The Portland Physician
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March 2016
Volume 34, Number 3
A publication of the Medical Society of Metropolitan Portland
www.MSMP.org

Battle of the Doctor Bands

To battle with the best, please complete the application which is now available online at www.MSMP.org

—Page 3

MSMP's Physician Wellness Program

The Medical Society of Metropolitan Portland's confidential program, accessible to all physicians and physician assistants at no cost, helps individuals address any challenges or concerns they have.

To connect, call 503-764-5663.

Venerable company answers call to help Physician Wellness Program

By Cliff Collins
For The Scribe

Physicians' Answering Service has come a long way over the years, from using the old cord-boards system of connecting callers to employing a highly sophisticated computerized system that encrypts physicians' messages.

Now the company, founded in 1927, is participating in a reunion of sorts. Physicians' Answering Service has volunteered to help the **Medical Society of Metropolitan Portland's Physician Wellness Program** by fielding after-hours calls, at no charge. The company and MSMP go back a long way: Physicians' Answering Service was owned and operated by MSMP until 1998, and shared leased space with the Medical Society from 1998 to 2005.

A father and daughter purchased the company from MSMP in 1998, and when Physicians' Answering Service moved to its own facility in 2005, it located just about a mile down Southwest Macadam Avenue from MSMP's current headquarters.

When MSMP Executive Director **Amanda Borges** approached the answering service about taking after-hours calls for the Physician Wellness Program, company officials floored her by offering to provide the service at no charge. "They were more than willing to offer free services to the Wellness Program to help support physicians," she said.

"They were very enthusiastic about it."

"All of us feel it's an honor that we were asked to do it, to be a partner of something that is close to our heart," said **Rhea Brightmon**, general manager of Physicians' Answering Service, who originally was a staff member of MSMP. She and **Cathy Todd**, the company's office manager, have been with Physicians' Answering Service for more than two decades, and the company's staff members average 20 years working there.

> "All of us feel **it's an honor that we were asked** to do it, to be a partner of something that is **close to our heart**."
>
> —Rhea Brightmon, Physicians' Answering Service

"When the opportunity arose to participate in the confidential hotline for our longtime colleague the Medical Society, we were thrilled to be able to help," said **Jane Dorosh**, director of operations. "We think of our relationship as a partnership and that we are giving back to the community. We felt it was something we can give back to the Medical Society. They've always been good to us."

Physicians' Answering Service's contribution of answering calls after business hours gratis for MSMP's Physician Wellness Program is "tremendously generous," Borges said.

Doctors who contact the Physician Wellness Program can reach someone 24 hours a day, seven days a week. Calls during normal business hours will be picked

*See **ANSWERING SERVICE,** page 14*

New lung cancer test helps Tuality get a jump-start on early detection

By John Bell
For The Scribe

When it comes to cancer, none takes more lives than lung cancer. And when it comes to lung cancer, there's little that can be more beneficial in treatment than an early diagnosis.

"One of the big problems with lung cancer is that we often find it late," said **Peter Hahn, MD**, an interventional pulmonologist at **Tuality Healthcare**. "The survival rate for advanced lung cancer is very poor, but if you catch it early, you can treat it and cure it. So what's been the holy grail is to find the best ways to diagnose it early."

PETER HAHN, MD

While a new genomic test called Percepta from diagnostics company Veracyte may not be that holy grail, it is an advanced tool that can bring clarity to the diagnostic dilemmas that physicians face today. Tuality is one of only a dozen or so sites in the country currently using the Percepta test, and when it started using it in September, it was the only facility on the West Coast to do so. As of late February, Providence Health & Services planned to start using the test soon, and Oregon Health & Science University was not using it. Legacy Health will be participating in clinical validation of this assay.

According to information from Veracyte, lung cancer is the leading cause of cancer deaths in the U.S. There were about 224,000 new diagnoses and 160,000 deaths in 2014 alone; all but 10 percent of those were smoking related.

Traditionally, physicians would use

*See **LUNG CANCER TEST,** page 14*

INSIDE THIS ISSUE

Focus on Pain Management

Pain specialists say appropriate management of chronic pain is complex, requiring a multipronged approach. "It's important to have a variety of treatments available," says OHSU's David Sibell, MD.

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March 30, 2016

The Portland Physician
scribe
March 2016

The Portland Physician Scribe is the official publication of the Medical Society of Metropolitan Portland.

"Connecting Physicians in Community"

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Prescription Abuse: *The Perspective of Law Enforcement, Pharmacists and Dispensing Clinicians*

March 31 @ MSMP Conference Room

This seminar for clinicians will address prescription abuse from several perspectives, including prescription fraud, drug diversion and managing patients on chronic opioid therapy.

Presenters will include Sonny Nguyen, JD, RRT, CPHRM; Sarah Olson, BNS, RN; and a distinguished panel of pharmacists, physicians and law enforcement.

Visit www.MSMP.org for more information or to register.

132nd Annual Meeting • May 10 @ The Benson Hotel

"Recreational and Medical Marijuana Use in Oregon: Implications for Physician Practice." Registration is required for this event, and is currently open at www.MSMP.org.

Paging all rock enthusiasts!

June 23 @ Lola's Room at the Crystal Ballroom

To battle with the best, please complete the application which is now available online at www.MSMP.org. The deadline to apply is April 11. Residents and students are also encouraged to apply.

Now accepting nominations: Rob Delf Award

MSMP is seeking nominations for the Rob Delf Award, the annual award the Medical Society's Board of Trustees created in recognition of Rob Delf's long service to the organization. Award recipients will receive $1,000 in recognition for their efforts. The award may be given to members of the medical community, the health education community or the general public.

Please visit www.MSMP.org or www.MMFO.org to submit your nomination. The deadline for nominations is March 10.

Now accepting nominations: Medical Student Award

MSMP is pleased to introduce our Second Annual Medical Student Award, paying tribute to a medical student who embodies our mission to create the best environment in which to care for patients. We are looking for a student who displays professional knowledge, skill, judgment, mentorship and compassion; strong community involvement; and strives for wellness to meet the highest standards of service.

If you would like to recognize a student member who has shown these attributes, please visit the Student Section at www.MSMP.org and complete a nomination form. Nominations must be submitted by April 15.

