MEDICAL SOCIETY OF METROPOLITAN PORTLAND

The Scribe

A publication of the Medical Society of Metropolitan Portland

PHYSICIAN PROFILE

Story illustrates sobering fact

Oncologist Jennifer Lycette's perspective shines light on the impacts of mental illness, lack of rural resources.

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OFF HOURS

A focus on photography

Family physician Randy Pitts, MD, finds rewards in capturing a range of images.

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INSIDE

Serving the Portland-area Medical Community Since 1884 www.MSMP.org February 2017

Oregon Gov. Kate Brown was among the many who marked the opening of Portland's Unity Center for Behavioral Health last month. The center, among other things, will provide 24/7 emergency psychiatric care for people experiencing a mental health crisis.

Photo by Tim Hall

Unity Center aims to boost mental health care services

By John Rumler
For The Scribe

Mental health patients who visit the Portland area's often crowded emergency rooms for treatment may face wait times of 24 hours or more, an extremely critical period as delays in intervention may contribute to homelessness, job loss, broken relationships, incarceration and even suicide. According to a 2012 report by the Oregon Health Authority, the state's suicide rate is 41 percent higher than the national average.

"Emergency departments don't typically have a psychiatrist on staff; that's a consult service that a patient may have to wait 24 hours or even longer for," says **Chris Farentinos, MD, MPH**, vice president of the **Unity Center for Behavioral Health**, the state's first and only psychiatric emergency department that opened last month in Northeast Portland. "At the Unity Center, we'll be able to initiate treatment and counseling services immediately."

Farentinos led the effort to create the Unity Center, a collaboration between **Legacy Health**, **Adventist Health**, **Oregon Health & Science University** and **Kaiser Permanente**, to consolidate current psychiatric units and to create a local 24/7 psychiatric emergency service especially for people experiencing a mental health crisis. The Robert D. and Marcia H. Randall Trust donated $20 million to help fund the $40 million center.

More than two years in the planning, the Unity Center will also be a teaching/training facility for medical and nursing students, family nurse practitioners and other related disciplines. Farentinos hopes to help grow a new generation of psychiatrists in Oregon.

Farentinos has an extensive track record in mental health services. In 1997, she became co-owner of ChangePoint Inc., an outpatient addictions clinic in Portland, and was a member of National Institute for Drug Abuse Clinical Trials Network from 1999 through 2008. In addition, Farentinos was COO for De Paul Treatment Centers from 2008-2013, as well as the project manager for behavioral health integration in a partnership with Legacy. She joined Legacy in 2013 as director for behavioral health services.

With a handful of administrators accompanying her, Farentinos visited acute mental health care centers in Arizona, California and South Carolina to learn what worked, what didn't and how to provide the highest level of care at the lowest cost. She also did extensive teleconferences with five similar agencies focused on meeting the Triple Aim. The result, she says, is that Unity Center patients are quickly evaluated by a psychiatrist, stabilized and a treatment plan is customized to their needs.

In addition, on-site navigators from community behavioral health organizations help coordinate continued

*See **UNITY CENTER,** page 14*

NOTE TO OUR READERS

Welcome to the electronic version of *The Scribe* newspaper. Please make note of some of the interactive features of this publication. Articles that jump between pages have hyperlinks on the continuation line for your convenience. We have also linked advertisements and other web references to their respective websites.

You can double-click the page to zoom in or out, and grab and drag when zoomed in, to navigate around

If you would prefer a print version of this paper, we encourage you to subscribe by calling 503-222-9977 or emailing *Janine@MSMP.org*.

We welcome your feedback, and appreciate your readership.

Thank you.

FOCUS ON AGING & ELDER CARE

Area housing strategies encompass aging homeless population

By Cliff Collins
For The Scribe

The deaths of several homeless people in the Portland area during this unusually cold winter serve as stark reminders of the impact of the much-discussed local housing crisis.

That "homelessness is a health problem" is a theme continually emphasized by **Central City Concern** as it attempts to serve people affected by the housing shortage, said **Meg Devoe, MD**, an internist and addiction medicine specialist with the organization and an assistant professor at **Oregon Health & Science University**.

