The Portland Physician
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September 2016
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Grants to improve health

Are you developing an initiative that improves health education and community health care delivery? Learn more about mini-grant funding opportunities through the Metropolitan Medical Foundation of Oregon.

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Collaboration brings opioid information to physicians

Event, sponsored by MSMP, The Doctors Company and Adventist, updates providers on guidelines for treating chronic pain

By Cliff Collins
For The Scribe

Writing a prescription for an opioid drug usually is not the best option for treating chronic pain. That was a main message at a recent seminar at **Adventist Medical Center**.

The meeting, held July 27 and co-sponsored by the **Medical Society of Metropolitan Portland**, **The Doctors Company** and **Adventist Health**, was titled "Managing the Use of Medications in Patients with Pain." It brought together more than 52 Adventist Medical Group physicians who registered for CME credits, as well as additional providers who attended, to learn about the problems associated with opioid use for pain treatment not associated with cancer or hospice. The seminar also highlighted the latest guidance regarding finding alternatives to opioid prescriptions.

"Our goal was to have physicians updated for guidelines for chronic pain," said **Sarah Winslow, MD, MPH**, a family physician who is board-certified in preventive medicine and is a member of Adventist Medical Group. Winslow, who spoke at the seminar, presented an update of Adventist's own guidelines, as modified in accordance with those recently released by the Centers for Disease Control and Prevention. "I think there are a lot of doctors out there who think that being on opioids helps people," she said. "It hasn't been shown in the literature to help chronic pain."


SARAH WINSLOW, MD, MPH

In the past, physicians were encouraged to give opioids to relieve pain, "but a few years later we found there was a lot of harm being done. There definitely has been a paradigm shift in how physicians have been told to treat chronic pain management. I think there's a little fear about that."

Many doctors think they have no other alternatives or resources besides opioids, Winslow said. But she pointed out that there are, including other medications, physical therapy, counseling, TENS and referrals to pain specialists.


JOSEPH THALER, MD

Joseph Thaler, MD, medical director of the **Oregon Medical Board**, agreed that recommendations changed as medicine gained more information and observation about the effects of opioid use. "There has been a dramatic shift from what physicians were told 10 years ago," said Thaler, who also spoke at the seminar. His principal theme to attendees was that prescription opioid use and abuse are epidemic, and that physicians' practices are key to helping solve the problem.

"The difficulty is, all doctors are well-meaning," he said. But "there is no medical evidence that opioids effectively treat chronic, nonmalignant pain," he said. "There are many reasons why physicians got trapped into thinking we were treating chronic pain effectively with opioids. However, we have written the prescriptions and continue to write them. We've got to change."


RALPH M. PROWS, MD

"Physicians are dedicated to relieving suffering," noted **Ralph M. Prows, MD**, chief medical officer of Adventist Health.

*See **OPIOID SEMINAR,** page 18*

Clinic tackles specialized needs of foster children, with positive results

By Cliff Collins
For The Scribe

Foster children often have complex health and social needs that are difficult to address in a standard health care setting. Recognizing those differences, a local clinic follows a model of care that has shown positive results.

When providers and administrators reviewed the American Academy of Pediatrics' "Healthy Foster Care America" recommendations, "We looked around and said, 'That's what we need to do for our children,'" said **Holly Hermes, LCSW**, a social worker who coordinates care for patients at **Randall Children's Clinic – Emanuel**. The academy's manual, "Fostering Care," in Chapter 5, discusses coordination of services that should be in place to ensure that children and adolescents in foster care receive high-quality, comprehensive and coordinated health care.


HOLLY HERMES, LCSW

After years of seeing gaps in health care for children in foster care, staff at the clinic obtained a grant in 2009 to create such a program. The grant, from the city of Portland's Children's Levy, was used to identify the gaps in care and find ways to coordinate each child's care, she said. Each foster child referred to the clinic is assigned a care coordinator, who works with the foster parents and caseworker to follow up and help monitor the child's care.

The five-year grant helped the Randall clinic improve care in demonstrable ways, such as reducing emergency room visits and increasing immunizations for these children. But Hermes said it also was limiting in that the grant paid only for children who lived in Portland or whose families lived in the city. Meanwhile, the clinic also was receiving referrals for children who were from other parts of the metropolitan area. When the levy funding ended in 2014, **CareOregon** picked it

*See **FOSTER CLINIC,** page 17*

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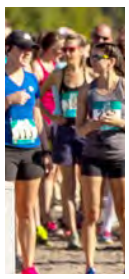
Scrub Run Derby 2016



Scores of people turned out at Portland Meadows for the Scrub Run Derby, the August event that raised money for Dollar for Portland and Doernbecher Children's Hospital.
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"Connecting Physicians in Community"

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

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Scrub Run Derby

Thank you to everyone who attended the Scrub Run Derby! Whether you ran the course or volunteered your time, the day would not have been possible without your participation and support!

A special thank you to our sponsors, **Finity Group** and **The Portland Clinic**.

Please turn to page 8 to see photos from the event.

Mini-grants available from the MMFO

The mini-grant program of the Metropolitan Medical Foundation of Oregon (MMFO) funds project requests up to $500. The third quarter mini-grant application deadline of Sept. 30, 2016 is quickly approaching.

The mini-grant program funds project requests that support activities which improve health education and the delivery of health care to the community.

Further information about MMFO activities, as well as grant applications, are available at *www.MMFO.org*.

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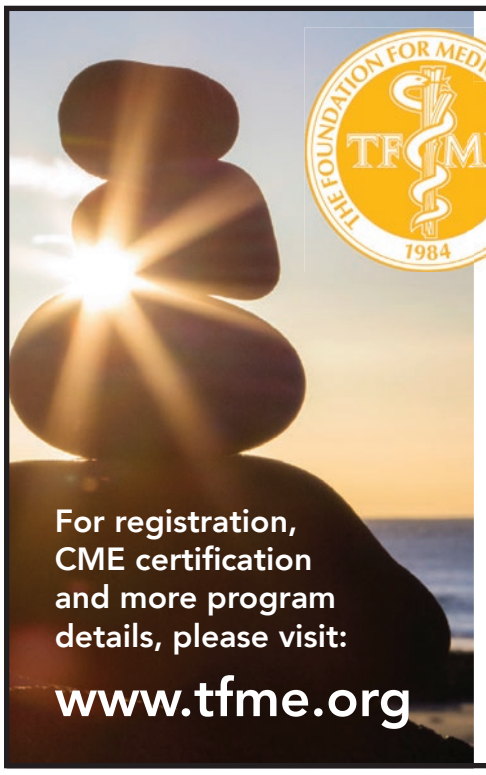

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OHSU a leader in MS research, treatments

By John Rumler
For The Scribe

In 2001, **Vijayshree Yadav**, who received her MD from SN Medical College in Agra, India, was doing her residency in neurology at **Oregon Health & Science University**. Multiple sclerosis was not even on her radar.

However, as Yadav began studying MS, she became intrigued by the disease, which afflicts 2.5 million people worldwide and about 400,000 Americans. She went on to complete fellowships in both neuro-immunology and multiple sclerosis and also earned a master's in clinical research.

"There's no cure for MS. We don't even know what causes it," said Yadav, clinical medical director of the **OHSU Multiple Sclerosis Center**. "MS was considered almost untreatable at that time."

Yadav's MS study, "Low-fat, plant-based diet in multiple sclerosis: A randomized controlled trial," examined whether a low-fat, vegan diet can change disability and relapse rates, improve fatigue and affect lipid biomarkers. It is online on the September 2016 *Multiple Sclerosis and Related Disorders* website.

The year-long study was a single-center, assessor-blinded clinical trial involving 61 subjects who were assigned to either a diet group, which limited itself to very low-fat, plant-based diet, or the control group.

Although there was no significant impact observed in MRI scans, or disability or mobility levels, the study is noteworthy because diet is by far the most popular complementary therapy among MS patients.

"The biggest thing we learned is that alternative therapies, including exercise and diet, has a considerable impact on MS patients. Their fatigue improved by nearly 50 percent and the participants lost an average of 20 pounds."

People started trying alternative methods of treating MS many years ago, including special diets and plant-based diets, Yadav said. "Although some of these things helped, it wasn't being seriously documented and recorded. We have a long way to go, but we're beginning to find alternatives to drugs."

