that they're compliant," as well as that any entities business associates work with are compliant. Physicians also should have annual risk assessments performed by third-party auditors to identify weaknesses in their electronic systems, he said. Proper documentation is an important defense against any challenges the Office of Civil Rights might introduce, he added.

In terms of licensing, physicians who perform telemedicine visits must be licensed in the state where the patient is located. If a physician outside Oregon is seeing a patient in the state via telemedicine, he or she must hold either a full medical license in Oregon or a special telemedicine license issued by the Oregon Medical Board, said **Catherine S. Britain**, program director of the **Telehealth Alliance of Oregon**, a private nonprofit organization that promotes telemedicine policy, education and resources.

Liability factors associated with telemedicine represent a new frontier, according to the Center for Connected Health Policy. "Very little information exists on the extent of malpractice liability and telehealth," the center notes. "There have been a few telehealth-related cases, but the results have been sealed. However, as telehealth…practices become more widespread and available, questions of medical liability will undoubtedly increase." Medical liability insurers "will need to identify and address these issues in the future, as this is for the most part uncharted waters."

Whether the community standard of care differs in a telemedicine visit than in a traditional in-person visit "hasn't been established yet," but "I would presume it's the same," said Bundy. Physicians often don't stop to realize all the clues they pick up from patients' actual physical presence that would be less obvious or not detectable seeing patients only on a video screen, he pointed out. These can include listening to the sound of their voice and their heartbeat, detecting odors, seeing subtle variations in skin color that might differ on video depending on lighting and resolution, and observing signs and symptoms patients don't volunteer but that only a doctor can notice.

"Are they getting the same care as if you're in the room with them? Maybe, but not all the time," he said. A jury is not going to be sympathetic if a defendant doctor says the patient's skin did not look red on a video screen if redness in fact existed, indicating infection, he said.

An additional liability consideration is determining whether the provider should insist on seeing the patient in person rather than via telemedicine or email, Bundy said. "Really, it boils down to professional judgment. Was it reasonable to treat this patient on video or email, or not?"

A physician who provides medical care across state lines through any form of telemedicine also may be subject to a potential liability lawsuit in the event a claim is filed in the jurisdiction where the patient resides, rather than in the jurisdiction where the provider maintains his or her offices, Cahill pointed out. "Undoubtedly, the standard of care will be determined by experts familiar with the community practices in the jurisdiction where the patient is located. Professional liability policies generally specify that indemnity coverage is only available for a claim that occurs in a specific territory or jurisdiction. A physician sued in a state other than the covered territory may find that no coverage is available to either defend the claim or pay indemnity if there is an adverse judgment."

The **American Medical Association** emphasizes that states' laws differ regarding the scope of practice permissible through telemedicine. The variations in state laws and policies range from a complete prohibition on the practice of telemedicine, to states in which there are no additional regulations beyond existing standards of medical care. "The immense range in law(s) means that it is essential for physicians to consult with the laws of all applicable states before providing telemedicine services," the AMA advises. "These states include both the state where the physician is located and the state where the patient is located."

In terms of prescription writing, AMA policy states that doctors who prescribe using telemedicine first need to establish a patient-physician relationship that includes obtaining a medical history; describing treatment risks, benefits and options; arranging for appropriate follow-up care; maintaining health records; and recording in the patient's chart any prescriptions issued.

The questions that arise are: when the relationship develops, whether that relationship can be established through remote interactions alone and, if a relationship exists, whether physicians can issue prescriptions. "The second question is where states differ the most," the AMA states.

Insurance coverage is another consideration. The Telehealth Alliance of Oregon's chief priority for 2015 is passage of Senate Bill 144, which would require health insurers to cover telemedicine visits regardless of the patient's location, as long as the patient and provider have a contractual relationship with the insurer. Because Medicare reimburses only for telemedicine visits to patients located in rural areas as defined by Medicare, most insurers currently do not pay for remote visits with patients in urban settings.

The bill's "objective is to expand payment to include services that are delivered in homes, schools" and other settings where health care services are offered that might be in urban or suburban areas, said the alliance's Britain. "It is to make sure that people get paid for delivering the services they provide."