The deaths of the homeless individuals from exposure – three out of the four who died in January were older than 50 – offer "very real examples of the fragility" of people who have no regular shelter and who are not only at greater risk of illness, but also of death, said Devoe.

Studies have been scarce and statistics vary across the country, but the estimated overall number of **people over age 50 living on the streets increased 20 percent** from 2007–2014, and now **make up 31 percent of the nation's homeless population**, according to the Department of Housing and Urban Development.

"The unhoused population has aged just like everyone else," said **Will Kennedy, DO**, a medical director with **CareOregon**. "That's an ever-bigger problem because older people are more susceptible to the weather if they don't have a home." He said the housing crisis potentially affects all of CareOregon's members, but especially the elderly because they often have "specific health

*See **AGING HOMELESS,** page 10*

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Virginia King, M.D., FPMRS — Dr. King is a board-certified urogynecologist. She received her medical degree from OHSU and completed her residency at Duke University. She returned to OHSU to complete a fellowship in female pelvic medicine and reconstructive surgery.

Lynn Osmundsen, M.D., FPMRS — Dr. Osmundsen is a board-certified urogynecologist. She pursued her medical studies at Tufts University and completed a master's in public health. She completed her residency at OHSU in obstetrics and gynecology.

Virginia King, M.D.

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"Connecting Physicians in Community"

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MSMP Board of Trustees nominations

Nominations are now open for the 2017–2018 Medical Society of Metropolitan Portland Board of Trustees.

We invite your recommendations and welcome self-nominations.

The Board represents the members of MSMP and the profession in determining and assuring exceptional organizational performance. Conversations are lively, direct, diverse and important.

Ultimately, the leadership success of the Board is a direct result of the imaginative and productive input of individuals and the collective participation of its members. These are exciting and changing times in medicine. Involvement on the Board of the Medical Society will allow exceptional individuals to be a part of shaping the future.

The 2017–2018 Board commences May 2, 2017, and meets monthly except for July and August.

If you have an interest in serving on the MSMP Board of Trustees or know of a colleague who has expressed an interest in serving, please submit your nominations to *amanda@msmp.org*. Nominations must be submitted by March 8.

Know an outstanding medical student?

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The Medical Society of Metropolitan Portland is pleased to introduce our **THIRD ANNUAL MEDICAL STUDENT AWARD**, paying tribute to a medical student who embodies MSMP's mission to create the best environment in which to care for patients.

If you would like to recognize a student member of MSMP who has shown these attributes, please visit *www.MSMP.org/Medical-Student-Award* and complete a nomination form.

Nominations must be submitted by April 4.

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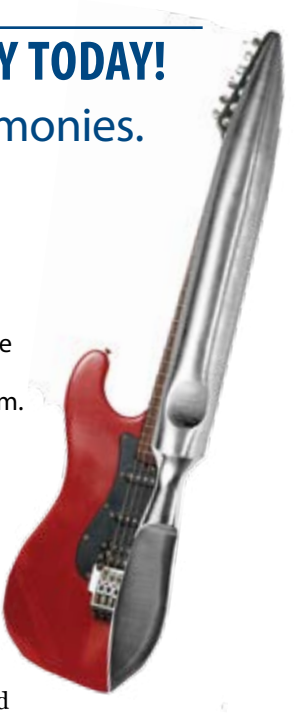

MSMP is looking for outstanding doctor bands to participate in our upcoming **BATTLE OF THE DOCTOR BANDS** on **JUNE 15** at Lola's Room at the McMenamins Crystal Ballroom. The only criteria for submitting an application is that one member of the band must be a member of MSMP.

If you would like to battle with the best, please visit *www.MSMP.org/Battle-of-the-Doctor-Bands* to complete the application. The deadline to apply is April 10.

For more information, contact *sarah@msmp.org*.