The resulting weight loss and decrease in fatigue was highly significant and very good news to people with MS, said **Nicholas LaRocca, PhD**, vice president of health care delivery and policy research at the **National MS Society**.

"Research studies of dietary approaches to MS have generally been of inadequate size and design to provide useful information," LaRocca said. "That's why Dr. Yadav's study is so important. Wellness, and the strategies needed to achieve it, is a high priority for people living with MS and for the National MS Society."

In March, the National MS Society founded the Collaborative MS Research Center at OHSU, but the MS Society has been supporting OHSU's research for decades, including studies by **Dennis Bourdette, MD**, executive director of the school's MS clinic, and more recently Yadav.

Though Yadav is encouraged by the findings, she acknowledges the disease is still not well understood and the causation is as mysterious as the baffling symptoms that wax and wane. Some people with MS become mildly disabled and have a normal lifespan, while others have their ability to walk and speak, among other things, severely impaired.

The incidence of MS is much higher in colder climates and it is twice as prevalent among women. It is not considered a hereditary disease, but there is believed to be a genetic component. MS affects people in myriad ways, with no two cases alike.

While the FDA has approved a dozen drugs to treat MS, they can do considerable harm, have numerous side effects and are very expensive, Yadav said. Healthline.com noted MS ranks second only to congestive heart failure in terms of health care costs for chronic conditions in the U.S. Also, there is no single "MS test." Diagnosis requires a neurological exam, MRI, spinal fluid analysis, blood tests and sometimes more.

Photo courtesy of OHSU

Dennis Bourdette, MD, and Vijayshree Yadav, MD

Although MS does not lead to obesity directly, Yadav explained, the accompanying fatigue and sedentary lifestyle causes some MS patients to be overweight. "The weight loss was very gradual, over the course of one year," Yadav added. "The fatigue improved by a great deal in just one month."

Yadav and the team of MS researchers are now planning a follow-up study to find the specific reasons for the weight loss and reduction of fatigue, hoping to perhaps find a key to the enigmatic disease. It is just one example of how OHSU is uniting experts across multiple specialties including neurology, nutrition, sports medicine, neuroimaging and naturopathic medicine in novel research projects.

It's all a part of the center's mission to provide people afflicted with MS with solid, evidence-based advice on whether those non-invasive measures/lifestyle changes can significantly improve their quality of life.

The MS center team has long been engaged in discovering and developing new therapies. Recent studies include using aerobic exercise to improve mitochondrial function in brain cells; using lipoic acid, an antioxidant, as a potential treatment for optic nerve inflammation and secondary progressive form of MS; evaluating whether optical coherence tomography, an eye scan that gives information about the nerve structure, can provide novel information about blood flow in MS patients; and studying factors that affected mobility and falls.

In addition, Bourdette was one of the country's first clinicians to draw the public's attention to the alarming rise of MS drug costs, publishing an article titled "The cost of multiple sclerosis drugs in the U.S. and the pharmaceutical industry: Too big to fail?" in *Neurology* (April 2015). He's also called out insurance companies for interfering with shared-decision practices and harming patients.

The National MS Society's financial commitment to the OHSU center is a part of the society's efforts to move closer to a world free of MS, and part of a $50 million investment in 2016 alone to support more than 380 studies around the world, LaRocca said.

"OHSU has long been at the forefront of investigating complementary approaches to treating multiple sclerosis," said LaRocca. "They were among the first in the MS field to apply painstaking, scientifically appropriate design and methods to conduct clinical trials of dietary supplements and other complementary strategies." ●

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LEGACY HEALTH

Advances in burn care help more patients recover, thrive

By Jon Bell
For The Scribe

For **Niknam Eshraghi, MD**, a surgeon with **The Oregon Clinic** and the associate director of the **Oregon Burn Center**, not much has changed in his 17 or so years of practice in terms of how burns impact people. Burns still damage tissue the way they always have, and smoke inhalation that often accompanies burn victims still causes the same kind of serious problems it's always caused.

What has changed, however, is often how people are burned. Thanks to improvements in smoke alarms, electrical code and other safety measures, Eshraghi seems to see fewer victims of home fires these days. Outreach campaigns have also helped reduce burn injuries among electrical and natural gas workers.

Oddly, though, along with those advancements have come changes in the other direction as well. For a time, Eshraghi said the Oregon Burn Center, which is on the campus of **Legacy Emanuel Medical Center** and is the only one of its kind between Seattle and Sacramento, saw a rise in burns from meth lab explosions, though those seemed to have tapered off. At the same time, he has seen a rash of explosions related to hash oil extractions that result in face and hand burns. And one other modern-day burn oddity: There's been an increase in incidents of people getting burned when they place battery-powered vaping devices in their pockets with other metal objects.

"You have these big, high-amp batteries in their pockets with coins and key chains," Eshraghi said, "and so their pants catch on fire. We have seen several of those over the past couple years."

If some of the ways that people burn themselves are changing, so too are some of the ways that physicians treat them. According to Eshraghi, there have not been any radical breakthroughs in recent times, but rather a shift over the decades from letting burns heal on their own to a much more active approach.

"I think all the advances have been aimed at removing the dead skin earlier and earlier and applying skin grafts or skin substitutes much earlier," he said. "It's been absolutely proven that if you can get the wound covered and get the dead tissue off the body, they recover much better and much faster."

Advances in critical care, and a multidisciplinary, team approach to treatment, much like that practiced at the Oregon Burn Center, have also been key to helping more people survive and recover from serious burns. Such an approach involves nurses, therapists, surgeons, dietitians, pharmacists and other team members working together; having the most advanced respirator care and equipment doesn't hurt either.

Photo courtesy of Legacy Health

Providers today are taking a much more active approach to treating burns, helping people recover better and faster. The largest multiplace hyperbaric chamber in Oregon was recently installed at Legacy Emanuel Medical Center.

Enoch Huang, MD, (pictured, with the chamber) program medical director for Hyperbaric Medicine/Wound Healing for Legacy Emanuel, said he hopes to be among those leading the charge to research hyperbaric therapy to help treat burns.

"We actually do quite well in keeping people alive and supported," Eshraghi said. "Even people with large, devastating burns, they do well. If there is a will and support, it's amazing how people can get through this and go on to a productive and good life. I've treated one- and two-year-olds with destructive injuries who are now in high school and doing fine. These are terrible injuries, but it's not necessarily a death sentence."

In fact, Eshraghi said, a relatively low 4 percent to 5 percent of all patients who come to the Oregon Burn Center die from their injuries these days.

"The vast majority end up doing well," he said.

Among the other advances in burn care have been the use of biologic glues rather than sutures or staples to attach skin grafts. Doing so makes changing the dressing on a wound much less painful. Similarly, new pain medications help keep burn patients comfortable, and the Oregon Burn Center has even taken to using virtual reality as a way to help distract patients from their pain.

Newer compression stockings help flatten out scars caused by burns; Eshraghi said lasers, too, have become much more common in treating burn scars, not just for aesthetic purposes, but also to reduce redness and itchiness. He also said innovative dressings with enzymes in them that could help protect live tissue are showing promise; others release silver ions, which help protect the wound better.

"That way you don't have to change the dressing as often and yet you're helping the wound heal," Eshraghi said. "And if it heals faster, there are fewer problems, less scarring and less pain."

Another innovative area that could be on the horizon for treatment of burn victims is the use of a hyperbaric chamber. Legacy recently installed the largest multiplace hyperbaric chamber in Oregon at Legacy Emanuel. The chamber can treat as many as 12 people at a time.

Enoch Huang, MD, program medical director for Hyperbaric Medicine/Wound Healing for Legacy Emanuel, said the chamber, which was installed in May, will be used to treat a range of afflictions, including diabetic foot ulcers, radiation damaged tissue and chronic bone infections. It can also be used to treat the bends and carbon monoxide poisoning.

"Helpful doses of oxygen can really help tissue survive," Huang said. "Oxygen is medicine and the hyperbaric chamber is the pill."

When it comes to treating burns with hyperbaric chamber treatments, Huang said there have yet to be any randomized, controlled trials to show its efficacy. As a result, it is not widely used to treat burns.

