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Building community, support

OHSU medical student Angela Steichen initiated the Women's Leadership Development Program to increase mentorship, leadership opportunities for female students.

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Primary care physician shortage being felt in Oregon

Solution will require public-private investment, 'political will'

By Cliff Collins
For The Scribe

The much-forecast primary care physician shortage is having an impact locally and statewide, according to representatives of health systems and medical clinics.

"We are feeling the shortage now," said **Jan Reid**, director of provider relations for **The Portland Clinic**. "We're expecting we will continue to feel it in increasing degrees here."

Current and future shortages have been widely documented. Consider:

- The physician population is aging along with the American population as a whole. The Association of American Medical Colleges noted that one-third of U.S. doctors are over age 55. More physicians retiring during the next decade will create challenges for patients who need access to care, said the association's president and chief executive, Darrell G. Kirch, MD.

  According to the Federation of State Medical Boards, from 2012 to 2014, the number of actively licensed physicians age 60 and older increased by 22 percent, compared with an increase of just 0.3 percent for those younger than 50. The 2014 Oregon Physician Workforce Survey, sponsored in part by the Oregon Medical Association, found that the number of Oregon doctors who plan to retire in the next five years approaches a third of the total practicing physicians in the state.

- Fewer primary care doctors practice full time. The federation's census of state medical boards shows that nearly one-third of actively licensed physicians are women. More physicians in general and more female doctors than male want to practice less than full time, which adds to the difficulty of filling slots for full-time physician needs, said **Lori Farrell, MD**, clinical vice president of primary care for **Legacy Health**.


LORI FARRELL, MD

- Most new physicians continue to go into subspecialties rather than primary care, a trend that has been evident for the past two decades, and growth of those who practice in primary care has been "relatively flat," said **Patrick Brunett, MD**, associate dean for Graduate Medical Education at **Oregon Health & Science University**. More than 80 percent of internal medicine residents subspecialize and don't end up practicing in general internal medicine, according to the American Academy of Family Physicians.


PATRICK BRUNETT, MD

THE PRIMARY CARE PHYSICIAN GAP

8% The projected increase in primary care physicians from 2010 to 2020

14% The projected growth in total demand for primary care physicians

Source: The federal Health Resources and Services Administration

- Demand for primary care physicians is expected to increase more rapidly than the supply. The federal Health Resources and Services Administration

*See **PHYSICIAN SHORTAGE,** page 18*

GIVING BACK

Improving health, quality of life for women

Rahel Nardos, MD, (at left) and other members of OHSU's Footsteps to Healing team have visited Ethiopia each year since 2010 to provide surgeries for pelvic floor disorders that can be exacerbated by the physical work women in rural areas there must do each day. Earlier this year, the team of faculty, residents and fellows performed 39 surgeries in Gimbie, Ethiopia, and they look forward to an expanded presence during their next visit in February.

*To read more about Footsteps to Healing and other organizations and volunteer providers who help deliver health care and more to those in need and who are underserved, please turn to our **Giving Back** focus section on pages 10 to 12.*


Photo courtesy of OHSU

INSIDE THIS ISSUE

Helping hands in Haiti


Portland providers respond to the vast needs of the island nation after Hurricane Matthew.

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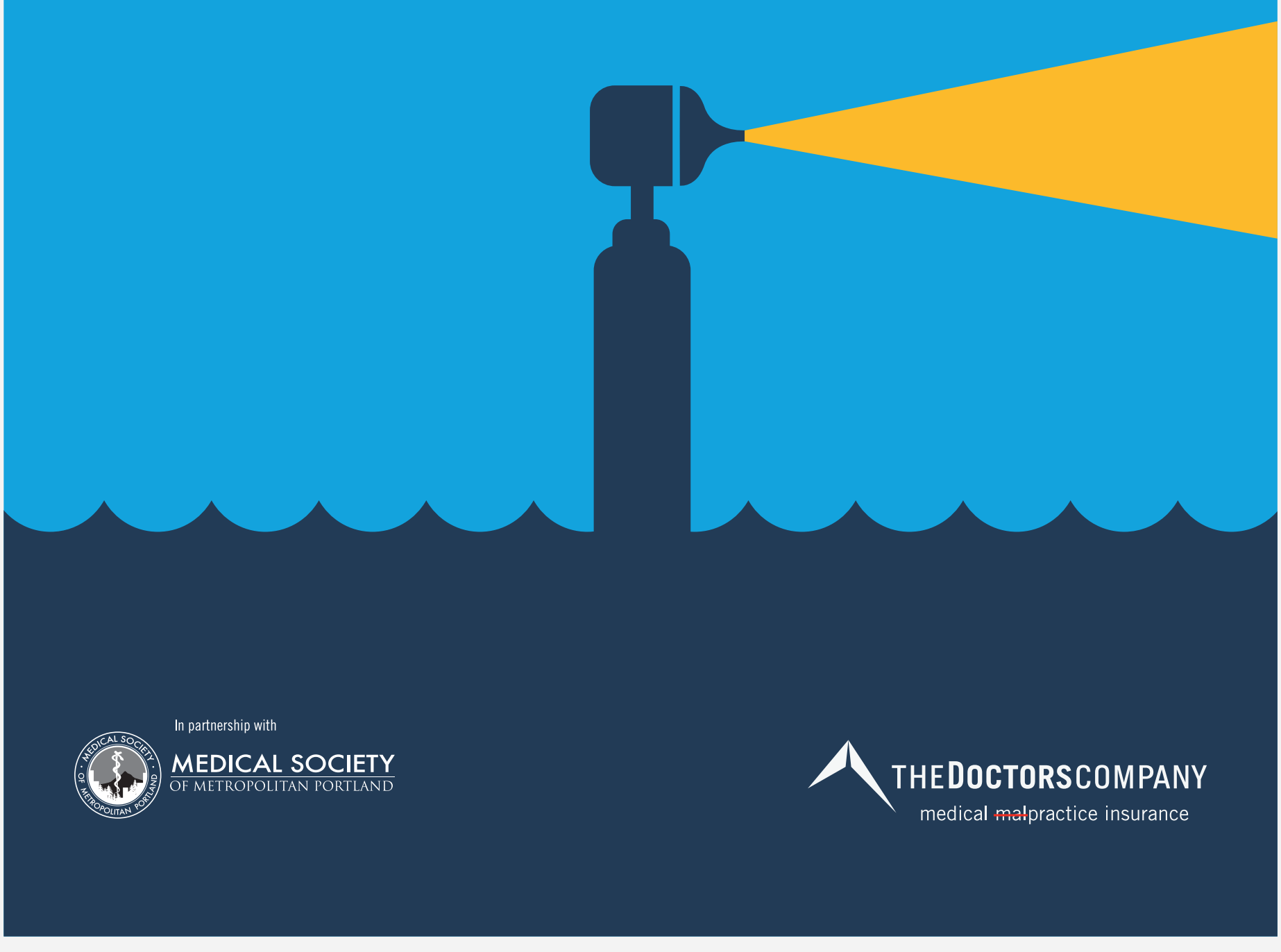

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Research links depression, lung cancer mortality

By Cliff Collins
For The Scribe

The percentage of people with lung cancer who suffer from symptoms of depression is higher than in the general population, and also higher than among patients with other types of cancer.

A Portland physician researcher found in a recent prospective, observational study that lung cancer patients who have symptoms of depression suffer overall lower survival rates than those without depressive symptoms.

What's more, study participants who experienced remission of depression symptoms experienced similar odds of survival as those patients who had not been depressed.

Although the research, headed by **Donald R. Sullivan, MD**, an assistant professor at **Oregon Health & Science University**, drew from data that did not indicate whether depressed patients had been treated for depression, the fact that patients who experienced remission of depression over the course of their disease had better survival rates shows promise, he said.

DONALD R. SULLIVAN, MD

It could mean that if lung cancer patients are diagnosed early and their depression is treated concurrently, their survival rates might improve, said Sullivan, who is board certified in both pulmonology and critical care medicine. Not much research has been done on long-term survivorship in lung cancer, he noted. The main reason is that survival is abysmally low: More than half of people with lung cancer die within one year of being diagnosed.

According to the American Lung Association, which along with the National Institutes of Health sponsored the OHSU-led research, the five-year survival rate is 17.7 percent. By contrast, the five-year survival rate for colon cancer is 64.4 percent, for breast cancer 89.7 percent and for prostate cancer 98.9 percent.

LINDA GANZINI, MD, MPH

CHRISTOPHER SLATORE, MD

The five-year survival rate for lung cancer is 55 percent for cases detected when the disease is still localized. However, only 16 percent of lung cancer cases are diagnosed at an early stage. After metastasis, the five-year survival rate drops to 4 percent.

Sullivan, who collaborated with **Linda Ganzini, MD, MPH**, and **Christopher Slatore, MD**, who, like Sullivan, are with the **OHSU Knight Cancer Institute** and the **Veterans Affairs Medical Center**, said longitudinal changes in depression during treatment, and their impact on survival, have not been studied to much degree.