The bill, supported by ZoomCare and Providence Health & Services, gained the backing of most Oregon health insurers and faced no major opposition, said **Jessica Adamson**, director of government relations for **Providence** in Oregon.

The support of insurance carriers has been crucial, and **Susie Fisher, RN, BSN**, Oregon director of telehealth services for Providence, attributes much of their backing to consumer demand.

"They may lose consumers from their health plan if they don't start covering these visits," she said. The change in the law will "help patients receiving care no matter where they are, especially those who can't travel. Health care should be available to serve the people wherever they are." •

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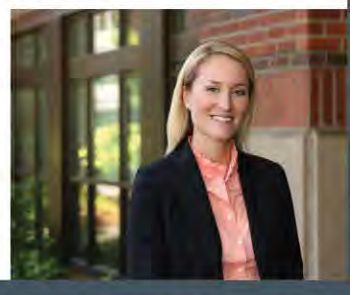
•Board Representation

Amber regularly defends healthcare professionals before their licensing boards. As a nurse attorney, Amber brings a unique perspective to her practice. She understands the issues healthcare professionals face and uses that knowledge to advocate for her clients and resolve their issues efficiently and effectively.



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PORTLAND EUGENE SALEM

WELLNESS *from page 7*

Ruminski said another key strategy to achieving the shift in perspective is for health care providers to remember that they entered the profession for a reason and to keep that reason at the forefront of their care.

"Then smile, take a deep breath and go take care of your next patient!" she says at the conclusion of her "Defining Difficult Differently" presentation. •

Leslie Ruminski, MSW, is the Medical Society of Metropolitan Portland's organizational readiness expert and speaks about topics designed to give new tools and strategies while providing support focusing on efficiency.

Clarification: In the April *Scribe*, Oregon Medical Board Executive Director Kathleen Haley was referring to the Physician Wellness Program created by Lane County Medical Society CEO Candice Barr, as a model for Oregon and the rest of the nation. As stated in the article, the MSMP program is modeled after the successful one established three years ago by the Lane County Medical Society, which has brought it national attention. MSMP's became the first wellness program to duplicate LCMS' model.

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Legal Focus

Study reveals why emergency medicine physicians are sued

Patient allegations, factors contributing to injury are analyzed

Emergency medicine physicians are more prone to be sued for diagnosis-related issues than many other specialists because they treat patients who are unknown to them and who have a broad range of clinical problems. A study issued April 13 by **The Doctors Company**, the nation's largest physician-owned medical malpractice insurer, showed that one of the top claims against emergency physicians was failure to diagnose, which was also a leading cause of patient injury.

The study of 332 emergency medicine claims that closed from 2007–2013 revealed the four most common patient allegations:

- Diagnostic-related issues, such as failure to establish a differential diagnosis or failure to consider available clinical information. (57%)
- Improper management of treatment, such as failure to stabilize a patient's neck following an accident with trauma to head and neck, resulting in paraplegia. (13%)
- Improper performance of a treatment or procedure, such as intubation of the respiratory tract. (5%)
- Failure to order medication, such as not initiating fibrinolytic therapy in acute MI or stroke within the recommended time frames. (3%)

Expert physicians reviewed the data and noted that inadequate patient assessment, found in 52 percent of cases, was the number-one contributor to failures in diagnosis. This included not using available clinical information. Other factors that were identified as contributing to patient injury included:

- Patient factors, such as obesity, which in some cases delayed the delivery of care due to lack of adequate equipment for treating or evaluating obese patients. (21%)
- Communication among providers, including failure to review the medical record. (17%)

*See **EMERGENCY,** page 13*

Emergency medicine

Tips to help prevent the top cause of patient injury

The Doctors Company's Emergency Medicine Closed Claims Study, a review of 332 emergency medicine claims that closed from 2007–2013, revealed that the top patient allegation—accounting for 57 percent of claims—was diagnosis related, including failure to diagnose, delay in diagnosis, and wrong diagnosis. Similarly, the study revealed that the top factor contributing to patient injury (52 percent of claims) was patient assessment issues, such as failure to establish a differential diagnosis and failure to order diagnostic tests.