Welcome new MSMP members!

Bernard Gasch, MD
Dermatology
Center for Dermatology and Laser Surgery
9135 SW Barnes Rd, Ste 875, Portland 97225
503-297-3440
Medical College of Wisconsin, 2003

Jill Hansen, MD
Internal Medicine
Legacy Medical Group
1130 NW 22nd Ave, Ste 220, Portland 97210
503-413-8988
UCLA School of Medicine, 1997

Beata Rydzik, MD
Dermatology
Center for Dermatology and Laser Surgery
9135 SW Barnes Rd, Se 875, Portland 97225
503-297-3440
University of Michigan Medical School, 2000

We invite YOU to become a member of MSMP

Your membership dues support these valuable programs which are available to you as a member:

Physician Wellness Program
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- Physician coaching
- Wellness groups

Education and Events
- Battle of the Doctor Bands
- CEUs
- Speaker event
- 5k Scrub Run
- OSHA/HIPAA courses
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Dr. Walter and Cathy Krieger
Mary McCarthy, MD, and Jonathan Holloway

$500 – $999
George Caspar, MD
Jack Kron, MD, and Ruth Whitham
The Portland Clinic
Thomas Welch, MD

To $499
Anonymous
Tammily Carpenter, MD
(In memory of Dan DeMerell, MD)
Robert Dreisin, MD
Karen Elliott, JD
John Evans, MD, and Maryam Evans
Carmen Gaston
John Holland, MD, and Jacqueline Holland
Linda Humphrey, MD
Anna Jimenez, MD
Amy Kerfoot, MD
Sharon Meieran, MD
Samuel Metz, MD
Adam Obley, MD
Frank Palmrose, MD
Marianne Parshley, MD
James Peck, MD
Linda Pope
Anushka Shenoy, MS
David Shute, MD
Jimmy Unger, MD
(In honor of Olaf Sohlberg, MD)
Lydia Villegas, MD
R. Bastian, MD, and Barbara Wagner, MD
George Waldmann, MD

The power of continuity

Reflections from the safety net

Sylvia Peterson-Perry

By Sylvia Peterson-Perry
For The Scribe

I first met John* while on my third-year inpatient internal medicine rotation at Oregon Health & Science University. He came in to the hospital for a swollen, painful left leg, was a current active IV heroin user, was homeless, and had no possessions but the dirty clothes he was wearing. He ate the hospital food more eagerly than any other patient I had during my five weeks on the wards, and was so excited when he was able to shower and change into hospital clothes.

Not long into his hospital stay, John was found to have a huge intramuscular abscess, which we drained and treated with IV antibiotics. The medical management of his condition was relatively straightforward. However, the rest of John's care was anything but—this hospitalization had been a wake-up call to him, and he was hoping to get in to treatment for his opiate addiction. He had no place to stay after we discharged him (with a still-draining wound); he had no way for us to contact him for follow up; he didn't even have clean or warm clothes. Most of the time, I think this would have been one of those cases that contribute to the depressing research on medical students losing their empathy and becoming more cynical during their third year.**

From my understanding, the usual situation for a patient like this would be a conversation with a social worker, who could maybe provide a few days in a motel and a list of shelters and places to go for donated food and clothes, encouragement (and maybe a list of resources) to stay off of heroin, and then discharging him essentially to the streets, where using again and being hospitalized again for the same condition is almost inevitable. This then contributes to burnout and associated victim-blaming thoughts and comments from providers that patients like this never change and aren't worth putting effort into, because they will just go back out and use.

Fortunately, this was not the case with John. John's care provided my first introduction to some really incredible programs at the Portland nonprofit **Central City Concern** to provide true wraparound care that addresses not only medical needs, but also the social determinants of health that are vital to making achieving health goals possible. We were able to connect John with Recuperative Care Program (RCP), a Central City Concern medical respite program that provides housing, case management and more, for a 30-day stay, connect him with medication-assisted opiate addiction treatment at a community treatment center, get him a cell phone with pre-paid minutes so follow up and care coordination would be possible (thanks, Obama!***) , and set up seamless and timely primary care follow up for him at **Old Town Clinic**.

When I heard about these programs in the hospital, I couldn't really believe it; it sounded like something we idealistically brainstormed in our "structural competency" course in medical school, but not something that actually existed in real life.

Just a few days after meeting John, I started my outpatient internal medicine rotation with Central City Concern, and it seemed like I saw John everywhere. I saw him in his room at RCP, in the RCP office, talked about his successes in care coordination meetings, and saw him for multiple office visits at Old Town Clinic. It was amazing to see how the support that sounded too good to be true was playing out in his life. He had support in getting food and clothes, right where he was living—he didn't have to trek across town or wait in line; he had guidance and accompaniment in completing basic but vital tasks like getting his ID and birth certificate, crucial for most formal transactions in our society; and, importantly, had daily support and encouragement as well as treatment for his opiate addiction. He even got into Central City Concern housing in what felt like record time, only a few weeks after his hospital discharge.

It was amazing to see how the **support that sounded too good to be true** was playing out in his life.

—Sylvia Peterson-Perry

I am confident that without so much attention from CCC to explicitly address the structural issues affecting John's health, he definitely would not be the success story he is today. He would most likely be back to using and possibly back in the hospital or worse. Of course, not all people, even with the best support, are going to be as successful as John, and even John is probably statistically likely to experience relapse—but I think what is crucial to maintaining optimism and avoiding burnout as a provider is the knowledge that success is possible.

My time at Old Town Clinic and at Central City Concern was a truly incredible experience to see what can happen when health care is provided in a context where the other components of health are also fully addressed. I like to hope that I was not at risk for losing my empathy or becoming cynical as a result of the third year of medical school, though odds were not on my side. However, I think that this rotation was a powerful tool in preventing empathy fatigue, and in helping maintain the energy and idealism needed (both as a student and, ultimately, as a physician) to provide exceptional patient care in all contexts, but particularly in safety-net settings serving some of our community's most vulnerable members. •

Sylvia Peterson-Perry is a third-year medical student in the MD/MPH dual-degree program in the OHSU School of Medicine. She grew up in Portland, received her BA in human biology from Stanford University and then worked for the Coalition of Community Health Clinics in Portland before starting medical school. Sylvia is still deciding which specialty to pursue, but hopes to practice medicine in underserved communities with a focus on women's health. This essay was published recently on OHSU's StudentSpeak blog.

