The Portland Physician
scribe
June 2016
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www.MSMP.org

Battle of the Doctor Bands!

Don't miss the Battle of the Doctor Bands at 6 p.m., June 23, in Lola's Room at the Crystal Ballroom!

Please see the flyer in this issue of The Scribe for more details.

MSMP celebrates health, wellness champions at Annual Meeting

Event panel offers informational discussion on marijuana's impact on physician practice

By Barry & Melody Finnemore
For The Scribe

Champions of health and wellness who have touched countless lives at home and abroad were celebrated at the **Medical Society of Metropolitan Portland's 132nd Annual Meeting** in May, an event that drew record attendance and featured a panel discussion about the implications to physician practice of recreational and medical marijuana.

Candice Barr, MSMP's 2016 Portland Presidential Citation recipient, was honored for her activism and innovation as CEO of the Lane County Medical Society (LCMS) for the past 34 years. Her leadership helped bring about health care parity and advances on many fronts, including education, making quality health care accessible to the underemployed and uninsured, and instituting a physician wellness program that has become a national model. Calling physician wellness the pinnacle of her life's work, Barr noted that MSMP was the first county medical society in the nation to duplicate the LCMS's physician wellness program. Now, 51 other county medical societies are in various stages of duplicating it.

MSMP's program "is successful because your board believed and your president and executive director were tenacious, compassionate and committed," Barr said during the Annual Meeting.

MSMP President **Bradley Bryan, MD**, expressed his gratitude for Barr's contributions to the medical society and her dedication to improving physician wellness. "I don't think we'd be where we are without the work you've done," he said to Barr while presenting her with the citation.

With Barr leading the way, the LCMS created a number of pioneering programs. Her concern for the poor and uninsured led to forming a program called MediShare, which provided medical care for the underserved in the county. Barr supported physicians who were being sued, attending their trials to provide

*See **ANNUAL MEETING,** page 16*

Recreational and medical marijuana use in Oregon and its implications for physician practice was the subject of a panel discussion during the Medical Society of Metropolitan Portland's 132nd Annual Meeting. Panelists included, from left, Donald E. Girard, MD, MACP, a member of the Oregon Medical Board; Paul Lewis, MD, MPH, Multnomah County and Tri-county health officer; and Stacey Mark, JD, a partner with the law firm Ater Wynne.

Photo courtesy of Wiley Parker

Doctors, medical groups prepare for big changes in Medicare

By Cliff Collins
For The Scribe

Physicians in Oregon and nationwide exulted that Congress in April at long last put the annual "doc fix" to rest and closed the book on the SGR, the outdated Sustainable Growth Rate in Medicare.

However, in its place is – well, have you got a minute? It gets complicated.

In keeping with the federal government's penchant for creating and using acronyms, the **Centers for Medicare & Medicaid Services** now has bestowed new ones for what comes next. These include MACRA (the bill that incorporated the changes), MIPS, APMs, ACOs, QPP and, last but not least, CPC+.

Doctors need not immediately fully grasp what each of these terms means. The overriding point CMS is trying to make is that the payment model for physicians is changing under Medicare. Pay for performance and merit-based payment incentives will become the order of the day during the next three years, and experts say physicians whose practices are not moving toward taking on risk and analyzing population health and prevention have their work cut out for them.

"**The Portland Clinic** is preparing for this transition from volume to value," said **Dick Clark**, chief executive officer. "We've been in the process of moving from fee-for-service, and we're now looking at how we can transition. We think this is going to be very beneficial and an excellent opportunity for patients to thrive."

DICK CLARK

Legacy Health and **Legacy Health Partners** are well-situated for the coming changes in payment strategies by

*See **MEDICARE,** page 14*

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Meeting 'a great need'

Orthopedic surgeon Hisham Bismar, DO, volunteers his services to treat those injured in Syrian conflict.

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The Portland Physician
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June 2016

"Connecting Physicians in Community"

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

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132nd Annual Meeting

Thank you to everyone who attended MSMP's 132nd Annual Meeting! A sincere thank you to our panelists, **Paul Lewis, MD, Stacey Mark, JD,** and **Donald Girard, MD,** and to our event sponsors, **The Doctors Company, Portland IPA,** and **Finity Group**.

Didn't get your question answered during the meeting? Not to worry, as we will be posting your questions and panelists' responses in an upcoming issue. And don't forget to check our website for photos of this year's meeting!

Please see pages 1 and 6 for articles about the event and its honorees.

Battle of the Doctor Bands

6 p.m., Thursday, June 23 • Lola's Room at the Crystal

Leaving their medical instruments in the ER, these docs are ready to throw down the mic! Join MSMP for our 3rd Annual Battle of the Doctor Bands.

Stepping up to the battle will be **Gordo and the Lazy Dogs, Wolf Meetings** and **Pink Hubcaps**. All ages are welcome!

This event benefits Medical Teams International. For more information or to purchase tickets, visit *www.MSMP.org*.

5k Scrub Run Derby

9 a.m., Saturday, August 20 • Portland Meadows

The name may have changed a bit, but there's no doubt MSMP's 2nd Annual Scrub Run Derby will be equally as fun and exciting as our inaugural run! The response to last year's Scrub Run was so positive that this year demanded we move to a larger venue. We are excited to announce this year's Scrub Run Derby will be held at Portland Meadows Raceway!

This unique family run includes specially designed Scrub Run Derby Medals for every runner, plus food carts, music by the winner of MSMP's Battle of the Doctor Bands and various raffles throughout the morning!

So, will it be a case of winner take all or will it finish with a dead heat? Register today before the closing bell rings at *www.MSMP.org*.

Correction Notice

Women's Healthcare Associates, LLC

At the MSMP, we hold the highest standards for the quality of work we put forth. So when we learned of an error made in the April 2016 issue of *The Scribe*, we wanted to immediately rectify the situation and apologize to our newest group member, **Women's Healthcare Associates, LLC** for listing inaccurate clinic locations.

The correct locations are detailed below:

Gateway: 177 NE 102nd Avenue, Building V, Portland, 503-734-3800

Hillsboro: 7431 NW Evergreen Parkway, #205, Hillsboro, 503-840-3400

Lloyd: 700 NE Multnomah Street, #1600, Portland, 503-249-5454

Newberg: 1003 Providence Drive, #340, Newberg, 503-538-2698

Northwest Gynecology Center, Peterkort: 9701 SW Barnes Rd, #150, Portland, 503-734-3535

Northwest Gynecology Center, Tualatin: 19250 SW 65th Avenue, #325, Tualatin, 503-855-1600

Northwest Perinatal Center – Eastside: 5050 NE Hoyt Street, #230, Portland, 503-482-1800

Northwest Perinatal Center – Westside: 9701 SW Barnes Road, #299, Portland 503-297-3660

Oregon City: 1508 Division Street, #205, Oregon City, 503-657-1071

Peterkort North: 9701 SW Barnes Road, #200, Portland 503-734-3700

Peterkort South: 9555 SW Barnes Road, #100, Portland 503-292-3577

Tualatin: 19250 SW 65th Avenue, #325 Tualatin, 503-692-1242

Administrative: 7650 SW Beveland, #200, Portland 503-601-3615

Welcome new MSMP members!

Patricia Engle, MD
Internal Medicine
Westside Internal Medicine
9155 SW Barnes Road, Suite 205
Portland, OR 97225
503-297-5581
Indiana Univ. School of Medicine, 2003

Tricia James, MD
Internal Medicine
Providence Portland Medical Group
5050 NE Hoyt Street, #540
Portland, OR 97213
503-215-6600
University of Colorado, 2008

Kellie Littlefield, DO
Internal Medicine
Oregon Health & Science University
3181 SW Sam Jackson Park Road
Portland, OR 97239
503-494-8311
Touro University, 2013

Lewis Low, MD
Internal Medicine
Legacy Health
1919 NW Lovejoy Street
Portland, OR 97209
503-415-5326
St. Louis Univ. School of Medicine, 1988

We invite YOU to become a member of MSMP

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Physician Wellness Program
- Confidential counseling
- Educational seminars
- Physician coaching
- Wellness groups

Education and Events
- Battle of the Doctor Bands
- CEUs
- Speaker event
- 5k Scrub Run Derby
- OSHA/HIPAA courses
- Scribe/Little Black Book

Join today at MSMP.ORG

Health issues in Latino immigrant communities focus of June conference

Health issues faced by Latino immigrant communities will be the focus of the **2016 Latino Health Equity Conference** in Portland.

The event, titled "Immigration and Latino Health: The Journey Ahead," is set for June 23 at Portland State University. Organizers describe it as a forum that focuses on individual and community issues addressing health equity through research, programs and policies.

The conference will bring together health care and social service providers and others to "raise awareness about roadblocks to health care" as well as the range of services for immigrant communities in order to make connections, leverage resources and clear those roadblocks, "because we all care about outcomes and quality of life," said **Jaeme Klever**, community engagement manager for **Familias en Acción**, which hosts and plans the annual conference.

Breakout sessions will focus on topics including a model for integrating community health workers into primary care teams; the effects of acculturation stress on well-being in Hispanic immigrant communities; co-placing community health workers in the school system; and understanding the role of family ethnicity and language in barriers to autism spectrum disorder diagnosis and therapy.