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Colorectal Health Northwest
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Health plan employs specialized teams to interact with clinics

FamilyCare service strategy spurred by desire to maintain 'small culture'

A FamilyCare Health P²ORT team holds a biweekly "port huddle" in which they discuss members with complex cases and special needs to strategize and help the members and their providers get the care and support they need. Pictured, from right to left, are Mike McMullen, Kelsey Knight, Melanii Lambert, Lisa Hess, Emily Petersen and Marie McJulien. *Photo courtesy of FamilyCare Health*

By Cliff Collins
For The Scribe

FamilyCare Health believes it has built a better mousetrap when it comes to customer service for its providers.

The health plan's Patient–Provider Oriented Resource Teams – called P²ORTS or Ports – use specialized staff teams to communicate with different types of medical practices in its coordinated care organization.

FamilyCare's intention is to enhance its provider relationships by facilitating referral and authorization support, service coordination, provider services and navigation services, said **Oscar Clark**, vice president of integrated services. "I grouped clinics together based on how they operate," and then matched them with a specially trained team that understands how each clinic works, he said.

OSCAR CLARK

For example, one Port team handles pediatric practices, another deals with small, private practices, another specializes in maternity, and a team works with safety-net Federally Qualified Health Centers. There also is a designated team for FamilyCare's Medicare Advantage customers. A total of nine Ports help CCO providers and member patients. Each Port team bears a Northwest river name, such as Rogue, Nehalem, Yakima and Umpqua.

The impetus for the Port concept was the Medicaid expansion that came with the Affordable Care Act, Clark explained. "It doubled our membership, (creating) a lot of demand on our providers. We wanted to keep the small culture FamilyCare has."

FamilyCare's main business is as a CCO for Oregon Health Plan patients, with a current enrollment of about 118,000 Medicaid members. Its Medicare plan covers approximately 4,000 members.

The program's objective is to streamline communication between FamilyCare and clinics to improve customer service to them, Clark said. Within each Port are representatives who assume different roles. A member navigator makes an initial welcome call to every member, which is "meant to engage members," he said. A second member navigator serves as an expert on enrollment. These two individuals are comparable to what normally are called customer service representatives.

A service coordinator acts as "our social-determinants expert" to help when member problems come up with matters such as those involving food or housing. A care coordinator handles "diagnosis-based chronic disease" management, mostly internally. A second care coordinator works primarily externally to monitor ED visits and discharges.

In clinics that are designated patient-centered medical homes, the clinics' care coordinators work directly with FamilyCare's care coordinators, which is "complementary," he said.

Each Port includes a provider-education services representative, who makes regular visits to clinics, communicates data about members and serves as a liaison between the health plan and the provider, Clark said.

Having a team specifically geared toward the Medicare Advantage plan is important because dealing with an older patient population requires "a different skill set" and a familiarity with community resources and diagnoses more common to those over age 65, he added.

Clinics' response to the Ports' personal touch has been positive, Clark said.

See ***FAMILYCARE,*** *page 14*

Organizational professionalism charter advances via recent publication

Pioneering document defines model principles to promote patient care, population health and provider well-being

By Barry Finnemore
For The Scribe

The development and dissemination of a pioneering charter that outlines model principles of organizational professionalism in health care took a major step forward recently as the document and an accompanying article were published in the journal *Academic Medicine*.

The **Charter on Professionalism for Healthcare Organizations**, developed by a diverse group including physicians, nurses, ethics experts, and hospital and patient representatives, sets out four themes: emphasizing patient-centered care as the priority; promoting broad access to health care; serving as good stewards of resources; and nurturing an ongoing learning environment.

The charter, described as aspirational, emphasizes that health care organizations have gradually evolved beyond treating disease and restoring health, so model organizations also should embrace health promotion, disease prevention, "value-driven care" and collaboration across medical disciplines and with community groups.

The document, which appeared online in the Association of American Medical Colleges' peer-reviewed monthly journal in January, is significant because of its potential to profoundly impact not only individual patient and community health, but also the wellness of physicians and other professionals who work for medical organizations amid a rapidly changing health care landscape, said **Barry Egener, MD**, medical director of the **Foundation for Medical Excellence**, the Portland nonprofit that spearheaded the charter's development.