The top patient allegation and the top contributing factor to patient injury highlight the importance of addressing diagnosis issues in the practice of emergency medicine. Emergency medicine doctors face unique challenges—particularly the challenges of diagnosing patients previously unknown to them, encountering a broad range of clinical problems, and pressures of workflow and workload in a busy emergency room.

These tips can help emergency medicine doctors avoid diagnostic errors:

- Avoid first-impression or intuition-based diagnoses.
- Complete a thorough differential diagnosis for each patient.
- Use diagnostic prompts when completing your differential diagnosis. Because emergency medicine doctors face such a broad range of patients and potential diagnoses, these prompts can help ensure all diagnoses are considered.
- Document your differential diagnosis. This step is especially important to reduce potential liability risks.
- Make sure that all specialists who are called to evaluate emergency department patients receive a comprehensive summary of the clinical picture, including history, physical findings, and diagnostic studies. During the handoff discussion, it should be clear who has responsibility for review and follow-up of all test results and diagnostic studies.
- Practice effective handoffs. Make sure there is interactive communication between physicians when the care of a patient is being handed off so they can determine each physician's responsibilities. Staff must have a clear understanding of which physician is in charge of the patient's care. •

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WHY DO EMERGENCY MEDICINE DOCTORS GET SUED?

MALPRACTICE CLAIM TRENDS IN EMERGENCY MEDICINE

An analysis of 332 emergency medicine malpractice claims that closed from 2007–2013 revealed underlying vulnerabilities that expose doctors to liability and place patients at risk.

TOP 4 PATIENT ALLEGATIONS IN EMERGENCY MEDICINE CLAIMS

332 CLAIMS

57% DIAGNOSIS RELATED (FAILURE, DELAY, WRONG)
- Conditions most often misdiagnosed included acute cerebral vascular accident, and myocardial infarction (MI), and spinal epidural abscess.

13% IMPROPER MANAGEMENT OF TREATMENT
- Cases included failure to stabilize a patient's neck following an accident with trauma to the head and neck, resulting in paraplegia.

5% IMPROPER PERFORMANCE OF TREATMENT OR PROCEDURE
- Examples included intubation of the respiratory tract and poor suturing technique.

3% FAILURE TO ORDER MEDICATION
- Examples included fibrinolytic therapy not ordered in acute MI or stroke within recommended time frames and antibiotics not ordered in cases of suspected pneumonia.

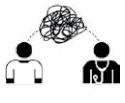
TOP 6 FACTORS CONTRIBUTING TO PATIENT INJURY IN EMERGENCY MEDICINE

Expert physician reviewers analyzed the claims to identify the specific factors that contributed to patient injury.*

52% PATIENT ASSESSMENT ISSUES
- Failure to establish a differential diagnosis.
- Failure to order diagnostic tests.
- Premature discharge.
- Failure to address abnormal findings or use available clinical information.

21% PATIENT FACTORS
- Physical characteristics (such as morbid obesity) that caused delay in care.
- Nonadherence with follow-up calls or appointments.
- Nonadherence with treatment plan.

17% COMMUNICATION AMONG PROVIDERS
- Failure to communicate.
- Failure to review the medical record.
- Poor professional relationships/rapport.



14% COMMUNICATION BETWEEN PATIENT/ FAMILY AND PROVIDERS
- Poor rapport with patient.
- Inadequate patient education regarding follow-up instructions.
- Language barrier.

13% INSUFFICIENT OR LACK OF DOCUMENTATION
- Failure to record information.
- Failure to review the medical record.

12% WORKFLOW AND WORKLOAD
- Evening, weekend, or holiday staffing inadequate for patient needs.
- Long wait time for patients with chest pain or abnormal vital signs.

*More than one factor can contribute to patient injury

READ THE FULL STUDY AT WWW.THEDOCTORS.COM/EMERGENCYMEDICINESTUDY

Source: The Doctors Company

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Second of two parts

Shoulder rehab advances offer improved mobility for patients

Editors' note: In April's *Scribe*, Suzanne Trebnick introduced techniques to help patients with shoulder problems retrain how they move. To read the first installment, please visit msmp.org.