Data were derived from the National Cancer Institute's Cancer Care Outcomes Research and Surveillance Consortium from five geographic U.S. regions over a three-year period. Participants were eligible to be enrolled in the study within three months of diagnosis, and then were followed up after 12 months. The results appeared Oct. 2 in the *Journal of Clinical Oncology* and titled "Longitudinal Changes in Depression Symptoms and Survival Among Patients With Lung Cancer: A National Cohort Assessment."

The researchers found that 38 percent had symptoms of depression at baseline and an additional 14 percent developed symptoms during treatment. At the 12-month follow-up, depressive symptoms were associated with increased mortality among participants with early-stage disease, as well as those with late-stage disease.

> "There is a lack of recognition that **mental health is an important part of the cancer treatment continuum.** This study leads you to believe (that) maybe if we study depression treatments, **we can improve overall survival** with their implementation."
>
> *–Donald R. Sullivan, MD*

The fact that mental health played a role in survival rates, particularly among patients with early-stage lung cancer, underscores the importance of early diagnosis, Sullivan pointed out. He noted that progress toward that end might come after the Centers for Medicare & Medicaid Services earlier this year began covering low-dose CT as a lung cancer screening technique for certain patients.

To qualify for an annual screening, patients must be 55 to 77 years old and must currently smoke tobacco or have quit within the past 15 years, smoked an average of one pack of cigarettes a day for 30 years, and have a physician or other health care professional's written order requesting the test, according to the American Academy of Family Physicians.

The academy, along with the Medicare Evidence Development and Coverage Advisory Committee,

*See **LUNG CANCER,** page 9*

Portland providers respond in Haiti after Hurricane Matthew

By Jon Bell
For The Scribe

Nearly seven years ago, catastrophe in the form of a magnitude 7.0 earthquake struck the island nation of Haiti. More than 250,000 homes were destroyed, 30,000 commercial buildings collapsed and well over 100,000 people died.

The country was still in the midst of a years-long recovery – including climbing back from Hurricane Sandy in 2012 – when disaster visited the country again in early October. That's when Hurricane Matthew descended upon Haiti, killing hundreds, wiping away roads and bridges, flooding fields and ravaging crops.

Just a few weeks later, the country was still upside down, but a massive recovery was underway. Helping spearhead those efforts: two Portland-based organizations known the world over for their roles in helping people recover after the unthinkable.

Both **Medical Teams International** and **Mercy Corps** have had operations in Haiti since the 2010 earthquake, so they were ready and able to respond as soon as Matthew unleashed its fury. As with other disasters in the past, both organizations ramped up to help with the recovery. *The Scribe* checked in with them to see how that effort was shaping up, what the nonprofits are focused on and how they'll be helping the people of Haiti for many months to come.

Medical Teams International

Right after Hurricane Matthew struck, Medical Teams International's 15- to 20-person staff in Haiti deployed to the southern reaches of the country where damage had been the greatest. What they found were washed-out bridges, trees over the roads, crops wiped out, and a population at risk of disease and malnutrition.

Working with other nongovernmental organizations, the United Nations and local government officials, MTI first helped distribute food rations, tarps, sleeping mats, water filters and other supplies. After that initial wave, the organization turned to an assessment phase, making contact with remote communities cut off by the storm and determining their greatest needs. With that work completed, the effort turned to one of recovery.

According to **Joe DiCarlo**, vice president of programs for MTI, some of the biggest concerns in late October were waterborne diseases, cholera in particular.

"When you don't have clean water, sanitation or hygiene there is a high risk of an outbreak," he said, noting that MTI had come across more than 510 cases of the disease in the wake of the hurricane. "It's endemic with a seasonal spike, but

Relief organizations such as Medical Teams International and Mercy Corps are responding to the tremendous needs in Haiti in the wake of Hurricane Matthew, including dispatching volunteer medical providers from the Portland area. The deadly hurricane has put survivors at risk of disease and malnutrition, and wiped out roads and bridges and caused other widespread damage.

Photo courtesy of Medical Teams International

because of the hurricane an increase is very likely. And cholera is a deadly killer."

On top of cholera, MTI will be looking to keep other diseases in check, including acute respiratory diseases, malaria, the Zika virus and diarrhoeal diseases, which can be especially dangerous in young children.

One of the main ways MTI staff will be keeping on top of the various challenges is by connecting with mothers in remote communities. DiCarlo said mothers are always "the first line of defense in a community" because they are the first to know when their children are sick and when they need to seek medical attention.

In mid-October, MTI had just received its first requests for additional medical volunteers to respond on the ground. As a result, local staff had begun recruiting from its roster of volunteers, mostly from the Northwest and Portland, and were expecting to send a team as soon

*See **HURRICANE MATTHEW,** page 18*

Providence researchers gaining on cancer

By John Rumler
For The Scribe

Clinical trials are a regular part of cancer care at the **Providence Cancer Center**, with scientists and physicians working together on upwards of 130 studies that are open to enrollment.

Patients may take part in studies initiated by translational researchers at the Robert W. Franz Cancer Research Center in the Earle A. Chiles Research Institute in addition to studies sponsored by the National Cancer Institute (NCI) or pharmaceutical and biotechnology companies.

"Each trial has its own set of eligibility criteria," said **Julie Cramer**, director of clinical research. "We have trial opportunities for all tumor types and we also have a large portfolio of Phase I trials which are often open to multiple tumor types."

For more than two decades, the research has focused primarily on immunotherapy, with people coming from as far away as Australia to enroll. The clinical research staff of 40 is comprised of research nurses and data coordinators, working together in disease-focused teams, alongside physician-investigators.

Two of the many promising studies are the clinical trials for chronic lymphocytic leukemia (CLL) and those for triple-negative breast cancer (TNBC).

CLL is a cancer of B lymphocytes, cancerous cells that originate in the bone marrow tissue and are present in the blood and lymph nodes. Generally a slow-growing cancer, CLL causes low blood counts and affects the immune system, causing increased infections. It is extremely difficult to cure, and early detection/treatment has not improved longevity.

Since chemotherapy has so many side effects, specialists often delay taking on the disease until symptoms appear and it is almost impossible to ignore.


JOHN GODWIN, MD

Principal investigator **John Godwin, MD**, is testing Ibrutinib, a drug that does not target the DNA or cell-dividing machinery as chemotherapy drugs do.

"Ibrutinib specifically targets the B cell survival-signaling pathways involving the protein Burton's tyrosine kinase (BTK)," Godwin said. "BTK connects several survival signals from the cell surface to internal cell signals and plays a role in B cells maturing into functional immune cells."

The discovery of BTK was connected to X-linked agammaglobulinemia type 1, a hereditary disease which is an immunodeficiency characterized by the failure to produce mature B lymphocytes, explains Godwin. "This is important because Ibrutinib is specifically toxic to B cells, especially the malignant B cells in diseases like CLL."

Ibrutinib has a very high response rate, about 90 percent, though not all responses are complete. So far, according to Godwin, there's no evidence of any residual disease. "Only about 25 percent of patients have no detectable disease at all, but the majority of patients feel well and their remaining disease is so minor that it is not causing problems."

The study, which began in January 2015, includes an enrollment of about 330 and is scheduled to finish in December 2017.

At the time the study opened, Ibrutinib was approved by the U.S. Food and Drug Administration for only CLL patients who had at least one prior treatment; however, this past March, it was approved for CLL patients as a first-line drug.

"The avoidance of chemotherapy is one great benefit of Ibrutinib, and the high efficacy – that is, it works most of the time – is another," Godwin said.

Harnessing the immune system

TNBC is an aggressive cancer with high mortality and limited treatment options: The only FDA-approved systemic treatment option for stage IV, or metastatic, TNBC is chemotherapy as other breast cancer therapies have not been effective.

"We're evaluating a new treatment strategy that harnesses the immune system to treat TNBC," said **David Page, MD**, Providence breast cancer specialist who is leading the trials. "The drug, pembrolizumab, is an engineered monoclonal antibody that targets T-cells, a type of immune cell that can recognize and kill cancer."


DAVID PAGE, MD

Pembrolizumab blocks regulatory signals that would otherwise inactivate T-cells. A regulatory molecule, called "Programmed death 1" (PD-1), is found on the surface of activated T-cells, and functions normally to suppress T-cell activity for the purpose of maintaining immune homeostasis and preventing autoimmunity.

Breast cancer cells may turn off anti-cancer T-cells by expressing the ligand for PD-1, or by secreting cytokines that promote PD-LI/L2 expression on other types of cells. Pembrolizumab functions by blocking PD-LI/L2 from binding with PD-1 and inactivating tumor-reactive T-cells.

Page is treating metastatic TNBC patients with pembrolizumab plus standard-of-care chemotherapy, either weekly paclitaxel or oral capecitabine.

In previous trials, pembrolizumab promoted tumor shrinkage or stabilization in approximately half of the tested patients. This trial is unique because it combines pembrolizumab with FDA-approved chemotherapy, Page explained.

"The rationale is that chemotherapy may promote inflammation within the tumor, which will facilitate immune cell recognition of the cancer, and may improve responses. This allows us to treat patients with immunotherapy earlier in the course of their disease, rather than waiting until chemotherapy stops working."

The study, available only at Providence Portland Medical Center and Providence St. Vincent Medical Center, has only five participants now, but Page anticipates enrolling 28 patients during the next one to two years. "Some patients are already responding, but it is too early to report any results," he said.