Indeed, attending to the well-being of clinicians and others involved in health care delivery could be considered a new, fourth component of the Triple Aim of improving the patient experience, advancing population health and reducing per-capita health care costs, Egener noted, citing an idea put forth by Thomas Bodenheimer, MD, and Christine Sinsky, MD, in an article titled "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," which appeared in the *Annals of Family Medicine* in 2014.

The article that accompanied the charter's publication noted that a Rand study on physician well-being found that "the same considerations that apply outside medicine – for example, fair treatment; responsive leadership; attention to work quantity, content, and pace – can serve as targets for policymakers and health delivery systems that seek to improve physician professional satisfaction."

Egener, who chaired the working group that drafted the charter, said it was modeled on 2002's "Medical Professionalism in the New Millennium: A Physician Charter." But unlike that document, the organizational professionalism charter delineates competencies and behaviors that define a forward-thinking hospital or health system's culture, values and workplace environment, which can have more of a profound impact than individual health care employees can on care quality, clinician well-being and an organization's bottom line, Egener noted.

"I can make a decision for myself, but it's hard to affect an entire culture unless that whole organization, at the leadership level, articulates that culture and its values," he said. "That's the impetus for this concept."

The charter extends into the realm of inter-organizational behavior, noting that "(o)rganizational behaviors do more than create an environment that influences the professionalism of those within it. They have a powerful influence on the environment beyond their walls: they interact with other organizations that affect health and can directly impact the social determinants of health in ways that individual professionals or healthcare professional membership organizations cannot."

The organizational professionalism charter's four

See ***HEALTH CARE CHARTER,*** *page 14*

Island at heart

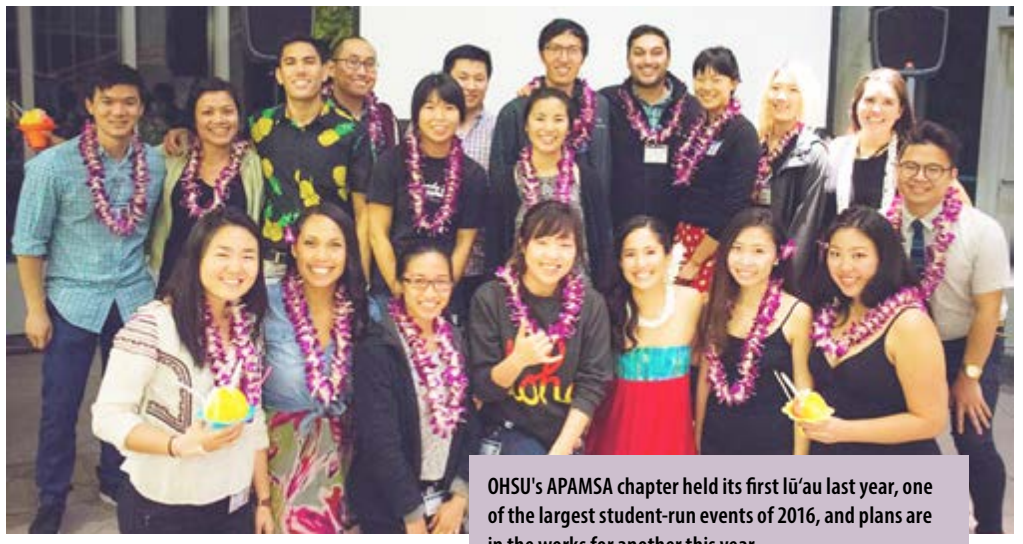
By Kelsi Chan

I am no stranger to living far away from home. Hawai'i is at least five hours away from land in every direction. As a young girl, I often traveled to the States for various soccer tournaments, but I always had my people by my side, whether in the form of parents, family, friends or teammates. Trips were always fun because it felt like I was in a new place experiencing new things, but I always, always was in the comfort of being with people who knew me and understood me.

When I was a junior in high school, a Massachusetts recruiter saw me play in a tournament in San Diego. It was my ticket to four years of higher education. When the day came for me to leave to start my freshman year, like many previous times before, I packed my bags and said goodbye to Hawai'i, only this time, I would be 13 hours away and for many months at a time. By then, I had seen snow. I had built a snowman. But I never knew what living through a Boston winter was like. It took a few months to get my footing, quite literally. I eventually joined the Hawai'i Club and immediately felt at home. I was a part of the school lū'au every year and loved sharing my culture with my non-Hawaiian classmates. Even though I was the furthest I'd ever been from that little rock in the middle of the Pacific, I found a home. I found the people who understood me and knew me without having to explain anything about myself.