The conference keynote will be delivered by **Steven Lopez, MPP, MPH,** manager of the Health Policy Project with the National Council of La Raza. The morning plenary session, titled "Immigration Policy and the Effect on Latino Health," will be facilitated by **Olivia Quiroz** of the Multnomah County Health Department and feature **Andrea Miller** of CAUSA, immigration attorney **Maria Cobarrubias,** and **Maria Caballero-Rubio** of Centro Cultural, an organization that promotes education and economic development, increases cultural consciousness, responds to community needs and celebrates understanding among diverse groups.

The afternoon plenary session, titled the "Impact of Immigration on Clinical Health Systems and Services for Latinos," will identify issues around and possible solutions for delivering clinical services to immigrants in a variety of settings and services, and cover potential options to address the needs of immigrants who may fall out of the clinical care system due to lack of insurance or other social determinants such as food and housing security.

Panelists for the afternoon plenary session include **Eva Galvez, MD**, of the Virginia Garcia Hillsboro Clinic; **Wilber Ramirez-Rodriquez, RDH, BSDH**, with Pacific University; **Lucrecia Suárez, MSW, LCSW**, with Western Psychological and Counseling Services; and **Evaristo Romero**, with One Community Health.

Gil Muñoz, CEO of the Virginia Garcia Memorial Health Center who will facilitate the afternoon plenary session, said the conference is an opportunity to "share best practices and understand how various groups are working to improve the health of their patients."

He said the Affordable Care Act has been positive in providing coverage for more individuals and families who are on low incomes, but many remain uninsured "for a variety of reasons." Many individuals and immigrant families are going on and off health plans, which can create confusion for patients and disrupt continuity of care, he added.

In addition, a difficult-to-navigate U.S. immigration system can result in stress for immigrant families. Uncertainty around immigration status can impact family health and well-being, Muñoz said, noting patients present at Virginia Garcia clinics with depression, anxiety and other conditions.

Despite the challenges, Muñoz is optimistic that progress is being made toward health equity. "I think that there is more of a focus on population health and social determinants of health, which is a positive thing in moving us overall toward health equity," he said. "I think that there is more attention paid now to providing culturally appropriate services at all different levels of delivery systems, from hospitals to primary care. This is all positive. There still remains a lot of challenges to achieve real health equity, but we think that conferences like this can help us move in the right direction." ●

For more details about the 2016 Latino Health Equity Conference, please visit www.familiasenaccion.org/conference.

More Latinas screened for breast cancer after promotora visits

Kaiser Permanente study finds peer-to-peer community visits help to reduce disparities in breast cancer screening

Latina women were nearly twice as likely to be screened for breast cancer after they were visited in their homes by trained community health workers, known as promotoras, according to a study published in *Cancer Epidemiology, Biomarkers and Prevention*.

Breast cancer is the most common cancer among women in the United States and the leading cause of cancer death among Hispanic women. Hispanics are more likely than non-Hispanic whites to be diagnosed with breast cancer at later stages when the cancer is more advanced and resistant to treatment. There are many reasons for this, including lower levels of education, limited access to health care, lack of health insurance and no consistent primary care provider.

"Promotora visits are essential in educating Latina women about the importance of breast cancer screening," said **Gloria Coronado, PhD**, lead author and cancer disparities researcher at the **Kaiser Permanente Center for Health Research** in Portland. "Our study showed a modest, but significant increase in screening rates. We are encouraged by these findings, and must continue to involve patients, clinics and communities in efforts to further reduce the inequity in breast cancer screening."

In Coronado's study, the promotora visits boosted screening rates nearly 8 percentage points. More than 19 percent of Latina women who received the visits at home completed a mammogram within a year, compared to 11 percent who did not receive a visit.

"This research goes a long way toward understanding how to reduce disparities and improve care for our vulnerable populations," noted **Ricardo Jimenez, MD**, study co-author and medical director of **Sea Mar Community Health Centers**.

The study examined the "Fortaleza Latina" (Strong Latina) program, which recruited 536 Hispanic women, ages 42 to 74, from four Sea Mar Community Health Clinics located in the Seattle area. Researchers used electronic medical records to verify that the women had not had screening mammography during the previous two years. The women completed surveys at the beginning of the study in 2011 and at its end in 2014.

Eighty percent of the women were born in Mexico, and 92 percent preferred speaking Spanish. Slightly less than half were employed, and the majority earned less than $20,000 a year. Most had completed less than eight years of formal education, and nearly three-quarters lacked health insurance.

The women were randomly selected to receive visits from promotoras or receive their usual care, which may have included reminders from their primary care providers that they were overdue for a mammogram. The promotoras received at least three days of training on the use of motivational interviewing techniques as well as health information regarding breast cancer and the importance of mammograms.

The community clinics had some mammography resources on-site or nearby, mostly using wheeled-in mammography units. Two of the clinics added mobile mammography vans to make screening more accessible, but the vans did not boost overall screening rates.

The authors say the study illustrates the importance of including peer-to-peer education as part of an overall strategy to reduce the disparity in breast cancer screening.

The study was funded by a grant from the National Cancer Institute. Additional authors include: Shirley A.A. Beresford, Donald L. Patrick and India Ornelas from the Fred Hutchinson Cancer Research Center and the University of Washington, Department of Epidemiology, in Seattle; Dale McLerran, Sonia Bishop and Beti Thompson from the Fred Hutchinson Cancer Center; and John R. Scheel from the University of Washington, Department of Radiology, and Seattle Cancer Care Alliance. ●

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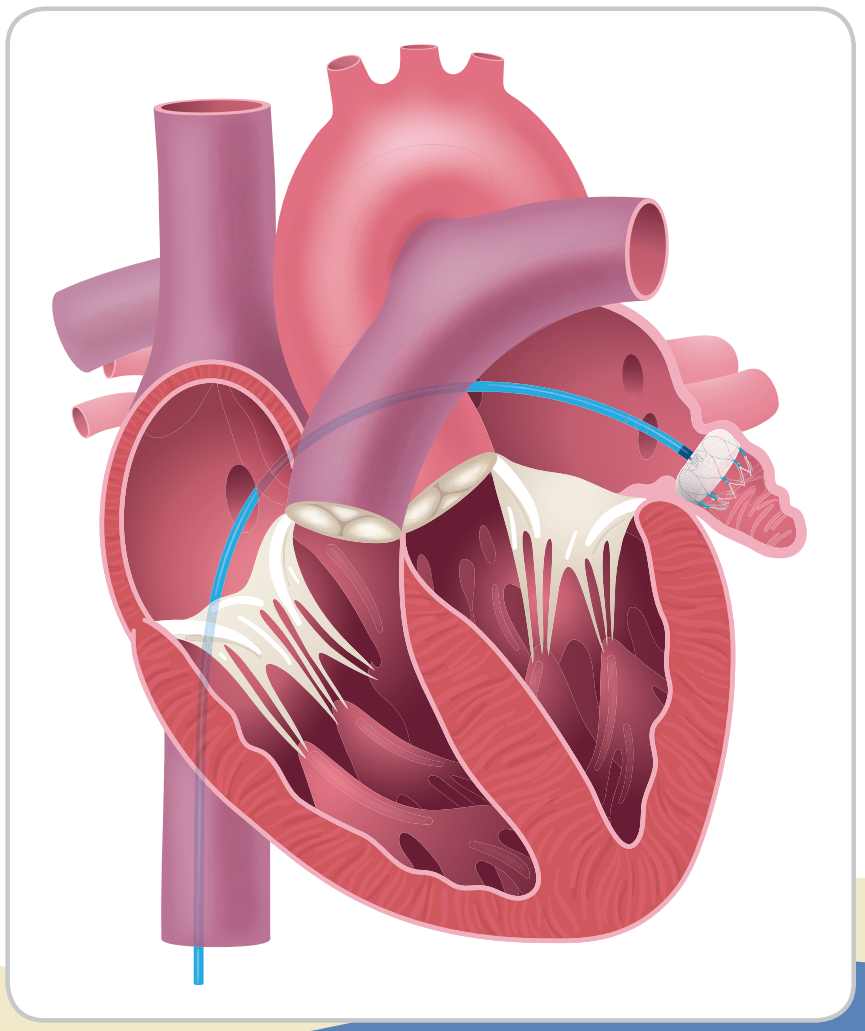
Questions?

To learn more or to discuss, we have a phone number just for providers: feel free to call us at **503-413-4831**.



LEGACY HEALTH

A passion for service and medicine

■ *Kelsey Priest, MSMP's 2016 Student Award recipient, lauded for leadership, vision*

By John Rumler
For The Scribe

The recipient of MSMP's 2016 Medical Student Award, **Kelsey Priest**, has 10 relatives active in health care. However, it wasn't until her father, a computer scientist, was diagnosed with Parkinson's disease a few years ago that she became determined to become a physician.

Priest attended Raleigh Park Elementary, Oregon Episcopal School and Beaverton High School, participating in soccer, basketball, and track and field. She was also active in the Health Careers program at Beaverton High, where she was introduced to health care/medicine by spending time with patients and providers in cardiac critical care units, physical therapy settings and operating rooms.