While pembrolizumab is approved for several types of cancer, the clinical trials in breast cancer are preliminary and FDA approval of TNBC is not anticipated anytime soon. However, based on early successes, Page said, these types of therapies are likely to play a vital role in treating breast cancer in the future.

"The greatest benefit to patients is the possibility of long-lasting tumor-controlling responses. In TNBC, chemotherapy is beneficial in controlling tumor growth for only about three to six months. Because pembrolizumab may stimulate long-lived immunity against the cancer, the responses can be long-lasting or indefinite."

While the studies and knowledge gained are still in the early stages, it is clearly good news for cancer patients not only in Oregon, but around the world.

"Some patients with other cancer types, such as melanoma, received immune-based therapy and experienced complete disappearance of their cancer for more than 10 years," said Page. "This raises the possibility that they have been cured of metastatic or stage IV cancer."

Last year, Providence Cancer Center had more than 1,200 people enrolled to participate in research studies and, as of October, the total number for 2016 was 996. The trials are funded through the NIH as well as through industry and foundation support. "With the decreases in government funding, philanthropy has become essential to our efforts to offer our patients clinical trials," Providence's Julie Cramer said.

For more information about Providence Cancer Center clinical trials, please call 503-215-6014 or visit *http://oregon.providence.org/clinical-trials/.*

Physical therapy emphasized in efforts to curb chronic pain, opioid epidemic

EDITORS' NOTE: *This story continues The Scribe's coverage of physical therapy and rehabilitation, which was the subject of the publication's September focus section.*

What **Sarah Gradis, PT**, calls the "partnership" begins when a patient with chronic pain visits her office.

While Gradis, who holds a doctorate in physical therapy and is a pain management specialist with Kaiser Permanente, is highly knowledgeable in her field, she considers her patients the experts about *their* body. Gradis describes herself as both an investigator and guide, helping individuals understand the causes and nature of their pain and developing a plan to address it.

The goal is an empowered patient, she said. "I start where they are and 'walk' with them."

For Gradis, that team approach to treating pain extends to specialists and primary care providers. Depending on the diagnosis and situation, she might refer a patient to a pain psychologist, social worker and/or other specialists in her clinic. And, she stressed her respect for primary care providers and the demands on their professional time and what they must cover with patients during visits.

She hopes to raise greater awareness among primary care providers about the important role physical therapists play in helping curb patient pain, and she wants primary care providers to feel confident in making "that warm handoff" of the patient to physical therapists like herself.

"I want them to know as a provider I'm here for them" and their patients, she said.

Ultimately, the regimen for Gradis' chronic pain patients often involves some combination of learning the mechanics and physiology of the body; exercise therapy; stretching; yoga; and improving posture and how a patient, in Gradis' words, "moves through the world."

Physical therapy allows patients to be "active participants" in their treatment.

The value of physical and other therapies in the health care toolbox for treating chronic pain has been highlighted in recent months through a handful of major initiatives that aim to curb Americans' dependence on opioids. Earlier this year, the Centers for Disease Control and Prevention issued its guideline that provides recommendations for primary care clinicians prescribing opioids for chronic pain outside of cancer treatment, palliative care and end-of-life care.

Also, the U.S. surgeon general in late August sent a letter to more than 2 million health professionals that asked them to lead a national movement to address the nation's prescription opioid epidemic. The letter, part of the surgeon general's Turn the Tide Rx campaign, was accompanied by a pocket card, adapted from the CDC's guidelines, that notes in part that before prescribing opioids for chronic pain providers should consider if non-opioid therapies are appropriate, including exercise or physical therapy or cognitive behavioral therapy.

In addition to the CDC's guideline and surgeon general's campaign, a broad array of providers, including physical therapists and pain specialists, are working to reduce prescription drug abuse and heroin use through a public-private partnership announced by the White House last fall. This effort includes more than 40 provider groups – among them physicians, dentists, advanced practice registered nurses, physician assistants, physical therapists and educators – committed to reaching more than 4 million health care providers with awareness messaging on opioid abuse, appropriate prescribing practices and actions providers can take to be a part of the solution in the next two years.

Participating organizations include the American Medical Association, American Osteopathic Association, American Academy of Family Physicians, American College of Emergency Physicians, American Academy of Hospice and Palliative Medicine, American Society of Addiction Medicine, American College of Osteopathic Internists and American Pain Society, among others.

The American Physical Therapy Association (APTA) is among the providers participating in the White House initiative, and is focusing its efforts on educating the public and its members that pain can be effectively managed through what the APTA noted in its newsletter *PT in Motion* are "conservative, non-drug approaches."

The APTA is also raising awareness about the pain-management benefits of physical therapy through its *#ChoosePT* campaign, launched in June. On its *moveforwardpt.com* website, the organization notes that "in some situations, dosed appropriately, prescription opioids are an appropriate part of medical treatment. However, opioid risks include depression, overdose and addiction, plus withdrawal symptoms when stopping use."

Jason Bellamy, the APTA's vice president of strategic communications and alliances, said during an interview that the "best physical therapy is active physical therapy" that appeals to a culture seeking empowerment about health issues. A risk of opioid therapy for chronic pain is that it "implies to patients there is a quick fix to pain," he noted.

Physical therapy, on the other hand, allows patients to be "active participants," he added.

Nora Stern, PT, MS PT, physical therapist and program manager with the Providence Persistent Pain Project and Rehabilitation Services Persistent Pain Program, said that the Persistent Pain Project has educated primary care providers, medical home team members and rehabilitation therapists about the complexities of the pain experience, including its psychological aspects, so that they are better equipped to help patients understand their pain and address things such as fear avoidance behavior.

A screening tool Providence has adopted is the STarT Back questionnaire that helps clinicians get a snapshot of a patient's pain experience. One of the

*See **CHRONIC PAIN,** page 16*

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PROVIDENCE
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Leadership program to provide mentorship, wellness training for female students

By Melody Finnemore
For The Scribe

It didn't take long for **Angela Steichen** and her fellow medical students who are women to notice that when somebody raises their hand to speak in class, the majority of the time they are male. After talking with some of her female peers, it also became clear that they shared a sense of isolation and felt like they didn't really belong in medical school.

Steichen, who will earn her medical degree in 2018, is a member of the first class at OHSU to participate in the new curriculum the university is implementing, which includes a requirement that each student complete a scholarly project. Steichen knew she wanted her project to relate to education and potentially help other members of her class. She also knew she was intrigued by the wellness aspect of the new curriculum and enlisted her academic advisor's help in establishing the **Women's Leadership Development Program**.

"We talked about what we wished we'd had and what would have helped us during medical school," Steichen said. "One thing we decided early on that is important is female mentorship in the program. We don't have a lot of women who are in leadership positions in academic medicine. Even though there are a lot of women in health care, few of them are in leadership positions.

"Having women as mentors helps you feel like you are part of the medical community," she noted.

A pilot of the program launched in September, will continue through June and includes 25 female medical students. The goal by the end of this academic year is for all of the participants to actively hold a formalized leadership role, and for the program to be added to the OHSU School of Medicine elective course options.

According to Steichen's grant application, there currently are no known leadership opportunities specifically for women medical students within OHSU's School of Medicine. Within the institution at large, there is a formalized group titled Women in Academic Medicine (WAM), which is comprised of senior faculty of all disciplines that started at OHSU in 1993. WAM's efforts focus primarily on supporting women faculty to find success in their careers. The Women's Leadership Development Program will collaborate with WAM to support its annual conference and to ensure program participants take part in the conference, she noted in her application.

Academic health centers continue to show few women in senior leadership positions despite the number of women in academic medicine being greater than men. There is still a documented pay difference for the same job based on gender, with men getting around $13,400/year more than their female counterparts. There is also a "leaky pipeline" or retention issues for women in academic medicine thought to be due to a lack of a supportive culture and an unfavorable climate for the female physician balancing significant responsibilities at work and home, Steichen's application states.

In addition to increasing the number of women in leadership positions in OHSU's student government, the program's vision is to increase their participation and contribution in medical school coursework. The program also will provide strategic career planning for students from women physicians in their specialty of interest, and build a professional community for women physicians early in training to enhance their residency prospects and opportunities.

> "One thing we decided early on that is important is female mentorship in the program....**Even though there are a lot of women in health care, few of them are in leadership positions."**
>
> *– Angela Steichen, OHSU MD candidate*

Workshops and lectures will center around wellness and resiliency as well as cultivating mentorships, leadership and career mapping. Another category of skills development in the course outline shows training in negotiations, professional portfolios and resumes, communication skills and gender assertion to be part of the curriculum as well.

Program participants meet on Monday evenings for the two-hour sessions, the first 20 to 30 minutes of which are dedicated to socializing and enjoying a potluck dinner. The remainder of the session includes activities such as group discussions and presentations, small-team problem solving, guest lectures and discussions of literature recommended by the guest presenters. The program has been scheduled to accommodate medical school exams. Participants who attend at least 10 of the 12 workshops will be designated a certified WLDP graduate.