Fast forward 10 years, I am now a second-year, soon-to-be third-year medical student at OHSU. I am not ashamed to say this wasn't my first application to medical school. After taking the years off between applications to make myself a more competitive applicant, I was finally able to get into several medical schools. I ended up choosing OHSU for many reasons, one of the most important being it was the closest to home besides the medical school in Hawai'i. At the time, I wasn't quite ready to go home for good and OHSU as an institution was too renowned to pass up. When I got here for my first day, I was shocked to find in my class of approximately 140 students, I was the lone Native Hawaiian. At a school in Oregon.

I don't really know what my expectations were coming to OHSU, but even in a place as far away as Massachusetts, I was able to find my home away from home by finding others from the islands. Here, to be honest, it has been more difficult. People who know me will tell you that I am loud, outgoing and I do make friends easily. I still made lots of friends and some really close ones, but something was missing. I missed having a Hawai'i club and having a place where my culture could be enjoyed and didn't have to be explained. I wanted to have a school lū'au like in Massachusetts. OHSU has no Hawai'i club and no annual lū'au. I guess I should've done more research and not made assumptions about coming here.



OHSU's APAMSA chapter held its first lū'au last year, one of the largest student-run events of 2016, and plans are in the works for another this year.

Photos courtesy of Huy Hoang, MD class of 2019

As time passed, the fact that I was the only Hawaiian in my class and one of very few in the entire institution really started to sink in. With gentle nudging by a close friend, I became one of the co-chairs for the Asian and Pacific American Medical Student Association (APAMSA), and attempted to funnel many of my own cultural frustrations there. When I became a leader of the club, there were probably only three active members. From that moment, my dream was to build a larger community for the Asian and Hawaiian Pacific Islander students at OHSU and to plan OHSU's first lū'au.

Almost an entire year after leading APAMSA, we finally threw the first lū'au ever, sponsored by the OHSU Center for Diversity and Inclusion. New, eager and passionate first-year APAMSA members, and in particular, a fellow Hawaiian (who is also the only one in her class), were instrumental to the fruition of the lū'au. The lū'au was one of the largest student-run events of the year. It was a huge success, selling out before doors opened. The event raised money and awareness for OHSU APAMSA, which now has 58 members, two of whom are regional managers and one who sits on the national APAMSA board. For the first time, OHSU will host the APAMSA Region 8 Conference Feb. 25 at the Collaborative Life Science Building. There are already plans for OHSU lū'au 2017 as well.

Being part of APAMSA has been one of my proudest moments as a medical student and has also taught me so much about myself. Within the past year, I actually did find what was missing and why I would feel alone in a room full of people at times. What was missing was my own open-mindedness. What was missing was acknowledgment of my own implicit biases and assumptions. The more I allowed myself to learn about my non-Hawaiian friends and allowed them to learn about me, I started to realize that OHSU has a ton of Hawaiians! Or, let's say, honorary Hawaiian souls. When I finally return home to Hawai'i to settle down and practice, I will be able to tell my family and friends that I have met some of the most wonderful people at OHSU and also found a true Hawaiian soul sister I never knew I had, who also played a huge role in realizing my dream lū'au. All I had to do was open my mind a little more to find my home away from home at OHSU, to find my island people. ■

Kelsi Chan is an OHSU medical student in the class of 2019. This article originally appeared on OHSU's StudentSpeak blog.

Norris stepping down as clinic's founding medical director

The greatest lasting impression **Dr. T. Michael Norris**' has of his time as founding medical director of **Clackamas Volunteers in Medicine – The Founders Clinic** is the appreciation of patients who receive care at the Oregon City nonprofit.

But the profound benefits go both ways, said Norris, MD. He and the other seasoned providers, as well as the pre-med and medical students who volunteer at the clinic, get just as much out of their time there as do the patients.

