The Portland Physician
scribe
August 2015
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A publication of the Medical Society of Metropolitan Portland
www.MSMP.org

Family fun, for a great cause

Don't miss the Scrub Run 5K Aug. 15 at St. Josef's Winery in Canby, benefiting Doernbecher Children's Hospital.

—Please see pages 2 and 3.

Law intended to make lawsuits a last resort marks first year

It's early, but Oregon Patient Safety Commission notes 'tremendous encouragement' in use of process

By Cliff Collins
For The Scribe

One year ago, Oregon launched a groundbreaking state law to test whether disclosure and discussion after adverse health incidents could head off lawsuits against doctors.

At that time, ours was the first state to run a voluntary **statewide early discussion and resolution (EDR) program** when serious physical injury or death occurs during health care.

And, although "we won't have sufficient data to begin understanding the impact of this program for a few more years yet," the **Oregon Patient Safety Commission**, which administers the program, is feeling "tremendous encouragement that people are using the process," said **Melissa Parkerton**, director of Early Discussion and Resolution for the commission.


MELISSA PARKERTON


ROBERT DANNENHOFFER, MD


BETHANY WALMSLEY

Despite typically a minimum of a six-month lag time from when patients or providers file notices to the commission of an adverse event and the commission asks for a report of the outcome, the agency had received 29 notices through the end of June, 72 percent of which were filed by patients, she said. The commission had been uncertain how many Oregonians would use EDR during its initial year. "We weren't sure people would understand the concept," she said.

Robert Dannenhoffer, MD, a Roseburg pediatrician who serves as co-chair of the task force that oversees the EDR law, said the state will have a better idea by 2017 or 2018 of how, and how much, the program was being used in 2014–15.

*See **EDR PROGRAM,** page 15*

Gifted in art and medicine

For spine surgeon **Jung Yoo, MD**, an accomplished oil painter, switching between the scalpel and paintbrush is natural due to many years of practice in both disciplines. He is drawn to the way stories and emotions can be conveyed through color and composition.

To read more, please turn to page 6.

Photo courtesy of Jung Yoo, MD

Inside:

Telemedicine in Oregon

Medical examinations where the patient and doctor are in different locations stand to continue increasing with the recent passage of a new state telemedicine law.

—page 12

OMA: Legislative session positive for health care in Oregon

Multiple bills sponsored or supported by the **Oregon Medical Association**—one that reduces an administrative burden on medical offices, another that requires payment by virtual credit card to be agreed to by insurer and provider, and legislation that increases transparency around public school immunization rates—recently became law.

OMA's Director of Government Relations **Courtni Dresser** described the 2015 legislative session as positive for health care in Oregon but stressed that the session ended with some unfinished business, particularly around the important issue of programs designed to encourage health care providers to practice in underserved/rural areas.

"We had some good bills pass, so for medical providers, things ended up going well. Of course, there is always more work to do on behalf of patients and providers in Oregon," Dresser said.

*See **LEGISLATIVE,** page 17*

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The Medical Society of Metropolitan Portland & Uberthons

5K

Walk Jog Run

August 15, 2015

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Dinner at 6:00pm

Concert at 7:00pm by Wolf Meetings

the winner of The Battle of the Doctor Bands

Register online at msmp.org/Scrub-Run

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The Scrub Run 5K

presented by MSMP & Uberthons

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

The Medical Society of Metropolitan Portland's first annual Scrub Run will start with a 5K 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 Wolf Meetings, the winner of MSMP's Battle of the Doctor Bands! Bring the whole family! Everyone medals! ***See details and register at MSMP.org.***

Women's Circle

TOPIC: **Seven Key Power Principles for Women Physicians to Create Work-Life Integration**

Aug. 13, 6–8 p.m. at the MSMP Conference Room

Learn the seven necessary principles for women physicians to gain the energy (i.e., power) needed to create the situation where work and life are not in constant conflict. Work-life integration may not be as hard as you think when you adopt even a few of these power principles! ***See details at MSMP.org.***

Women's Circle meetings are held the second Thursday of each month from 6 p.m. to 8 p.m.

Advanced HIPAA Compliance & OSHA Training

Oct. 7, 1–4 p.m. at the MSMP Conference Room

OSHA annual training is required. The ONC, OCR and AHIM recommend annual HIPAA training. Attendees will receive a certificate of participation for their employee file. $75 for MSMP members. Participants qualify for the member price if they are a co-worker of an MSMP member. ***See details and register at MSMP.org.***

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- CEUs
- Speaker event
- 5k Scrub Run
- OSHA/HIPAA courses
- Scribe/Little Black Book

Join today at MSMP.ORG

Mindfulness techniques help providers in both personal and professional lives

By Jon Bell
For The Scribe

Every morning, **Elizabeth Stephens, MD**, wakes up and takes 10 minutes for herself to meditate. The daily sessions allow her to focus and quiet her mind in preparation for the day—just before her two young sons wake up.

Retreat set for September

WHAT: **Mindful Medicine Physicians Retreat**

WHY: **Physicians can learn practical, evidence-based mindfulness skills to reduce stress, improve communication and job satisfaction, and rediscover the joy of practicing.**

WHO: **Put on by the nonprofit Mindful Medicine, the retreat will be facilitated by Laura Martin, a mindfulness-based stress reduction coach, and Teddy Gardner, a professional coach who utilizes wellness techniques.**

WHEN: **Sept. 11–13**

WHERE: **Maitripa College, 1119 S.E. Market St., Portland**

MORE INFORMATION: **www.mindfulmedicinepdx.org**

ABOVE PHOTO:

The Portland nonprofit Mindful Medicine uses workshops and retreats to teach mindfulness and compassionate communication skills to health care providers. The group's goal is to increase coping skills and resiliency for providers, to enhance empathy and compassion, and to address the isolation in the health care community through opportunities for collaboration.

Photo courtesy of Providence Health & Services

"I just breathe and quiet my mind," said Stephens, an endocrinologist who has been at **Providence Portland** since 2007. "It's just a chance to get ready for my day."

Stephens' meditation routine is just one aspect of mindfulness, a kind of mental state that finds people focusing on the moment and on their mental and physical states. She uses the approach not only in her personal life, but in her professional one, as well.

Stephens is one of a handful of providers behind **Mindful Medicine**, a Portland nonprofit that uses workshops and retreats to teach mindfulness and compassionate communication skills to health care providers. The goal of the group is to increase coping skills and resiliency for providers, to enhance empathy and compassion, and to address the isolation in the health care community through opportunities for collaboration.

"A few of us who had been practicing mindfulness all got together because we had seen a lot of benefit in our ability to handle stress and pressure," Stephens said. "We thought it would be nice to teach others so they could realize the same benefits."

For the past few years, the group has offered workshops and, more recently, weekend retreats to area physicians. A cornerstone of the approach is teaching meditation methods, including guided meditation and walk-through meditation. Stephens said the retreats also include group sessions, where participants gather to not only talk about medicine and their practices, but also to listen to their peers.

"Physicians are increasingly operating in silos these days," she said. "In the old days, we'd all be in the hospital together and have this sense of community. These days, the clinics and hospitals are often very isolating and lonely, so these groups just kind of help people talk and reconnect and realize that we're all in the trenches together."