"I think the burn community in general has not really embraced hyperbaric therapy," he said, noting that it also can be difficult to get reimbursement for hyperbaric treatments, even though the Food and Drug Administration has approved its use for some indications. "I'm trying to change that."

Huang himself hopes to be among those leading the charge to research the therapy and prove that it can be helpful in treating burns. He said it has been shown to help save tissue in other cases, and he believes it can be proven to work for burns, as well.

Until that time comes, Huang said Legacy surgeons have been supportive and would likely be willing to consider the treatment once the research backs it up. Eshraghi agreed.

"Right now we have not incorporated that into our burn algorithm," he said. "But it's exciting to have the modality here on the campus, and I think it is something that we would consider in the future." ●

What doctors need to know about Zika virus

By Dan Wright, JD, RN
Vice president of patient safety, The Doctors Company

Physicians should practice vigilance to ensure patient safety and reduce risk of potential adverse events as we continue to learn more about the Zika virus. As of August 2, the Florida Department of Health has reported that there have been 14 confirmed Zika infections from mosquitoes in Southern Florida, and this number continues to grow.

Stay informed. Ensure you are staying abreast of Centers for Disease Control advisories. They are frequently updated, and you want to provide your patients with the most current information. Diagnosis of Zika is based on a person's recent travel history, symptoms and test results.

Watch for the symptoms. Tell-tale signs of Zika virus are an acute onset of fever, maculopapular rash, joint pain and conjunctivitis. For symptomatic pregnant women with exposure to Zika virus, testing of blood and urine is recommended up to two weeks after symptom onset. In addition, asymptomatic pregnant women should be tested if they have traveled to an area with Zika, live in an area with Zika, or have had sex without a condom with a man confirmed to have Zika virus infection. Document if the testing is declined.

Ask pregnant patients about travel history at every visit. Ensure that patients are asked at the time of intake about their travel history, especially in high-risk areas. Ensure that travel history is available to all practitioners involved in the patient's care. Pregnant women should not travel to areas with Zika. If they must travel, tell pregnant patients to protect themselves from mosquito bites and to take steps to prevent sexual transmission during and after travel.

Provide specialized care for pregnant patients. Consider amniocentesis for pregnant women who have traveled recently to an area with Zika virus transmission and have ultrasound findings of microcephaly or intracranial calcifications. Consultation with a maternal-fetal medicine specialist should be considered. Report laboratory-confirmed and probable Zika diagnoses to local, state and federal agencies.

At birth, test and document. Test for Zika virus infection in babies:

- Born to women with possible travel-associated or sexual exposure to Zika.
- Born to women who lived in an area with ongoing Zika virus transmission during pregnancy.
- Diagnosed with microcephaly or intracranial calcifications detected prenatally or at birth.
- Born to women with positive or inconclusive test results for Zika virus infection. ●

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 health care 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.

OHSU class of 2020 most diverse in school's history

The recent "White Coat Ceremony" at the OHSU School of Medicine marked the most diverse entering class in the school's history.

Women comprise more than 61 percent of the class. Nearly 30 percent of entering students report having come from a racial or ethnic background other than Caucasian. Approximately 24 percent of students come from a rural background. Five students have completed military service, according to OHSU.

OHSU celebrated its 129th entering class with the ceremony, which symbolizes the beginning of each MD student's journey to becoming a physician. ●

Scrub Run Derby 2016

The second annual 5k Scrub Run Derby took place Aug. 20 at Portland Meadows and raised money for Dollar for Portland and Doernbecher Children's Hospital.

To view more photos from the Scrub Run, please visit *www.msmp.org/Scrub-Run*.

Joel David Moore with MSMP staff, from left: Deena Stradley, Janine Monaco, Amanda Borges, Paula Purdy, and Sarah Parker. Moore's acting roles have included *Bones* and *Avatar*.

Photos courtesy of Wiley Parker

Rip City Slammers

Wolf Meetings, winner of this year's Battle of the Doctor Bands, performed for runners and other attendees of the Scrub Run Derby.

Scrub Run Derby attendees included, from left, Laura Bledsoe, MD, John Evans III, MD, Mary McCarthy, MD, Joel David Moore and Lydia Villegas, MD. Drs. Evans, McCarthy and Villegas serve on MSMP's Board of Trustees.

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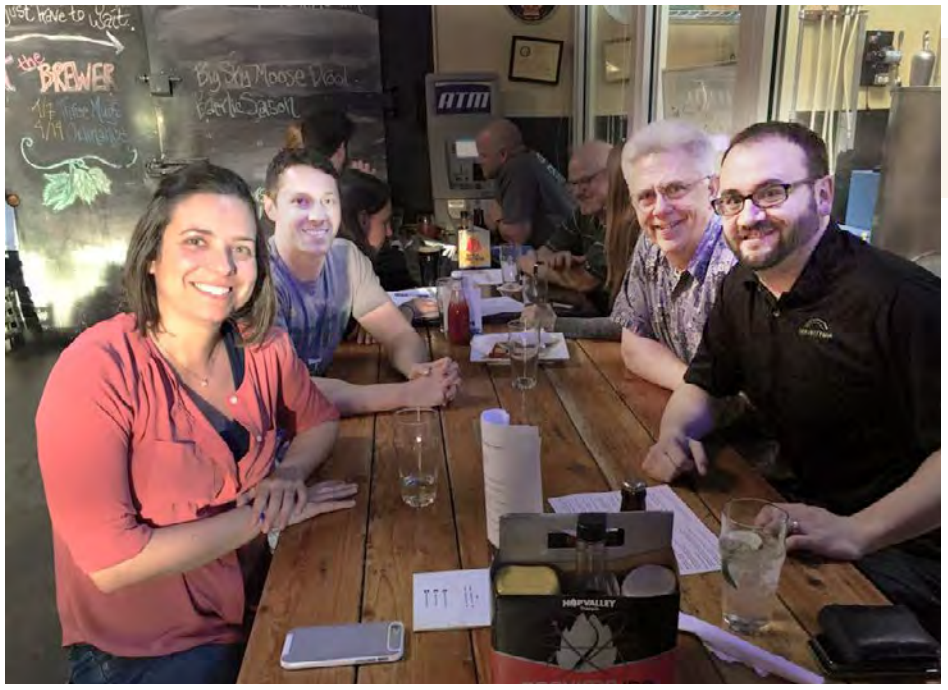
Providers say 'Night Out' bolsters their professions

By Jon Bell
For The Scribe



From left, Dani Anderson, ND, Bryan Lang, PT, Jerry Henderson, PT, and Derek Fenwick, PT, enjoy Health Care Night Out, a monthly gathering of health care providers who get together to network, collaborate and socialize.

Photo courtesy of the Oregon Physical Therapy Association

It started informally about four years ago, just a handful of local physical therapists, all part of the **Oregon Physical Therapy Association**, getting together at a pub once a month to talk shop, catch up and enjoy each other's company.

Eventually, though, practitioners from other fields – occupational therapy and speech pathology, for example – started to show up as well. And that led **Derek Fenwick, PT**, president of the OPTA, to believe that there was a bigger opportunity brewing.

"Because it became a regular event and more people were coming, it prompted me to reach out to other associations and say, there's something good going on here and would you be interested in being a part of it?" he said.

The answer from the **Occupational Therapy Association of Oregon** and the **Oregon Speech-Language & Hearing Association** was a resounding yes. And so, in October of 2015, the associations officially launched **"Health Care Night Out,"** a regular gathering of varied providers who convene on the third Thursday of every month to network, collaborate and socialize.

"It's really a time and a place where we can bring practitioners together outside of the clinic to increase the communication and not only open up the opportunities for ideas that can be carried into the clinical world, but also the policy and advocacy efforts in Salem," Fenwick said.

The various associations involved in Health Care Night Out – nursing has been added recently, too – each host their own gatherings in about a dozen cities around Oregon such as Portland, Gresham, Salem and Corvallis. Some meetings are held at restaurants, some in parks – one even took place at a swimming pool. Fenwick said the meetings are fairly informal, but they're also focused, for a while anyway, on a topic pertinent to the profession.

For the OPTA monthly event, Fenwick said the association's membership committee comes up with a topic of discussion in advance to get the conversation started. One recent meeting focused on student debt. He said the conversation usually stays focused on the topic for 20 minutes or so before people start splitting off into side chats about everything from their practice to their home lives.