By Suzanne Trebnick, PT, OCS, COMT
For The Scribe

We have more skills, more tools, more research, so what do we do now?

1. We teach patients to retrain their brains by emphasizing cognitive control as they move. Nonfunctional movement patterns performed two to three minutes, twice a day, over eight to 10 weeks allow movement patterns to become "autopilot." The winner of the race is the one who finishes last, not first.
2. High-load and low-load exercises are added as motor recruitment timing improves.
3. Taping the shoulder, AC joint, scapula or thorax aids in support and sensory feedback to help patients learn to move safely and pain free.
4. Exercises that emphasize weight bearing or closed chain with the arm pressing down, as well as open chain where the arm is free to move, recruit different muscle groups to help stabilize the shoulder girdle complex. Patients progress to be able to press a ball against a wall without pain with a dynamic moving surface.
5. Assess what occupational hazard is involved that contributes to repetitive shoulder movement or static holding of the arm in one position. I often have patients bring in a cell-phone photo of their workstation that shows them sitting or standing to recommend changes. Shoulder protection techniques are taught to help prevent re-injury.
6. Pilates reformer and chair reformer work in open and closed chain upper extremity positions to establish proper alignment of the spine and scapula. We have Pilates reformers available at all three of our locations.
7. Aquatic therapy rehab for total shoulder joint replacements or any post-surgical procedure to allow freedom of movement in a supportive, buoyant environment. Results are more rapid when patients can regain movement on their own versus having an external force applied.
8. Graston or Astym tools to help break up scar tissues and adhesions and release soft tissue contractions and muscle trigger points.
9. Acupuncture to help relieve pain and improve blood circulation for healing.

The key to a successful shoulder rehab program is the clinical reasoning framework to identify all the factors involved that create pain. Each patient needs a very individualized program as one size never fits all. The shoulder is a very complex, multidirectional joint, and scapular control is essential to be able to move in any direction and not hurt. The final rehab phase is to have the patient swing a golf club, play tennis, shoot baskets, work at a computer, play an instrument—do what they enjoy comfortably and without pain. That is our job.

And that is why, years ago, I ventured into ergonomics and consulting. I worked with the Portland Opera during "The Flying Dutchman" to many thrills and too many violinists complaining of shoulder and neck pain. The concertmaster for the symphony that played during "The Nutcracker" needed to learn to hold her instrument in a different posture to be able to play so many performances in a limited number of weeks.

Shoulder rehab advances in our clinic means bring in your golf club, instrument or tennis racket, and we will help you move without pain and enjoy doing what you love to do. •

Suzanne Trebnick, PT, OCS, COMT, is co-owner of Laurelhurst Physical Therapy Clinic LLC. She can be reached at suzanne@laurelhurstpt.com.

***EMERGENCY** from page 10*

- Communication between patient/family and provider, including inadequate follow-up instructions or language barriers. (14%)
- Insufficient or lack of documentation, including inadequate documentation about clinical findings. (13%)
- Workflow and workload concerns that included fewer staff or services available on a weekend, night or holiday. (12%)

"This study indicates that the broad base of clinical problems faced by emergency physicians increases risks and highlights the importance of taking steps such as completing a thorough differential diagnosis for each patient," said **David B. Troxel, MD**, medical director, The Doctors Company. "If an incorrect diagnosis was to occur and documentation shows it was considered and ruled out, that may reduce the physician's liability risk. The Doctors Company is committed to analyzing our data to anticipate emerging trends and provide insights to reduce risk and promote patient safety."

"I commend The Doctors Company for releasing this important data to assist emergency physicians in identifying areas of improvement," said **Roneet Lev, MD**, director of operations, Scripps Mercy Hospital Emergency Department, in San Diego. "The nature of the business of emergency medicine is to be the first to diagnose, but that also means being the first to make the wrong diagnosis. This data will help physicians to focus on specific quality measures that will reduce exposure to malpractice claims and improve patient care." •

About The Doctors Company

Founded and led by physicians, The Doctors Company (www.thedoctors.com) is relentlessly committed to advancing, protecting, and rewarding the practice of good medicine. The Doctors Company is the nation's largest physician-owned medical malpractice insurer, with 76,000 members and $4.5 billion in assets, and is rated A by A.M. Best Company and Fitch Ratings.