Priest earned a master's degree in public health at Portland State University and garnered a research assistant position at **Oregon Health & Science University's Balance Disorders Laboratory**, which turned out to be one of the most influential experiences of her life.

"The meaningful personal connections with our research participants inspired many of my career goals as I realized the importance of one-on-one relationships with patients," she said. "This also demonstrated the challenges and disconnect of implementing research into practice and led me to think broadly regarding systems and how they interact."

Kelsey Priest attended MSMP's Annual Meeting with her husband Christian Eickelberg, JD, her mother-in-law, Veva, and her father-in-law Steven Eickelberg, MD.

Photo courtesy of Wiley Parker

Besides being a member of the inaugural class that is the first to experience OHSU's new MD curriculum, Priest is a dual-degree MD/PhD student in the School of Public Health, a collaboration between OHSU and PSU.

She hopes to use the skills and knowledge gained from her training to contribute to improving the interface between health delivery systems and social services, specifically for underserved populations with substance use disorders.

Fellow medical student **Matt French** worked with Priest on an OHSU project called **REMEDY** (Recovered Medical Equipment for the Developing World) that is part of the outreach efforts of the **Association of Students for the Underserved**, a group that began in 1992 and does a variety of volunteer activities such as helping provide meals and medical services for the homeless, volunteering for Habitat for Humanity, and hosting lectures on topics such as health care access and ethics.

Kelsey Priest, MD/PhD student, School of Public Health

> "Kelsey Priest's **indefatigable pursuit of growth** and excellence for herself and others is fueled by a **rare passion for service and medicine**."
>
> *–Matt French, OHSU medical student, in nominating Priest for MSMP's Medical Student Award*

"While working in research, Kelsey identified an opportunity to divert unused medical supplies from terminated research studies to groups who could put them to good use," French said in Priest's nomination for the award. "She recruited, led and inspired an inter-professional group of students, volunteers and OHSU employees in carrying out her vision. Her efforts resulted in the donation of thousands of dollars worth of useful supplies and equipment that would have otherwise been needlessly wasted, and which instead have been put to good use by organizations serving the underserved from Oregon to Angola."

Her short-term goal, Priest said, is to enjoy and absorb all of the educational and mentor-based opportunities during her doctoral training program and her third/fourth year of medical school to become the best physician-scientist that she can be.

"First and foremost, I want to learn how to foster deep and meaningful relationships with my patients and their families that will aid in the transformation of their health issues."

Priest's intermediate goal is to continue expanding upon her dissertation and to further hone her clinical skills, while her long-term goal is to make a difference in her patients' lives, to contribute to the transformation of the health care system, and ultimately improve the health of everyone in the community.

Someday, she'd like to join the OHSU faculty, where she can work to improve patient care while also helping to train the next generation of physicians.

"With the tools garnered from my personal and professional journey, I envision my role as a physician encompassing a broad spectrum of care. I want to influence the future of health care by teaching and leading the next generation of medical professionals."

Priest's hobbies include weightlifting, practicing yoga and hiking. She also is a connoisseur of Portland's fine foods, especially baked goods and cakes.

David Jacoby, MD, vice chair for research in OHSU's Department of Medicine and director of the MD/PhD training program, saw Priest up close, as a program coordinator for the Critical Care Academic Associates program, where she oversaw 25 students.

"Kelsey provided strong guidance and mentorship, helping the program to be a big success and leading many of the volunteers to go on to medical or graduate school."

Professor of public health in the Mark O. Hatfield School of Government at PSU, **Sherril Gelmon, DrPH**, describes Priest as a passionate student with deep convictions who is also open to other opinions and is willing to consider other beliefs.

"More than most medical, public health or PhD students, Kelsey exemplifies the criteria of personal knowledge, skill, judgment, mentorship, compassion, community involvement, and strives for wellness in order to meet the highest standards of service." ●

Next chapter in medical scribes: custom, virtual

By Jon Bell
For The Scribe

Warren Johnson, founder and CEO of the medical scribe service **Scribe-X Northwest**, is quick to tout the benefits of not only using a scribe, but of using one from his company.

More time to focus on the patient and the practice instead of paperwork? Scribes can foster that. Cleaner notes that can yield higher reimbursement rates? That's something scribes can help with as well. More income as a result of that saved time? According to Johnson, physicians can pay for the cost of a scribe by adding just a patient or two more per day – something they're able to do since they have more time to practice. Johnson also noted that a $35,000 investment in a scribe service can yield a return of between two and eight times that much.

"The return on investment is dramatic," said Johnson, a former nurse who started and sold a nurse staffing agency before launching Scribe-X with emergency physician **Joshua Hurwitz, MD.**

But more isolated and rural clinics may not have access to quality scribes, which means they may be missing out on the potential benefits.

Now, however, Scribe-X has launched its Tele-Scribe service, which makes it possible for the company's scribes to service remote clinics virtually. Through the new service, Scribe-X employs technology, along with a video camera and a microphone, that lets physicians in rural clinics access a scribe almost as if the scribe were right there in the office.

"It basically achieves the same thing as having someone in the same room," Johnson said.

Through the service, the virtual scribes are also able to connect directly to the clinic's electronic medical records and make notations directly into it. The service is fully HIPAA compliant and integrates seamlessly with various technology tools that many clinics already use for things such as prescriptions, clinical notes and hospital registration. It's also accessible through a computer or even mobile phones and tablets.

"It's a new service for us, so we're still evaluating it," Johnson said, noting that some clinics in rural Oregon, Washington and Montana already are using the service.

Virtual scribes are relatively new across the industry, and other than Scribe-X, there don't yet appear to be any other providers offering the service from Portland. Johnson said some other national providers offer virtual scribe services, but many outsource the work to scribes based overseas.

"We staff it out of Portland, so it's not like we're shipping jobs overseas to India, which is what some tele-scribe service providers do."

Among the other providers who offer virtual scribe services are **ScribeMR, eData Medical Scribe Services** and **Elite Medical Scribes**. The latter provider, which is based in Bloomington, Minn., has partnered with one of only 10 Google Glass Certified Partners in the country and is currently beta testing Google Glass in clinical settings to determine how the technology can be best used for virtual scribes.

Virtual or in-person, Johnson said medical scribes can make a big impact on a physician's practice. Scribe-X, he added, goes an extra mile to customize its services and pair the right scribe with the right physician. That requires standard scribe training but also time spent with physicians to understand their individual preferences and approaches to medicine.

"When we were starting this, no matter where I went or who I talked to, all physicians feel like their practice is very unique," he said. "Their opinion was that if you have a scribe work with me, they need to know me and my practice. So we decided to run with that."

Johnson said when it comes to customization, Scribe-X works hard to identify physician preferences, who the patients are and even what a physician's personality is like. Then, Scribe-X matches a physician with the best scribe for the job.

"That customization is really important," Johnson said. "We try to get a good understanding of what type of person that doctor would be most compatible with, because they're going to be spending more time with that person than almost any other person in their life, so they better enjoy them." ●

Meeting 'a great need'

Orthopedic surgeon Hisham Bismar, DO, volunteers his services to treat those injured in war in Syria

By Jon Bell
For The Scribe

Hisham Bismar, DO

Hisham Bismar, DO, grew up in Syria but left the Middle Eastern country when he was 18 to come to the United States and study engineering. Over the next three decades, he never went back.

But a few years ago, overwhelmed by the reports of mounting casualties in the brutal civil war in his home country, including word that medical professionals were being targeted, Bismar decided he needed to return, if not to Syria proper, then at least somewhere nearby where he could lend a hand.

"I just thought, I have a useful skill, and there is a great need for it over there," he said. "So I went."

Bismar's useful skill: He's an orthopedic surgeon in Portland at **Kaiser Permanente's Interstate medical office.** Through his involvement with the Syrian American Medical Society, Bismar made contact with a hospital in Turkey near the Syrian border and volunteered his services to help treat refugees who'd been streaming out of the war-torn country.

Right around the same time, Bismar had been treating a Portland filmmaker, Skye Fitzgerald, for a hand injury that he'd suffered in a biking accident. The two got to talking about the Syrian civil war and Bismar's plans to travel overseas to help. Intrigued, Fitzgerald inquired about joining Bismar on the trip and filming along the way.

The idea panned out and eventually became the short film **"50 Feet from Syria,"** a documentary about Bismar's journey that went on to be short-listed for an Oscar nomination. It chronicled Bismar's work with the refugees – and even some combatants – on his first trip to help. That trip was not his only one; he's since been to Turkey again and once to Jordan. And in July, he's heading to Turkey to lend his services again.

"The situation has really deteriorated in the past six months, but I'm planning on going back if it doesn't get too much worse," said Bismar, who lives in Lake Oswego with his wife and two children. "There are still a lot of people in need over there."

Born and raised in Syria, Bismar came to the United States to study engineering at the University of Dayton in Ohio. He later earned a master's degree in biomedical engineering from Wright State University, which is also in Dayton. But after spending some time as a researcher – often in a basement by himself – Bismar realized he wanted something more out of his career.