*This post has been selectively edited to protect patient privacy. Locations, names, genders, ages, times, conditions, details and more have been modified or excluded.

**Hojat, M, Vergarge, MJ, Maxwell, K et al. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. Academic Medicine. 2009 Sep;84(9).

***"Obama phones" is a common name for government-funded, pre-paid cell phones people who are low income or homeless can be eligible to receive.

132nd Annual Meeting

Tuesday, May 10th 2016 • 6:30-8:30pm @ • The Benson Hotel

Register at MSMP.org

The Medical Society of Metropolitan Portland

invites you to join us and our distinguished panel,

Paul F. Lewis, M.D. and Donald E. Girard, M.D.

as we discuss Recreational and Medical Marijuana use in Oregon.

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MEDICAL SOCIETY OF METROPOLITAN PORTLAND

Evers shares evolution, successes of Northwest Permanente wellness programs

By Melody Finnemore
For The Scribe

After more than a quarter century of helping physicians with physical and mental health issues and substance abuse challenges, **Kitty Evers, MD**, has seen firsthand just how much the concept of physician health and wellness has evolved.

A psychiatrist with **Northwest Permanente**, Evers was already counseling physicians and their families when she joined **Robert Senft, MD**, in developing Permanente Advocate Resources (PAR) in 1993. They established the clinical program to provide medical and therapy services for physicians under stress when it became clear that existing programs were primarily non-voluntary and punitive.

"It wasn't really about the health and well being of the physicians. For example, it was more about no drinking on the job," she said. "In terms of protecting patients that has validity, but it tends to make people go underground."

Many of the voluntary programs that existed at the time were started by physicians who had experienced health and wellness challenges themselves and were well-intentioned, but the programs lacked continuity and follow up, Evers said.

As PAR's mission of serving Kaiser physicians, dentists and administrative staff gained support and funding from Northwest Permanente, Senft emphasized the importance of providing services for their families as well.

"His reasoning for that really was that if a physician is preoccupied and has, for example, a child with ADHD or is going through a divorce or has an alcoholic spouse, he or she is probably not going to be doing their best at work," said Evers, who replaced Senft as PAR's leader when he retired.

As a growing number of physicians began participating in PAR, Evers established a smaller program called the Health and Renewal Program (HARP) and serves as its lead physician. She said she started HARP because, while it is essential to help people through their problems, it's also important to try to prevent those problems in the first place.

Through HARP, physicians receive an uplifting "Monday Message" via email, encouraging them to reflect on and tell others what inspires them. "It could be a poem or a story or something a patient has told them," she said.

Those messages are compiled into a book every five years or so, and then mailed to physicians' homes. Evers mails brochures about HARP and information about the pressure and stress physicians face to their homes as well.

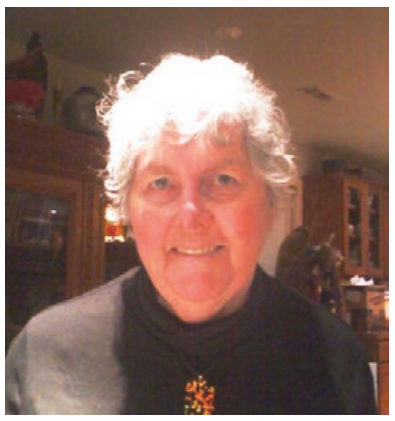
"The logic behind sending it to people's homes is that physicians are inundated with information at work and are literally starving for time. When you send it home, often the spouse or partner gets it and will point things out," she said.

HARP also organizes social offerings that allow providers from different clinics or offices to meet each other while enjoying outings at OMSI, the Portland Art Museum, Portland Center Stage or other venues.

Over the years, Evers has worked with various physician groups both within Northwest Permanente and outside of it. In her experience most want to go beyond simply meeting legal and regulatory requirements, and actually promote health and wellness for physicians. It's still a challenging paradigm shift, she noted.

"Part of the physician culture is that you have to be perfect, and that squeezes the joy out of it. I think as more women get involved that's changing, but it's still a big part of the culture," Evers said.

Of the people who have used PAR's services, a significant portion dealt with depression, anxiety, insomnia, or difficulties with children and relationships. The biggest issue she sees, however, is burnout.



Kitty Evers, MD

Evers noted that when she earned her medical degree in 1969, medicine was very hands on and physicians spent much more time interacting with their patients. As medical technology advanced, medicine became more of a business and is less human-based, she said.

"My theory is that as medicine became much more of a business and became more focused on procedures and testing, some of the pleasures that used to be part of practice became less and less," she said, adding even tools that were designed to improve efficiency, like electronic medical charts, take time away from talking with patients.

"For many physicians who come in idealistically wanting to make a difference and help ... they tend to be forced into time increments so they are moving through the day faster and faster," Evers said, referring to studies that show the steep rate of burnout among residents.

As a result, she noted, many physicians don't take time to care for their own health. "Over the years, many times what I've seen is that physicians haven't been in for a physical exam in forever and they may have something going on. They may think they have depression, but it's actually something physical going on."

As awareness about the significance of physician health and wellness grows, however, the programs designed to serve physicians and their families will see clear signs of success, Evers said.

"One of the vital signs of a program that is successful is how many people are self-referring when they come in versus a disciplinary action," she said. "About 75 percent or more of our physicians are self-referred or referred by colleagues who went through the program." •

Kitty Evers, MD, also serves as a consultant to Northwest Permanente's Physician Health & Work-life Committee and a liaison to The Foundation for Medical Excellence.

> "One of the vital signs of a program that is successful is **how many people are self-referring when they come in versus a disciplinary action**. About 75 percent or more of our physicians are self-referred or referred by colleagues who went through the program."
>
> —Kitty Evers, MD

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UNCOMPROMISING PROTECTION

Physician finds joy in caring for kids, and writing books for them

By Jon Bell
For The Scribe

Simply put: **Dilek Bishku, MD**, is drawn to children and always has been.