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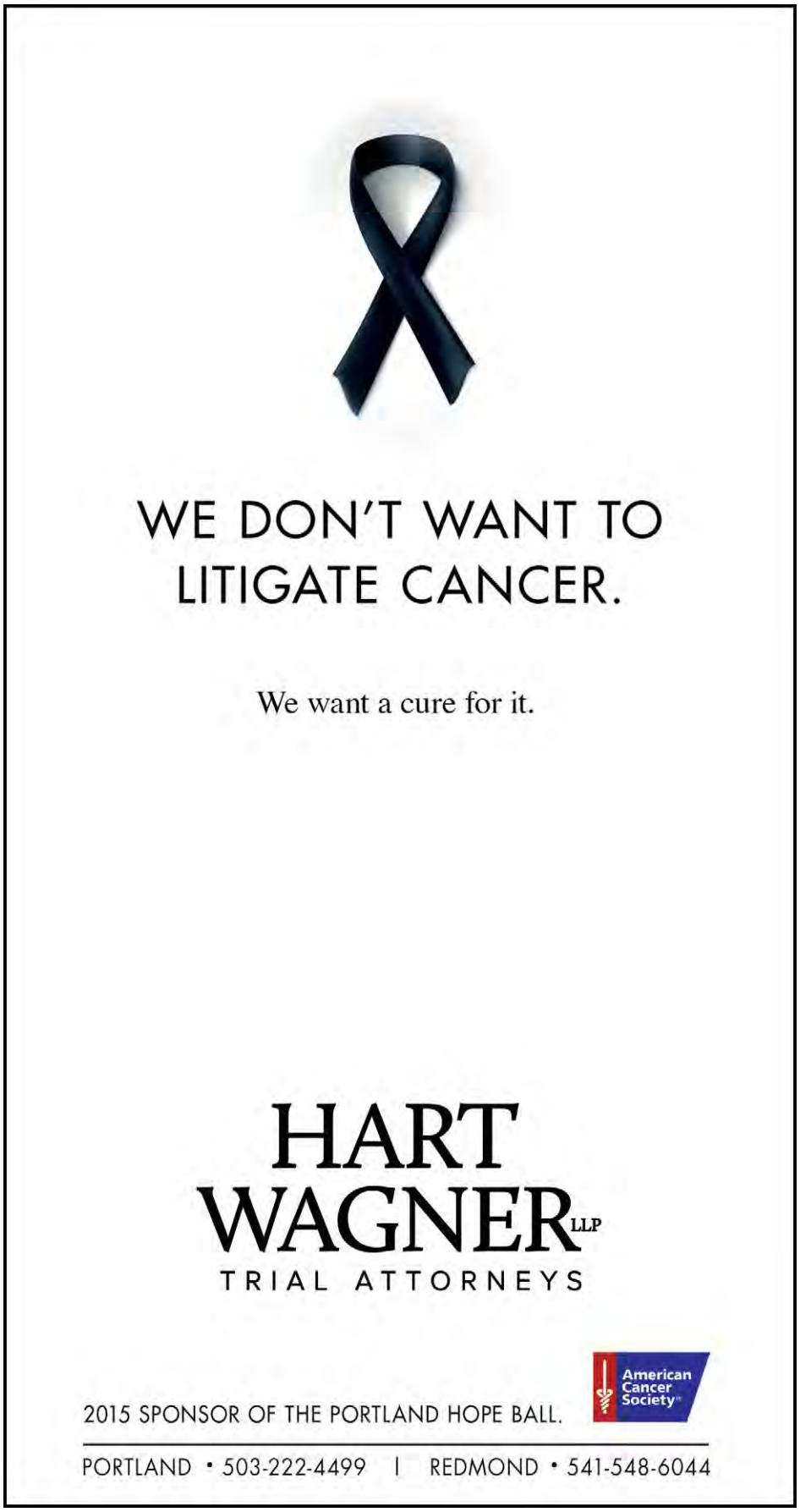

***PROVIDENCE** from page 1*

a senior product manager for Providence's digital services team. "But I was glad it was just for one day."