In addition to its workshops and retreats, the Mindful Medicine nonprofit is conducting an ongoing randomized controlled trial sponsored by Providence to back the benefits of mindfulness with some actual data. The first phase of the study, which focused on about 30 providers, found that three months after attending a mindfulness retreat, participants showed improved resilience and decreased stress and burnout.

"A few of us who had been practicing mindfulness all got together because we had seen **a lot of benefit in our ability to handle stress and pressure**. We thought it would be nice to teach others so they could realize the same benefits."

—Elizabeth Stephens, MD, on the Portland nonprofit Mindful Medicine

David Schroeder, MD, a cardiologist with the **Providence Heart Clinic**, got his first glimpse into mindfulness about 10 years ago purely by chance. While experiencing a stressful transition in his personal life, Schroeder came across the writings of Jon Kabat-Zinn, a well-known mindfulness advocate, scientist and professor. Schroeder gradually started a daily practice that improved both his personal and professional lives.

"My hope for mindfulness was that it would help me cope with the change and stress I was experiencing, and I felt that it did," he said. "I was pleasantly surprised to note that within a year or two, I had better experiences with patients. I felt that I was more relaxed, a better listener and able to communicate in a way that felt more natural."

For years, Schroeder felt he was alone in using mindfulness to improve his practice. Then in 2013, he met Stephens and **Jeff Horacek, MD**, another physician at Providence. They, along with **Dan Rubin, PsyP**, a clinical psychologist in private practice, connected with mindfulness teachers and developed a curriculum based on a publication from Wisconsin University aimed at physicians. That work led to the founding of Mindful Medicine.

For Stephens, mindfulness has been incredibly helpful in her practice.

"If I'm in a difficult situation and my mind is swirling, I've learned ways of using breathing and being aware of my mind and body to quiet myself," she said. "I'm also able to be there with people and to be able to not take on their distress. I'm able to be present with it, but not be engulfed by it."

Schroeder has seen similar benefits. One technique that he uses centers around four components: stop, notice, feel, and relax. The technique finds him limiting other mental activities—like planning or remembering—and instead focusing on the patient in front of him.

"Stopping this activity as much as I can allows me to notice the human being in front of me more deeply. I listen more intently, am aware of their body language and incorporate other family members or friends in the room," he said. "This attention itself can be healing. Truly noticing and feeling the concern of a patient may sound time consuming or exhausting, but the surprise finding is that patients often feel more relaxed in a way that usually makes the visit seem easier." •

"My hope for mindfulness was that it would **help me cope** with the **change and stress** I was experiencing, and I felt that it did. Within a year or two, I had **better experiences with patients**. I felt I was **more relaxed, a better listener** and able to communicate in a way that felt more natural."

—David Schroeder, MD

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From scalpel to paintbrush

Physician Jung Yoo's talents run deep in two worlds

By John Rumler
For The Scribe

Growing up in Korea and immigrating to the United States at the age of 12, **Jung Yoo** lived in Chicago near the Art Institute of Chicago. He became a frequent visitor to the world-famous center and was fascinated by the works of French Impressionist Pierre Auguste Renoir, particularly his painting titled *Two Sisters* (*On the Terrace*).

JUNG YOO, MD

Deeply impressed by the careful and deliberate placement of each brush stroke, Yoo was inspired to begin painting himself. Now 30 years into an illustrious clinical and research career, Yoo, MD, relies on the teachings of both art and medicine in his everyday work as a clinical department leader within Oregon's only comprehensive academic health center.

Yoo, who joined Oregon Health & Science University in 2004 as professor and chair of the Orthopaedics and Rehabilitation Department, completed his residency in orthopaedic surgery at Case Western Reserve University in 1990. His main clinical interest is spine surgery and his research interests include enhancing the success of spine fusion and the engineering of new bone and cartilage from patients' own stem cells.

The same intensity and focus that makes Yoo a highly accomplished doctor and scientist is manifested in his artwork. He's evolved into a gifted artist specializing in oil paintings. One of Yoo's works, *Pears and Flowers*, won an honorable mention in a recent Oregon Society of Artists show, his very first art exhibit even though he's been painting for more than four decades.

For Yoo, switching between the scalpel and the paintbrush is a natural process due to many years of practice in both disciplines.

Initially drawn to impressionism, Yoo would walk from his high school to the Art Institute where he would contemplate the masterpieces of the world's great artists. Eventually he began creating his own paintings, although over the years he's moved from Impressionism to a more expressionistic, and sometimes abstract, style that he finds liberating.

Yoo is drawn to the way stories and emotions can be conveyed through color and composition. Unlike the exactitude of surgery and science, "Nothing is definite in abstract art," he says.

This deftness at balancing the rigors of academic medicine with the ambiguity of abstraction has become a signature part of the leadership role he's held since joining OHSU.

Simmons notes that this Jung Yoo painting shows "bold and adventurous use of color" and is "very evocative and liberating." The piece, he added, demonstrates an "admirable and fearless handling of paint."
Photo courtesy of Jung Yoo

A gifted artist, Jung Yoo, MD, was inspired to take up painting after visits to the renowned Art Institute of Chicago. Portland multimedia artist James Simmons, who has taught art classes and juried art shows around the U.S., says this Jung Yoo work is a nod to Matisse in its "strong use of primary forms and colors."
Photo courtesy of Jung Yoo

"I tell my trainees that surgery is looked on as technical work, but every good artist has to be a good technician. At the same time, when a good surgeon's work is done, it should look like art. It should be pleasing."

Firmly believing that everyone has an inner creative desire, Yoo has inspired several of his patients to take up painting as part of their rehabilitation process.

In spite of multiple demands, he carves out at least 10 hours a week, often in the pre-dawn hours, solely for oil painting and tapping into his inner drive to be visually expressive. "You have to do something in your life that expresses pure joy," Yoo explains.

Jacqueline Munch, MD, a sports medicine/orthopaedic specialist and faculty member at OHSU, met Yoo six years ago when she interviewed for an internship in his office. She was struck by the nearly dozen of his paintings adorning his office and the surrounding halls.

"At OHSU, he's getting to be almost as well known for his talent as an artist as he is as a doctor. It's great that he's going to be getting wider recognition for his paintings."

Munch said that last month when Yoo had an artist's reception for his First Thursday show at Elizabeth Lofts in the Pearl District, around 75 colleagues and coworkers turned out to support him.

"Dr. Yoo never brags about his skills, but he really lights up when anyone discusses art or oil painting. We all know that it's such an important part of his life that he'll rise in the wee hours of the morning just so he has time to paint, and he'll show us pictures on his iPhone of the paintings he's working on."

While Yoo has been oil painting for 42 years, because of his professional demands, his works have been completed alone in his studio, and he has only recently joined the Oregon Society of Artists.

He is self-taught, having learned through experimentation and by studying great paintings and art throughout the world. Yoo paints mainly landscapes, some still lifes and occasionally portraits.

His canvases range in size from 4 inches by 6 inches to 4 feet by 4 feet and can take him anywhere from a single day to many weeks to complete. He's painted in acrylic and watercolor, but says it was the richness of oil colors that he could not reproduce with other mediums that attracted him.