"Engineering was a little bit dry for me by itself," he said. "I thought it was more interesting to try and work with engineering for a purpose. I wanted more human interaction and wanted to work with biological systems more than engineering ones."

So Bismar headed to Michigan State University for medical school, then completed a residency in orthopedic surgery and two fellowships that focused on elbow and shoulder surgery. His wife later saw an ad for a job in Portland, which is what brought Bismar and his family to the Rose City area about eight years ago.

"We liked it here, so we stayed," he said.

The need for care is great

When the crisis in Syria heated up, Bismar, who still has some friends and non-immediate family in the country, headed over to volunteer his services. Refugees who had been flowing into Turkey had been finding treatment at Turkish hospitals, but also in makeshift facilities near the border.

On his first visit, which lasted three weeks, Bismar worked in an established hospital that had been set up in a hangar-like building just across the border from Syria, thus the name of the documentary. He said most of the people he operated on were refugees coming into the country from Syria and most had suffered injuries from the war. A large portion of those injuries were from the now-notorious barrel bombs that the Syrian government has employed in the conflict. Essentially barrels filled with explosives and shrapnel or chemicals and dropped from aircraft, the bombs are indiscriminate and often severely injure civilians.

Many of the injuries that Bismar treated were also old ones that had not healed or been treated properly the first time around. Syria lacks orthopedic specialists, and supplies of implants, such as plates, screws, rods and artificial joints, are low.

"Many of the injuries were older. They were compound injuries to the extremities that included bone injuries and damage to the nerves, skin and vessels," Bismar said. "A lot did not heal right and needed to have a secondary procedure."

His patients ranged in age from children through older adults, and while most were civilians, he did operate on some combatants as well. And the stream of patients coming in was almost never ending.

"The number of people was very significant," he said. "I would have 30 to 40 patients waiting anytime I had a clinic."

Though he didn't cross the border at all, Bismar said the scene was intense and there were several bombings in a nearby town that kept everyone on alert. When he went back and worked in Jordan, Bismar stayed farther away from the border, so it wasn't as high-strung.

Looking back on his youth in Syria, Bismar said the country is a far cry from what it used to be. He still has a place for it inside him, which is part of the reason he went back, but the violence and war that have descended upon it are nothing that he encountered growing up there.

"It was very peaceful and one of the most stable countries in the Middle East," he said. "It was multiethnic and multisectarian, but everyone got along well. There was heavy authority imposed by the government, but that wasn't any different than any of the other Middle Eastern countries. It was pretty peaceful, and it was a pretty country."

> "The number of people was **very significant.** I would have **30 to 40 patients waiting** anytime I had a clinic."
>
> *–Hisham Bismar*

Photos courtesy of Jeff Ball

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MD-JDs say broad background benefits them, patients

By Cliff Collins
For The Scribe

All doctors are aware of how rigorous medical training is. Attorneys, too, consider law school challenging and sometimes stressful. A few individuals chose to undergo both these forms of education.

The Scribe asked the following Portland physicians how their combined expertise is beneficial to them in their practice, research or policy development.

Krenie Stowe, MD, JD
Caring for the underserved

"I act like a doctor and think like a lawyer," explains **Krenie Stowe, MD, JD,** when she reflects on how her dual degrees impact how she practices medicine.

"The intersection between medicine and law has been compelling for me," she says, especially the ways that health policy and programs affect "the individual person. I have had a sociological interest in health care, the disenfranchised and marginalized communities all my life."

Since 2013, Stowe has been a pediatrician with **Virginia Garcia Memorial Health Center**, a federally qualified health center that provides care to underserved and high-risk populations, including migrant farm workers. She also provides in-patient care to newborns and pediatric patients through Willamette Valley Medical Center in McMinnville. Before moving to Oregon, she had accumulated 25 years of experience serving underprivileged people in Texas, North Dakota and big cities on the East Coast.

Born in Connecticut and raised in New York City by a single mother who was "struggling but very committed to social service," Stowe got exposed to poverty early in life. Her mother had come from a prosperous, educated family, but had little money after her divorce. When Stowe was 12, her mother decided to go to medical school in Mexico. Stowe lived with her in Mexico for a couple of years, then was accepted into the prestigious Phillips Academy in Andover, Mass. From there, Stowe went to Yale University, where she earned a bachelor's degree, majoring in literature and pre-med.

She then obtained her medical degree from Albert Einstein College of Medicine in the Bronx. Early in her pediatrics residency she was assigned to the neonatal ICU, where she first became what she calls "a gadfly and critic of our system."

She was appalled that massive resources were being spent on certain areas of medical care, while at the same time a measles outbreak occurred in the city. "There were all these kids with no primary care access, no immunizations," she remembers. "We should have been going door to door to offer vaccinations.

"I was pretty disgusted with the system," Stowe says. "I decided I would abandon clinical medicine and went to law school." She felt she could use her legal training, which she obtained at Harvard Law School – where she earned her JD degree magna cum laude – to work on legal services for the poor. Her various stints after gaining her law degree included community organizing and outreach; legislative and policy research; and legal advocacy for individuals with HIV.

Stowe enjoyed public interest law, but she missed the day-to-day contact with patients. She decided to return to doing a medical residency, this time at Montefiore Medical Center in the Bronx, in the pediatric tract for social medicine. Following her residency, Stowe spent two years as a staff physician on an American Indian reservation in North Dakota. Stowe then practiced for about two decades in rural southeast Texas, providing medical care and social and support services to low-income children and families.

Stowe was attracted to Oregon because of its natural beauty and climate as well as its progressive approach to health care. She says the years in Texas were "exciting but exhausting, with constant pressure. I have a 'save-the-world' problem. It creates a lot of stress; it creates difficulty for your own life."

She says Oregon "has done a great job of covering children," but does not have enough physicians to handle the expanded coverage for adults, and too many people are still going to emergency rooms.

"My law degree has more to do with the way I see things and analyze things," she says. "I would love to be involved more in policy."

Ken Gatter, MD, JD
Health law and medicine

Unlike Stowe, **Ken Gatter, MD, JD**, went to law school before obtaining a medical degree. Now an **Oregon Health & Science University** associate professor of pathology and vice chair of anatomic pathology, Gatter received his law degree from Boston University, worked in the Bronx district attorney's office, then got married and moved to his wife's native Nebraska.

There, he worked in a 30-person law firm, handling corporate law. A history major as an undergraduate, Gatter had not paid "attention to science" in high school and college, he says; but he decided to go to medical school at the University of Nebraska, with the intention of being a pediatrician. Once in med school, he also considered emergency medicine and pathology, eventually settling on the latter.

Gatter, who specializes in hematopathology and surgical pathology, did a residency at Case Western Reserve University and University Hospitals in Cleveland and completed his residency and a fellowship in surgical pathology at OHSU. He is board-certified in anatomic and clinical pathology.

"You're a different student after working as a lawyer," he says. He found that pathology is "a visual specialty. It came relatively easy to me." Pathology offers a "case-based solution to a patient's stay. You get to do something before they leave. A biopsy is taken; you make a diagnosis. There's an end to it."

He also never lost interest in the interaction of health care and the law. Gatter's research on health law issues is published in legal literature. He served as an adjunct professor at Willamette Law School for 10 years, teaching a health law class to law students and medical students meeting in the same classroom. He held some classes at OHSU and some in Salem. A Lewis & Clark Law School student in one of his health law classes now is working with Gatter and **Health Share of Oregon** on a medical-legal partnership.

In the arrangement, as described in a July 2015 story in *The Scribe*, legal professionals train health care teams to identify social and legal needs of patients and refer them to a legal team, which then offers them appropriate legal services.

"The idea is that the social determinants of health are important, and some of those can be addressed from a legal standpoint rather than medical," Gatter explains. "That's exciting. There's a lot of interest around the city."

The medical-legal partnership is one example of how he thinks his legal background helps him in medical practice. Another is that it aids his understanding of the myriad government regulations that pertain to medical labs. A third is that his legal knowledge aids him in serving on institutional review boards, which are designed to protect human subjects in research projects and are subject to Food and Drug Administration regulations.

Gary Rischitelli, MD, JD, MPH
Using legal skills in practice

Gary Rischitelli, MD, JD, MPH, likes to joke that the many years he spent in school are "evidence of my misspent youth."

Raised in "a small steel town" near Pittsburgh, he says he was used to being around working people, an experience that proved to be valuable many years later when he became an occupational medicine specialist.

No one in his family was in the medical field, but becoming a doctor was "something I wanted to do from a very young age," he says. "My pediatrician was inspiring. I wanted to be like him."

After obtaining an undergraduate degree in biology from Saint Vincent College in Pennsylvania, Rischitelli went to Baylor College of Medicine with the intention of becoming a pediatrician. But once he got there he found he "liked everything, but nothing enough to commit to a specialty." One of the options he considered was to become an environmental and natural resource lawyer.

*See **MD-JD,** page 11*

COLE KIMBALL, AIF

Financial advisor offers tips for physicians on how to meet short-, long-term goals

Many attending physicians enjoy watching their financial assets grow as loans and other obligations are paid off and they can invest a greater portion of their income to meet personal and professional goals.

At the same time, however, demands remain and the time frame for meeting goals becomes more limited. Plans change, making it even more imperative for physicians to call for professional financial, tax and legal advice along the way.