Having the formal Health Care Night Out events every month has made it easier for people who used to only see each other maybe once or twice a year to stay in better contact, Fenwick said.

"Prior to the Night Out, people in our association had the opportunity to come together once a year or so during a conference," he said. "Now there are at least 12 opportunities, so the relationships are growing much faster."

That gives people the chance to broaden both their personal and professional connections. In fact, Fenwick said one of the physical therapists who has been taking part in the gatherings from early on ended up retiring and selling his practice to another therapist who he'd connected with through the Night Out meetings.

"There's a lot of cool stuff like that that goes on," Fenwick said. "I don't even know if I know the depths of all that goes on."

Other benefits include networking and referrals, particularly when one practitioner may have an expertise or specialty area that another may not.

"(Night Out) events have allowed us to connect with occupational therapists outside of our work environments that we would not usually encounter," said **Nicole Wandell**, a Portland occupational therapist and the continuing education chair for the OTAO. "We have also had OTs traveling from other states see the event on our website and show up to meet others, which has been really fun."

In addition, Fenwick said the gatherings help practitioners coalesce around advocacy issues that are important to them and that need to be shared with lawmakers in Salem. Recent topics along those lines have included telehealth, licensure and cutting the red tape that many insurance companies make practitioners wade through to provide care.

The monthly gatherings attract anywhere from six to 12 people most nights, Fenwick said, though some months are busier than others, particularly if a group brings in an outside speaker. The program has been going strong for almost a year now, and Fenwick said he would like to see it gather even more momentum going forward.

"I would love to see us increase the number of professions participating – physicians, naturopaths, chiropractors. We could all benefit from it," he said. "Getting it up to 10 or 12 different groups, that's when it gets really fun and really helpful." ●

To find out more about the various Health Care Night Out events, visit the website www.healthcarenightout.org.

"I would love to see us increase the number of professions participating – physicians, naturopaths, chiropractors. **We could all benefit from it.**

Getting it up to 10 or 12 different groups, **that's when it gets really fun and really helpful."**

–Derek Fenwick, Oregon Physical Therapy Association president, on "Health Care Night Out"

Oregon first state to join PT licensure compact

As noted by the publication *PT in Motion* a few months ago, Oregon became the first state to join the Physical Therapy Licensure Compact (PTLC), the goal of which is to make it possible for physical therapists (PTs) and physical therapist assistants (PTAs) to practice in multiple states through a single license and privilege.

The legislation, signed into law by Gov. Kate Brown, "adopts standard language allowing Oregon to participate in a system in which a PT or PTA with a valid, unencumbered license in one participating state may practice in any other participating state. Qualified PTs and PTAs would be able to choose any or all participating compact states to gain practice privileges, but would only need to maintain licensure in their 'home' state," reported *PT in Motion*, the **American Physical Therapy Association**'s magazine.

The Federation of State Boards of Physical Therapy and APTA, working with state APTA chapters, state regulatory boards and supporters of increased licensure portability, have spearheaded efforts toward compact adoption.

As of July, the most recent update by the federation, Tennessee, Arizona and Missouri had signed the compact into law.

PT in Motion noted that to become operational the system must have at least 10 participating states. In a *PT in Motion* article, APTA Vice President of Government Affairs Justin Elliott said that states should consider moving on the issue soon. "The creation of a compact for PTs and PTAs is truly going to transform the state licensure process," Elliott said, "all while maintaining and even improving the level of public protection in the compact states."

"The federation is thrilled Oregon was the first state to enact the Physical Therapy Licensure Compact," said federation President Maggie Donohue, PT. "This is a demonstration of how APTA, the FSBPT, the Oregon Chapter, and the Oregon Physical Therapy Licensing Board can work together to benefit the health care consumer. We trust Oregon is the model for continued collaboration and advancement of patient access to physical therapy services."

In the wake of Oregon's decision, APTA President Sharon L. Dunn, PT, PhD, OCS, said she hoped that other states would follow suit.

"The PTLC is a common-sense solution to provide greater licensure portability and increased patient access, and to facilitate the use of telehealth." Dunn said. "We applaud the state of Oregon for being the first to enact the compact legislation and look forward to more states joining in the near future." ●

Surgeon general asks providers to help 'Turn the Tide' on prescription drug epidemic

In an unprecedented step, **U.S. Surgeon General Dr. Vivek H. Murthy** in late August sent a letter to 2.3 million American health professionals, asking them to lead a national movement to turn the tide on the nation's prescription opioid epidemic.

The surgeon general urged clinicians to visit a website his office launched last month, *TurnTheTideRx.org*, where they can pledge to combat opioid misuse by enhancing education for treating pain, by screening patients for opioid use disorder, and by leading a shift in the public perception of addiction so that it is treated as chronic illness rather than as a moral failing.

The letter is accompanied by a pocket card, adapted from the Centers for Disease Control & Prevention's opioid prescribing guidelines, that highlights physical therapy as a non-opioid therapy to consider.

"I know solving this problem will not be easy," Murthy wrote. "We often struggle to balance reducing our patients' pain with increasing their risk of addiction. But, as clinicians, we have the unique power to help end this epidemic."

This effort builds upon the U.S. Department of Health and Human Services (HHS) Opioid Initiative focused on tackling the nation's opioid epidemic, as well as the National Pain Strategy, the federal government's first coordinated plan to reduce the burden of chronic pain in the United States.

Murthy's letter points out that nearly 20 years ago the medical community was encouraged to be more aggressive about treating pain. As the number of prescriptions for opioid pain relievers increased, so did the number of deaths from opioid overdose. In 2014 alone, there were nearly 240 million prescriptions dispensed for opioids. In the same year, more than 14,000 people died from overdose of those drugs.

The pocket card notes, in part, that "(o)pioids can provide short-term benefits for moderate to severe pain" but that "(s)cientific evidence is lacking for the benefits to treat chronic pain." In general, it emphasizes, "do not prescribe opioids as the first-line treatment for chronic pain (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care)."

The card also notes that before prescribing opioids providers should consider if non-opioid therapies are appropriate, including exercise or physical therapy or cognitive behavioral therapy.

This marks the first time that a U.S. surgeon general has sent a letter directly to the nation's health professionals seeking their support in addressing a public health crisis. Since April, Murthy has visited American communities hardest hit by the opioid epidemic, talking to health professionals, community leaders and people who have recovered from opioid use disorder. And later this year, he will release the first-ever surgeon general's report on alcohol, drugs and health. ●

Look for the Portland Physician Scribe's coverage in October about the ways physical therapists and pain specialists are helping patients manage pain without opioids. That coverage also will touch on the American Physical Therapy Association's #ChoosePT campaign, a national effort to promote physical therapy as a safe and effective alternative to opioid use in treating pain, and physical therapists' involvement in a White House multidisciplinary working group that aims to address the opioid epidemic.

Cardiac rehab improves health but cost, access hamper success

Despite evidence showing cardiac rehabilitation programs substantially cut the risk of dying from another cardiac problem, improve quality of life and lower costs, fewer than one-third of patients whose conditions qualify for it actually participate. Various studies show women and minorities, especially African Americans, have the lowest participation rates.

Advocates say cardiac rehab may gain traction, partly because the federal health care law puts hospitals on a financial hook for penalties if patients are readmitted after cardiac problems. Studies have shown that patients' participation in cardiac rehab cut hospital readmissions by nearly a third and saved money. The law also creates incentives for hospitals, physicians and other medical providers to work together to better coordinate care.

But many patients still face hurdles. Uninsured patients simply can't afford cardiac rehab. For those with some form of coverage, copayments are often a barrier. Medicare and most private insurers generally cover cardiac rehab for patients who have had heart attacks, coronary bypass surgery, stents, heart failure and several other conditions. Most coverage is two or three hour-long visits per week, up to 36 sessions.

Insured patients usually must make a per-visit copay to participate. For regular Medicare members, that's about $20 a session, although many have private supplemental insurance that covers that cost. For patients with job-based insurance – and enrollees in the alternative to traditional Medicare called Medicare Advantage – out-of-pocket costs can range from nothing per session to more than $60.