A native of Turkey who initially came to the U.S. after medical school for her residency at the University of Florida Shands Teaching Hospital, Bishku is herself a mother. She has also always practiced in pediatrics, whether that was her general pediatrics fellowship at Boston Children's Hospital or her work at the University of Chicago's Department of Pediatrics or La Rabida Children's Hospital, where she directed the Failure to Thrive Clinic. Having fallen for Portland during a college visit with her son a few years ago, Bishku moved here from Chicago in 2013 and joined Willamette Falls Pediatric Group. There, she practices general pediatrics.

"I just like children and childhood," she said, "how everything is so new and fresh and interesting."

DILEK BISHKU, MD

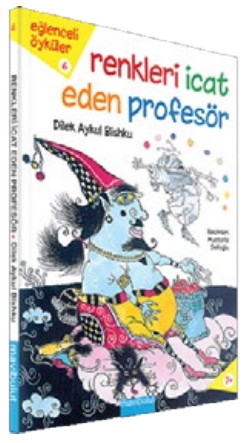
Bishku has also expressed that affinity for children in another way, as well: she is the author of several published children's books. She said she wrote her first one when her now-grown son was about three or four years old. Though they spoke English in the house growing up, Bishku said she decided to write in her native Turkish language.

"We spoke English at home and his father was American," she said, "so it felt a little weird to write in a language that he didn't know too well, but that's what I did."

Bishku, who also has a master's degree in biomedical engineering, said her books are either collections of stories or stand-alone stories, most of which are for reading aloud to children. They are vividly illustrated by other artists and have sold fairly well in Turkey, even garnering Bishku several awards.

"I was very delighted for those," she said.

One of Bishku's books is called "renkleri icat eden profesor." Translated through an online translator, the title reads "The Professor who Invented Colors." In addition to her books, some of Bishku's



stories have appeared in children's magazines and some have landed in school textbooks. Others, too, have been adapted for children's theater performances.

While she will likely write other children's books in the future, Bishku said her latest literary endeavor is taking her in a new direction. She's currently at work on a novel, and this time she's writing in English.

"I don't really like to talk about my work that isn't published yet, but that's what I'm working on now," she said. "It's not a children's book, but it is a young person's novel, probably middle school to high school."

In addition to her own fondness for the written word, Bishku's writerly ways may have also rubbed off on her son, too. He's now a journalist living in Turkey. •

Beyond opioids

Experts offer multidisciplinary strategy to address chronic pain

By Cliff Collins
For The Scribe

Pain specialists say appropriate management of chronic pain is complex, requiring a multipronged approach to treatment. In that regard, Oregon's public academic medical center's pain clinic fits the bill.

Oregon Health & Science University's Comprehensive Pain Center employs a multidisciplinary strategy that combines medical management with rehabilitation and behavioral health, all under one roof.

"The key is synergy, putting those in the same organization," said **David M. Sibell, MD**, OHSU associate professor of anesthesiology and perioperative medicine. "It's important to have a variety of treatments available."

Too often, physicians are not aware of the alternatives to prescribing opioid drugs, said **Andris Antoniskis, MD**, a longtime addictions specialist at **Providence Portland Medical Center**. After the Joint Commission in the early 2000s established treating pain as the "fifth vital sign," that standard, which was intended for assessing acute pain in the hospital, got extrapolated to other settings, he explained. Acute pain and chronic pain came to be seen in the same way, when they are entirely different, and that created "an iatrogenic problem," he said.

A report the **Oregon Health Authority** issued last October on reducing opioid overdose, misuse and dependency suggested numerous strategies for these goals, and noted, "Use of opioids for long-term management of chronic non-cancer pain lacks evidence of benefits, and may lead to poor results and negative side effects"

Antoniskis said many doctors could benefit from learning what is available besides opioids, and which patients would be most suitable for modalities such as cognitive behavioral therapy, physical therapy and mental health treatment.

Sibell, who is board certified in both pain medicine and anesthesiology, said the OHSU pain center offers multidisciplinary treatment options for patients with migraines, acute pain, chronic pain and cancer-related pain. It includes five physicians who specialize in pain management, three clinical psychologists, a nurse practitioner, a physical therapist, a chiropractor, a massage therapist and two acupuncturists.

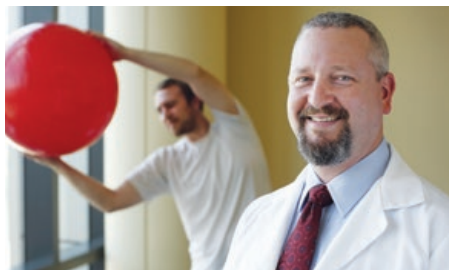
"We have different approaches depending on the patient's need," he said. "Some may see only a psychologist or physician or physical therapist." The center applies a team assessment for patients who present with more complex needs, such as those who have had several spine surgeries or who suffer from complex regional pain syndrome. For these patients, "No one type of treatment is effective," he said. They usually need a comprehensive approach that may include combining therapy, interventional procedures or medicine.

OHSU's pain management experts provide consultations to patients and physicians, and offer a range of treatments for conditions such as back and neck pain, sciatica, cancer pain, headaches and migraines, shingles and post-herpetic neuralgia, complex regional pain syndrome, and diabetic neuropathy.

For all pain patients, "The goal is to make them self-sustaining, and return them to their primary care provider," Sibell said.

He noted that the addition of integrative therapies - chiropractic, massage therapy and acupuncture - is "new as of last year," and is "ad hoc right now. Patients are driving that." Some patients want those therapies available or combined with their other treatment.

Because of the problems that became apparent with using opioid drugs for chronic pain not associated with cancer, their use has "changed a lot in the last decade," he observed. Today, "It's pretty controversial to use for that. As a nation, we have learned that that model is rarely successful, and caused unanticipated harms." He explained that besides risking addiction and overdose and worsening sleep apnea, the drugs also can cause a hypersensitivity disorder known as opioid-induced hyperalgesia, in which high-dose opioid use can cause parts of the patient's body other than the original site of pain to become painful.