Mellon was one of 10 Providence employees who were part of the nine-day trip to Guatemala in February. The PHI team also partnered with **Medical Teams International** on the effort, which ended up building 40 latrines for villagers in the isolated mountain village, a place where very few existed.

PHI and another one of the team members who went on the recent service trip. "All of the programs that we fund are centered on those four key impact points."

The trip in February was part of a larger service initiative of PHI, which began focusing primarily on Guatemala in 2012. Grey said Guatemala became PHI's main focus because of its needs, its relative safety and its proximity to the U.S. as well as key partners who work in the country. Those include MTI and **Faith**

machetes to hack lumber from trees—for a concrete foundation, which they mixed by hand. Prefabricated seats were then installed on the foundation.

"After the first few, we all worked together like a well-oiled machine," Mellon said. "It was just part of that exchange of learning and interacting that made it work so well."

The Providence team members spent their days working in the village, then would ride a bus more than an hour

"We had kids following us around, like the circus was in town," she said. "And we found by the end of the week that the teachers were teaching the kids some English, so they'd say, 'Good morning, good morning.'"

Though it's too early to tell how effective the new latrines will be in curbing illnesses, Grey said the earlier efforts of PHI, MTI and the other partners have already made a difference. Based on programs done in 2013, Grey said there's

"These relationships are really **crucial to making an impact on a community**. But they also make an impact on our employees. When they have an opportunity to serve internationally, **they come back inspired to serve their own communities**, too."

—Brittn Grey, manager of international volunteers for Providence Health International

According to Providence, 97 percent of the families living in the area were without sanitary latrines. Combine that reality with the fact that nearly three-quarters of mothers in the area said they didn't practice hand-washing, and there's a recipe for disaster. Diarrheal illness can run rampant, and almost 50 percent of the children who die before age 5 die from the effects of diarrhea. Compounding the matter is the fact that widespread poverty plagues much of Guatemala; 88 percent of the population lives on less than $2 a day.

"Our primary goals are to reduce the incidences of diarrhea, respiratory illness, malnutrition in kids under five and rates of maternal death," said **Brittn Grey**, manager of international volunteers for

in Practice, a nonprofit that aims to help Guatemala's poor through short-term surgical, medical and dental mission trips and health-related educational programs. Providence also partners with Universidad Rafael Landivar, a Jesuit university in Guatemala City.

PHI has targeted its efforts on eight specific communities. Earlier service trips had been focused on building cleaner, well-ventilated stoves for villagers to try and reduce the incidence of respiratory illness. The February mission was the first of PHI's to work on latrines.

Mellon said many of the villagers in El Soch had already dug holes for the latrines when the PHI team and MTI arrived. Members then worked with villagers to build wooden framing—using

away to their accommodations in the city of Chicamán. Mellon described the setting as one "like paradise," of "green mountains and mist over the hills." While it appears idyllic on the surface, however, she said life for those who live there isn't easy.

"The setting is kind of a juxtaposition," Mellon said. "It looks like Hawaii minus the ocean, and at a very superficial level, they live a very simple rural life. But they have so few resources and they struggle to keep their families healthy, so life's hard."

Despite seeing some of the struggles of daily life in the village, Mellon said there was nothing but camaraderie and goodwill among the team members and the locals.

already been a reduction in the number of kids with diarrhea and also an increase in the proper response from mothers when their kids come down with it; the same goes for respiratory illnesses.

Beyond the direct health results, Grey also noted that there are other benefits from these trips as well.

"With this trip we were really able to see something, and that is the transformative power of intercultural friendships," she said. "These relationships are really crucial to making an impact on a community. But they also make an impact on our employees. When they have an opportunity to serve internationally, they come back inspired to serve their own communities, too." •

Study: New technology can improve management of leading causes of blindness

Researchers at **Oregon Health & Science University's Casey Eye Institute** have developed technology that can improve the clinical management of the leading causes of blindness. Optical coherence tomography (OCT) angiography could largely replace current dye-based angiography in the management of these diseases, research shows.