Another reason so few patients participate is many are never referred to a program. Some hospitals are addressing this disconnect by building automatic referrals into their discharge system. Patients may be reluctant to attend cardiac rehab, especially if they had not been physically active before their heart problem. Others are discouraged by time constraints, or having to travel long distances to the nearest program.

And existing programs can't accommodate all patients who are eligible. A recent study in the *Journal of Cardiopulmonary Rehabilitation and Prevention* surveyed 812 programs in the U.S., finding that even if they were expanded modestly and operated at capacity, they could still only serve 47 percent of qualifying patients. ●

To read the full article by Julie Appleby, please visit Kaiser Health News at http://khn.org/news/cardiac-rehab-improves-health-but-cost-and-access-issues-complicate-success/.

Providing the foundation for better health care

▪ *OHSU's growing MD/PhD Training Program prepares newest generation of physician-scientists*

By John Rumler
For The Scribe

Succeeding as a physician-research scientist has never been easy, but today it is fiercely competitive, not to mention the enormous expense of training. OHSU's **MD/PhD Training Program** maximizes a student's chance for success by providing focused research training coupled with comprehensive mentoring.

The program accepts only one out of about 40 extremely qualified applicants, and recent grads are completing residencies at Harvard, Yale, Duke, the University of Chicago, Stanford, Brown and other top institutions.

The training program (one of 118 MD/PhD training programs in the nation) recently received a $1 million grant to support its mission to train outstanding physician-scientists with the breadth and depth of knowledge to become leaders in medicine and trans-disciplinary biomedical research. The Medical Scientist Training Program (MSTP) grant, distributed over five years, is courtesy of the National Institute of General Medical Sciences.

KATIE LEBOLD:

"Dr. Jacoby offers mentorship throughout every stage of training, tackling both big-picture and nitty-gritty topics, everything from how to choose a research laboratory to defining career goals and how to successfully pursue them."

"Receiving this grant speaks volumes about the quality of our students," said director **David Jacoby, MD**, professor of medicine and chief of the Division of Pulmonary/Critical Care Medicine. "Not only are they outstanding physician-scientists, but they have also built a culture of high expectations, support for each other and collaboration that makes OHSU very proud."

George Mejicano, MD, senior associate dean for education with the OHSU School of Medicine, said, "This award is recognition of the excellence of the OHSU MD/PhD program and its place among a select group of medical schools offering MSTP-funded programs."

Although health care and medicine has changed enormously since OHSU's program began in 1982, its objectives/goals remain the same: to provide the best possible training for the next generation of physician-research scientists. In recent years, Jacoby said, there has been an additional emphasis, beyond traditional science and medicine, on written/oral communication skills, leadership and grant writing.

Jacoby, director since 2008, has grown the program to 36 students with 11 graduate programs participating. Interest in the program continues to increase, with 195 applicants this year, up from 120 five years ago.

ANDREW TERKER:

"During my time at OHSU I realized how passionate I am about science and research, and I intend to use my skills as a physiologist to improve the medical care of patients. I've been fortunate to have great mentorship and creative colleagues, both of which I credit for my development as a scientist."

The program, which takes an average of eight years to complete, is fully integrated, with students working on research and medicine throughout. The greater emphasis for the first 18 months is on the MD curriculum, after which the students focus on their PhD research for three to four years. This is followed by the remainder of the MD curriculum for two years. In addition to their thesis projects, OHSU MD/PhD students often undertake clinical projects as well as collaborative research outside their thesis work. To allow them to focus solely on their training, the students' tuition is fully paid and they receive a stipend for living expenses.

Starting her fifth year, MD/PhD candidate **Katie Lebold**'s ultimate goal is to treat patients in the ICU and ED while continuing to research pulmonary disease. Lebold said the program teaches her to identify important clinical problems that demand attention and also how to lead a team to solve a crisis.

"This program provides the foundation for lifelong dedication to, and scientific pursuit of, better health care." Of all the benefits so far, she said the most valuable is how the experience has transformed her ability to think. "I am now able to contextualize and synthesize like never before."

MOLLIE MARR:

"I want to use research on PSTD, its identification, diagnosis, and treatment to push systems like health care, child welfare, and the juvenile justice/prison system to support traumatized individuals."

In his ninth and final year of the program, MD/PhD candidate **Andrew Terker**'s long-term goal is to be an independent clinician-scientist at an academic medical center. The biggest benefit to him, Terker explained, is the opportunity to work in a scientific environment where he receives excellent guidance and mentorship, while being given ample independence to address important scientific issues.

"In addition to a great medical education, I've acquired the skills necessary to conduct research: learning to ask important questions, testing hypotheses, writing grants and papers, giving scientific presentations and critically assessing scientific literature."

Mollie Marr, MD/PhD candidate, is a second-year student with an end goal of practicing clinical medicine and conducting research while working with public systems to promote change. She is deeply

*See **MD/PhD TRAINING,** page 14*

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Oregon ballot Measure 97: Two points of view

■ *Measure 97 will improve health, decrease number of Oregonians without health insurance*

By Dr. Paul Hochfeld and Dr. Ken Rosenberg

Measure 97 will increase corporate income taxes for the 1,000 largest companies registered in Oregon – corporations that do more than $25 million in Oregon sales. The tax will only affect one-quarter of 1 percent of the businesses registered in Oregon, with 85 percent paid by corporations with more than $100 million a year in Oregon sales – corporations such as Comcast, Walmart and Genentech.

Measure 97 will generate an estimated $3 billion in revenue each year, according to the Legislative Revenue Office. By law, the revenue generated from Measure 97 will be allocated to health care, public education (early education and K–12) and senior services.

This new revenue will likely help fill the anticipated $1.7 billion gap in Medicaid funding the state faces in the next biennium. And, despite recent improvements, nearly 383,000 Oregonians still lack insurance, according to data from the American Community Survey. Even when people have insurance, it is often prohibitively expensive: Based on the Oregon Basic Health Program Study, Oregonians with modest incomes will pay about $1,600 in out-of-pocket expenses per person per year, which is almost 7 percent of their total yearly income. When it comes to public health spending, Oregon also falls short. According to a report by the Trust for America's Health, Oregon spends about $25 per person on public health, compared to $40 per person in Washington and $95 per person in Idaho. There are so many programs that will benefit from corporations paying their fair share.

The main reason we have these problems is that corporations in Oregon have quietly and steadily found ways to stop paying the taxes they owe. In the 1970s, corporations' share of the income tax revenue in Oregon was around 18 percent. Today, it's fallen to less than 7 percent. In 2013 alone, 530 C-corporations dodged their corporate income taxes completely. For three years in a row, Oregon has ranked fiftieth – dead last – in corporate taxes.

Oregonians like us pay our fair share in taxes. It's time that big corporations do the same.

A study done by the Oregon Consumer League shows that corporations have national pricing strategies, meaning that consumer goods are the same price here, where we have the lowest corporate taxes in the nation, as they are in Alaska and North Dakota, where they have the highest corporate taxes in the nation. This means that corporations don't pass on corporate taxes directly to consumers and Oregon's consumers will be protected from price increases.

This November, we have a choice: vote with big corporations at the expense of patients, or vote in the interest of the thousands of Oregonians who can't afford the out-of-pocket costs for medication, who don't have access to primary care in rural Oregon and who are unable to access the preventive public health care they need to make lasting impacts in their lives.

As doctors, we are responsible for the health of our patients, not the bottom line of big corporations. Thousands of Oregonians, including economists, parents, teachers, 250 businesses, health groups such as Health Care for All Oregon and the Oregon Public Health Association, and most recently, Gov. Kate Brown, have all come out in support of Measure 97. We hope that those of us in the health care field will serve as an example to our patients, friends and neighbors by supporting Measure 97 this November. ●

Dr. Paul Hochfeld is a retired emergency physician at Good Samaritan Regional Medical Center.

Dr. Ken Rosenberg is a physician at the OHSU–PSU School of Public Health.

Note to readers: The Medical Society of Metropolitan Portland maintains a strong focus on helping its members serve their patients and their communities. Because optimal health depends on an intricate mix of finance, policy and social justice issues, MSMP is publishing external commentaries on an upcoming ballot measure that will measurably affect the way in which our members deliver care to their patients. In this issue, we present discussion in favor of and in opposition to ballot Measure 97.