Over the years, Yoo has given many paintings to friends, donated others to charity art auctions and kept a good number of favorites. "I have many I like for different reasons, but I also see faults in every one of them," he says.

Perhaps ironically, Yoo finds painting in the studio more liberating than painting in nature. "I am too restricted to the reality in both shapes and colors when I am looking at them, while painting in the studio allows my imagination to run free."

The greatest reward Yoo receives from oil painting is something he feels inside, something deep and abstract, not unlike some of his paintings.

"When you first create a work of art, it is like creating something from nothing. There was just some paint, a few brushes, a canvas, and then there is something beautiful and real. It is like you have created something good out of nothing but your own heart and soul." •

Physician who revolutionized optical diagnosis two decades ago is still making advances

By Jon Bell
For The Scribe

Some 25 years ago, **David Huang, MD**, was conducting research for his medical engineering and medical physics PhD at the Massachusetts Institute of Technology. His professor, James Fujimoto, had asked Huang to build an interferometer to measure the thickness of the cornea and the retina. Such a device uses interference of light waves to measure things such as distance or wavelength.

But Huang, who earned his MD from Harvard Medical School, discovered there might be an even better use for the technique. He figured that a similar approach could be used to obtain three-dimensional, cross-sectional images of the eye and give physicians the ability to peer deeply into the various layers of the retina.

That discovery became known as **optical coherence tomography angiography**, and it has since become one of the most widely used diagnostic tools in the world of ophthalmology. The tool allows physicians to measure blood flow, nerve function and other factors in a non-invasive way and look for irregularities that could be signs of common diseases of the eye.

David Huang, MD, and co-researchers have been refining and improving optical coherence tomography (OCT) angiography. The researchers recently published an article in the "Proceedings of the National Academy of Sciences" detailing an algorithm they devised that greatly improves the quality of OCT angiography.
Photo courtesy of OHSU

The original paper on OCT angiography, which Huang served as lead author on and which was published in the journal *Science* in November 1991, has since been cited in well over 5,000 journal articles. One write-up hailed OCT angiography as the "most important diagnostic advance in the history of ophthalmology since the invention of the ophthalmoscope in the 1850s." And without a doubt, OCT angiography has become the most commonly used eye imaging test to detect, diagnose and help treat the leading causes of blindness, including macular degeneration, diabetic retinopathy and glaucoma.

But even though all of the original groundwork on OCT was laid nearly 25 years ago, Huang has never strayed too far from it. He completed his ophthalmology residency training at the University of Southern California and a fellowship at Emory University. He worked at several hospitals and as a surgeon before heading up the University of Southern California's Doheny Laser Vision Center. And then in 2010, Huang came to Oregon to join **Oregon Health & Science University's Casey Eye Institute** and continue his OCT research.

"OHSU has provided excellent support for my laboratory and myself, including

*See **PHYSICIAN PROFILE,** page 15*

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Lung cancer screening reduces mortality

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MSMP Student Trustee Anushka Shenoy finds career change a challenge well worth it

By John Rumler
For The Scribe


Anushka Shenoy

> "She's a **self-starter, learns quickly and eagerly**, and she's **very comfortable** in this environment. Most second-year med students haven't been exposed to very much, but Anushka really **dialed into the patients**. She's going to be a wonderful doctor."
>
> —Ellen Madnick, MD

With both of **Anushka Shenoy**'s parents deeply imbedded in high technology—her father a microchip designer at Intel Corp. for 32 years and her mother a software engineer and accountant—a career in medicine was not even on her radar.

Growing up in Portland, she went to the Montessori School of Beaverton, and to Catlin Gabel before attending Columbia University, where she graduated magna cum laude with economics and mathematics degrees.

Shenoy was hired as a management consultant at Bain & Company, one of the world's most prestigious consulting firms. After two years she took a position in corporate strategy at the software giant Intuit Inc., where, within 12 months, she was promoted to management.

It seemed Shenoy was on track to end up as a CEO or CFO of a Silicon Valley Fortune 500 company, or perhaps lead her own start-up, when her life took an unexpected detour.

During the time Shenoy was working at Intuit, she saw and felt the impacts of mental illness on several people she was close to. She started a blog about the personal impacts of mental illness, helping to share personal narratives from patients and their loved ones. The blog took off and Shenoy received many messages from friends, family and even strangers about how much the blog meant to them and how they wanted to learn more about the topic.

At the same time, Shenoy, who turns 29 this month, was facing some major life decisions. Would she pursue an MBA? Continue in corporate strategy at a large firm? Start her own company?

After a period of deep soul-searching, Shenoy realized she wasn't compelled by any of those options, nor was she eager to pursue the paths of her business mentors. Instead, she wanted to become a psychiatrist.

"I took a big step back and saw that mental health was my true passion and decided to pursue a post baccalaureate at Portland State University," she says.

Although Shenoy's heart clearly told her she needed to change careers, it wasn't easy for her head to accept. Just the day before she told her boss at Intuit that she was leaving, he'd promoted her.

"He was such a wonderful ally and mentor to me, I felt really bad telling him I was so dramatically changing paths, but then it was such a big challenge to take on the pre-med coursework that I didn't have time to dwell on the transition, and it's only become more clear, over time, that I made the right choice.

"I certainly wasn't a top executive, but starting a new career and to be back at the bottom of the food chain is definitely teaching me humility," she adds. "There are many people at OHSU who were more successful than I was in other fields and also made a decision to start over. They had to leave even more behind, so that puts my own choice into perspective. I feel very fortunate to have the opportunity to become a doctor."

She completed the pre-med requirements in 18 busy months and then started medical school at Oregon Health & Science University. Shenoy started as **Medical Society of Metropolitan Portland** student trustee in April 2015. Since she plans to stay in Portland, she wanted to explore and learn much more about the local medical community.

Shenoy says it's beneficial for her to see the work that MSMP does, particularly with the Physician Wellness Program, and to participate with the **Metropolitan Medical Foundation of Oregon**.

Her biggest surprise so far? "It's learning how close-knit the medical community in Portland is and also that so many people have ties to OHSU in one way or another," she says.

During her stint as student trustee, Shenoy has three main goals. First, she hopes to increase the general knowledge of MSMP and its various programs to students. Second, she'd like to share a student perspective, particularly about concerns regarding rising student debt as well as the problem of limited residency spots in Oregon and nationally. Finally, she wants to raise awareness among current physicians about the challenges medical students face and what trends and developments they find exciting.

Shenoy brings an impressive and highly unique blend of education and experience in high-tech firms and nonprofits to her MSMP role and also to her future medical practice.

She ran cross country in high school and was active in mock trial and drama. She did economics research in college, worked as an interpreter in Guatemala, attended the London School of Economics in 2006–2007, and has been involved in numerous leadership and teaching roles at nonprofits such as Outside In and the Southwest Community Health Center.

At Outside In, Shenoy met her preceptor, **Ellen Madnick, MD**, an internal medicine specialist at OHSU for 30-plus years. Madnick, who's worked with and mentored hundreds of students and interns through the years, says her protege is a standout.

The two worked together over 10 months in the agency's outreach medical van and at Cascadia Behavioral Healthcare Woodland Park in outer Northeast Portland. Shenoy took histories, learned diagnosing techniques and discussed treatment plans on a wide range of patients.