Cole Kimball, AIF, chief investment officer and financial advisor for **Finity Group** in Portland, recently spoke with The Scribe about the most common questions and concerns he hears from physicians regarding their financial stability. He also shared ways they can craft strategies that ensure their financial security well into retirement.

Scribe: ***In your experience, do many physicians have a good understanding of the need for financial planning, and do they have a solid strategy in place?***

Kimball: Most physicians understand the need for financial planning, much like any other profession, but what many physicians don't understand is the type of financial planning they need – specialized advice. Physicians' career paths are much different than other professions; their earnings potential is both greater and delayed, and their student loan burden is generally higher relative to other professions as well. This, among other things, puts them in a situation where they not only need to understand the importance of financial planning, but financial planning that is unique and specific to their career path.

Scribe: ***What are some common questions or concerns you hear from physicians regarding their financial situation?***

Kimball: How can I save for retirement? How much should I save for retirement? When should I start saving for retirement? How should I go about paying down my student loans? When should I, and what, insurances should I look into? How much cash should I have on hand? All of these are typical questions we'll receive from clients. The answers, though, are going to be different for each client we work with, as everyone's situation is unique. Individuals also have different preferences, so that plays a role in answering these questions as well.

Scribe: ***What key points do you help educate physicians about when it comes to financial security?***

Kimball: Expanding on the points above, which are good, but what also should be said is that we realize everyone has a limited amount of dollars to deploy in their financial plan. We cannot accomplish everything at once. Emergency reserves and risk management are important aspects of financial security, but it's our job as the advisor to figure out which goals are most important. Some of our clients like having a higher level of cash on hand, some like more robust insurance protection, some hate the idea of insurance and want to self-insure more risks.

As it relates to the longer term side of the plan, it is important that physicians understand the risks that they are taking with their investments and only take on the risks that they need to meet their financial goals. We'll educate our clients on all the areas we can when it comes to financial security, but we will tailor the information specific to what the client wants to learn about in relation to their specific goals.

Scribe: ***What is your goal as a financial planner when you meet with physicians?***

Kimball: The goal that governs our process as financial planners is to assist clients in meeting their specific objectives, whatever they may be. Each individual financial situation is different, though the nature of physician training in the U.S. certainly creates commonalities in many cases. Two physicians with similar situations on paper can have very different goals and prioritize areas of their plan in very different ways; so our first concern is to understand what the person we're speaking with wants to achieve and when. From there we help them understand the options they have to accomplish these goals and the risks associated with each route. ●

This is the first in a three-part series about financial planning for medical professionals. In the July issue of The Scribe, Kimball will address financial strategies for residents and fellows.

MD-JD *from page 10*

"I took the LSAT as a lark," he says, referring to the aptitude test for law school. "I did extremely well on it. The next thing I knew, I was getting letters from law schools." He ended up choosing Lewis & Clark Law School, due to its reputation for training environmental attorneys.

By then he had a wife and child, so he practiced medicine during the day, went to law school at night, and simultaneously pursued a degree remotely for a master's in public health from the Medical College of Wisconsin. His medical practice involved occupational health, and "I really fell in love with it," Rischitelli says. After obtaining his law degree, he went back for residency training in occupational and environmental medicine at the John Hopkins School of Public Health.

He currently splits his professional involvements several different ways. His primary focus is serving as staff medical director for **Bunch CareSolutions**, a company of Xerox Corp. Rischitelli also practices part time as a physician with **Northwest Occupational Health Associates**. He has authored more than 30 articles and book chapters, and serves as medical director of the **OHSU Global Southeast Asia Occupational Health Center of Excellence**.

Rischitelli finds that his legal training meshes perfectly with his specialty of occupational medicine. "On so many levels, we deal with the law every day," he says. "So my understanding of legal processes empowers me to do my job" with greater comprehension. For example, occupational medicine specialists deal with regulatory matters and employment and labor law on a regular basis. He became an expert on employee testing.

He says law school teaches you to reason and speak clearly. "You learn so many other fundamental skills."

Contrasting his experiences in law school and in medical school, Rischitelli says: "I found medical school exhausting. Law school is intellectually stimulating. Medical school is more draining from a physical and emotional standpoint. There's not a lot of room for creativity. In law school, creativity is everything." You're presented a set of facts, and you evaluate and use that information in a way that is helpful to your case and client.

"I found the perfect fit for me," he says. "I was lucky in that I can utilize my skills, use these fundamental, basic skills, every day." ●

Planning to relocate, merge, or close your medical practice? *Follow these tips*

By Susan Shepard, MSN, RN
Director, Patient Safety Education, The Doctors Company

Physician practices undergo closure for many reasons, including physician illness, death, relocation, or the physician's decision to sell, practice solo, join another group, or retire. Especially in this time of health care mergers, more physicians and practice administrators are facing changes. Of paramount concern during any change in practice is the continuity of patient care to ensure that no patient is neglected. Issues of liability for medical record retention are also an important concern.

Ensuring patient safety in an emergent practice change

If the practice change is abrupt, as in the circumstance of a death, the following safety measures will assist in ensuring patient safety and continuity of care:

- Review all previously scheduled appointments to determine the appropriate action: Immediately contact a physician of the same specialty to arrange patient care, or provide patients with a list of practitioners of the same specialty within the area. Transfer all inpatient care to another physician immediately. Use the services of the hospital risk manager if you are unable to locate an available physician.
- Ensure the availability and accessibility of office medical records as needed for the continuity of patient care.
- Post a notice of closure in the office and in the local newspaper.
- Inform all physicians who customarily refer patients to the practice and all contracted managed care organizations, local hospitals, and the medical malpractice carrier.

Important steps for all practice changes

In any type of practice change, notify the following individuals and entities:

- All patients and legal representatives in the "active" caseload. This includes any patient seen in the past six months to three years or others the physician considers "active" and any patient in an acute phase of treatment.
- All peer physicians within the community.
- Local hospitals and medical societies.
- All third-party payers (to include Medicare and Medicaid) and managed care organizations.
- The DEA (if you are retiring or if you are moving to another state).
- The state licensing board.
- Professional associations in which you hold membership.
- Your CPA or financial adviser.
- Your employees.
- Landlords, lenders, and creditors.
- Insurers that cover the practice, the employees, and the physical facility.

Draft a letter to each patient that contains all of the necessary details. The same letter can be used for everyone listed above. It is recommended, if possible, that letters be sent by first class mail and that a copy of the letter with the return receipt be kept. If a patient is considered high risk, consider sending the letter certified with return receipt requested. Post a notice in a local newspaper for at least one month to inform inactive patients or those who have moved away. Include directions for obtaining acute, critical, or emergency care if a new physician has not been selected by the time the practice closes.

Send the notice at least 60 days prior to the anticipated closure. This gives patients an opportunity to locate a new physician and to obtain copies of their medical records without undue stress.

Other responsibilities before final closure include:

- Consult with your personal or practice attorney and the state licensing agency to ensure that you have met all regulations.
- Destroy remaining prescription pads.
- Keep the narcotics ledger for a minimum of two years.
- Dispose of drugs.

Medical records issues

When a practice closes, the physician or group is responsible for making appropriate arrangements for the disposition of all medical records – regardless of whether the records are in paper or electronic format. The possibility of a lawsuit after a physician has left or a practice has closed always exists. To help defend against any future claims, the retention of records is paramount.

Although states may have different guidelines or laws, The Doctors Company makes the following recommendations for retaining medical records:

- Adult patients: 10 years from the date the patient was last seen.
- Minor patients: 28 years from the date of birth.
- Deceased patients: Five years from the date of death.

Physicians who turn their practices over to replacement physicians should have agreements in place that stipulate the recommended retention time and access capability.

If a physician chooses to destroy clinical records after a set period of time, confidentiality must not be compromised. There are record destruction services that guarantee records are properly destroyed without releasing any information.

When a practice closes and medical records are transferred, patients should be notified that they may designate a physician or another provider who can receive

*See **OFFICE CLOSURES,** page 14*

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a copy of the records. If a patient does not designate a physician, records may be transferred to a custodian (a physician or a commercial storage firm).

Custodians who agree to retain records can be physicians, non-physicians, or commercial storage facilities. Custodial arrangements for retaining records are usually entered into for a fee and should be in writing. A written custodial agreement should guarantee future access to the records for both the physician and patients and should include the following points:

- The custodian will keep and maintain the medical records for the retention times specified above.
- No one can access the information contained in the medical records without a signed release from the patient or a properly executed subpoena or court order.
- The original physician or physician's personal representative will be notified of any change of the custodian's address or phone number.
- Terms apply to all persons in the custodian's employment and facility.
- Copies of medical records will be released to a person designated by the patient only with the patient's written request.
- The custodian will comply with state and federal laws governing medical record confidentiality, access, disclosure, and charges for copies of the records.
- There are agreed-upon fees for maintaining the records.
- It contains language that addresses any personal practice decisions made by a custodian (retirement, selling, or moving) to ensure the safety of and continued access to the records by the original physician or physician's personal representative. ●

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

MEDICARE from page 1

JON HERSEN

CMS, said **Jon Hersen**, Legacy Health's vice president of care transformation. "The move CMS is making fits very well with our overall view of health care. We believe that it is a necessary transition that will be good for the community we're serving and fulfilling our mission."