The measure is closely tied to the cost and accessibility of health care for all Oregonians, especially those at economic disadvantage. MSMP welcomes thoughtful discussion from its members, in order that we may all exercise our voting rights in the manner that supports the ideals of affordable, high-quality health care statewide.

■ *Measure 97 would hurt our patients*

By Colin Cave, MD

There are a lot of good reasons for opposing the huge $6 billion tax measure on the November ballot, but the primary reason I oppose it is simple.

Measure 97 hurts my patients.

When the Oregon Medical Association decided to oppose Measure 97, it expressed similar concerns. "The regressive nature of Measure 97 would mean that our patients, especially those with lower incomes, could face additional barriers to accessing quality care at a reasonable price. The cost of health care is already a great burden on families. We believe Measure 97 would compound the problem."

Measure 97 changes the so-called "minimum tax" on corporations with Oregon sales of more than $25 million to $30,001 plus 2.5 percent of sales above $25 million. Businesses with high-volume sales and low margins – like grocers, pharmacies, medical practices and wholesale distributors – would be hit most directly.

Because this would be a new tax on gross sales – not profits – businesses would be required to pay the tax on their total revenues, regardless of whether they make any profit. That would mean many employers would have to raise prices or cut jobs, or both.

The cost of the tax can compound because it can be charged at each step in the supply chain. For example, a drug manufacturer could pass the 2.5 percent tax on through a higher price to the distributor, which could add its 2.5 percent tax on to the price paid by the pharmacy that would then sell it to a consumer at a price that covers the pharmacy's 2.5 percent tax – and all the taxes paid along the way. This could amount to a 7.5 percent increase in the price of medications.

The nonpartisan Legislative Revenue Office (LRO) said two-thirds of the $6 billion tax won't end up being paid by the big companies subject to the tax, but by Oregon consumers in the form of higher prices for everyday essentials – utilities, clothing, food, prescriptions, insurance and even medical care.

The LRO called the Measure 97 tax "regressive." Higher prices will impact lower-income families and the working poor most heavily.

Unlike a retail sales tax, Measure 97's hidden sales tax includes no exemption for medications that I need to prescribe for patients. So, the state makes money every time a patient fills a prescription to treat an illness or maintain their health.

My older patients, typically on fixed budgets, generally need more medications. It is not right for the state to make money from their sickness or medication they need to stay healthy. It is not right that some of my patients would literally have to choose between eating, heating their home or perhaps not filling a prescription as their only choices on how to make ends meet with the additional hundreds of dollars a year this measure will cost them.

The quickest way to poor physical and emotional health is to not have a job or lose a job. Jobs keep people active, contributing and able to meet the needs of their family. The LRO estimates Measure 97 would cost Oregon more than 38,000 private-sector jobs.

Finally, as a surgeon, people put their trust in me and hold me accountable for results. Measure 97 releases legislators from accountability for their spending, and that is not right. Both jobs should demand accountability to the public.

While the measure appears to promise funding for schools, health care and senior services, legislative counsel made it clear that lawmakers can spend the money any way they want. Effectively, Measure 97 is a blank check with NO accountability.

It's costly and damaging. It hurts my patients and all Oregonians. We need to vote NO on Measure 97. ●

Dr. Colin Cave is past-president of the Oregon Medical Association.

MD/PhD TRAINING, *from page 12*

interested in the impact of psychological trauma and PTSD across the lifespan and how systems can support individuals who've been traumatized.

The biggest benefit to her so far, Marr said, is the opportunity to work with brilliant and supportive faculty. "We're encouraged to think critically and creatively and we are guided through each phase of our training. I'm constantly inspired by the intelligence and achievements of my colleagues."

It's clear from faculty and students alike that the mentoring component is crucial to the program's – and the students' – success. The overall mentor to each candidate is Jacoby, who helps each student match with the right individual mentor who can maximize their learning experience.

The process isn't casual, nor is it rushed. Terker, for example, didn't officially choose his mentor until his third year in the program. However, before he even began medical school, he, as other new candidates, was assigned a peer mentor, a student who was much nearer to completion. He also benefited from a Scientific Oversight Committee that assists students with navigating the clinical and research environments and keeps them on track with their goals. Terker completed numerous research rotations, trying out several possible mentors before he chose **David Ellison, MD**.

"I'm extremely happy with my decision as Dr. Ellison has prepared me well for my career as an independent scientist. He's had the largest role in teaching me the day-to-day skills of an academic scientist and has given me a great foundation." ●

An annual soccer match between Northwest Permanente and Permanente Dental Associates providers is one of several components of the system's holistic health and wellness program.

Photo courtesy of Northwest Permanente

Resilience at the heart of Northwest Permanente program

By Melody Finnemore
For The Scribe

A heated soccer match will take place later this month that pits physicians against dentists in a bid for bragging rights and a chance to raise money for a worthy nonprofit organization. Last year, **Permanente Dental Associates** beat **Northwest Permanente** and directed the Northwest Permanente team to donate to the Dental Foundation of Oregon.

The match is just part of Northwest Permanente's employee health and wellness program, which includes quarterly "passports" designed to encourage participation in physical, emotional, spiritual, financial, occupational and social activities that reduce stress and boost resilience, said Justin Pfeifer, wellness consultant for Northwest Permanente's CME & Professional Development.

Some examples of activities included in the passport are volunteering in the community for occupational wellness, coloring in an adult illustration book for spiritual wellness and walking for 30 minutes five times a week for physical wellness. The suggested activities change with each season, but consistently highlight the holistic aspect of health and wellness.

"Fall is my favorite time of year but it can also come with a lot of stress around Thanksgiving and the Christmas holidays, so we focus on emotional wellness, making sure everyone is getting a good amount of sleep and encouraging people to reduce their screen time," he said, noting screen time includes not only television, but also tablets, smart phones and other electronic devices.

Pfeifer said Northwest Permanente's staff is pretty healthy in terms of body mass index and other physical benchmarks. The bigger concern at this point is physician burnout, a problem that is on the rise nationwide. This fall, Northwest Permanente will initiate a pilot Stress Management and Resilience Training (SMART) program. Founded by Dr. Amit Sood and the Mayo Clinic, SMART helps providers increase their present-moment awareness, gratitude, compassion, acceptance, meaning and forgiveness to increase their sense of peace, happiness and resilience.

"We're very careful about having another class that physicians have to do that takes away time from seeing patients or from their families or personal life, so we will explore different ways to implement it so it doesn't create another obligation," Pfeifer said.

In addition, Northwest Permanente is exploring how Balint groups might be able to help reduce physician burnout. Named for psychoanalyst Michael Balint, the groups bring providers together to talk about emotionally challenging cases and their relationships with patients.

"Physicians are human beings and as a physician you carry those patients around with you wherever you go, so Balint groups provide a place to talk about that experience with a group of peers," he said. ●

Promoting parenting prowess

■ *Pediatrician relishing producer role on cable TV show*

By John Rumler
For The Scribe

Less than a year ago, **Troy Stoeber, MD**, an Oregon City pediatrician, was enlisted to produce a cable TV show that focuses on supporting healthy parenting skills. For a time, it seemed he had a tiger by the tail.

After facing a steep learning curve and mastering the basics of production and editing, he's becoming addicted to the thrill of creating a quality TV show, and the program, "The Motherload," is receiving such favorable feedback that he hopes to expand the audience worldwide through YouTube.

After completing medical school in 1998 at Creighton University in Omaha, Neb., Stoeber completed his specialty training in pediatrics in 2002 at the University of Kansas School of Medicine-Wichita. He and his wife, Amy, a clinical psychologist, have lived in the Portland area for 11 years.

In spring 2013, Stoeber launched **Pioneer Pediatrics**, his solo practice.

Stoeber, who has two children ages 8 and 6, enjoys exercising, traveling, reading and volunteering for community-based activities, such as serving on the board of directors of the Children's Center, a child abuse intervention center.

Outside of his family and medical practice, Stoeber's biggest current passion is the cable TV show.

He's now proficient at mixing camera shots, directing, communicating with camera operators, lighting, audio, set construction and tear down – almost every aspect of TV production. He's also become literate in Adobe Premiere, the software program used to edit the show.