"It benefits the doctors as much as the patients," Norris said. "It keeps (providers') brains going, thinking about something … we know how to do and do well."

Moreover, the clinic's scheduling system means appointments are no less than 30 minutes. "Most have never had that much time with a doctor, and many doctors in recent years have not had that much time with patients."

This month, Norris is stepping down after five years as medical director. But he won't be leaving the clinic entirely. The longtime family physician plans to continue volunteering at The Founders Clinic, seeing patients and serving on its board of directors.

Norris' clinic leadership dates to even before the nonprofit opened its doors. He championed the idea of a free clinic that would fill the need for medical care for uninsured, low-income people after the county closed federally qualified health clinics; helped raise and secure the clinic's endowment; and helped recruit its earliest volunteers. Norris also advocated for the Volunteers in Medicine model the clinic embraced of recruiting retired providers, as well as those not yet retired, to serve as volunteers.

Karen Shimada, The Founders Clinic executive director, is unequivocal in her view about Norris' impact. "This clinic would not be here if it weren't for him," she said.

Shimada described Norris as modest and hands on, exhibiting a "personal commitment" to every patient. She also underscored his "unwavering heart to serve" and attention to detail. She called him tenacious, pointing as an example to his strategies to acquire affordable prescriptions.

The clinic, which opened in 2012, expanded under Norris' leadership, going from being open one day a week to the current three and expanding services that include vision, dermatologic and gynecologic care. Norris' connections also led to numerous partners – The Oregon Clinic, Legacy Health, Providence Health & Services and EyeHealth Northwest among them – providing free services. In addition, Kaiser Permanente has provided significant grants for community clinics, Shimada said.

She said she hopes the clinic can attract a replacement for Norris as soon as possible. The clinic is open to ideas for how the medical director position would be structured going forward, including having the position filled by a single provider or even a team. She added that the clinic has a grant for a patient care coordinator to carry out some of the duties Norris handled as medical director.

The clinic has two full-time staff members – an executive director and a patient care coordinator/clinic manager – a three-quarter-time volunteer coordinator, a Vista program development coordinator, and a contracted grants manager and contracted accountant. Shimada said 33 physicians are credentialed to volunteer with the clinic, and of those about 20 volunteer regularly.

Since the clinic opened, it has served more than 6,500 people, many with chronic conditions that for years had been untreated, Shimada said. Among other things, the clinic is qualified by the Centers for Disease Control and Prevention as a pre-diabetes prevention center, with services offered in Spanish and this year in English. Thanks to donations of equipment and provider time, the clinic also recently broadened its vision care, offering exams and eyeglasses.

T. Michael Norris, MD, is stepping down this month as founding medical director of Clackamas Volunteers in Medicine – The Founders Clinic. Executive Director Karen Shimada praised Norris, who will continue to volunteer with the organization, for his commitment to patients and being a prime mover in the clinic's creation. *Photo courtesy of Clackamas Volunteers in Medicine*

Norris, a graduate of what is now Oregon Health & Science University who did his residency at Harbor – UCLA Medical Center, was in private practice in Oregon City from 1974 to 2010 and practiced in Seattle two years prior to that, said he and his wife, Alice, a community activist and former Oregon City mayor, would like to do more traveling in the future. They enjoy a time-share in Mexico, but hope to travel more widely as well.

"We'd love to go to more places," Norris said. "It's a big world." ■

Room to grow

Image courtesy of Legacy Health

Legacy Health will break ground this year on a new home for the Oregon Burn Center, the first major expansion on the Legacy Emanuel campus since Randall Children's Hospital opened in 2012. The $210 million, four-story facility will provide new surgical suites and parking for 100 cars adjacent to the hospital and operating rooms. Legacy Health recently consolidated all open heart surgery at Emanuel in addition to adding advanced and interventional cardiology services and a new multi-person hyperbaric oxygen therapy chamber.

The campus offers additional outpatient services, a comprehensive stroke center, extra corporeal membrane oxygenation, and a Level 1 trauma center. The Legacy Oregon Burn Center is the only facility of this kind between Seattle and Sacramento.