Although change is always difficult, and some of CMS' deadlines are rather aggressive, the switch to emphasizing value and population health "will be in the best interest of our health system," Hersen said.

Passage of the Medicare Access and CHIP Reauthorization Act, known as MACRA, was Congress' answer to permanently replacing the Medicare SGR method of paying doctors. In its place are incentives to move to measuring quality of care, such as under the new Merit-Based Incentive Payment System – or MIPS – which was part of the legislation.

Medical homes, where multidisciplinary care is coordinated, "focus on wellness, prevention and the social determinants of health, and away from transactional and episodic care," said Hersen.

KATIE DOBLER

But, at the same time, third-party payers must acknowledge that reimbursement for coordinated care must cover "the costs to care for the whole patient," said **Katie Dobler,** chief of support services for The Portland Clinic. "Our physicians are very interested in this, because they know this is the transformation happening in health care."

As usually happens with changes in Medicare, private insurers follow. She said the medical group has been moving toward value-based care for quite some time, partly because of what Medicare is doing. "Insurance companies are starting to introduce value-based contracts," Dobler said. "We continue to see contracts leaning more toward having payments tied to value. We talk with insurance companies on a weekly basis about how we can align with MACRA."

According to CMS, MACRA makes two major changes to how Medicare pays, beyond ending the SGR formula: These changes, which CMS refers to as its Quality Payment Program, or QPP, are to institute a new framework for rewarding providers for better care, not just quantity of care; and to combine CMS' existing quality reporting programs into one new system. The QPP replaces a patchwork system of Medicare reporting programs with a flexible system that offers the choice of two paths that link quality to payments: either MIPS or Advanced Alternative Payment Models, known as APMs.

Clark said the changes in payment will affect both primary care physicians and specialists in The Portland Clinic, because of the law's emphasis on "appropriate utilization" and outcomes measures.

"Certainly the practices that are not as far along the path to population health are really trying to play some catch-up right now," said Hersen. "For those practices that have not started that journey, that is certainly causing a heightened sense of anxiety."

A result of the changeover to managing population health is that physicians and clinics are "going to be in a closer partnership with our patients," because how well doctors keep patients healthy and manage chronic diseases is "how we're going to be paid," observed Clark. In keeping with that strategy, he added, The Portland Clinic developed a new website and new "message: 'Where relationships matter.'"

Hersen said the purpose of Legacy Health Partners, which includes Legacy-employed primary care and specialty doctors and "select private-practice, independent primary care and specialty physicians," is to support "our care transformation efforts and allow for like-minded physicians to work much more closely together to integrate continuity of care." Legacy Health Partners also functions as "a forum to accelerate" doctors' efforts in converting their practices away from fee-for-service care, he said.

Insurers will play a key role in Medicare transformation, because CMS will choose certain states that the agency deems willing and prepared to test early stages of payment for performance; and the insurance carriers in those states must choose to apply to participate in Comprehensive Primary Care Plus, or CPC+, explained Dobler.

CMS hopes the CPC+ model will contribute to the goal of having 50 percent of all Medicare fee-for-service payments made via alternative payment models by 2018. According to the agency, "CPC+ is an advanced primary care medical home model that rewards value and quality by offering an innovative payment structure to support delivery of comprehensive primary care. The model will offer two tracks with different care delivery requirements and payment methodologies to meet the diverse needs of primary care practices."

CPC+ is a five-year demonstration project that will commence in January. CMS began soliciting payer proposals in April in order to select regions with high payer interest. Once CPC+ regions are selected, eligible practices may apply beginning this July.

"We are carefully evaluating this opportunity and having discussions with state and federal stakeholders," said **Jared Ishkanian**, a spokesman for **Regence BlueCross BlueShield of Oregon**. "This is an exciting time for Oregonians as we look for ways to transform our health care system to be more patient-focused and reward improved health outcomes."

Similarly, **Providence** is preparing for changes as a result of MACRA, said spokeswoman **Olivia Ramos**. "We are assessing the CMS rules and gathering feedback from our internal experts so we can participate in the final rule-making process, which will occur this fall. We are confident that many of our population health efforts already underway across Providence will prepare us for the changes within MACRA. In addition, strategic discussions are underway at the Providence organizational level to determine how we will act on new care, payment and delivery models."

"We're encouraging insurance companies" to apply to participate, Dobler said. "We see this as a terrific jump-start. We hope Oregon recognizes this," because the emphasis on keeping a patient population healthy and controlling chronic diseases represents where "health care is going to go." ●

Nurturing nature

David Peter, MD, finds fulfillment tending his Canby property, designated a conservation management area

Nearly all of Dr. David Peter's property along the Molalla River is designated a Fish and Wildlife Conservation Management Area. Among other efforts, he is nurturing endangered western bluebirds. *Photo courtesy of John Rumler*

By John Rumler
For The Scribe

In the course of his medical training, **David Peter, MD**, spent time on a Navajo reservation in Ganado, Ariz., and in Barrow, Alaska, with Eskimos. He also spent six months practicing medicine in Kingston, Jamaica. There he photographed endangered Jamaican iguanas and, in 2004, he took a month off to track lemurs in the Madagascar rain forest for the organization **Earthwatch**.

Peter's current ecological efforts are much closer to home: He's turned his 24-acre Canby property into a conservation project.

Growing up in suburban Richmond, Va., many of Peter's favorite memories are of happy times spent in the nearby forests and lakes. One day he got a fishhook imbedded in his hand, spurring a visit to his family doctor. "I was in a painful, vulnerable position and he was able to help me," Peter recalls.

In the Explorer Scouts he became friends with another doctor who participated in overseas medical missions. Those experiences started him on a medical path, and a high school biology teacher, who took the class to wetlands and involved students in activities at wilderness sites in New Hampshire, was just as influential.

Peter earned a bachelor's degree in biology and his MD at the Univ. of Rochester. After completing his residency at Duke, he began practicing as a family doctor at Legacy Medical Group–Canby in 1993.

In December 2014, the **Oregon Department of Fish and Wildlife** designated all but one acre of his land, which is next to the Molalla River, a Fish and Wildlife Conservation Management Area. His home is on the one acre of residential property.

ODFW District Biologist Don VandeBergh said the program aims to promote native habitats which are quite scarce. "Because part of Peter's property is on the Molalla River it is particularly important. Birds and animals migrated on river corridors for eons, which makes that land and ecosystem even more significant."

Dr. David Peter has worked to promote native habitats on his property, in part with riparian planting trees and shrubs. He says these efforts have made him "the happiest and most fulfilled I've been in my personal and professional life." *Photos courtesy of David Peter*

Property owners who participate in wildlife conservation efforts may be eligible for property tax benefits, but they must submit detailed annual reports. Peter has listed every animal, bird and plant that he's seen since moving onto the property in 2010.

The snowberry shrubs he planted along the one-quarter mile of riverfront property tripled in size and reduce erosion and improve the Molalla's water quality. "It benefits more than the fish," he explains. "There's microorganisms and plankton and algae which support that entire ecosystem."

But some efforts haven't enjoyed such success. In March 2012, with help, Peter planted 2,400 trees in a single day. Less than one-third survived due to floods. Last year he planted 120 Oregon Ash tree seedlings. Every one of them died because of a drought. "Everything in nature is an experiment," he says.

Peter has learned to adapt, such as switching over to a Ponderosa Pine species that, unlike the variety in Central Oregon, do well in extremely wet or dry conditions.

The first year was by far the hardest. The property was once a fruit orchard but the apple, peach, and pear trees were sick and dying from neglect, and much of the area was overgrown with blackberry bushes and aggressive invasive species, particularly Japanese knotweed.

Peter pulled weeds by hand, the first task in rehabbing the property. It was backbreaking, stoop labor, but once the knotweed was gone, the willows and other fauna returned.

Red-tailed hawks, great horned owls, herons, and American kestrels are just a few of the many birds he's seen. He's also planted narrow leaf milkweed to draw monarch butterflies, and he is nurturing endangered western bluebirds as well. Volunteers with the Sherwood nonprofit **Prescott Bluebird Recovery Project** have placed two bluebird boxes on his property and a nesting pair of bluebirds has produced five eggs.

"David's property is ideal for bluebirds, who are ground-feeders," said PBRP volunteer Claudia Fredricks. "It's heartwarming to see him working so diligently to restore this area so it protects and attracts native wildlife and plants."

Native Fish Society of Oregon City and grant supporters doing a fish survey two summers ago went into a side channel of the Molalla along the property and found young salmon and steelhead gathering in schools near the shady banks in the cooler waters. Another volunteer from the county found Pacific giant salamander eggs attached to the stems of pond weeds.

This is the first year that Peter will not have to plant trees. Now, he's waiting for them to grow and provide shade for the native shrubs and flowers he will plant.

His big challenge will be nurturing all the tender saplings until they become established, which will take another two or three years. Peter envisions his property becoming a mature forest with a rich and diverse natural ecosystem, although he acknowledges that he won't see the end results in his lifetime.