"When I looked at the goals of the show, which are to **help parents and families get stronger through communal support, knowledge and entertainment**, I was happy to volunteer on the production and to also lend financial support as a sponsor." *–Troy Stoeber, MD*

Executive director for Willamette Falls Media Center (known as WFMC, where the show is produced), Melody Ashford has known the Stoebers since they started out there. She calls "The Motherload" one of the best programs ever produced at the studio, as the content is entertaining and educational. She describes Troy Stoeber as hardworking, enthusiastic and eager to learn. "He can have just performed a circumcision at the office and still runs to the studio on his lunchtime to work on editing the next show."

The idea for "The Motherload" was hatched by Amy Stoeber and her friend, Ann Brown, who met at The Marylhurst School where Amy Stoeber was a student and Ann was teaching parenting classes. The two women clicked in such an entertaining fashion that friends suggested they team up as a duo.

The idea for a cable show wasn't too much of a reach, Troy Stoeber says, and at first it was believed that a producer and crew would be available. That didn't turn out to be the case, however.

"The short version is that I was inspired by my wife telling me I needed to do it," Stoeber explains of his role as producer. "When I looked at the goals of the show, which are to help parents and families get stronger through communal support, knowledge and entertainment, I was happy to volunteer on the production and to also lend financial support as a sponsor."

The show was originally envisioned as more of a radio talk show, where viewers called in with parenting questions, and after some entertaining/ humorous banter, advice or answers would be given.

But after some market research and experimentation, the format evolved into five- to seven-minute segments that focus on one topic and are intended more for informational purposes than for entertainment.

"We also learned that the audience prefers Amy and Ann fielding prepared questions, as opposed to coming spontaneously from live guests," Troy Stoeber says.

His biggest surprise so far, Stoeber says, is discovering how labor intensive the production process is. "I also had no idea it would become so addictive."

At first, his progress was painstaking, Stoeber says, but as he gained experience and confidence he found the experience exhilarating. "Now I can't get enough," he says with a laugh.

The Stoebers have scoured the internet and not found any programming similar to theirs. "Most of the stuff is experts providing discussions in a lecture format," Troy Stoeber says.

The Stoebers anticipate growing a much larger audience, on cable access and on YouTube, as "The Motherload" has 693 "likes" (as of late August) on its Facebook page. A recent video about diversity and race relations accumulated 187 hits in only two days. Another recent "Motherload Morsels" short video about spanking had 837 views in one week. They are constantly receiving enthusiastic feedback from viewers, they said.

None of this surprises Sheila Walker, the head of The Marylhurst School, who's been involved since the inception and believes the program could easily go viral nationally. "The synergy is fantastic. They're so clear and concise and supportive, and creating the show is so much fun we're constantly laughing."

Now nearing the end of the first season, Stoeber has produced nine half-hour episodes that are scheduled to broadcast through September.

Stoeber and his volunteer crew tape two half-hour shows at a time, which takes about six hours, at WFMC in Oregon City. The biggest job is the video editing. First, Stoeber downloads the video, cleans and edits it, slips it into a template, adds the graphics and credits, and exports it out of the software. He easily spends eight hours a month on the process, but what was once a chore is now a labor of love.

Amy and Troy Stoeber plan to promote "The Motherload" to friends across the country, including those involved in pediatrics. "I think they'd get a kick out of it, and some of the topics might benefit their own patients," Troy Stoeber says.

Many producers have started out at community cable shows and moved up to network TV, Ashford explains. "It does take a while to grab an audience and create a following, so consistency is very important. Troy's work ethic and consistency are admirable." ●

"The Motherload" can be seen on local cable access television channel 27 on Mondays at noon, Wednesdays at 6 p.m. and Saturdays at 9:30 p.m.

Survey: **Gun violence an issue in most pediatricians' communities**

Pediatricians see firsthand the effects of gun violence in the lives of children and their families. Nearly one in seven pediatricians reported treating or consulting on a gun injury in the past 12 months, and 88 percent agree violence prevention should be a priority for all pediatricians, according to an **American Academy of Pediatrics Periodic Survey of Fellows**.

Among the survey results:

- Pediatricians were more likely to report treating a gun injury if they were in an inner-city practice (26 percent) compared to urban, non-inner city (20 percent), rural (10 percent) or suburban (6 percent) areas.
- 55 percent of pediatricians reported gun violence is a problem in their practice community.
- 70 percent of pediatricians agreed they are comfortable discussing firearm safety in their practice, but only 20 percent agreed there is sufficient time in patient visits to address it.
- 36 percent of pediatricians reported that parents resent being asked about firearms.
- The majority of pediatricians reported that in their health supervision counseling they always or sometimes identify families with firearms in the home and recommend parents unload and lock firearms. ●

The survey was conducted from August 2013 to January 2014. Surveys were mailed to 1,624 non-retired AAP members in the U.S., with a response rate of 44%. Analysis was limited to 654 pediatricians, including residents, who provide direct patient care.

Adventist Health, OHSU Partners, OHSU pursue affiliation

Adventist Health, **Oregon Health & Science University** and **OHSU Partners** announced last month they signed a nonbinding letter of intent (LOI) to pursue an affiliation. If a final agreement is reached, the affiliation would integrate Adventist Health's Portland-area clinical enterprise with OHSU's clinical enterprise, under the direction of OHSU Partners. The parties hope to reach a final agreement by year's end.

OHSU Partners is a management company that oversees and directs the clinical programs and services of Salem Health, OHSU Healthcare and Tuality Healthcare as an integrated system. Salem Health and OHSU created the company and affiliation model in 2015. As a founding member of OHSU Partners, Salem Health was integral to affiliation discussions and approved this LOI, the organizations said in a news release.

Adventist Health Portland has a 302-bed medical center, 34 medical clinics, and home care and hospice services in the Portland–Vancouver area. ●

FOSTER CLINIC, *from page 1*

up. That allowed coverage for children from a broader geographic range: Since 2014, the clinic doubled its referrals and, since the program's beginnings, has seen more than 400 children. Currently, 194 children in foster care are receiving care. The CareOregon funding was slated to end in September.

Health problems often beset foster children

Coordinated care is important partly because of the many constraints on children, families and caregivers related to foster care. For example, the Oregon Department of Human Services and the Oregon Health Authority require foster parents to obtain assessments of a child's physical, mental and dental health – plus developmental health if a child is under 4 years old – within 30 days of a placement. That requirement can be challenging to meet, especially when gaining appointments with different types of practitioners and when several children are involved for one foster family.

"We know that if we can intervene early, we have **a better chance of heading off bigger issues** down the road."

– Kelly Alexander, RN

"We work hard to be sure we have open appointments to be sure they come in within 30 days," said Hermes. "We do not provide dental and mental health care, but as care coordinator, I assist the family in finding that to get those assessments."

She also does investigative work to prepare the child for appointments with doctors at the clinic. "The children who come into our clinic often have had little or sporadic medical care," she said. "Their health records may not exist or are lost." She tries to find information about their medical histories, where or if they've been seen, whether they've had immunizations and so forth, which can be difficult to determine, particularly if the child is from out of state.

According to the American Academy of Pediatrics, due to poor prenatal care, neglect and other family issues, children and teens often enter foster care with a variety of health problems, including physical, mental, behavioral and dental issues, along with developmental and educational delays. For instance, they experience problems such as cavities, untreated illness and immunization delays at higher rates than other children. Up to 60 percent of kids in foster care are estimated to have chronic health conditions.

Of the approximately half-million children and adolescents in foster care in the United States, experts estimate that up to 60 percent suffer from emotional and behavioral problems. The rate of posttraumatic stress disorder among former foster children is five times that of the general population, the academy reports.

An estimated 12 percent of young children in foster care receive no routine health care, 34 percent receive no immunizations, and 32 percent have some identified health needs that are not met. A large majority of young children in foster care are at high risk for HIV as a result of parental drug abuse, yet only about 9 percent are tested for HIV.