When it comes to management of patients' chronic pain, OHSU's David Sibell, MD, says, "It's important to have a variety of treatments available."
Photo courtesy of OHSU

"We're not anti-opioids," Sibell emphasized. "We just see a much less role for their use." Some people have done well on low-dose opioids, but "because of the generalized failure of high-dose opioids," if a patient comes in who has been on high doses and has not achieved satisfactory pain relief, the clinic will look for alternatives, he said.

Interventional procedures constitute an important part of OHSU's armamentarium, and these may be combined with other treatments such as rehabilitation. One type of intervention the center uses, epidural steroid injections, generally is restricted to acute lower-back pain such as that caused by a herniated disc, he said. Although he said that is the only pain procedure found among the top 100 listings in Medicare billing data, "there is not a lot of evidence for using it for anything else" other than for acute low-back pain. "The majority of epidurals are done for conditions that are not evidence-based."

Other interventional procedures for diagnosing and treating pain problems include:

- Medial branch block and medial branch denervation, which is used to determine whether pain in the neck or back is coming from arthritis or from facet joints
- Radiofrequency facet denervation, which is used to treat central neck or back pain associated with arthritis
- Peripheral and sympathetic nerve blocks
- Botox
- Spinal cord stimulator, a medical implant used to treat pain from nerve damage or an inadequate blood supply

Sibell acknowledged that insurance can be a problem. "There are increasing difficulties in accessing pain coverage," he said. Most pain diagnoses fall below the line on the Oregon Health Plan's priority list and are not covered. Medicare is restrictive on paying for pain management; and with third-party payers in general, getting authorization for behavioral health care or physical therapy can be difficult, he said. •

Clinic provides array of techniques to treat pain

By Cliff Collins
For The Scribe

Patients in the Columbia River corridor also have access to a multidisciplinary pain clinic that offers pharmacologic, interventional and behavioral approaches to treating pain.

In addition, **Columbia Pain Management**, based in Hood River, provides services that are not frequently available in pain care, including stem cell procedures and platelet-rich plasma injections. The clinic, which also operates a satellite office in The Dalles, began offering these two therapies, known as regenerative injection therapy, about a year ago.

Columbia Pain Management added regenerative techniques because they offer patients an option that could delay or even prevent surgery, said **Laura Scobie, PA-C**, a physician assistant with the clinic. Other factors for adoption were the turn away from prescribing opioid drugs for chronic pain and the fact that therapies such as steroid injections can offer only temporary relief, but not a cure, from pain conditions,


LAURA SCOBIE, PA-C

"With regenerative medicine, you can regenerate tissue," she said. "It's nice for people wanting a cure without surgery," and convenient due to the availability of it in an office setting rather than the hospital.

For this type of therapy, the clinic affiliates with a Colorado-based company, **Regenexx**, which she said uses a protocol that is superior to that of other similar companies in that blood and bone marrow are manually processed rather than done by a centrifugal machine. This translates into a more concentrated blend and generally better results, said Scobie, who serves on the Oregon Pain Management Commission and on the state's Prescription Drug Monitoring Program's Advisory Commission.

In the stem cell procedure, a physician numbs the back of the hip and takes a small bone marrow sample through a needle, as well as a blood draw from a vein in the arm. The stems cells then are isolated from the marrow sample, and platelets are isolated from the blood sample. After preparation, these two components are injected directly into the damaged area of the joint using image-guidance equipment in what the clinic calls its fluorosuite.

Patient selection is important for regenerative procedures, Scobie noted. Unhealthy patients or those with several chronic diseases generally would not be able to provide adequate healthy stem cells to transplant, and thus would not make good candidates for the procedure. For platelet-rich plasma injections, the patient's general health status is less significant.

Other types of interventional and diagnostic procedures the clinic offers include:

- Dynamic diagnostic musculoskeletal ultrasonography
- Botox injections and intrathecal baclofen for dystonia and spasticity
- Image-guided cervical, thoracic and lumbar epidural steroid injections
- Joint and hip injections
- Medial branch blocks and radiofrequency neurotomy for facet pain
- Therapeutic nerve blocks
- Electrodiagnostic studies
- Spinal cord stimulation

Radiofrequency ablations can provide pain improvement for a year to 18 months, and can be repeated, though with diminished returns over time, she said. The spinal cord stimulator is like a pacemaker for pain, she explained, implanted under the skin to cancel pain signals. It can be helpful for arm or leg pain after surgery, after "failed" back or neck surgery, or for peripheral neuropathy, particularly when caused by diabetes, she said. The technology has seen advances just in the past year, such as allowing adjustment of the stimulator's intensity via a mobile device and Bluetooth technology.

Conditions treated by the clinic include joint pain and osteoarthritis; lumbar and thoracic compression fractures or pain; ineffective back or neck surgery; complex regional pain syndrome; sciatica; radiculopathy; dystonia and spasticity; and cancer-related pain.

Insurance coverage can be spotty for pain conditions. Insurers may pay for injections, but not for processing blood or bone marrow, which becomes an expensive out-of-pocket cost for the patient. In the past couple of years, insurers increasingly have required prior authorization for pain procedures, Scobie said. In addition, in many instances insurance won't preauthorize a safer, schedule III medication until the patient tries and fails less-safe schedule II medication on the carrier's formulary, she said.

Phamacologic therapies given by the clinic include buprenorphine, a partial opioid. It is safer than full opioids but can still give significant pain relief, according to Scobie.

Two Columbia Pain Management staff members—a licensed clinical social worker and a substance abuse counselor—offer patients pain education and counseling, including for those addicted to opioids. The counselor educates patients before they use medications, and provides patients who are taking opioids, especially at high doses, with a naloxone rescue kit. Naloxone is an opioid antagonist that reverses narcotics overdoses, and which now is available as a nasal spray.


Columbia Pain Management began offering regenerative injection therapy abut a year ago to provide patients with an option that could delay or even prevent surgery.
Photo courtesy of Columbia Pain Management

The clinic, which also consists of three physicians—**Trey A. Rigert, MD, David Russo, DO,** and **Shelley Smith, MD**—two other physician assistants besides Scobie, a nurse practitioner and two RNs, prescribes opioids only if a patient's pathology warrants their use, satisfies specific criteria and has failed other lower-risk treatment options, and if there is a reasonable expectation for prolonged functional improvement. Scobie said opioids offer an appropriate and safe treatment for some chronic pain patients, but they require close monitoring to assess for functional benefits and to minimize harm.