"She's a self-starter, learns quickly and eagerly, and she's very comfortable in this environment. Most second-year med students haven't been exposed to very much, but Anushka really dialed into the patients. She's going to be a wonderful doctor. "

Madnick says Shenoy often came in on her day off, on her own time, to help out and that she asked lots of questions, especially, "Why?"

"She's bubbly, energetic, a total pleasure to be around, and with all her questions she pushed me, in a good way, because some of the things she asked, I had to find out. We're all hoping she'll come back and do a rotation with us."

The skills and knowledge Shenoy acquired for her high-tech career will be put to use in a new setting. She hopes to use her business background to reduce and streamline costs associated with mental health care and to try to improve services across the board.

To Shenoy, the most important factor in practicing medicine is to maintain empathy for and kindness to patients, and she says she's fortunate to have many mentors who've demonstrated genuine compassion at every turn.

"People's thoughts and feelings are interesting to me and I'm drawn to mentally ill and psychotic patients with complex histories. I'd especially like to work with women and/or pursue child psychiatry."

While Shenoy acknowledges that her long-term goal hasn't crystallized yet, she realizes it's the journey, not the destination, that is important. She's just entering clinical medicine, which will give her opportunities to explore and delve deeper into the future possibilities that a career in psychiatry offers. She's already considering opening an area clinic that focuses on integrating mental and physical health.

Rivfka Shenoy, Anushka's younger sister, just started her third year of medical school at New York University. The stars lined up so that the two siblings started medical school—although in different parts of the country—on the same day.

Rivfka says Anushka amazes her in many ways.

"Her application of theories and concepts is unparalleled. What makes her so unique is that her problem-solving abilities and critical thinking skills come so easily and naturally to her. I can't wait to see how she applies all that to help her patients and solve medical issues."

Rivfka, who plans to become a pediatric surgeon, also says that Anushka's strong ability to connect with people will be a huge asset.

"She makes others feel comfortable, at ease, and she brings out the best in everyone around her. Anushka feels the depth of people. I think her brilliance combined with her passion for people will make her an amazing psychiatrist." •

Security experts offer tips to protect patient data from growing number of threats

By Melody Finnemore
For The Scribe

Security breaches of patient data and other confidential information continue to escalate for the health care industry, reaching new highs in 2014, and cyber attacks against physicians have skyrocketed during the last five years, statistics show.

The health care industry was the most breached industry in the U.S. last year, accounting for nearly 43 percent of major data security breaches, according to the national Identify Theft Resource Center.

The Fifth Annual Benchmark Study on Privacy & Security of Healthcare Data (www2.idexpertscorp.com/ponemon), published by Portland's ID Experts, states that cyber attacks against health care organizations have risen by 125 percent since 2010. Cyber criminals recognize that health care organizations manage a treasure trove of financially lucrative personal information, and they often do not have the resources, processes and technologies to prevent and detect attacks and adequately protect patient data, according to the report.

Ken Westin, senior security analyst for Portland's **Tripwire Inc.**, called the situation a "perfect storm," noting organized criminal syndicates have found ways to monetize data found in databases of health care insurers and clinics through various types of fraud, increasing the illegal demand for this type of data.

"Once data has value it has a bounty on its head, and hackers will begin to target organizations that have this information," he said. "If we pair the fact that health care is now a target with the fact that, for the most part, health care is ill prepared for the level of sophisticated attacks now targeting their data, we have a pretty serious situation."

Tara Costanzo, an associate attorney with Portland firm **Lindsay Hart**, works with medical professionals who have experienced breaches ranging from the theft of medical records from a storage unit to employees taking flash drives loaded with patient records outside the office.

Costanzo noted that the federal Office of Civil Rights stepped up its investigations to ensure medical professionals are adhering to patient privacy protections outlined by HIPAA.

"Really, anybody in the health care field can be subject to an audit, and they (Office of Civil Rights) go online to find out if a breach has occurred," she said. "If a physician or health care organization doesn't identify a breach and report it themselves, they can get into a lot more trouble than if they had reported a breach."

Costanzo said it's essential for physicians to improve their awareness of HIPAA rules so they can understand how breaches commonly happen and how to prevent them. "Most doctors don't go out on their own and learn every aspect of the rules, so they really aren't aware of the intricacies until they get into trouble," she said.

Rick Kam, president and co-founder of **ID Experts**, advised health care organizations to perform risk assessments required under the HIPAA Security Rule, which can improve their understanding of potential threats to their networks and regulated data. They also should participate in threat sharing forums to identify threats from new malware and cyber attackers, he said.

"I also suggest that organizations assume they are breached at this point and direct resources into forensics to determine what malware exists in their networks," Kam said. "When Anthem announced its data breach earlier this year, other organizations did this to see if they had been affected by cyber attacks. As an example, within a few weeks Premera and CareFirst announced they had found similar malware in their systems."

While cyber attacks have spiked, employee negligence remains the top concern for many health care organizations. Kam said many organizations he works with are implementing more employee awareness and training regarding protected health information.

"I expect to see data breaches from employees who work in health care organizations decrease as a result. What isn't happening fast enough is business associates doing the same, and I expect we will continue to see increased employee negligence from business associates," he said. "Many of the data breaches over the past few months have been caused by a business associate or contractor giving up their user name and password in a spear-phishing attack that is then used to infiltrate the covered entity's network."

Westin said many health care organizations have realized that simply following regulatory compliance like HIPAA is not going to keep them secure from the threats they now face.

"Network and data security can no longer be just a checkbox but must be integrated into business processes, and this includes not just technology but also people," he said. "Raising awareness with regards to the damage that can be inflicted on individuals and health care organizations as a whole when this data is compromised is a good first step. However, health care needs to do a better job of identifying who has access to sensitive data, limiting who has access to it, and monitoring and logging when and where it is accessed."

Westin advised medical professionals to review their current security practices and then identify additional security controls that can be implemented with the solutions they currently have.

"I have seen a number of health care organizations that have spent a lot of money on security controls and failed to implement them properly," he said. "Many times the databases and data warehouses they are using have security features built in, such as encryption and additional authentication measures, but often times they are not implemented either because staff are not trained how to use these features or they are disabled or never implemented due to them being inconvenient."

Westin also said businesses should follow the "Data Golden Rule" and treat sensitive data as if it were their own. •

3 Questions with Rick Kam, president and co-founder of Portland-based ID Experts

The Scribe: The PHI Protection Network advises health care organizations to be more proactive about protecting patient data, yet the Fifth Annual Benchmark Study on Privacy & Security of Healthcare Data states that many do not have the resources or funding for it. How can they be more proactive given these limitations?

Kam: Health care organizations are looking for security and privacy initiatives that help them utilize their scarce resources most effectively. This may take the form of joining alliances that share best practices on protecting PHI (protected health information) such as the Medical Identity Fraud Alliance (MIFA—www.medidfraud.org).

The Scribe: How can the health care industry encourage greater reporting and transparency when it comes to security breaches and patient data?