The program will track the number of women in formalized leadership roles at OHSU and compare this data to previous years. Pre- and post-program surveys in self-identified leadership qualities will be administered. And throughout the year, participant wellness and sense of burnout will be assessed with a published, peer-reviewed survey.

The Women's Leadership Development Program is supported by a grant from the **Metropolitan Medical Foundation of Oregon**, a nonprofit of the **Medical Society of Metropolitan Portland**, and the **Robert L. Bacon Medical Education Enrichment Award**.

LUNG CANCER, *from page 4*

recommended against Medicare coverage for the procedure, both citing insufficient evidence of benefits versus the harms of screening. But CMS approved coverage, anyway. According to the lung association: "Screening for individuals at high risk has the potential to dramatically improve lung cancer survival rates by finding the disease at an earlier, more treatable stage. At least 8.6 million Americans qualify as high risk for lung cancer and are recommended to receive annual screening. If half of these high-risk individuals were screened, over 13,000 lung cancer deaths could be prevented."

"I sometimes liken a cancer diagnosis to the experience of PTSD for a traumatic event," said Sullivan. If depression appears at or shortly after diagnosis, it tends to persist, he added. "There is a lack of recognition that mental health is an important part of the cancer treatment continuum. This study leads you to believe (that) maybe if we study depression treatments, we can improve overall survival with their implementation."

Smoking contributes to 90 percent of lung cancer deaths in men and 80 percent of lung cancer deaths in women, according to the lung association. Compared with people who never smoked, men who smoke are 23 times more likely to develop lung cancer, and women are 13 times more likely. The "stigma" and belief that it is a "self-inflicted disease" probably contribute to the widely documented high depression rates among patients at the time of their diagnosis, Sullivan said. Many lung cancer patients, especially men, do not talk with others about their depression, believing that depression is a normal part of having lung cancer, Sullivan said.

Especially given the fact that lung cancer is the leading cause of deaths from any cancer, the disease receives far less funding and advocacy than other types of cancer, he noted. Given patients' low survival rates, the responsibility "falls on their families to advocate. I'd like to see more advocacy, more funding, more research about lung cancer so we can help people" and show the importance of mental health in survival associated with the disease, he said.

Wallace reaches out to help kids, families read together

By Melody Finnemore
For The Scribe

The Wallace Medical Concern is launching a reading library to encourage its pediatric patients and their families to read aloud together, with the support of a grant from the **Metropolitan Medical Foundation of Oregon**, a nonprofit of the **Medical Society of Metropolitan Portland** that supports activities that improve health education and health care delivery to the community.

Wallace Medical Concern Program Manager **Maria Perez** said the nonprofit, which provides medical and dental services to low-income families in Portland and Gresham, is now organizing its providers to complete the required online training about how to participate in the **Reach Out and Read** program. It also is determining which books to order, as prescribed by the evidence-based, national program.

> "This is such a **small thing that we can do** and **it will impact in a big way**. I live in this community and my children go to school with other kids who don't get read to a lot, and teachers are working with kids who don't do a lot of reading and need that extra support. The simple act of giving a child a book and having that impact is very gratifying for us."
>
> *–Maria Perez, Wallace Medical Concern*

Reach Out and Read builds on the relationship between parents and medical providers to develop critical early reading skills in children, beginning in infancy. As recommended by the American Academy of Pediatrics, the program incorporates early literacy into pediatric practice, equipping parents with tools and knowledge to ensure that their children are prepared to learn when they start school.

Reach Out and Read program, The Wallace Medical Concern

FOUNDED	2016
WHAT IT DOES	The program incorporates books into pediatric care and encourages families to read aloud together.
LEARN MORE	www.reachoutandread.org www.wallacemedical.org

Reach Out and Read serves nearly 4.5 million children and their families annually across the country; these families read together more often, and their children enter kindergarten with larger vocabularies and stronger language skills. During preschool, children served by Reach Out and Read score three to six months ahead of their non-Reach Out and Read peers on vocabulary tests. These early foundational language skills help start children on a path of success when they enter school.

The Wallace Medical Concern's service area is home to 41,000 low-income residents, and more than 37 percent of children there live below the poverty line. Low-income parents often struggle to balance demands of work, school and daily life, and find it difficult to carve out time to read to their kids. They may lack money to buy books, or access to or time to visit libraries. Many do not have the skills to read to their children.

"Our providers see this need every day with the patients they treat, so they were definitely on board," Perez said.

The Wallace Medical Concern is launching the Reach Out and Read program, which builds on the relationship between parents and medical providers to develop critical early reading skills in children, beginning in infancy.

Photo courtesy of The Wallace Medical Concern

During each regular check-up between the ages of 6 months and 5 years, kids will receive new books to take home. In addition, Wallace will create literacy-rich environments in its clinics with children's reading corners, stocked with books for waiting room use.

"This is such a small thing that we can do and it will impact in a big way. I live in this community and my children go to school with other kids who don't get read to a lot, and teachers are working with kids who don't do a lot of reading and need that extra support," Perez said. "The simple act of giving a child a book and having that impact is very gratifying for us." ●

Alliance fosters brain injury education, advocacy and support

By Barry Finnemore
For The Scribe

Nearly five decades ago, the car in which **Sherry Stock** and her 3-month-old son, **Mark**, were riding was hit by a drunk driver. Stock broke her back in the crash. Her son sustained a severe brain injury.

"He went from lifting his head and trying to roll over (prior to the crash) to not doing anything," Stock recalled. "Then he started having seizures."

Mark wasn't expected to survive, but he did. Traumatic brain injury resulted in significant cognitive and physical impairments for Mark, who lives in a care home with a nurse and doctor available around the clock. Now 49, Mark is 6-foot-3, Stock noted, but "cognitively an 18-month-old."

In an interview, Stock shared her family's story to underscore her motivation to prevent brain injuries, improve treatments through professional education and research, and advocate for and help TBI survivors and their families through support groups and changes in the law. As executive director of the **Brain Injury Alliance of Oregon Inc.**, Stock heads a nonprofit whose volunteer leaders are stakeholders in the brain injury field, including survivors, family members, health care providers, attorneys, researchers and others.

"We're making a difference in people's lives," she said.

A focus for the alliance is training health care providers about brain injuries. Stock, who is internationally certified to deliver trainings on brain injury, presents with leaders in the field such as **James Chesnutt, MD**, with Oregon Health & Science University. Their presentations focus in part on how to diagnose brain injuries. The alliance also educates employers and those who support military veterans about TBI, post-traumatic stress and other issues.

Alec Giess is a military veteran who was referred from a VA hospital in California to the Brain Injury Alliance of Oregon. The alliance works, in part, to train health care providers about brain injuries, including how to diagnose them. It also connects survivors of traumatic brain injuries and their families with support groups, and it advocates for policy change.

Photo courtesy of the Brain Injury Alliance of Oregon

According to the Centers for Disease Control and Prevention, nearly 140 people in the United States die every day from injuries that include TBI. And, as the alliance notes on its website, the CDC estimates that 5.3 million American children and adults – 2 percent of the population – currently live with disabilities resulting from TBI. The alliance each year co-sponsors a four-state conference about brain injury. In 2017, the event will be held March 9–11 at the Sheraton Portland Airport Hotel. This year's conference addressed everything from concussion treatment and helping school-aged youth with TBI to the challenges faced by military veterans with brain injuries.

Brain Injury Alliance of Oregon Inc.

FOUNDED	1984
WHAT IT DOES	The alliance is the only statewide nonprofit dedicated to creating a better future through brain injury prevention, advocacy, education, research facilitation, support and peer mentoring.
LEARN MORE	www.biaoregon.org

The alliance also connects TBI survivors and their families with support groups, and it advocates for policy change. In 2009, for example, Oregon became at the time only the second state to pass a law, supported by the alliance, that requires health insurance companies to cover medically necessary therapy and services to treat TBI the same as they would for stroke, including physical therapy and cognitive rehabilitation.

Stock said it's gratifying to see growing awareness around TBI, but more needs to be done in terms of professional education, access for more survivors to care facilities, and support for survivors and families. She stressed that a number of alliance members who are physicians speak to support groups regularly.

"Support groups are so important," she said. "People need to know they are not alone. It's important to get with other people, learn new things and see that things can get better." ●

Monthly 'Night Strikes' provide medical, dental care and more for homeless

By Jon Bell
For The Scribe

Lesley Snider remembers thinking that her husband had lost his mind.

It was 2004, and Snider and her husband, **Marshall**, were in Portland's Old Town Chinatown neighborhood when a thought overcame him: I am supposed to wash people's feet and this is where I'm supposed to do it.

"He's thinking he's supposed to wash feet here, and I'm thinking he's crazy," Snider said.

Formerly a youth pastor, Marshall ended up sitting in a chair with a basin of warm water one night in Old Town. The first person to come along was a drunk homeless man. Marshall washed his feet for him.

"I think Marshall was being asked to be obedient and do something that was uncomfortable," Snider said. "I was there. I saw it. He said he felt like he met Jesus for the first time there in that chair."

During weekly Night Strikes, volunteers for Because People Matter distribute food and clothing, provide hygiene services and offer time to listen to homeless people under Portland's Burnside Bridge.