"That doesn't matter. This is still the happiest and most fulfilled I've been in my personal and professional life," he says. "I know future generations, including my three daughters and five grandchildren, will enjoy this area."

After purchasing the property, Peter cut back from a 60-hour workweek to 45. "I'm glad Legacy gave me the opportunity to work a few less hours and have more balance," he says. "I feel that my patients are gaining from this, too, because I can give them more attention and be less stressed out."

A riparian specialist with **Clackamas Soil & Water Conservation District**, Jennifer Reische has worked with Peter since shortly after he took over the property and she did the initial habitat assessment.

"These restoration projects take so much time, energy and resources that David's efforts should be applauded," Reische says. "He's always trying new ways to improve the habitat, whether it's crafting raptor perches or experimenting with different native plant species to find out which will thrive best. It's easy to see how passionate he is, just by looking at his numerous accomplishments."

MSMP *Annual Meeting*

Candice Barr, former CEO of the Lane County Medical Society, accepts MSMP's 2016 Presidential Citation from Bradley Bryan, MD, president of MSMP's Board of Trustees.

Photos courtesy of Wiley Parker

Robert Wells, MD, shares information with MSMP Annual Meeting attendees after receiving the Rob Delf Honorarium Award for improving community health and the practice of medicine. The award is presented by MSMP and the Metropolitan Medical Foundation of Oregon.

***ANNUAL MEETING** from page 1*

emotional support before, during and after, and she also established a "litigation retreat boot camp," which became a model for a nationwide program sponsored by The Doctors Company.

Her contributions also include starting the Access for the Medically Underserved, spread nationally by the Robert Wood Johnson Foundation; forming the first medical society-sponsored Medical Reserve Corps, spread nationally by the federal government; and, after collaborating with the late **Ralph Crawshaw, MD**, a former MSMP president, Barr took the Mini-Internship Program nationwide through the American Medical Association.

Through this program, community leaders do a two-day "walk a mile in their shoes" micro-internship experience with local physicians. This prototype was adopted by many county medical societies across the nation, and Congress also adopted a version.

Robert Wells, MD, received MSMP's **Rob Delf Honorarium Award** for exemplifying the medical society's ideals through his efforts to improve community health both at home and abroad. Wells, a family practitioner with Providence Health & Services and Providence Portland's medical director for quality and patient safety, provides volunteer medical care for impoverished residents in Guatemala.

Since 2003, he has made at least 17 trips there. Wells leads teams of volunteer providers – many from Portland but also from other Providence locations and even farther across the country – on annual trips that typically last about nine days. A typical trip will see up to 2,500 patients over four days, many of whom are impoverished native people who have never seen a physician before.

Wells also travels to Kenya with Kizmani, a Portland-based organization that provides medical care, builds water wells and puts on a unique sports and arts camp for kids in Nairobi. Wells got involved with the group about five years ago after his wife first volunteered for it. He's been to Kenya five times and is scheduled to go back later this year.

Wells said that through Kizmani – the name means "the well" in Swahili – 610 people were served in 2011, which increased to 1,400 in 2015. The organization partners with local doctors to provide services to those in need, many of whom suffer from high blood pressure and diabetes. Wells said he would donate the $1,000 honorarium to Kizmani.

Bryan referred to Wells as a vital member of the medical community for more than three decades and an "instrumental leader" in developing multidisciplinary teams. "We should all aspire to do the same quality of work both locally and internationally," he said.

This year's Medical Student Award was presented to **Kelsey Priest**, who is a dual-degree MD/PhD student in the School of Public Health. She hopes to use the skills and knowledge gained from her training to contribute to improving the interface between health delivery systems and social services, specifically for underserved populations with substance use disorders.

She also is involved in an OHSU project called REMEDY (Recovered Medical Equipment for the Developing World) that is part of the outreach efforts of the Association of Students for the Underserved, a group that began in 1992 and does a variety of volunteer activities such as helping provide meals and medical services for the homeless, volunteering for Habitat for Humanity, and hosting lectures on topics such as health care access and ethics. (*To read more about Priest, please turn to page 6.*)

Annual Meeting attendees were invited to participate in an interactive panel discussion about recreational and medical marijuana use in Oregon and implications for physician practice. The panel included **Stacey Mark**, a partner at **Ater Wynne** and chair of its Labor and Employment Group; **Donald Girard, MD, MACP,** previously associate dean for graduate and continuing medical education and a professor at Oregon Health & Science University's School of Medicine; and **Paul Lewis, MD, MPH**, Multnomah County and Tri-County health officer.

Mark explained that the state laws allowing those 21 and older to possess, use and buy recreational marijuana in limited amounts changes nothing for employers in many states because most of the laws have no effect on drug testing and disciplinary policies. In such states, an employee who uses recreational marijuana remains subject to employer testing and may be disciplined or fired if the test is positive. She acknowledged that in states where the law requires employers to prove impairment, employers face a challenge because the drug can be detected in a person's system for several weeks and there is currently no accurate test available to prove impairment.

Mark noted that employers are not required to accommodate medical marijuana use under the Americans with Disabilities Act because marijuana is still illegal under the federal Controlled Substances Act. She also pointed out that the rules have not changed for physicians with respect to prescribing medical marijuana. Under regulations enforced by the Drug Enforcement Administration, physicians can be reprimanded or lose their license if they prescribe medical marijuana.

Girard, a former president of the **Oregon Medical Board** and MSMP, said that more research is needed about the potential medicinal benefits. He noted that federal funding for unbiased research is essential.

"There may be some value, but we don't know yet where the value ends and abuse begins," he said, noting that it's a complex issue.

Lewis reviewed the high rate of marijuana use among youth and young adults in the Portland metro area compared with the state and nation. Compared with other intoxicants such as alcohol, tobacco and opioids, the harms from marijuana to users and the public are modest. That said, acute intoxication clearly occurs among adults and children as does an increased risk of car crashes among those so impaired, he noted. The important topic of long-term impacts such as lifetime achievement, schizophrenia and cognitive functioning are devilishly difficult to study, and making causal connections between marijuana use and these outcomes may be impossible, Lewis added.

As a pediatrician, he shared his special interest in childproof packaging for marijuana-infused snack foods like cookies, candy and ice cream.

Lewis referred attendees who are interesting in learning more about marijuana legalization and policy to the September 2015 issue of *Multnomah County Vital Signs (https://multco.us/file/46419/download)*, the book *"Weed the People: The Future of Legal Marijuana in America"* by Bruce Barcott, and the summer 2014 series on marijuana legalization in *The New York Times*. ●

Read more about Candice Barr and Dr. Robert Wells in the May 2016 issue of The Portland Physician Scribe. You can find back issues at www.msmp.org in the publications section.

Please look for ongoing marijuana-related news coverage in future issues of The Scribe.

PTSD: 'We are not immune,' physician cautions

■ *Emergency medicine providers at increased risk, research shows*

Faced with such challenges as treating critical injuries, interacting with patients and families impacted by substance abuse and domestic violence, and communicating tragic news to patients' families, physicians, nurses, paramedics and others working in emergency medicine face an elevated risk of post-traumatic stress disorder, according to a growing body of international research.

The **American Psychiatric Association** notes that PTSD can be triggered by directly experiencing a traumatic event, witnessing a traumatic event in person, or experiencing repeated exposure to the details a traumatic event.

A survey of nurses working in emergency departments found that 17 percent reported exposure to at least six traumatic events within a six-month period; 23 percent had witnessed four or five events; 32 percent had experienced two or three events; and 15 percent had seen only one event, according to a host of international studies posted by the **U.S. National Library of Medicine's National Center for Biotechnology Information** (NCBI).

The NCBI broke down the top 10 traumatic events reported by ER nurses:

1. Dealing with the sudden death of young people (31.6 percent)
2. Dealing with the death or resuscitation of a baby or young child (25.6)
3. Handling victims of car and train crashes (alive and dead) (15.1)
4. Confrontations with patients with physical trauma and burns (8.7)
5. Dealing with suicide (4.6)
6. Dealing with aggression, violence and threats (3.9)
7. Inability to deliver good quality of care (3.2)
8. Inability to help chronically ill patients (2.9)
9. Dealing with relatives of victims/patients (2.5)
10. Confrontation with child abuse and negligence (1.1)

The international studies posted by NCBI show an estimated 1 in 10 emergency workers have PTSD, with ambulance workers impacted at the greatest rate at 1 in 5.

The link between emergency medicine personnel and PTSD is not new. A survey of emergency medicine residents in 2003 found that nearly 12 percent met the criteria for PTSD, and 30 percent had one or more symptoms. The longer a resident worked in an emergency department, the more likely they were to have positive symptoms, the study found. At that time, however, there were few, if any, national or international studies exploring the prevalence of PTSD among emergency medicine personnel, according to the NCBI.

Nearly 12% of emergency medicine residents met the criteria for PTSD and 30% had one or more symptoms.

This issue was a key topic of the **American Academy of Emergency Medicine**'s 21st Annual Scientific Assembly, held last year in Austin, Texas. Leslie Zun, MD, from Mount Sinai Hospital in Chicago, spoke during the conference and cautioned the medical community to be aware of the symptoms of PTSD and learn to manage it.