Oncologist's story shines light on impacts of mental illness, lack of rural resources

By Jon Bell
For The Scribe

Here's a sobering fact: According to the Health Resources & Services Administration, in all of Clatsop County, the roughly 1,100-square-mile county in the northwestern corner of Oregon, there is not a single psychiatrist.

That's a reality that came into clear focus for **Jennifer Lycette, MD**, an oncologist with **Oregon Health & Science University's Knight Cancer Institute**, while she was working with a breast cancer patient in Astoria. Lycette, who joined OHSU in 2013 to serve as the Columbia Memorial Hospital/OHSU Cancer Center's medical director, could scarcely believe the size of the tumor that appeared on the woman's CT scan. Even more unbelievable was the fact that someone could live with such a tumor – and receive no medical care for it – for as long as she had.

Then Lycette met the patient in person, and it became evident how that had come to be: mental illness was at play.

"There are situations where mental illness does not play a role," Lycette said. "In this situation, I did have concerns that it was a big part of the reason that she hadn't come to see anyone for her cancer until it was very, very advanced."

For Lycette, a native Alaskan who had gone through the University of Washington's Regional Medical Education program that trains medical students in five western states, the experience of working with such a patient in an area that's short on mental health resources was an impactful one. So much so that she put pen to paper, digitally speaking, and wrote about it in a column for the *New England Journal of Medicine* in December.

Among other topics, *The Scribe* talked with Lycette recently about her experience with the patient and why she felt compelled to share her story with others in the field.

> "It may still be underappreciated just **how big a comorbidity mental illness can be.** It is **every bit as impactful as other diseases**, but I think it can be underestimated."
>
> *–Jennifer Lycette, MD*

First of all, how did you end up out in Astoria working with OHSU? After medical school, I did an internal medicine internship and residency in Boston, and I think it was there that I really felt a calling toward oncology based on the experiences I had with patients. I returned to the Northwest and did my fellowship at OHSU, and from there I went into practice in Portland. I had been in a large group practice, and I was looking for a change and not really getting the same regard out of medicine that I had earlier in my career. About three-and-a-half years ago, I took the position out in Astoria. It afforded me the opportunity to get back into rural health care and to play a role in growing and developing a cancer center for the region.

Had OHSU had cancer care in Astoria before then? About two years before I started, OHSU had started sending an oncologist out here two days a week for infusion services. Then I came on in 2013. Three months ago, we had a groundbreaking for the new cancer center that OHSU and Columbia Memorial Hospital are building. It will be a brand-new facility for medical oncology, with an infusion center but also radiation.

Why did you feel like you wanted to write about your experience with this particular patient? I really wanted to share the challenges that I faced in trying to care for this woman for several reasons. First was the fact that she hadn't come to see anyone for her cancer, even though it was very advanced. Mental illness, I believed, was part of the reason. The second reason was that, even once she came to me and allowed some treatment, she was not willing to go back on any treatment for her mental illness. It may still be underappreciated just how big a comorbidity mental illness can be. It is every bit as impactful as other diseases, but I think it can be underestimated.

How did mental illness impact her and her cancer treatment? At the beginning, there was her fear and distrust of the medical system that contributed to her not accepting care until she was at a very advanced stage. There's also a challenge with underlying mental illness where we worry that it can impair the person's ability to play a role in managing and monitoring their own health during treatment.

Did she ultimately undergo treatment? She had one treatment and then went home and decided she didn't want to come back. She was just a wonderful person and she had a loving family who wanted to respect her autonomy and wishes. I wrote a bit about how the family struggled to help manage her quality of life with pain medications and wound care. She would not let home health services in, no nurses. She didn't want people in her home other than her family. It was very, very challenging to know that we had the tools to help her but she did not want to accept them.

Did she survive? She died from her cancer. The family heroically tried to take care of her and abide by her wishes, but they finally had no choice but to bring her into the hospital. The real tragedy was the lack of mental health care resources. This case was one of the more intense cases I've ever had, but working out in this area, we deal with these frustrations over and over, not having all the resources we would like to have for our patients.