The clinic was founded by Rigert, who is board-certified in both physical medicine and rehabilitation and addiction medicine, and serves on **Providence Health & Service's Oregon Region** board and as quality medical director and medical staff vice president of **Providence Hood River Medical Center.** Clinic referrals come from primary care providers, orthopedists, other surgeons, as well as patients self-referring. Patients come to the clinic from as far away as Seattle, Canada and Montana, she said.

Scobie, who has worked in the field of pain management since 2004, said she continues to "find its challenges, complexities and variety incredibly satisfying. The past 10 years in this specialty have been dynamic, to say the least. The dramatic shift in opioid prescribing and recent advancements in regenerative medicine, in particular, continue to keep things interesting."

She said the work also is rewarding: "I genuinely feel that I have made a profound impact on the quality of my patients' lives by helping decrease their pain and suffering. Hearing their reports of returning to playing with their grandkids, getting back on their skis or kiteboards, riding their horses again, or returning to work are so gratifying and keep me coming to work each morning." •

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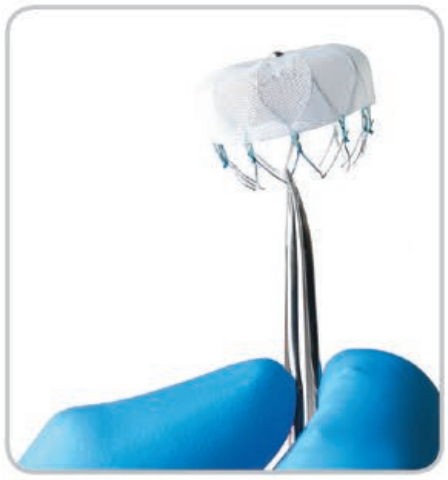

National leader in the procedure

Amish Desai, M.D., Director of the Structural Heart Program at Legacy Medical Group–Cardiology, is a national leader in the technology, having performed the procedure since 2005. His team is the only one in Oregon currently offering this service.

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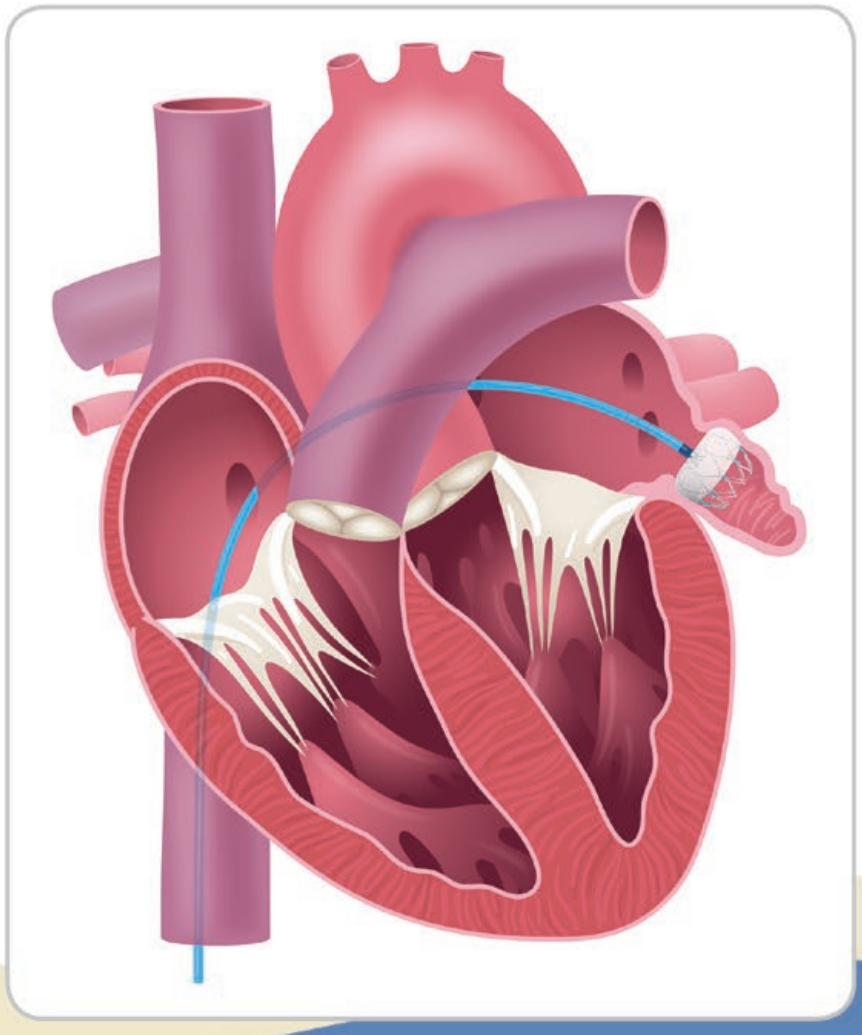

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Chronic pain patients partnering in Kaiser Permanente research

By John Rumler
For The Scribe

Maris Burton didn't envision himself as a part of a growing medical trend of patients being enlisted as partners in medical research. He was simply tired of hurting.

For more than 38 years, since he injured his back lifting a box at work, Burton has been one of upwards of 100 million people nationwide who suffer from chronic pain. His doctor kept prescribing stronger pain medications, including morphine, but Burton didn't like the side effects and wanted to explore other options, he said in a video about the research.

According to the Institute of Medicine, chronic pain affects more Americans than cancer, diabetes and heart disease combined, costing about $635 billion annually in medical costs and lost productivity. It's also the leading reason patients visit their primary care providers, often in hopes of, if not a cure, at least relief from pain, according to Portland's **Kaiser Permanente Center for Health Research** (KPCHR).

Burton found another physician willing to work with him to formulate strategies to address the source of pain instead of just treating the symptoms. He lost a substantial amount of weight, cut back on his pain meds and had neck surgery. Burton also began walking and worked his way up to five to six miles almost every day. Although his pain didn't completely go away, his condition improved so dramatically he was able to once again play basketball with his grandchildren and go fishing.