Zun, in a 2015 interview with *Medscape Medical News*, estimated that, nationally, about 17 percent of emergency physicians experience PTSD, compared to 18 percent of nurses in emergency departments and 15 percent of trauma surgeons.

"Help is available, but our biggest hurdle in medicine tends to be this feeling that we cannot admit our weakness. We can't admit that we have a problem, especially a mental problem," Zun said during the interview. "But we are just like everybody else. We get affected by events that occur around us or are directed at us, and we need to take appropriate measures to deal with those things. We are not immune."

Symptoms of PTSD include flashbacks, nightmares, anxiety, guilt, depression, insomnia, angry outbursts, lack of interest in hobbies, withdrawal from family and friends, among others, according to the **National Institute of Mental Health.** ●

Preventing resident burnout

Mayo Clinic takes unique approach with initiative designed to be replicated in resident programs nationwide

By Tanya Albert Henry

A cardiology fellow at the Mayo School of Graduate Medical Education at Mayo Clinic in Jacksonville, Fla., launched a program-wide wellness initiative that helps physicians in training reduce stress and prevent burnout through activities not usually associated with medicine.

It started with one fellow's idea

When cardiology fellow **Olufunso Odunukan, MBBS**, took a year off between residency and fellowship, he signed up for ballroom dancing classes once a week while working as a hospitalist. He found it was a great way to reduce stress.

When he jumped back into the learning environment for his fellowship at the Mayo School of Graduate Medical Education, Odunukan looked at the medical literature to find ways to combat burnout during training. While he found plenty of research on the extent of burnout, there was frustratingly little written about how to intervene and prevent burnout.

"Then an epiphany came when I volunteered with a heart failure support group," Odunukan said. "It wasn't all lectures. … They had an instructor who taught people how to paint or make origami boxes. I had no background in either, but in 10 minutes I made the most beautiful box, and I had a sense of accomplishment."

It left Odunukan wondering if this approach would help physicians in training lower their stress as well. So he tested his theory.

"It is a strong message that we don't just care for patients but **we have to care for ourselves**. It is just very reassuring to see an institution **placing value on the wellness and well-being of residents**."

– Cardiology fellow Olufunso Odunukan, MBBS

Can arts and meditation reduce stress?

Odunukan created a pilot project that revealed that internal medicine residents who participated in one hour of art class were less fatigued and had improved work-related motivation when compared to their colleagues who participated in the usual noon conference.

He then followed up with a three-month study that included arts and humanities activities every two weeks, which replicated his initial finding. Afterward, he ran a randomized, crossover study that compared the impact of art and meditation on reducing stress and fatigue.

The results showed that group participation in arts led to improved bonding with colleagues, while meditation was more effective for lowering stress and fatigue. "They were complementary to each other," Odunukan said.

Today, the internal medicine program at Mayo Clinic's campus in Florida designates one noon conference every month as "Humanities Thursday." The **Fellows' and Residents' Health and Wellness Initiative** (FERHAWI) humanities program includes discussions of artwork, guided visual imagery and art projects, such as watercolor painting, screen printing and origami.

The initiative has received rave reviews, leading Mayo Clinic to earmark funds for resident wellness programs on all three of its campuses, Odunukan said. The Mayo Fellows Association also began a quarterly Wellness Fair at the Florida campus, where residents and fellows have a three-hour period to come and go and participate in arts, chair massages, yoga and pilates, among other things. And physicians in training can visit vendors to gather information, such as healthy eating tips.

"It is a strong message that we don't just care for patients but we have to care

*See **BURNOUT,** page 18*

Grant to fund CareOregon training for long-term care facilities

The Oregon Department of Human Services (DHS) Aging and People with Disabilities program has awarded **CareOregon** a two-year grant from the Long Term Care Quality Care Fund to develop and test a program of quality improvement training for long-term care facilities.

"Quality is critical to the safety, health and well-being for Oregonians living in long-term care settings," said **Ashley Carson Cottingham**, director of DHS Aging and People with Disabilities. "We are looking forward to direct care staff having the skills and tools needed through this simple, yet innovative approach."

Long-term care services and support is an area of health care facing enormous challenges. A fast-growing number of older adults, plus increasing levels of acuity among residents, makes the demand on caregivers more difficult. Long-term care service and support organizations face challenges attracting, training and keeping quality staff, while the staff often feel undervalued and underpaid for their hard and caring work, CareOregon said in a news release.

CareOregon said it will use the grant to establish a methodology of staff-directed change management based on the organization's long history of providing training and collaborative learning opportunities for providers.

CareOregon will build on the components of its Releasing Time to Care program offered to hospital nurses since 2010, and on a companion program for long-term care facilities it piloted last year in the upper Willamette Valley and Portland area. Both programs have elements of Lean Management, person-centered improvement methodology and collaborative learning.

"Participants from the hospital setting and long-term care settings have praised CareOregon's programs for their ability to make quality improvement possible for front-line staff, and to provide them with the tools to make it happen," said **Barbara Kohnen Adriance**, CareOregon's senior business leader for learning and innovation. "Improvements in staff and consumer satisfaction, safety, teamwork, leadership and engagement have been demonstrated."

"I think that the whole profession will benefit from having this tool and set of resources," said **Linda Kirschbaum**, vice president for quality and services at the **Oregon Health Care Association**. "It is so different than what's been available traditionally and so relatively easy to implement because, again, it doesn't require a top-down effort and really can be driven by the people that are most influenced by it."

During the first year of the grant, CareOregon will develop and pilot the program with 20 community-based care organizations. In the second year, CareOregon will scale the program to an additional 40 long-term care facilities, after which it will expand to other facilities in the state. Participating facilities will be selected based on location, size, governance structure and specialty to provide a robust learning opportunity in preparation for statewide rollout. The grant will provide as much as $731,410 over two years. ●

***BURNOUT** from page 17*

for ourselves," Odunukan said. "It is just very reassuring to see an institution placing value on the wellness and well-being of residents."

Improving residents' well-being

The program, which won the David C. Leach Award of the Accreditation Council for Graduate Medical Education in February, is one that could be replicated in resident programs nationwide. FERHAWI is featured in the **American Medical Association's STEPS Forward** collection of practice improvement strategies. The collection contains an online module that explains what is needed to prevent burnout among physician trainees, based on lessons learned by successful residency wellness programs.

Studies have shown there are six key factors in fostering residents' personal wellness, including practicing good nutrition and fitness, meeting emotional needs and participating in preventive care. Through the STEPS Forward collection, the AMA is helping physicians and physicians in training take those steps.

A wide variety of ideas will be shared at the **International Conference on Physician Health**, which the AMA will host Sept. 18–20 in Boston. This collaborative conference of the AMA, the Canadian Medical Association and the British Medical Association will explore the theme "Increasing Joy in Medicine." The conference showcases research and perspectives into physicians' health and offers practical, evidence-based skills and strategies to promote a healthier medical culture for physicians. ●

This article originally appeared in the AMA Wire.

A special gathering

Photo courtesy of Providence Health & Services

Providence St. Vincent Medical Center recently hosted a reunion for families whose children began their lives in the neonatal intensive care unit (NICU). The event gave families a chance to meet, mingle and share their common experience. It also gave doctors and other caregivers a chance to reconnect with patients and families and see their progress.

Among the attendees were Kathleen and Jim Riehl, their son Noah and daughter Fiona. Kathleen delivered twin boys, Nicholas and Noah, in June 2015 at 25 weeks. Baby Nicholas only lived five weeks. To honor her son, Kathleen now volunteers her time in the NICU.

Providence opens clinical trial on device to curb trismus

Providence has opened a clinical study of a device that could lessen the effects of trismus, the decreased ability to open the mouth, a common result of oral, neck and head cancer and its treatment.

Oral, head and neck cancer is the world's sixth most common form of cancer. Physicians will diagnosis more than 100,000 cases in the United States this year alone. Treatments can stretch over years and have difficult side effects, trismus being one of them. It can have a profound impact on the health and quality of life of a cancer survivor, Providence said.

The device could lessen the effects of trismus, even in patients years or decades out from their diagnosis and treatment, Providence noted.

"We know trismus can occur, at least temporarily, in more than 90 percent of patients treated with surgery and/or chemotherapy and radiation," said **Amber Watters, DDS**, a dental oncologist with **Providence Oral, Head and Neck Cancer Program and Clinic**. "In some people the problem becomes chronic. This trial will help determine if early intervention will improve outcomes related to trismus in patients with head and neck cancers."

A recent study showed early intervention helped participants increase their mouth opening by an average of 7 millimeters. This may seem small, but can make a big difference in limitation of oral function and quality of life after cancer treatment, Providence said.

Trismus results from scar tissue created by radiation and surgery. Many oral, head and neck cancer patients can develop the condition very early in their treatment.

Providence Portland Medical Foundation is supporting the clinical trial with a $21,300 grant, which will be used to purchase 100 Orastretch devices for participants.

Patients in the trial will receive the dynamic jaw stretching device and will use it for a set number of exercises over a scheduled period of time. They will be followed by Watters and a speech therapist to gauge the device's success. ●

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