Kam: HIPAA/HITECH legislation already creates a reporting structure for data breaches to (the Office of Civil Rights). But this is only for confirmed data breaches that require notification. There are significantly more cyber security incidents that don't result in a reportable data breach. Organizations such as MIFA are ways for industry participants to share data on cyber security and best practices in protecting PHI.

The Scribe: Are health care organizations required to compensate patients for identity theft that occurs because of a security breach?

Kam: Many health care organizations do offer credit monitoring and identity restoration services as a way to compensate patients for breaching their data. Organizations will remove charges created by an identity thief if they are able to verify fraud. What is needed is for organizations to offer medical identity monitoring when a breach of PHI occurs. Like credit monitoring, medical identity monitoring will alert patients when their medical identity is used to create a transaction for prescriptions and goods and services. This allows the patient to determine whether or not they received these goods and services and help stop medical identity theft and medical fraud before it happens. •

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Oregon now requires insurers to cover urban telemedicine

Earlier this year, Providence introduced its latest iteration of Health eXpress, which offers remote face-to-face visits directly to individual consumers in their home or anywhere they may be, for common health problems that normally would be seen in an urgent care setting.
Photos courtesy of Providence Health & Services

By Cliff Collins
For The Scribe

Medical examinations where the patient and doctor are in different locations stand to continue increasing with the recent passage of a new telemedicine law in Oregon.

Proponents praised Senate Bill 144, which requires health insurers to cover telemedical visits regardless of the patient's location, if 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 don't pay for remote examinations of patients in urban settings. The new statute applies only to commercial plans, not Medicare or Medicaid. It becomes effective Jan. 1, 2016.

The legislation faced no organized opposition, and strong backers included **Providence Health & Services** and **Zoom+ Performance Health Insurance System**. The law was developed over a period of months by a legislative-appointed work group.

The statute's final language met Providence's two main objectives, according to **Jessica Adamson**, director of government relations for **Providence in Oregon**. Those objectives were "making sure that reimbursement could be wherever the patient was," and ensuring that whatever technology is employed is compatible with privacy and security, she said.

Earlier this year, Providence introduced its latest iteration of Health eXpress service, which offers remote face-to-face visits directly to individual consumers in their home or anywhere they may be, for common health problems that normally would be seen in an urgent care setting. Using their own technology such as a smartphone, consumers who register online can pay $39 and see a health care provider on their screen and be diagnosed and prescribed medicine, if necessary.

Historically, most telemedicine in Oregon has been used primarily as a doctor-to-doctor resource among hospitals, where a physician in a suburban or rural location can consult a specialist such as a neurologist or dermatologist using video technology.

Seeing patients via video represents an effective way to use technology to improve access to care and to reduce costs, said **David Sanders, MD**, chief executive of Zoom+. "The passage of SB 144 means more people will have access to Zoom+Care because their visit will be covered by insurance," he said.

After the bill was signed into law, Zoom+ announced its Zoom+Care Video service, which it is offering to self-pay patients at $35 a visit, and free to Zoom+ Performance Health Insurance members. ZoomCare, the company's name until a recent change, has strongly advocated for the use of video exams as a safe, effective way to handle urgent care needs. According to the company, it collaborated with **Oregon Health & Science University** on a study published in February. The study, in the *Journal of Telemedicine and Telecare*, found that video-enabled office visits were safe and effective.

In 2012, the **Oregon Medical Board** released a statement of philosophy on telemedicine, a move which "came in part from our working with ZoomCare," said **Kathleen Haley**, executive director of the OMB. It sets a standard that is the same as for in-person visits, she explained.

KATHLEEN HALEY

It reads: "The Oregon Medical Board considers the full use of the patient history, physical examination and additional laboratory or other technological data all important components of the physician's evaluation to arrive at diagnosis and to develop therapeutic plans. In those circumstances when one or more of those methods are not used in the patient's evaluation, the physician is held to the same standard of care for the patient's outcome."

Oregon's medical board was an "early adopter" of telemedicine, developing regulations in the mid-1990s governing the practice, Haley said. A board member at the time, **George Porter, MD**, of OHSU, "had foresight" and was "very forward-thinking" in realizing the application and value of telemedicine to a mostly rural state, she said.

Members of the OMB visited an eastern Oregon hospital for a demonstration of how physicians in another state could see patients in the hospital's ICU, and board members were impressed by the technological capability, she said. "We've tried to keep up with and address" new technological developments in medicine, Haley said.

With passage of SB 144, Oregon joins just two other states in requiring only private insurance, and not Medicaid, to reimburse for services provided through telemedicine, according to data compiled by the Federation of State Medical Boards. However, Oregon's law does not require parity, Adamson pointed out. Instead, rates for telemedical visits are negotiated between providers and insurers, she said.

The federation notes that 23 states require both private insurance and Medicaid to cover telemedical services at the same level as in-person consultations.

In terms of licensing, physicians who perform telemedical visits must be licensed in the state where the patient is located. That requirement holds true in 49 states, according to the federation. For physicians outside of Oregon who perform telemedical visits on patients in Oregon, the OMB requires that the doctor hold an active Oregon medical license along with a telemedicine status, Haley said.

The federation reports that 12 other states issue either a special-purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine. •

Countdown to ICD-10

Key facts to know during the transition

By Tom Gehring,
Chief Operating Officer, San Diego County Medical Society

The Oct. 1, 2015 deadline for transitioning to ICD-10 is approaching fast. As practices transition from ICD-9 to ICD-10, they face many risks. It's important to take steps to avoid these risks because if not properly implemented, ICD-10 could greatly affect reimbursement.

Avoiding fraud, waste and abuse

No physician wants fraud, waste or abuse to occur in his or her practice—during the transition from ICD-9 to ICD-10, practices must be careful to avoid technology and coding errors. This transition has the potential for errors in two areas:

1. As you transition from ICD-9 to ICD-10, the technology may inadvertently submit multiple claims for the same service.
2. Your coders and your coding processes may inadvertently make mistakes that start to look like fraud or abuse.

To help avoid these risks, you must ask the hard questions about your products and vendors. Ask your vendors directly: "How will you prevent inadvertent double billing?" Second, sit down with your coders and say: "I want to code honestly. What do you need from me to accomplish this?"

Be aware that your coding error rate and denials as a result of those coding errors will increase in October 2015 as you implement ICD-10 coding. These increases will directly impact your receivables and bottom line. Plan for an impact on your cash flow using these seven mitigation steps:

1. Budget for potential cash-flow impacts.
2. Prepare for delayed payment and claims adjudication.
3. Prepare for IT software updates, patches, conversion and testing.
4. Adjust accounts receivable reserves as needed.
5. Prepare for productivity delays and educational expense outlays.
6. Prepare for increased denial tracking, trending and reporting.
7. Right-size staff to handle increased workload and volume.

The importance of vendors

The implementation of ICD-10 in your practice will be heavily dependent on the successful implementation of ICD-10 by your vendors. There are two fundamental risks that you need to address. First, be aware of what vendors have to do in terms of ICD-10—take a vendor inventory. Second, be aware of the risk of unsuccessful vendor implementation of ICD-10. These six steps can help ensure your vendors don't prevent you from having a successful ICD-10 implementation:

1. **Inventory your vendors.** Who is providing what software, hardware and processes that will be affected by the transition?
2. **Create a vendor implementation plan.** What are the dates, checkpoints and milestones that you need to synchronize to?
3. **Develop a regular communication schedule** to ensure your vendors aren't falling behind.
4. If things aren't going well with a particular vendor, **act quickly to cut your losses.**
5. **Have a Plan B.** If Vendor 1 is failing, be prepared to shift to Vendor 2.
6. **Foster a culture of interdependence.** Their success should be your success, and your success should be theirs.