Table 1: Program improves area foster children's health

	Before Care Coordination	*After Care Coordination*
Well-child visits completed	58.2%	76%
Current on immunizations	67%	73.4%
Developmental screenings completed	45%	68%
Total visits to the emergency department	251	112
Average number of ED visits per child	2.39	0.59
Total number of hospitalizations	53	7
Average number of hospitalizations per child	0.505	0.036

Improved health under coordinated care

In the face of these daunting statistics, Randall Children's Clinic – Emanuel has documented evidence that foster children seen there under coordinated care have improved their health in measurable ways. During the years 2009–2014 under the Children's Levy, the program recorded a variety of improvements, compared to data from before they received care coordination *(see Table 1)*.

The clinic's most recent statistics, taken from the second quarter of this year, show that the percentage of patients receiving well-child exams was 90 percent, immunizations 93 percent, developmental screenings 80 percent, depression screenings 76 percent, and average number of ED visits per child 0.12.

In addition, part of the program at the clinic includes a workshop that is free to all foster parents called "Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents."

"When we first developed our medical home program for foster children, we knew that children in foster care are often moved between one foster home to another," said Randall – Emanuel spokeswoman Ashley Stanford Cone. "This can be due to a variety of reasons, but it is often due to the challenging behaviors a child exhibits in a foster home. We wanted to figure out a way to help increase placement stability of the foster children we see at our clinic by supporting and educating the foster parents that we work with."

The National Childhood Traumatic Stress Network developed this curriculum to help foster parents better understand how these traumatic events impact children and how to handle the challenging behaviors they are seeing. The goal of the workshop is to help foster parents have a better understanding of what trauma is and how trauma affects the children in their homes. It is designed to help foster parents make better sense of their child's behaviors, feelings and attitudes, improve their ability to communicate with their child, learn skills and techniques to influence their child's behaviors and attitudes, learn ways to reduce the stress of parenting and of the traumatized child, and increase positive experiences that make being a foster parent worthwhile.

The health of area foster children has improved measurably through a coordinated care program at Randall Children's Clinic – Emanuel.

Photo above and on page 1, courtesy of Legacy Health

"CareOregon does not fund these classes, and we are always looking for funding to help cover the cost or increase the availability of them," Stanford Cone said.

"A lot of the children have chronic health issues due to what the child has experienced," said Hermes. The clinic follows children until they turn 18, then helps them transition to adult health care, she added. "We know that if we can intervene early, we have a better chance of heading off bigger issues down the road," said **Kelly Alexander, RN**, the clinic's other care coordinator for foster children.

Both coordinators said their work is challenging but rewarding.

Foster children often "have gone through a lot," Alexander said. "And anything we can do to help them has huge benefits." ●

OPIOID SEMINAR, *from page 1*

"That's what we try to do." Along with those efforts, doctors have a responsibility to weigh the use of medications in terms of their risks versus benefits, he said.

Given that fact, Adventist wanted to explore opioid risks for its providers, patients and the community, and collaborated with MSMP and The Doctors Company to host the meeting. The information and resources presented were "very pertinent and highly engaging," Prows said, adding that he was grateful to the two co-sponsors who organized the seminar. MSMP arranged for speakers, who included two law enforcement officers from the Washington County Sheriff's Office. MSMP also took on the formidable task of successfully obtaining CME credit for those attending.

Sarah Parker, CMA (AAMA), development associate for MSMP, said the medical society and The Doctors Company had partnered on presenting an educational seminar on opioids held at MSMP in March. Space filled up quickly, and "we had so much interest" from Adventist Medical Group that the July seminar was planned at Adventist in order to accommodate the providers who had wanted to attend in March, she said.

When health systems approach MSMP with requests that help physicians in their practices, the Medical Society is always willing to participate and collaborate, Parker added.

"I think people are getting the message that opioids are not to be used long term," said Thaler. "That can be a week." If a prescription lasts beyond three days, the risk of dependency is higher, he said.

Thaler pointed out about the state's opioid epidemic that 25 percent of Oregonians received a prescription for opioids in the past 12 months. He said the board receives complaints frequently from patients claiming that their doctor is withholding opioids from them by tapering their doses. "We try to educate them that that is in their best interests. These patients are afraid they won't have any alternative. We tell them, 'Your doctor is doing the right thing.'"

"The whole purpose of the board is to keep patients safe and to educate providers about what can be dangerous to patients," he explained. The OMB strives not to restrict physicians' practices but to "educate them so they are aware of this particular problem."

Thaler noted that the board is composed of two public members, and the remaining members all are practicing physicians who "know how hard it is out there. We don't want doctors to quit treating chronic pain; it's just that opioids are not the answer. We act as a resource for licensees and the public who call with questions. The board's goal is to provide physicians with the education and resources they need to appropriately treat their patients' pain."

Thaler said if doctors are investigated by the board based on a complaint from a patient, family member, law enforcement officer, pharmacist or another health care provider worried about patients due to a doctor's prescribing, the board will review medical records to see if the provider is following guidelines established by the physician's health system, the tri-county area, the state of Oregon and the CDC.

If the board requests medical records from a doctor and finds concerns that a problem may exist, it sends out the case to a consultant in the physician's specialty for review. If the consultant and the board agree there is a problem, the doctor will be asked to come in for an interview to explain his or her prescribing. The OMB ultimately can "take action to require you to get additional education about opioid prescribing and further monitoring," Thaler said. "If education has not worked, the board can limit your prescribing of controlled substances. Restrictions on your license can have an effect on your specialty board certification."

Thaler and Prows concur that weaning patients who have been taking opioids for a long period of time is challenging. "The most difficult patients are those who have been taking high doses for years," Thaler said. But many who have been tapered successfully later have thanked the board, expressing such sentiments as, "I feel like I'm getting my life back," he added.

Related to that, also hard, Prows said, is persuading providers to change their routines, and convincing members of our society that popping a pill, although quick and simple, may not be the best choice. "How do we move people to make lifestyle and behavior changes rather than resorting to drugs?" he asked.

Another challenge is aligning treatment strategies with reimbursement if insurers don't cover alternatives to drug treatment, Prows pointed out. Doctors can become confused and frustrated if a health plan doesn't pay for treatments other than opioids, or restricts referrals for pain specialists to a limited number of providers, he said. ●

In Memoriam: Dr. Alan Bates

Dr. Alan Bates, a longtime primary care physician in Southern Oregon and a state lawmaker who played a central role in developing the landmark Oregon Health Plan, passed away Aug. 5 at age 71.

Following his death, remembrances poured in, with colleagues in medicine and politics describing Bates as collaborative, caring and a deft leader who put others first.

"Al was a friend of more than 35 years," said Jeff Heatherington, president and CEO of FamilyCare Health. "It's a loss both personally and professionally. He was the main champion of the Oregon Health Plan. He had the history. He was on the original task force that put it together in the early '90s – not as a legislator but as a physician."

Bates built and maintained a family practice for more than 30 years, a biography on his legislative webpage noted. In addition to his practice, he had served as chief of medicine at Rogue Valley Medical Center and Providence Medical Center, a founding board member of a primary care physicians' group and a board member for Asante Physician Partners.

Before completing medical school at the Kansas City College of Osteopathic Medicine, he served two years in the U.S. Army, including a tour in Vietnam.

Prior to entering politics, he served 10 years on the Eagle Point School Board, plus two years on a governor's task force on education quality, the bio noted.

In 1989, Bates was appointed to a commission instrumental in designing and implementing the Oregon Health Plan. He was reappointed by former Govs. Barbara Roberts and John Kitzhaber. He chaired that commission for three years until resigning to run for public office.

Bates first served in the Oregon House of Representatives from 2000–2004. He was elected to the state Senate for Jackson County, serving Medford, Talent, Phoenix, Jacksonville, Applegate, Ruch and Ashland in 2004.

A family statement on Bates' legislative webpage noted, in part: "He was such a great man with an impact on Oregon, his community, his patients and, most of all, his family. He saved so many lives through a lifetime of practicing medicine, helping generations of southern Oregonians better their health. He went on to help many more people in his work in the Oregon Legislature.

"His loss will be felt throughout the state. The family welcomes thoughts and prayers while we grieve together. We are comforted in the fact that he passed after a day of doing something he loved: fly fishing (with) his son. We will always think of him when we hear the sound of the river, feel the summer sunlight and see a fly line cast upon the water." ●

A memorial service was held in his district Aug. 20 and a second is slated for 2 p.m. Sept. 20 in the Oregon Capitol's Senate Chamber.

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