Thinking that other people could learn from Burton's experience, his doctor suggested he join a research team that was studying chronic pain. The pilot study, *Effects of a Patient-Driven Assessment Process with Complex Pain Patients*, was conducted by KPCHR, was funded by the Patient-Centered Outcomes Research Institute (PCORI), and lasted more than two and a half years.

PCORI, based in Washington D.C., was founded as part of the Affordable Care Act. Since 2012, it has funded about 670 patient-centered research projects in the U.S. In terms of pain and pain management, as of December 2015 PCORI had funded 42 patient-centered comparative effectiveness research projects on non-cancer chronic pain management or opioid use. PCORI has also funded several studies on acupuncture and other forms of complementary medicine, which is finding a bigger place in pain care as physicians continue moving away from opioids.

Including the KPCHR pilot, PCORI has funded 17 patient-centered research projects either led by Kaiser principal investigators or involving Kaiser organizations on research topics ranging from COPD and opioid management to gender reassignment and therapies for implanted defibrillators.

The pilot study's goal, which involved other chronic pain patients, patient advocates, clinicians and researchers, was to see if a standardized assessment form could be improved upon to result in better patient outcomes.

Patient Maris Burton was part of a research team studying chronic pain. The research was conducted by the Kaiser Permanente Center for Health Research.
Photo courtesy of KPCHR

"Clinicians and researchers haven't always involved patients, and it's important when we're trying to improve their lives for things that are important to them that we involve them, from the beginning to the end," Principal Investigator **Lynn DeBar, PhD, MPH**, said in the pilot study video.

LYNN DEBAR, PHD, MPH

The original form asked patients to rate their symptoms and activities using only a numeric value. Based on the patients' feedback, the form was modified so patients had space to write more details explaining whether their condition was getting better or worse. Additional questions asked patients to describe what it would be like if their condition improved or worsened.

Including patients on the research team led to the creation of a more user-friendly form that was also beneficial to the doctors, in that it helped them more clearly understand what was most important to the patients.

"A second thing that the form has really helped me with has been to focus our attention in these conversations on improving function," **Charles Elder, MD, MPH**, lead author of the study, said in the video. "So if we're treating a patient with chronic pain, even if we improve the pain, if the patient can't do the things that are important to him or her we haven't made the progress we need to make,"

CHARLES ELDER, MD, MPH

A separate 2015 pain study by KPCHR suggested that communication between patients and physicians could be greatly improved. It found that a majority patients with chronic pain sought relief from alternative therapies, but many did not inform their primary care doctors. The study, funded by a grant from the National Center for Complementary and Integrative Health, surveyed more than 6,000 patients in Oregon and Washington who were KP members and had three or more outpatient visits for chronic pain within 18 months.

Researchers found that 58 percent of the patients received alternative therapies, including acupuncture and chiropractic care or both. However, 35 percent of the patients who received acupuncture and 42 percent who had chiropractic care did not inform their primary physician.

"Our study confirms that most of our patients with chronic pain are seeking complementary treatments to supplement the care we provide in the primary care setting," Elder said in a previous statement. "The problem is that too often doctors don't ask about this treatment, and patients don't volunteer the information."

In an interview with The Scribe, Elder touched on the importance of patient-physician communication, patients' use of complementary treatments and other topics:

SCRIBE: What is the greatest benefit of having patients participate as team members in research projects regarding pain management?

ELDER: It is very valuable to have patients involved in the research process. As clinicians and researchers we are ultimately trying to help patients, so when they aren't involved we are likely to make assumptions that aren't accurate. Chronic pain is difficult to manage and the patients do most of the management, so they can teach us valuable lessons and what works and what doesn't.

SCRIBE: Are there any potential drawbacks?

ELDER: Because most patients do not have training or experience with research, they may not immediately perceive the need, or reasons, for doing things in a particular way. For example, there may be regulatory requirements, or scientific concerns related to study design, which mandate that the investigators take measures or precautions which may otherwise not seem intuitive. So with patients as study team members things may proceed at a slower pace because more explanation and discussion are required. But it's more than worth it for the added perspective that the patients bring.

SCRIBE: Do you think some patients are reluctant to share with their doctors, who may have a more traditional approach, that they are using acupuncture, taking herbs, seeing a chiropractor or utilizing other alternatives?

ELDER: Yes, they might be worried about the doctor's reaction, that we might judge them or discourage this care. We need to acknowledge that patients are going to use this type of care because they are not getting the result they want from traditional therapies like medications. Pain is complicated and for many patients massage, physical therapy, chiropractic care and acupuncture help them to manage their pain.

SCRIBE: The 2015 study, which was published in the American Journal of Managed Care, indicated that better care coordination is needed among patients and physicians. Is this surprising to you?

ELDER: Not at all. Patients with chronic pain are receiving their care from multiple sources. Not only do patients see the doctor, they may also be seeing an acupuncturist. In addition, some patients may be treating themselves with supplements or other approaches based upon the experience of friends or information on the Internet. Yet appointment times in primary care clinics are not long, so there are a lot of things that may not get communicated.

SCRIBE: Do you think most people would assume that communication between patients and physicians would be better than this?

ELDER: I think a lot of people who are not involved with pain management as either a clinician or patient will find this surprising. People may not appreciate the complexity of the issue.

SCRIBE: As opioids are not nearly as frequently dispensed as freely as a few years ago, are patients seeking more healthy options such as meditation and yoga to reduce pain? Will studies and research on pain management increase?

ELDER: Yes, our study found that 75 percent of patients with chronic musculoskeletal pain used some type of alternative treatment, including yoga, tai chi, supplements, meditation massage, chiropractic care or acupuncture.

I think that attention on this issue in the research community will grow, because chronic pain is such a prevalent problem and there is so much that we don't know.

SCRIBE: What do you think are the best options in improving communication and coordinated care management between physicians and patients?

ELDER: Communication is a mutual responsibility between patients and clinicians, but if our patients don't talk to us about the non-conventional therapies they are using, we should be asking them. We should also be talking to other alternative providers about our patients' care, just like we talk to specialty physicians. If one modality has worked in the past it might work again, and if we don't know about what a patient has tried, we don't know what to recommend. •

For more information about the pilot study and to view the video about the research, please visit the videos section at https://research.kpchr.org.