And that's basically what kicked off **Because People Matter**, formerly called BridgeTown Inc., a nonprofit that serves the homeless of Portland with a range of services every Thursday night under the Burnside Bridge. The weekly event, called Night Strike, finds scores of volunteers serving food, handing out clothing, manning haircut and shaving stations and, sometimes, just listening. Because People Matter also brings in one of Medical Teams International's dental trucks one or two times per month to offer dental and hygiene services. Volunteer doctors and nurses are on hand usually once a month to provide basic medical care in the nonprofit's renovated RV, as well.

On top of that, Because People Matter has volunteers who go on walkabouts, handing out sandwiches and drinks to people on the streets. Snider estimates that the nonprofit serves around 500 people during each Night Strike.

Because People Matter

FOUNDED 2004

WHAT IT DOES Because People Matters offers services and supplies to Portland's homeless population at weekly Night Strike events under the Burnside Bridge. BPM also provides weekly educational and recreational programs for children in various communities around Portland.

LEARN MORE www.bridgetowninc.org

Medical students and nurses man the mobile medical station where homeless people can see a doctor each month. Physicians volunteer their time to provide care as part of Because People Matter's services, which also include dental treatment.

Photos courtesy of Because People Matter

In addition to the Thursday events, Because People Matter also has "Transformation Trips," which offer students weekend or weeklong experiences around the nonprofit's work, and the BTown Kids program, which operates at four different sites on Saturdays in the summer. Because People Matter volunteers set up stations that offer not only fun and games for kids, but also a curriculum designed to instill character and values.

"It's really designed to engage families who are walking that poverty line," Snider said, "and give them an expectation for a better tomorrow."

But Snider said what Because People Matter does is about much more than providing services or handing out food.

"We all have a mandate to love our neighbors and make a difference," she said. "When we started, we knew we would be about more than just giving things away. We started with the hopes that we would become friends with whoever we were serving. That's who we are."

Though Because People Matter has a small paid staff, the bulk of the work is done by volunteers and funded by private donations. Snider said the nonprofit is always looking for more volunteers and would love to have more physicians who could help out during the Night Strikes.

Organization meets area need for pasteurized donor breast milk

By Jon Bell
For The Scribe

Eight years ago, if a woman in Oregon wanted to donate her breast milk or if a hospital here needed to use donated milk, they had to turn to milk banks in California and Colorado. To a group of local health care professionals and breastfeeding advocates, setting up an option that was closer to home seemed like a much better idea – so that's what they did.

JOANNE RANSOM

"With such a strong breastfeeding culture in the Northwest, it made sense to have a bank here to collect locally and meet the local need for pasteurized donor milk," said **Joanne Ransom**, a registered nurse and the clinical director for the **Northwest Mothers Milk Bank**, the nonprofit that formed in 2008 to meet those needs.

Though it started in 2008, the nonprofit needed another five years of raising both awareness and money before it could actually open its doors and begin operation, which it did in 2013. It started with 10 collection sites in the metro region; now it's up to 31. In its first year, the nonprofit dispensed 140,000 ounces of milk, and this year it's on track to surpass 200,000 ounces.

"The Northwest was really ready for a not-for-profit milk bank," Ransom said.

Ransom said most of the milk the nonprofit pasteurizes goes to infants in the neonatal intensive care unit and level 1 and 2 nurseries. Hospitals order milk from the bank for those patients and pay a fee for that, which helps fund the bank. When there's milk left over after the hospital orders, outpatient families can also order milk as they're leaving the hospital.

"We try to never say no to a family who requests milk, even if it is for just a short period," Ransom said. "We work with families to assure their infants get off to a great start, especially the first two weeks of life."

Northwest Mothers Milk Bank

FOUNDED 2008

WHAT IT DOES The Portland nonprofit safely collects and distributes donated breast milk to help vulnerable babies get off to a good start.

LEARN MORE www.donatemilk.org

Donors must be healthy non-smokers who have enough milk for their own babies before they can donate. They go through a screening process, the cost of which is covered by NWMMB. Ransom said some donors received donor milk when their own babies were in the NICU and feel drawn to give back; others have extra milk and recognize the need, and still others may have lost a baby and find comfort in helping another baby get off to a good start.

As it heads into the future, NWMMB expects by year's end to offer more advanced analyzation of donated milk. Ransom said such analysis will help it better address the unique growth needs of premature babies. In addition, the nonprofit will hold the first Northwest Donor Milk Symposium in February as a way to promote education about donor milk.

Footsteps to Healing takes on 'silent epidemic' to improve women's health

By John Rumler
For The Scribe

OHSU's **Footsteps to Healing** program has provided approximately 250 desperately needed pelvic organ prolapse surgeries for women in rural Ethiopia; that's the good news. The not-so-good news: According to a May 6 *New York Times* article by **Rahel Nardos, MD**, an ongoing survey of three regions there estimates that upwards of 250,000 women suffer from pelvic organ prolapse.

Pelvic floor disorders are a silent epidemic among Ethiopian women, deeply affecting their quality of life. Pelvic floor muscles can be damaged during protracted childbirth, especially in areas with limited health care. Even if a specialist can be found the surgery to fix a prolapse costs around $200, about 10 years' income for an average family in rural Ethiopia.

In extreme cases, the damage can result in pelvic organs like the bladder, the bowel and the uterus to "prolapse" out of the body through the vagina. In addition, Ethiopian women experience a lifetime of strenuous physical activity – typically working 13 or 14 hours a day carrying wood and water over mountains – which makes the condition much worse.

Nardos, OHSU adjunct assistant professor of obstetrics and gynecology, **Renée Edwards, MD**, associate professor of obstetrics and gynecology, and **W. Thomas Gregory, MD, FACOG**, associate professor of obstetrics and gynecology, and their team of health care providers visit Gimbie, Ethiopia, at the beginning of each year going back to 2010. Last January, their surgical team performed 39 surgeries. The outlook for the next mission, February 2017, is even brighter, as Footsteps' team will include experts in cardiology, gastroenterology, emergency medicine and midwifery in addition to the surgical team.

Footsteps also now sends smaller teams of two or three, including faculty, residents and fellows, every few months to provide ongoing clinical and academic support while at the same time providing global health learning opportunities

"I never imagined I would be educated in the U.S.," says co-founder Nardos, who grew up in Ethiopia and is a driving force of the program. "For some reason things kept falling into place, so I now have access to medical skills and treatments that are out of reach for most people in Ethiopia."

The Ethiopia–OHSU urogynecology fellowship team (left to right): Dr. Renate Roentgen (fellowship director); Dr. Fekade Ayenachew (Hamlin fellow and medical director); Dr. Renée Edwards (urogynecologist and co-director of the OHSU Center for Women's Health); Dr. Kimberly Kenne (OHSU fellow); Dr. Dawit Asrat (St Paul fellow); Dr. Melaku Abreha (Ayder/Hamlin fellow and fistula surgeon); and Dr. Rahel Nardos (urogynecologist with OHSU/Kaiser, founder of Footsteps to Healing and board member for World Wide Fistula Fund). *Photo by Joni Kabana, Kabana Photography LLC*

The missions provide valuable experience, especially for OHSU residents who assist in as many as six surgeries a day, says Nardos. "They can participate in more pelvic floor surgeries in one day than they sometimes would in an entire surgical rotation."

Footsteps is also helping to train three skilled gynecologists and fistula surgeons – the first formal urogynecological trainees (fellows) in the history of Ethiopia – who will continue to provide care to women with pelvic floor conditions while receiving ongoing support and mentorship.

Footsteps to Healing will host its annual Ethiopian Dinner fundraiser Nov. 14. For more information, please visit *www.ohsu.edu/xd/health/services/women/community-outreach/collaboration-in-ethiopia.cfm*

Footsteps to Healing, Oregon Health & Science University

FOUNDED	2010
WHAT IT DOES	The program performs women's surgeries in Ethiopia and strives to improve women's overall health through international/local partnerships.
LEARN MORE	www.ohsu.edu/xd/health/services/women/community-outreach/collaboration-in-ethiopia.cfm

On the front lines rehabilitating people and lives

By John Rumler
For The Scribe

Since 1999, opioid-related deaths have quadrupled and about 2 million people in the U.S. have a prescription opioid use disorder – also contributing to increased heroin use and the spread of HIV and hepatitis C. **CODA Inc.**, the oldest opioid addiction treatment program in Oregon, treats people whose health and quality of life are compromised by opioids and other drugs, alcohol and mental health challenges.

"With the help of our donors and community partners, this year alone we have served more than 3,700 people at our 10 locations in the tri-county area," said **Stephen Cassell**, director of marketing and individual gifts. "As we look ahead to 2017, we are grateful to be providing this life-saving care, especially considering that the opioid epidemic facing our families requires the best efforts of everyone in our community."

Volunteers from the Junior League of Portland recently helped out at CODA's Hillsboro Recovery Center Outpatient, where they beautified planter boxes (left) and painted a mural (above) to be hung at the center. *Photos courtesy of the Junior League of Portland*

With its patient-centered care, partnerships with other health care providers and community partners, and through advocacy for effective public policy, CODA helps bring about health and recovery through compassionate, evidence-based care.