These questions can be helpful in framing the discussions with your vendors:

- Do you have fully functional, compliant products and services ready in time to allow for thorough ICD-10 testing?
- How are you going to help me avoid potential reimbursement issues and interruptions to workflow?
- Will you be notifying me of system upgrades and replacements needed to accommodate ICD-10?
- What are the costs involved and will upgrades be covered by existing contracts?
- When will upgrades or new systems be available for testing and implementation?
- What kind of customer support and training will you provide?
- How will your products and services accommodate both ICD-9 and ICD-10 as you work with claims for services provided both before and after the transition deadline for code sets?
- Can we set up regular check-in meetings to keep progress on track?
- Who will be the primary contact at your organization for the ICD-10 transition?
- Can my practice send test claims with ICD-10 codes to see if they're accepted? If so, when will you begin accepting test claims?
- Do products give you the ability to search for codes by the ICD-10 alphabetic and tabular indices? By clinical concept?

The implementation of ICD-10 will have significant impact on your workforce, creating frustration, additional work and changes in processes. Help support your staff by being honest that the transition is going to be difficult. But by putting a comprehensive plan and support systems in place, you can help ensure a successful move to the new coding system. •

Contributed by The Doctors Company, the exclusively endorsed medical malpractice carrier for the San Diego County Medical Society. For more transition resources, visit www.thedoctors.com/ICD10.

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EDR PROGRAM *from page 1*

According to Parkerton, there are three main reasons for this delay. First, filing resolution reports is voluntary. "We are hopeful that people will choose to share their experiences with this process, but we know that some will opt out," she explained. In addition, "We have no baseline data on actual numbers of incidents or how those incidents have been resolved. It will take time to be able to see trends without actually knowing definitively where we started."

Third, the EDR process is intended to be confidential. "While we want to share all useful information, we are also very committed to maintaining the confidentiality of participants. This means that numbers have to grow significantly before we can talk about some of the things that we're seeing without risking any kind of inadvertent breach of confidentiality," Parkerton said. "We'll get there, but it will take time."

"It will take a while for people to get used to the system," Dannenhoffer added. "It will be interesting after a few years to see if malpractice claims" fell after the program commenced.

Public and provider awareness are key, and Parkerton and the commission have spent the first year of the program doing outreach, speaking and educating Oregonians about the existence of EDR and how to use it. "This process is going to work only if people know about it," she said. For that reason, she has led or co-led presentations to more than 50 organizations statewide, including many medical groups.

The **Oregon Medical Association's Mark Bonanno**, general counsel and director of health policy, said physicians express lots of concerns about the law, including that they will bare "their souls" in the EDR process "and what comes out of it is a lawsuit." But he said we can't know in one year whether this new concept is going to work and do what it is intended to do: treat patients in a respectful way while leading to a path of resolution other than litigation. But he thinks the process ultimately could prove beneficial for both patients and physicians.

"I believe it can be a success," he said. "It's bringing the patient into the equation." Many studies show that patients just want to be told when something has gone amiss with their treatment, Bonanno said. "A lot of the time that's all the patient wants," for the doctor to take time to talk with the patient and explain the facts of what occurred.

Program considered a national model

The EDR program was created by statute, passed by the 2013 Legislature as Senate Bill 483. It resulted from a document created in 2012 by a state advisory group appointed by then-Gov. John Kitzhaber. He and several OMA leaders, including then-OMA President **William "Bud" Pierce, MD**, and the association's **Medical Liability Reform Task Force**, strongly endorsed the proposal that became law. They stated that the EDR concept has the potential to improve the liability climate in Oregon, and that it represents a collaborative approach to reduce lawsuits, lower administrative costs and improve patient safety.

The statute contains a three-pronged approach to addressing adverse patient outcomes: early discussion and resolution; mediation; and litigation. The statute defines an adverse health care incident as "an objective, definable and unanticipated consequence of patient care that is usually preventable and results in the death of, or serious physical injury to, the patient."

Dannenhoffer, who also served on the initial task force that designed the process that became law, said at the time that the task force saw EDR "as a much better way to handle disputes. It's a totally voluntary process, which is good. I think this will become a model for the rest of the country."

In fact, other states either are considering starting or already have implemented similar programs, though most, including in Michigan and Massachusetts, are based within certain hospitals or health systems rather than statewide.

According to Parkerton, the Beaver State also recorded two other firsts associated with the EDR law: It allows such discussions to take place in settings other than just hospitals, and it permits patients or their representatives—not just facilities or providers—to initiate the process.

CNA, a large commercial and professional liability carrier with a strong presence in Oregon, supports transparency and disclosure in communications with patients, said **Melanie Spiering**, underwriting director for the company. She advises policyholders to contact CNA immediately if the EDR process is initiated by any party.

"We want to be notified so we can help the provider navigate through the process," she said. "EDR notification can also trigger coverage. We can help with the initial steps doctors need to take." In addition, CNA can offer guidance about protecting confidential information. The insurer has developed resources about the EDR law, as well as risk-management materials offering providers tools to assist them in disclosure conversations. In conjunction with the OMA, CNA offers face-to-face workshops to educate physicians about the EDR law, how to prepare for an EDR meeting, and how to disclose an adverse event to patients and their families, Spiering said.

During the planning stages for the EDR program, some physicians expressed concern that discussions of adverse events could end up being reportable to the national databank, or admissible to court if a patient files a lawsuit.

However, Oregon's EDR law contains confidentiality provisions to protect discussions that take place between patients and providers, as well as any written communications created during the process. The only exception to that protection is this: If in court, a statement is made that—in the words of the statute, "a party"—deems directly contradicts something a provider said during the discussions, and "the court or other decision-maker" deems that the statement is material to the case, the confidentiality may not apply. Otherwise, all communication during the process, whether written or oral, is protected whenever the EDR process is employed, Parkerton said.

At the request of the Oregon Patient Safety Commission, the secretary of the U.S. Department of Health and Human Services issued a memorandum in May 2014 clarifying Oregon's reporting requirements associated with the EDR process and the National Practitioner Data Bank. The memo stated that only payments to a patient resulting from a written demand for payment are reportable. "This was an important distinction," said **Bethany Walmsley**, executive director of the Oregon Patient Safety Commission. "It makes it clear that a confidential notice filed to trigger the EDR process under the Oregon law does not, by itself, trigger NPDB reporting."

The commission has created a number of resources on its website that explain how the EDR process works and how to obtain help. Information can be found at (not preceded by "www"): http://edr.oregonpatientsafety.org/reports/content/provider. •

PHYSICIAN PROFILE— DAVID HUANG, MD, *from page 7*

funding and laboratory space," Huang said. "I've also got to say that the clinical departments here within the eye institute have been very supportive of my research."