ANSWERING SERVICE, *from page 1*

up by MSMP, and after-hours calls will be answered by Physicians' Answering Service. Messages to the Physician Wellness Program will continue to be handled with the utmost confidentiality. Borges said Physicians' Answering Service's long history of confidential messaging, along with its experienced, well-trained staff, give physicians assurance.

Dorosh said that long before the HIPAA law existed, the answering service applied complete confidentiality for clients and their callers. Employees receive HIPAA certification and adhere to strict guidelines. "The messages going to a doctor have to go through a secure app, and when it goes to their cell phone, it is password-protected." In addition, Brightmon added that the company's office space itself is secured behind two security doors.

She noted that many physicians have been clients of Physicians' Answering Service for years. One is **Mary McCarthy, MD**, a psychiatrist who serves as medical director of the MSMP Physician Wellness Program, who has used the answering service for about 25 years and said she is grateful for what the company is providing MSMP's Physician Wellness Program.

"As a psychiatrist, having a competent answering service is so important," McCarthy said. "They allow for personal preferences in how they handle my calls, which I greatly appreciate. I am very pleased PAS has offered to answer after-hours calls for the MSMP Physician Wellness Program. I'm certain they will handle the calls with the utmost professionalism."

The Medical Society undertook the Physician Wellness Program last spring to meet an increasingly prevalent need: the rapid rise in physician stress and burnout, which now has been widely documented nationally. The program's intent is to address and remove the obstacles that typically prevent doctors from getting the help they need, Borges said. It offers them confidential, appropriate counseling specifically tailored to physicians, with appointments available to them quickly at their convenience. The program is accessible to all physicians and physician assistants at no cost. Its aim is to help doctors address any problems or concerns they may be experiencing.

When doctors come to the Physician Wellness Program, counseling and visits are not reportable to the Oregon Medical Board, no information is disclosed to others, no electronic medical records are kept, no diagnosis is given and no insurance is billed. Physicians needing to access the program at any time should call 503-764-5663.

Brightmon said MSMP's and Physicians' Answering Service's previous joint location, on top of the hill on Southwest Kelly Avenue, "was a very family, comfortable setting," and all the staff loved the setting and spectacular views of Mount Hood and the Willamette River. The hill to the top did present some challenges during inclement weather, such as when the occasional ice storm caused some employees to have to sleep over at work. On the other hand, the rooftop of the building served as a perfect observation deck for Fourth of July fireworks, she recalled.

Physicians' Answering Service is answering after-hours calls to the Medical Society of Metropolitan Portland's Physician Wellness Program, at no charge. Pictured are PAS staff members who have been with the organization since it was co-located with MSMP. They are (from left to right) Jimmy Orr, Cathy Todd, Minta Harding, LaTosha Moreland, Carol Johnson, Kristine Karnosh, Brent Padilla and (kneeling in front) Rhea Brightmon. (Not pictured: Melody Rowe, Michelle Ashworth and Faith Luckhaupt) . Photo courtesy of Physicians' Answering Service

Referring to Brightmon and Todd, Dorosh said: "Rhea and Cathy made that place. They're the reason doctors feel comfortable with that service."

Dorosh said physicians can feel confident that so many of the answering service staff members are still there. "The retention of our employees, especially those from Southwest Kelly who came here, is amazing. They really care about the doctors. They want to be there for their clients." •

LUNG CANCER TEST, *from page 1*

low-dose computed tomography screening for lung cancer. Although fairly effective, the technology has a record of being somewhat inconclusive or even triggering a high number of false positives on a suspicious nodule. What often follows such results are more invasive screening procedures. The standard procedure is bronchoscopy, where a physician uses a scope to look inside the lungs and airways and occasionally to take tissue samples for a biopsy.

"The problem," Hahn said, "is that there is a portion of patients who we still get no evidence on or where we're not certain it's benign."

The dilemma then: What to do next? A physician could send a patient on for an even more invasive biopsy, one where a needle is inserted through a small incision. Hahn said that procedure is not the best option and there are risks: Needle biopsies cause a collapsed lung in nearly 25 percent of patients.

"So you think, what do I do?" Hahn said. "Do I send them in for a more invasive procedure, send them straight to surgery or do we just follow them for three to six months with another CT? But if it is cancer, you may be missing critical time."

That's where the Percepta test comes in. If initial screening cannot rule out cancer, a physician can conduct the Percepta test by using a small brush to scrape one of the major airways for samples. The samples are then sent off for the genomic test. If the results come back negative, physicians will likely monitor the patient a few months later with another CT.

According to Veracyte, the Percepta test has been clinically proven in three major studies at more than 30 different medical centers in the U.S. Those trials showed Percepta to be more than 90 percent accurate in identifying patients that were at low risk for lung cancer. When used along with bronchoscopy, the test had a 97 percent "sensitivity," meaning the ability to identify patients who positively had cancer.

> "Every patient we do this on we collect data, and with **more and more data**, the test is going to be more robust. I think this is a **really disruptive technology** in a good way."
>
> -Peter Hahn, MD, Tuality Healthcare

Hahn said that the Percepta test has been incredibly helpful in several patients at Tuality.

"We've had about six where it really changed what we were going to do," he said. "We did the bronchoscopy, the results were non-diagnosis and the Percepta was negative, so we opted to monitor them with CT. Those patients have continued to be benign."

At present, the Percepta test only works for current or former smokers. That's because smoking causes changes or "gene expression alterations" in the airways. The Percepta test analyzes the changes and can size up a patient's risk of lung cancer without a sample from the nodule or lesion, according to Veracyte.

Hahn said the test does not yet work on lung cancer that is caused by something other than smoking, such as radon exposure. There is a similar test for thyroid cancer, also from Veracyte, and Hahn said further advances are possible as more and more data are collected from the use of the Percepta test. Those could eventually make the test even more effective in the early detection of lung cancer.

"Every patient we do this on we collect data, and with more and more data, the test is going to be more robust," he said. "I think this is a really disruptive technology in a good way." •

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