CODA was originally established as part of a state effort to provide methadone to clients in need of treatment, often related to detoxing. CODA became an independent 501(c)3 in 1979, and between 1986 and 2007 it added transitional housing, outpatient, residential, detoxification and recovery centers in Gresham and Tigard, as well as mental health and DUII services.

During that period, CODA added residential programs serving adults with severe and persistent mental illness and clients under jurisdiction of the state's Psychiatric Security Review Board. In 2007, CODA opened its first Stepping Stones transitional housing for women in recovery (moms being reunited with children who had been in foster care) and in 2011–12, it built two Stepping Stones transitional houses in Aloha. CODA now offers a total of 15 programs in Multnomah, Washington, and Clackamas counties. It also has administered multiple alcohol and drug programs in Washington County, including drug court, community corrections, and DUII and outpatient treatment since 2008.

For many years CODA has collaborated with numerous regional and national partners, including OHSU, Dartmouth College, University of Pittsburgh, University of Washington, Virginia Commonwealth University, Kaiser Permanente, and other research institutions funded by the National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism and others.

Believing that treatment driven by real-time data is critical to optimal patient outcomes, CODA, for nearly a decade now, has operated a separate research division within its organization. CODA Research was one of three recipients of the SAMHSA 2012 Science and Service Award.

CODA Inc.

FOUNDED	1969
WHAT IT DOES	CODA, the oldest opioid addiction treatment agency in Oregon, provides alcohol and drug recovery programs among its many services.
LEARN MORE	www.codainc.org

Physician wellness among topics addressed in Portland IPA podcast series

By Melody Finnemore
For The Scribe

The **Portland InterHospital Physicians Association** (IPA) recently announced a series of podcasts that will address physician wellness among a host of other topics of interest to local health care providers.

Portland IPA launched the series earlier this month and its inaugural presentation featured **MSMP's Physician Wellness Program**. During the podcast, Program Psychologist **Beth Westbrook, PsyD**, discussed burnout and explained emerging issues such as stress, malpractice and anxiety and how the program helps people dealing with these issues. MSMP Executive Director **Amanda Borges** described the Physician Wellness Program, including its confidential nature and who it serves.

The intent of MSMP's program is to address and remove the barriers that typically prevent doctors from getting the help they need. The program is accessible to all physicians and physician assistants at no cost. Counseling is held at MSMP's offices in a confidential room with a private entrance; no information is disclosed to others and no electronic medical records are kept; there is no diagnosis given; and no insurance is billed.

"We wanted to kick off with MSMP and physician wellness because it's such an important part of the work that our physicians do. It's a universal issue, basically," said **Janel Lewis**, Portland IPA's project coordinator.

Physician burnout experts at the AMA and the Mayo Clinic conducted a survey of 6,880 physicians to "evaluate the prevalence of burnout and physicians' satisfaction with work-life balance compared to the general U.S. population relative to 2011 and 2014," according to the study, which was published in *Mayo Clinic Proceedings* earlier this year.

"In 2011, we conducted a national study measuring burnout and other dimensions of well-being in U.S. physicians as well as the general U.S. working population. At the time of that study, approximately 45 percent of U.S. physicians met criteria for burnout," the study authors wrote.

When a follow-up survey was conducted in 2014, 54.4 percent of physicians reported at least one sign of burnout. Physicians also reported lower rates of satisfaction with work-life balance in 2014 compared to a similar sample of physicians in 2011.

In addition to physician wellness, the quarterly podcasts will highlight some of the innovative ways physicians have utilized Portland IPA grants and address issues such as palliative care, medical weight loss before surgery, specialty medical homes and the future of payment reform, among other topics. An additional podcast about physician wellness will be offered later in the series as well, Lewis said.

She noted that she and **Tom Gragnola, MD**, Portland IPA's medical director, talked last year about how to bring independent physicians together to collaborate and strengthen their practices in an interactive setting that is also convenient. Gragnola suggested the podcast series as a means of engaging physicians in a more conversational forum than a webinar or similar format.

For now, the podcast series is available exclusively to Portland IPA members, though the presentation on MSMP's Physician Wellness Program is available through MSMP. Portland IPA is exploring ways to make the podcasts more accessible for public use in the future, as well as the possibility of doing the podcasts more frequently. ●

For more information about the podcast series, please contact the Portland IPA office at 503-731-7500.

> "We wanted to kick off with MSMP and physician wellness because **it's such an important part** of the work that our physicians do. **It's a universal issue**, basically."
> *– Janel Lewis, Portland IPA*

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'The spice of life'

Olive oil production among the interests that fuel cardiologist Douglas Dawley

Photos courtesy of Douglas Dawley

Douglas Dawley, MD, has enjoyed an array of hobbies over the years, including picking olives and making olive oil with family in Italy. Dawley and his wife, Paula, followed a family tradition by naming an olive tree, pictured here, after their daughter Clara.

By Barry Finnemore
For The Scribe

For **Douglas Dawley, MD**, hobbies provide what he calls "the spice of life."

From olive oil production to learning to make single malt Scotch whisky to playing music, the Portland physician's varied interests allow him to learn and do new things with others.

"You can't just go to work every day and come home and do the same, old thing," he said. "You venture out into the world, and develop different knowledge bases."

When it comes to some hobbies, it's a family affair. Over 16 years, Dawley and family members would meet every other year at his architect uncle's property in central Italy's Tuscany region to pick olives, make olive oil at a 150-year-old local community press, and bring the oil home to enjoy it at their own tables.

"It was a fun, family thing," Dawley said.

Parents to three daughters now ages 27, 25 and 23, Dawley and his wife, Paula, would travel to Italy every other November, enjoying family traditions such as listening to opera music while picking olives from the property's 240 trees. Dawley and his cousins have 24 children between them, so they named some of the trees after their kids and hung name tags on the trees.

Dawley's interest in olive oil dovetails with – and helps inform – his work as a cardiologist. He's evaluated data from clinical trials pointing to the positive cardiovascular and other health outcomes experienced by people whose diet includes olive oil, noting the beneficial monounsaturated fatty acids and polyphenols found especially in extra virgin olive oil.

Dawley, who practices with Northwest Cardiovascular Institute, also has delivered numerous talks, including a local grand rounds presentation several years ago, about the health benefits of fish, olive and other oils. And, his hands-on olive harvesting and oil-making has been a vehicle by which he introduces the health benefits of olive oil to his patients. At his suggestion, some patients, he said, have jettisoned butter in favor of olive oil and made other lifestyle changes, returning to Dawley's office to report they've shed weight.

"When you generate interest with patients, it's nice. You've connected with them, and that's a good thing."

Though his uncle no longer owns the property in Italy, Dawley continues to have an interest in olive oil production, noting that more production is occurring in Oregon, including in the Dundee area. It's something he may return to in the not-too-distant future.

Tasting – and sharing – the fruits of their labor

A decade ago, Dawley and a friend, Tad Elmer, trekked to the Scottish isle of Islay to learn to make single malt Scotch whisky – from mashing grain to running stills – at the Bruichladdich Distillery. At the time, the distillery allowed the pair to buy a barrel and store, rent free for 10 years, the whisky they helped make.

A few weeks ago, Dawley and Elmer returned to Islay to taste the fruits of their labor. "It was really good … a golden color with a distinct taste and very smooth," Dawley said. The distillery offered them 8,000 pounds for the liquor, but Dawley and Elmer have decided to bottle it – they each will have 340 bottles – and, once they navigate the ins and outs of importing it into the United States, will give it as gifts to friends and family.

"It'll be nice to have the remembrance of our whisky academy experience," Dawley said.

The experience is both gratifying and surprising, Dawley added, because at the time of their trip to Scotland a decade ago, neither he nor Elmer fathomed that one day they'd share with those closest to them the Scotch they had a hand in crafting.

Dawley's interests also include the clarinet. During his medical residency and fellowship, he played in an orchestra comprised primarily of health care providers in Boston. Since the early 1990s, concerts performed by the group, known as the Longwood Symphony Orchestra, have benefited underserved populations in the Boston region, according to its website.

Dawley, who was inspired by his mom – herself a clarinetist – to learn the clarinet as a youngster, has played with many groups over the years, including in pit orchestras for musicals and other performances. And while his medical practice today leaves precious little time for playing in groups, Dawley hopes to get back to music again soon.

"It was a lot of fun, and an important part of my life," he said. ●

Free training for those who work with Latino patients, families

Familias en Acción has partnered with the California State University Institute for Palliative Care to develop in-person and online training to help health care providers, medical students and others who work with Latino patients and their families.

The Portland nonprofit is offering a four-hour, in-person training that educates participants about strategies for building patient engagement, culturally appropriate chronic disease management, integrating community health workers and patient navigators into care coordination, and didactic and interactive training with group discussions.

The course is free due to a grant from the **Cambia Health Foundation**. Providers and health systems are asked to select their training dates, and Familias en Acción will develop a promotional flyer, coordinate the registration and facilitate the training. The organization asks that hosts schedule the space and send the promotional flyer to internal and external lists as appropriate. For more information about the in-person training, contact Jaeme Klever at 503-201-9865 or *info@familiasenaccion.org*.

For participants who want to obtain the four CE hours available through the course, there is a $25 per-person processing fee. For questions about the CE hours, email *info@familiasenaccion.org*.