In recent years, Huang and his co-researchers, including **Yali Jia**, an assistant professor of ophthalmology at OHSU, have been refining and improving OCT angiography even more. Earlier this spring, the researchers published an article in the "Proceedings of the National Academy of Sciences" detailing an algorithm they devised that greatly improves the quality of OCT angiography. Known as "**split-spectrum amplitude-decorrelation angiography**," the algorithm and associated software helps provide much more detailed results when diagnosing diseases like glaucoma and macular degeneration.

Huang, who said he was first intrigued by this kind of work years ago in part because he was attracted to lasers and optics, said the continued work on OCT—and not just his, but other researchers across the country—has helped advance the technology in a number of different ways, including its speed.

"The technology didn't stand still for 20-plus years," he said. "The speed has increased probably 100,000 times, so you can now get a whole dimensional volume in just a few seconds."

The major benefits of OCT in general, speed notwithstanding, are that it's much less invasive than more traditional angiography, which required injecting a dye into patients to detect irregularities. Not only was that uncomfortable for patients, many of whom would become nauseous as a result of the procedure, but it was more expensive and much less convenient than OCT.

"The resulting images are also much cleaner and the contrast is much better than using a dye," Huang said.

Though other researchers have been working to improve OCT, Huang said his team at OHSU is the first to make the latest advances clinically practical by developing effective software. OHSU has filed patent applications for the invention and the SSADA software algorithm is patent pending to an OCT company. Huang, Jia and Fujimoto also all have a stake in a company called Optovue that specializes in medical devices that use OCT technology.

To date, the latest advance in OCT angiography has not been approved by the Food and Drug Administration for use in the U.S., though it is being used in experiments here. In other countries, the technology is already being utilized, and Huang is hopeful that it won't be too long before it's approved for use in the U.S., too.

Looking forward, Huang said his team is looking into inherited retinal degenerations and doing studies in gene therapy and stem cell therapies. There will likely be further advances, too, in the world of OCT, with improved hardware and faster systems that will allow physicians to scan larger areas than they're currently able to. Other experiments are aimed at precise measuring of blood flow and vessel size and many other factors.

"There's still quite a lot to be understood," Huang said. •

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***LEGISLATIVE** from page 1*

Here's a brief rundown:

- With the passage of HB 3021, Oregon became the first state in the country to require **advance notification of fees** associated with virtual credit card payments or any other form of electronic funds payment used to reimburse health care providers. Effective Jan. 1, 2016, insurers must communicate any virtual credit card transaction fees or other charges before the payment is issued. Providers can then choose whether to opt-in and accept the specific form of payment offered. Those who don't opt in must be offered an alternative form of payment, including an option that doesn't have any fees, such as a paper check.

Dresser said that, as it now stands, providers who receive virtual credit cards often only find out about the transaction fees after the fact. When they then try to opt-out of the payment, they run into hurdles. Providers are charged as much as 5 percent by third-party credit card companies. "Physicians have to pay to get paid," she said, noting Oregon is at the vanguard of the issue, "We think many other states will follow suit."

- Legislation that provides **timely grace period notification** also became law. As of Jan. 1, 2016, qualified health plans will be required to provide prompt notice of the grace period status of patients enrolled in a subsidized exchange health insurance plan. A provision of the ACA expanded the usual 30-day grace period allowed for patients to catch up on unpaid premiums to 90 days for patients with health insurance purchased through an exchange.

Due to a lack of clarity in the current federal rules on how and when the insurer is required to notify the provider of the patient's grace period status, providers often find out about the patient's grace period after services have been rendered and the insurer is no longer required to pay. The same rules only require the insurer to cover services rendered in the first 30 days of the grace period. The passage of SB 523 remedies this late notification by requiring insurers to notify providers within two days of checking a patient's eligibility, benefits or coverage—as long as the eligibility check is within seven days of the patient's visit. If an insurer fails to notify a provider of a patient's grace period status at the time of the check, the insurer must reimburse the provider for any resulting services rendered in the grace period.

Dresser said this legislation was an opportunity to address an issue before it became a widespread problem. "This is really a win-win-win," she said. "Qualified health plans will receive their premium, providers will be reimbursed by the health care plans and patients will stay up to date, with everyone getting what they need from the system."

- OMA supported a successful bill that aims to bring **greater transparency to immunization rates** at schools and children's facilities. Schools and centers will be required to post immunization rates for individual facilities on their websites, main offices and in materials sent home to parents.

Dresser said the idea is to provide immunization rate information in a more useful and easy-to-understand format so that parents and families can make informed decisions to protect their children's health. She cited the example of a family with a child enrolled in school who has an immune deficiency.

OMA did support an earlier bill that would have eliminated nonmedical exemptions for public schoolchildren on their school shots, which generated heated controversy. The association will track the issue moving into the next legislative session, Dresser said.

Another critical issue that remains a priority for the OMA concerns ensuring **health care access in rural areas** of the state. A bill introduced by the OMA and other coalition partners sought to fund a study by the **Oregon Health Care Workforce Institute** and **Oregon Center for Nursing** to review incentive programs for providers practicing in rural areas.

Lawmakers allocated $180,000 for the study as part of legislation that sunsets incentive programs in 2018. Dresser said the OMA believes the funding is insufficient to support a robust study. While the sunset was intended to help ensure timely outcomes in terms of evaluation and decision-making regarding existing and new programs, the current plan now allows for existing programs to sunset without replacements.

"It's hard to say (to providers) we have these incentive programs, but we don't know how long we will have them or what they will look like in the future," Dresser said. "We need rural providers, and we need to find a way to make sure we have people to take care of rural Oregonians. In the end, we'll be at the table to ensure good policy for the '17 session."

Near the end of the session, tax credits for some rural providers were reduced, starting in the 2016 tax year, another concern for the OMA.

"Changes to these programs may be necessary, but the changes should be done with more information on how it will affect rural patients and their providers."

Separately, a bill that would have increased the wrongful death cap from $500,000 to $1.5 million stalled in the legislative process. The OMA noted the bill would have encouraged lawsuits and discouraged the use of the Early Discussion and Resolution program.

The OMA is due to issue a legislative report to members on the 2015 session this month, Dresser said. •

News Briefs

Swanstrom honored

The Oregon Clinic's Lee Swanstrom, MD, has received the **George Berci Lifetime Achievement Award** from the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). It is SAGES' highest honor, granted to endoscopic surgery innovators in scientific, technological or educational arenas.

In addition to heading gastrointestinal and minimally invasive surgery at The Oregon Clinic, Swanstrom is president/founder of the nonprofit Foundation for Surgical Innovation & Education, which supports quality in minimally invasive surgery research and education. Swanstrom also is a director with the American Board of Surgery and past president of SAGES and the Fellowship Council. He is director of Providence Health Systems' Complex GI and Foregut Surgery Postgraduate Fellowship Programs in Portland, and director of the Innovations Fellowship program at the Institutes des Hopitaux Universitaires of the University of Strasbourg. In addition, he is a clinical professor in Oregon Health & Science University's Department of Surgery.

Swanstrom has published over 300 scientific papers and 50 book chapters, and is editor of two major surgical textbooks, including *Mastery of Endoscopic and Laparoscopic Surgery*, a leading laparoscopic textbook. His research focuses on technology assessment and new procedure development, which has resulted in 13 patents.