OHSU researchers found that OCT angiography has considerable advantages over conventional techniques for the diagnosis and management of macular degeneration, diabetic eye disease and glaucoma, the leading causes of blindness in the United States. Their research was published recently in the Proceedings of the National Academy of Sciences (PNAS).

"This is a significant breakthrough technology that could fundamentally change the way ophthalmologists diagnose and care for patients with retinal vascular diseases that cause blindness," said **David Wilson, MD**, director of the Casey Eye Institute and chair of the Department of Ophthalmology in the OHSU School of Medicine, in a news release. "It will also allow us to diagnose patients earlier, permitting more timely treatment to avoid irreversible loss of vision."

OCT angiography has been in development for several years in a few centers around the world. The key breakthrough that **Yali Jia, PhD**, study investigator and assistant professor of ophthalmology at the OHSU School of Medicine, Casey Eye Institute, and **David Huang, MD, PhD,** study investigator and Peterson Professor of Ophthalmology, OHSU School of Medicine, Casey Eye Institute, achieved was an algorithm called "split-spectrum amplitude-decorrelation angiography" (SSADA) that improved the quality of OCT angiography.

OHSU has filed patent applications for this invention and licensed these patent rights to an OCT company. Utilizing the algorithm, the scientists developed new methods in OCT angiography segmentation, visualization and quantification. OHSU has also filed for patent protection over these new angiography methods. These new methods, powered by SSADA, yield the exceptional results.

"We worked very hard to bring this new technology to clinical use only three years after its invention," Jia said. "We are thrilled that its initial clinical demonstrations in a number of important eye diseases could be made public in a prestigious journal such as PNAS."

The OCT angiography used in the study is a noninvasive, three-dimensional alternative to conventional angiography. It does not require injections and allows clinicians to measure vascular density and blood flow in vessels in a quantitative manner. This provides new information that is very useful for clinical diagnosis and management.

Conventional dye-based angiography produces a two-dimensional image that cannot be evaluated quantitatively. It also is an invasive procedure in which orange dye (fluorescein) is intravenously injected to illuminate the blood vessels. This procedure can cause nausea and vomiting, and, rarely, anaphylaxis.

"The new OCT angiography will be much less invasive for patients. As a result, it is ideal for screening patients for disease and routine checkups to see if treatments are working," Huang said. "I believe this technology will be used much more frequently than conventional dye-based angiography because it is faster, better, safer and cheaper. This will also surely lead to better management of eye diseases."

The paper, "Quantitative Optical Coherence Tomography Angiography of Vascular Abnormalities in the Living Human Eye," was authored by Casey Eye Institute researchers Jia; Huang; Steven T. Bailey, MD; Thomas S. Hwang, MD; Mark E. Pennesi, MD; David Wilson, MD; Scott M. McClintic, MD, PhD; Christina J. Flaxel, MD; and Andreas K. Lauer, MD. Co-authors include Joachim Hornegger, PhD, of Pattern Recognition Lab and the School of Advanced Optical Technologies at University Erlangen-Nuremberg, Germany, and James G. Fujimoto, PhD, with the Department of Electrical Engineering & Computer Science and Research Laboratory of Electronics at the Massachusetts Institute of Technology. •

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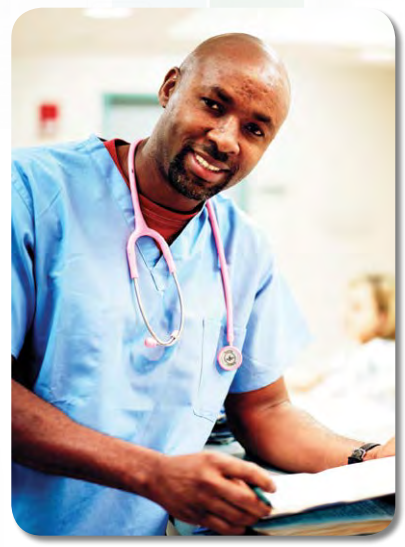

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