Familias en Acción and the CSU Institute for Palliative Care also have created an online adaptation of the course called "Care of Latinos with Serious Illness." The four modules are categorized as Latinos and Care, Building a Cross-Cultural Relationship, Patient-Centered Care for your Latino Patients, and Difficult Discussions with your Latino Patients.

The online course is designed to be easily accessible for busy professionals and students, and its self-paced format is available 24/7. It features an engaging format and realistic videos that enhance cultural awareness, which can lead to improvement of healthy outcomes and quality of care, according to Familias en Acción. For more information, please visit *www.csupalliativecare.org/programs/latinos/*.

Health care–acquired infection report shows patient safety improvement

Oregon does better than the national average on all health care–acquired infections (HAIs) and surgical site infections that are reported to the state, according to a recent report by the **Oregon Health Authority**.

The report shows that Oregon hospitals continued to reduce infections, including central line-associated bloodstream infections, MRSA bloodstream infections, C. Difficile infections, and catheter-associated urinary tract infections, as well as a number of surgical site infections.

Oregon hospitals also met or exceeded targets set by the Department of Health and Human Services in nine of the 13 reported infections.

"Oregon hospitals are committed to providing safe and consistent quality care for every patient on a daily basis. Part of that commitment is to report and learn from data so that the health care team can focus on opportunities for improvement," said **Diane Waldo**, associate vice president of quality and clinical services at the **Oregon Association of Hospitals and Health Systems**. "Hospitals do this work through a number of programs and initiatives, including the CMS's Partnership for Patients program, ongoing hand hygiene efforts, patient and family engagement, and others."

Zintars Beldavs, manager of the **OHA's Public Health Division's Healthcare-Associated Infections Program**, said the data in this year's report is promising, but more needs to be done to meet national targets for reducing HAIs, particularly as antibiotic resistance becomes an increasing factor in hospital outbreaks.

"This year's HAI report reflects efforts by Oregon hospitals to prevent infections in health care settings," he said. "But it also highlights other growing problems, such as multidrug resistance, inappropriate use of antibiotics that allow organisms such as C. Difficile to thrive, and central line-associated bloodstream infections affecting our most vulnerable patients in intensive care units. We need to keep working together to keep people safe from infections in health care settings."

The Oregon Healthcare Acquired Infections Report stems from legislation passed in 2007 to create a mandatory reporting program to raise awareness, promote transparency for health care consumers, and motivate health care providers to prioritize prevention. The report is available at *www.healthoregon.org/hai-reports*.

OHSU announces major award, Department of Defense contract

The U.S. Department of Defense has awarded a contract to **Oregon Health & Science University** in collaboration with the University of Pittsburgh and the University of Colorado that could lead to $90 million over the next decade to improve trauma care for civilians and military personnel.

The first $10.8 million project aims to create a nationwide network of trauma systems and centers capable of conducting detailed research to improve injury care. The Linking Investigations in Trauma and Emergency Services (LITES) Network will include extensive data collection to obtain and link information ranging from pre-hospital care through recovery after discharge on potentially thousands of trauma cases across the country.

Initially, the LITES Network is expected to provide epidemiological data on moderate and severe injuries in the U.S., and identify any regional variations in the types of injuries and the way they're managed.

A recent National Academies of Sciences, Engineering and Medicine report determined that hundreds of U.S. service members' lives could likely be saved in future wars if trauma care were optimal, and that those gains would lead to tens of thousands of civilian lives saved if such improvements were shared with U.S. trauma centers. That report set a goal to achieve zero preventable deaths after injury and minimal trauma-related disability.

OHSU also announced that **Doernbecher Children's Hospital** researchers have been awarded more than $9 million to fight Fanconi anemia. With the $9.9 million grant from the National Heart, Lung and Blood Institute, a team led by **Markus Grompe, MD**, director of the Oregon Stem Cell Center at OHSU and the Papé Family Pediatric Research Institute at Doernbecher, will work to understand human response to novel drug treatments that have shown promise in FA-positive animal models.

In partnership with the laboratories of Alan D'Andrea, MD, of Harvard University and Akiko Shimamura, MD, PhD, of the Dana Farber Cancer Institute, OHSU will conduct three scientific projects over the course of five years. Two of the projects will prioritize viable drug compounds for clinical study, using animal and human cell models. The results will lead to the third project: a human clinical trial.

Fanconi anemia is a severe and frequently fatal genetic disease that causes birth defects, bone marrow failure and increased risk of cancer. Despite research advances, medical therapies for the condition have not evolved in more than 30 years.

CHRONIC PAIN, *from page 6*

questions – "It's not really safe for a person with a condition like mine to be physically active" – aims to help providers educate patients on the difference between pain and harm, in part so patients "can approach the work of rehabilitation differently," Stern said.

"The old way of thinking about pain focuses on bodily damage, so solving the pain mystery has been about finding the 'source' of the problem, through tests and studies, and looking for something to 'fix.' But pain is a multifaceted process and we need to understand that whole process, from input (body and tissues), through processing (brain and nervous system) to the output of the pain sensation and experience."

Stern said that through the Persistent Pain Project physical therapists have partnered with primary care providers on the neurophysiology of pain to help support their efforts to change opioid prescribing. In addition, Providence has focused on patient education, inviting those experiencing pain to view videos, read written materials, and attend classes and then have follow-up conversations with their clinician and/or rehabilitation therapist (For more on Providence's education materials and offerings, please visit *http://oregon.providence.org/our-services/p/providence-persistent-pain/persistent-pain-toolkit* and *http://oregon.providence.org/our-services/p/providence-persistent-pain*).

Stern said Providence is making its education tools and training, both live and online, available to any clinician group inside or outside the Providence system. Greater understanding of pain and the factors that contribute to it, including depression and the fear of harm through movement, among patients and providers across the care continuum is important because patients can better understand how various treatment options can help them, Stern said.

"That has been really exciting," she added.

Stern noted good news with respect to insurance, pointing out that as of July 1 there is an increase in Medicaid coverage for non-pharmacological treatment options for back pain through the Oregon Health Authority. This allows physical therapy, chiropractic and acupuncture coverage for back pain. In addition, many Medicaid insurers have begun to provide some amount of rehabilitation coverage regardless of reimbursement for all pain conditions because "they have begun to recognize the critical need for real options for patients," she said.

Greg Smith, PhD, founder of Progressive Rehabilitation Associates, also takes an integrated approach to treating patients and his Portland and Vancouver clinics house a range of specialists, from physical and occupational therapists to an MD, nurses and psychologists. He noted that the biopsychosocial treatment model is the most effective for chronic pain, and his programs include behavior change courses to help patients make different decisions for themselves beyond medication.

For example, they can participate in cooking and nutrition classes to encourage an anti-inflammatory diet; "activity coaching" teaches patients how to engage in modified physical activities they thought they couldn't do because of pain; yoga and acupuncture helps keep patients limber; and they can take part in peer group sessions where they learn from fellow patients about successful strategies for managing pain. Each patient has a case manager who helps the patient identify goals, create a treatment plan and connect with other resources that can help meet their goals.

"If they sort of drop off the radar and have appointments but don't show up, the case manager will contact them and follow up with them," Smith said, adding if a patient has difficulty getting to the clinic for some reason, transportation can be arranged for them to attend. "The effort is to help them see that there is a better way. It has to be their goals and something they see as valuable so it's organized around something they want, and it's not us telling them what to do."

Smith said he recently participated in a conversation with several primary care providers with a large practice group about how physicians and physical therapists can work together to decrease the need for primary care doctors to provide ongoing treatment for chronic pain patients. The value of such increased communication and cooperation benefits primary care physicians, many of whom are overburdened with chronic pain patients, and, ultimately, the patients themselves.

"It helps when the referring physicians tell their patients, 'There's nothing further I can do to treat you with opiates,'" he said.