SAGES, which represents thousands of surgeons from every state and over 50 countries, supports academic, clinical and research achievement in gastrointestinal endoscopic surgery. •

Relief for tinnitus patients

In the largest U.S. clinical trial of its kind funded by the Veterans Affairs Rehabilitation Research and Development Service, researchers at the **VA Portland Medical Center** and **Oregon Health & Science University** found that transcranial magnetic stimulation significantly improved tinnitus symptoms for more than half of study participants. Findings were published recently in the journal *JAMA Otolaryngology–Head & Neck Surgery*.

Study participants were a mix of military veterans and non-veterans. **Robert L. Folmer, PhD**, and colleagues, including **Sarah Theodoroff, PhD**, used a TMS system that generates a cone-shaped magnetic field that penetrates the scalp and skull to interact with brain tissue. The higher the stimulation intensity, the deeper the magnetic field can penetrate and affect neural activity. Currently, the Food and Drug Administration has approved transcranial magnetic stimulation only for treatment of depression. Folmer hopes to conduct a larger clinical trial to refine protocols for the eventual clinical use of TMS for tinnitus. The study was authored by Folmer; Theodoroff; Linda Casiana, MS; Yongbing Shi, MD, PhD; Susan Griest, MPH; and Jay Vachhani, AuD.

Tinnitus affects nearly 45 million Americans. Military veterans are at greater risk of developing it. In fact, tinnitus is the most prevalent service-connected disability in the VA health system. •

Discovery could improve IVF success rates

Oregon Health & Science University, **Stanford University**, **University of Valencia** and **IGENOMIX scientists** have discovered that chromosomal abnormalities in human embryos created for in vitro fertilization can be predicted within the first 30 hours of development at the cell-1 stage which results from the union of a female egg and male sperm.

This discovery, published recently in the journal *Nature Communications*, could improve IVF success rates, which have hovered around 30 to 35 percent for numerous years worldwide. It is estimated that between 50 to 80 percent of embryos created for IVF have a chromosomal abnormality and typically do not develop into a pregnancy, instead resulting in a miscarriage.

Key findings of this research, conducted by **Shawn L. Chavez, PhD**, and colleagues at Stanford and analyzed at OHSU, showed that by looking at the duration of the first mitotic phase—a short period in the cell cycle—one can identify chromosomally normal versus abnormal embryos up to approximately the 8-cell stage. Most importantly, by looking at a single cell level, researchers were able to correlate the chromosomal makeup of an embryo to a subset of 12 genes that are activated prior to the first cell division. These genes likely came from the gametes—the eggs or sperm—and can be used to predict whether an embryo is chromosomally normal or abnormal at the earliest stage of human development. As a result of these findings, clinicians and embryologists can more quickly identify the healthiest embryo for implantation and reduce the time an embryo is cultured in a lab prior to transfer. •


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OTHER MEDICAL OPENINGS

OREGON HEALTH & SCIENCE UNIVERSITY

BOARD CERTIFIED INTERNAL MEDICINE OR FAMILY PRACTICE PHYSICIAN NEEDED FOR 1.0 FTE MEDICAL DIRECTOR in OHSU's Joseph B. Trainer Health and Wellness Center (Student Health) in Portland, OR. The Medical Director is responsible for medical oversight of all licensed medical health providers. They work collaboratively as part of the core JBT leadership team which consists of the Medical Director, Behavioral Health Director and Practice Manager. In addition, they provide direct office-based primary patient care for acute and chronic disease management for health science student and post-doc population, and consultations to assist staff with diagnosis and treatment of patients. The Medical Director is also a liaison to the OHSU medical and academic community, and serves as the medical lead for all clinical health related student policies. Required: MD, min. 10 years of experience in primary care clinic, 5 years of demonstrated clinical management. Send CV to Sarah Lemley at lemley@ohsu.edu and apply online at www.ohsu.edu. IRC# 46251.

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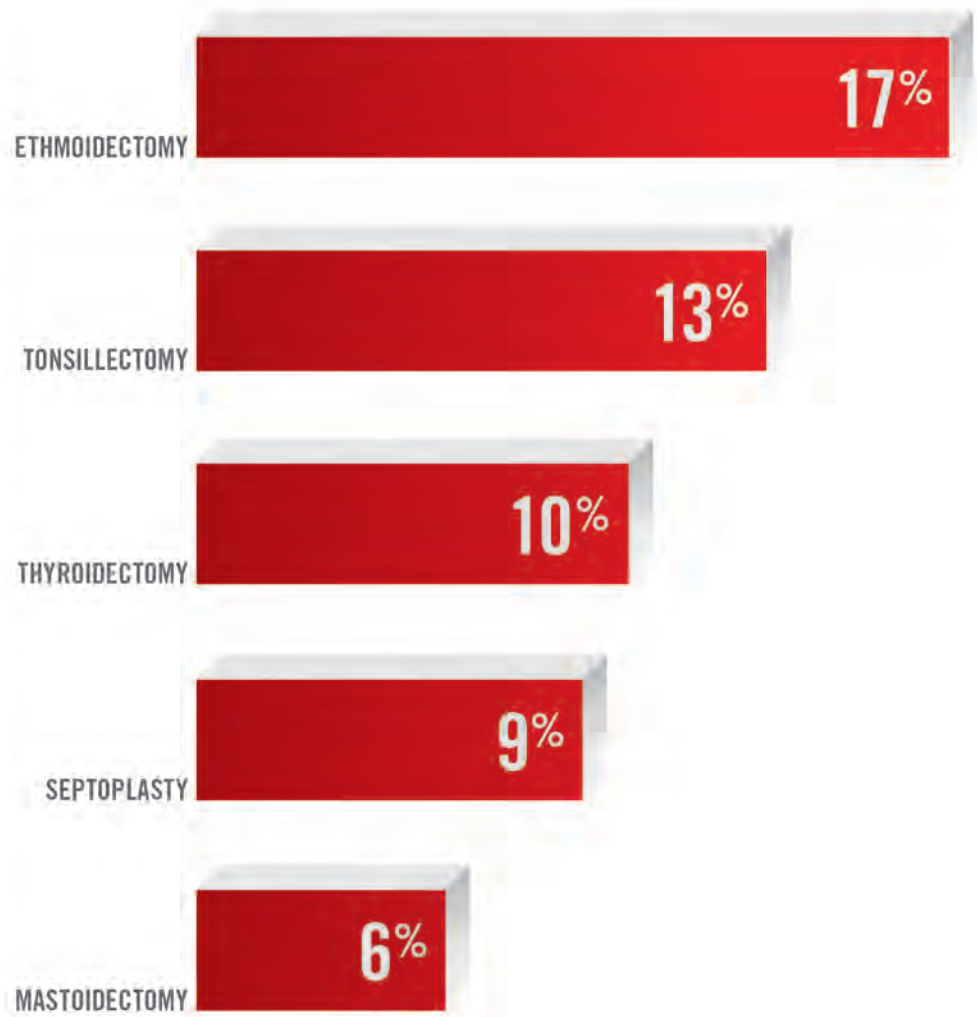

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