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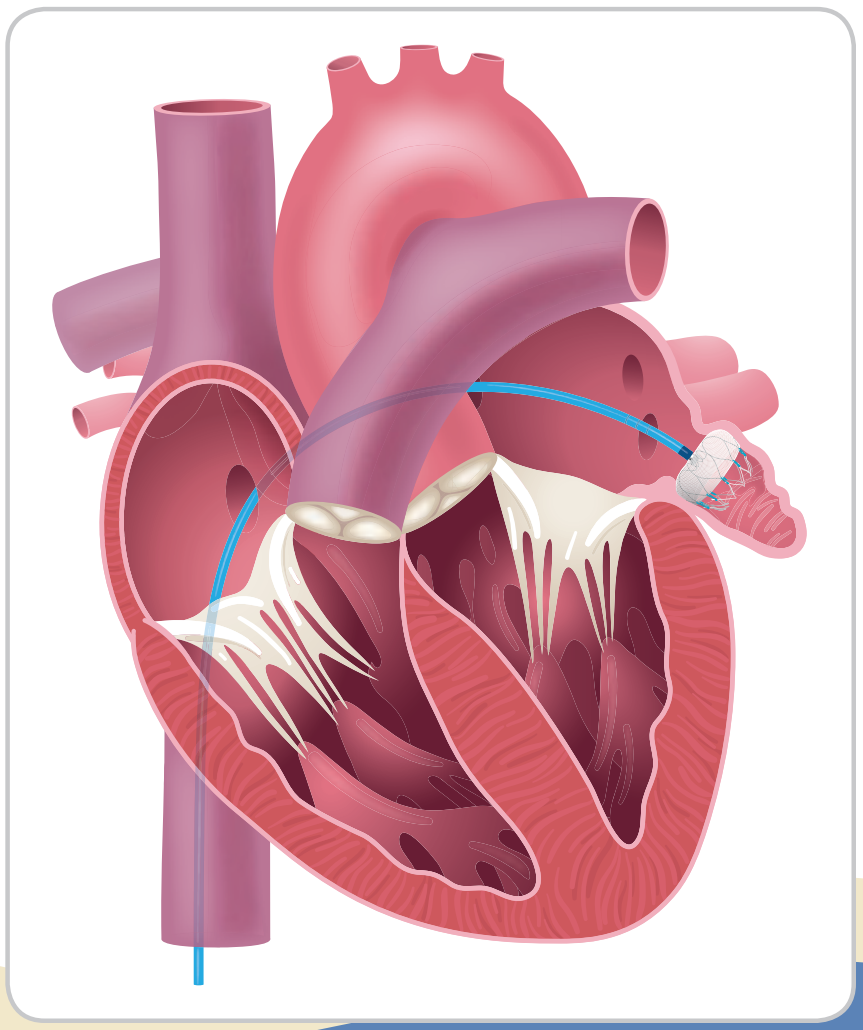

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PHYSICIAN SHORTAGE, *from page 1*

reported that aging and population growth are projected to account for 81 percent of the change in demand between 2010 and 2020. "The remainder of the projected change in demand is associated with the estimated expansion of health insurance coverage under full implementation of the Affordable Care Act, including an assumption that all states expand Medicaid," HRSA noted.

The number of primary care physicians is projected to increase by only 8 percent from 2010 to 2020, while the total demand for primary care physicians is projected to grow by 14 percent, the agency reported. "Without changes to how primary care is delivered, the growth in primary care physician supply will not be adequate to meet demand in 2020, with a projected shortage of 20,400 physicians. While this deficit is not as large as has been found in prior studies, the projected shortage of primary care physicians is still significant."

- The use of teams may help mitigate the shortage, but likely won't fully solve the problem. As HRSA put it, the growth of patient-centered medical homes and their attendant use of physician assistants and nurse practitioners within a team-based approach to care potentially "could somewhat" alleviate the physician shortage.

"We're looking at that as a solution, but we're not sure it is going to be all it's hoped for," said Farrell.

Brunett, who serves on the Oregon Health Policy Board's Healthcare Workforce Committee, added that the ACA has increased coverage for millions of people. "But coverage doesn't necessarily mean access." He expects team-based care will continue to expand both "by necessity" and because the concept "provides a more comprehensive, holistic approach to care."

Part of the attraction for medical graduates to specialize is the proliferation of new technologies and procedures, said Brunett. "But in my opinion, if we could catch people earlier from needing those procedures" through health promotion and maintenance, "that is the role of primary care teams."

Strategies and possible solutions

Health systems and medical clinics are employing various approaches to deal with current and future shortages. They note that young physicians place a premium on work-life balance and location.

"Recruitment and retention are equally important," pointed out **Dick Clark**, CEO of The Portland Clinic. The clinic tries to emphasize the advantages of practicing in the Portland area, the support the clinic provides practitioners, including the latest electronic medical records systems, and the potential to attain partial ownership.

DICK CLARK

The company is set up as a limited liability partnership and is run by a consortium of owners, he explained. After three years of practicing there, a physician can be nominated by the partners to be considered for a buy-in, he said. Many doctors enjoy having a stake in the enterprise, Clark said. "We see this as critical to retaining long-term practice here. Getting them started on the right foot helps them be successful." Forty-four of the total of about 100 providers are partial owners of the clinic, said Reid, the provider relations director.

Supporting physicians and promoting the use of team-based care also are important, she added. For example, the clinic offers medical scribes to help take the record-keeping burden off physicians. Aging patients have more complex needs, and that factor adds to stress on doctors, Clark said. "As a medical community, we need to assess what we can do to support these physicians."

"The doctors coming into primary care, more and more they feel the burden of being the sole provider for a panel of patients," said **Michael S. Alberts, MD**, vice president of human resources and professional development for **Northwest Permanente**, the medical group of Kaiser Permanente. In recruiting primary care doctors, Kaiser underscores for potential recruits the advantages of practicing within a fully integrated system, where all providers share the same EMR system and evidence-based medicine, he said. Also, "We believe our organization's mission, including prevention and the health of the community, appeals to physicians," Alberts said.

MICHAEL S. ALBERTS, MD

"Virtual visits," which he defined as those taking place via phone, computer or email, are popular with patients, and "younger physicians are asking about this," he said. "They really want us to provide that kind of care." Kaiser is starting to use the virtual concept for primary care, and "we're asking departments to determine what are the best applications for virtual visits." Kaiser is using these for dermatology and in urgent care, and the concept appeals to primary care physicians, he said.

Northwest Permanente also wants to leverage older physicians' experience by encouraging them not to retire but to remain in practice and mentor younger doctors, Alberts added.

Farrell noted that Legacy faces a primary provider shortage, period, not just a primary care doctor shortage, and that some specialties such as trauma surgery also are feeling the pinch. She said Legacy's downtown clinic slots are easier to fill than outlying area clinics such as in Gresham.

OHSU's Brunett said that although the Portland area and Willamette Valley "could use more primary care access," in many small towns and rural areas "the ratio of primary care provider to patient really goes down." Many areas of the state are having trouble recruiting doctors and a few are even losing the ones they have, he said. The state Healthcare Workforce Committee has been compiling a study on the effectiveness of existing incentive programs for drawing primary care physicians to rural areas. He is optimistic that the situation can improve because of the active efforts in Oregon to generate training sites around the state.

Where new doctors do their residencies is the most important and significant factor in where they end up practicing, Brunett said. "If you could get residents out for some or most of their training, they would put down roots and maybe can develop a patient panel," making it easier for them to stay in rural areas to practice. "Therefore, getting people into rural residencies is a powerful tool, and specifically in primary care."

Brunett said there is a "huge amount of interest" around the state in addressing the primary care physician shortage, but solving the problem depends on both public and private investment in resources, as well as having the "political will." ●

HURRICANE MATTHEW, *from page 4*

as possible. That team, likely a doctor and three nurses, will be part of a mobile medical unit that travels to remote areas to provide care. Their stint will be about three weeks or a month, at which time they'll rotate out with another volunteer team. DiCarlo said that MTI expected to dispatch two or three such teams in succession and then reassess from there. All in all, he expected MTI's short-term recovery efforts to last anywhere from three to six months.

"Then we will be evaluating how it's going and what more can be done," he said.

Locally, DiCarlo said anyone wishing to help out could best do so by making a financial contribution at *www.medicalteams.org*. As of mid-October, MTI had received a $150,000 donation that would be used to match any donations made to the nonprofit.

"Anything at all will allow us to assist our neighbors in Haiti," he said.

Mercy Corps

Like MTI, Mercy Corps has had a permanent presence in Haiti since the 2010 earthquake, so it was ready to respond when Matthew came to town. To help with the response, Mercy Corps also sent two emergency responders from Portland.

Even before the hurricane hit, however, Mercy Corps staff had reached out to networks, such as village savings and loan associations and farmers groups, to help communicate news of the impending storm to people in remote communities who hadn't known what was coming.

Photo courtesy of Medical Teams International

"We were able to spread word quickly, making people aware of the approaching danger and helping people stay safe during and after the storm," said **Lynn Hector**, senior communications officer for Mercy Corps.

In the wake of the hurricane, the nonprofit delivered supplies and shelter kits, including tarps, blankets, mosquito nets and solar lanterns with phone chargers, to people in Nippes, an area in southern Haiti hit especially hard. Staff were also working to combat waterborne diseases and bring in clean water.

In the more northern areas of the country, Hector said Mercy Corps was providing financial assistance to families whose homes had been destroyed and farmers who lost crops.

She said the lingering damage and fallout from the earthquake six years ago, along with devaluated currency and inflation, have made the impacts from Matthew even more devastating.

"Nationwide, some 60,000 are still living in displacement camps from the earthquake," she said. "Haiti is still not fully recovered from these crises, with many people lacking access to sufficient food. This year was the first good harvest in some time – and many of those crops were completely wiped out."

Mercy Corps plans to continue its work in Haiti, work made possible in part through generous donors, many of who live in the nonprofit's hometown of Portland.

"Although we are a global organization," Hector said, "our home is in Portland, and it is thanks to the generosity of our donors – many of whom live in Oregon – that we can do the work we do empowering people in more than 40 countries to survive through crisis, build better lives and transform their communities for good." ●

"Although we are a global organization, our home is in Portland, and it is thanks to the generosity of our donors – many of whom live in Oregon – that we can do the work we do **empowering people in more than 40 countries to survive through crisis, build better lives and transform their communities** for good."

–Lynn Hector, Mercy Corps

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