The lack of mental health resources seems to be a pretty pressing concern in rural areas. I think it really is a crisis. Looking at the table (from HRSA about the number of psychiatrists per 100,000 residents in Clatsop County) and seeing a big fat zero there for our county really hit home to me. It's worrisome for the future. There are no easy or ready solutions. I was hoping that sharing this could bring attention to the problem by putting a story behind it, a real-life example of how it affected this person and her family. ■

To read Lycette's article, "Neglected – Cancer Care and Mental Health in Rural America," please visit www.nejm.org/doi/full/10.1056/NEJMp1612129.

Scribe Focus

Aging & Elder Care

Each month, *The Scribe* focuses on a health topic, providing a deeper look into issues and advances that impact the area's medical community and patients. Next month, we will delve into Pain Management.

Serving as a 'bridge'

OHSU's Healthy Aging Alliance educates community, physicians about elder care

By Jon Bell
For The Scribe

Back in 2009 and even before, **Elizabeth Eckstrom, MD, MPH**, a geriatrician at Oregon Health & Science University, and others in the medical field began to think that there had to be a better way to get medical research from its earliest stages into the real world on a much shorter timeline.

"It's crazy that you can discover something in the lab and it doesn't help your patients for at least 10 years or more," she said, "and so a number of groups started to think about how we need to make it faster."

At OHSU, those groups included some of the university's schools and institutes, which came together in 2009 to form the **OHSU Healthy Aging Alliance**. Now in its eighth year, the alliance continues to focus on speeding up the process for translating research into treatment for the elderly. But it also works to educate providers and patients, and span the gap between community resources for the elderly and the physicians who provide care.

"We decided we could not just be the research people," said Eckstrom, who serves as co-director of the alliance with **Henryk Urbanski, PhD, DSc**, director of the Neuroscience of Aging training program at OHSU. "We have to work as a bridge across the whole spectrum of aging so we can do our best to share knowledge and bring it to the forefront more quickly."

The alliance, which includes not only researchers and clinicians but also community members, focuses its research on several topics related to geriatrics, including Alzheimer's and dementia, the impact of aging on hormones and preventing falls. It also concentrates on other areas to help patients age successfully, such as physical activity, nutrition, technology and education.

Eckstrom said some of the alliance's main accomplishments thus far have revolved around educating both practitioners and community members in a variety of ways. The primary ones have been several major conferences around healthy aging. The most recent brought in 330 attendees, including an equal mix of researchers and community members.

Eckstrom noted that another goal of the alliance is to connect community partners like the Alzheimer's Association, Meals on Wheels and Oregon Care Partners with physicians who may not be aware of how beneficial those partners can be.

"When I talk with primary care doctors in these huge rooms, I'll ask them if they have ever referred a patient to one of these organizations," she said. "Sometimes, there won't be one hand raised. So, we bring people in so that doctors can see who they are and see the value in forming relationships with them."

Lastly, Eckstrom also said the alliance strives to spread the word about geriatrics. Simply put, in Oregon and elsewhere, not that many providers choose to become geriatricians. One of the main reasons, according to Eckstrom? Salary.

"Being a geriatrician is one of the lowest paying practice areas," she said, adding that the way Medicare developed is largely why doctors in the field get paid less than what others do. "But one of the latest physician satisfaction surveys showed that of all the specialties, geriatricians had the highest job satisfaction, just because it's so rewarding."

Eckstrom is hopeful that more physicians will take the time to learn more about caring for elderly patients. For starters, they can do that by looking into the Healthy Aging Alliance.

"I think that, across the board, many doctors do not have all the knowledge they need to care for the older adults they take care of," she said. "Most physicians have had very little training in the special aspects of older adult care, but they should. The better we can all do at learning how to care for older adults, the more we'll be able to care for everyone." ■

"The better we can all do at learning how to care for older adults, the more we'll be able to care for everyone."

–Elizabeth Eckstrom, MD, MPH, geriatrician at Oregon Health & Science University

Study seeks to understand prevalence of marijuana use in older adults

The recent legalization of recreational marijuana use in a handful of states, including Oregon, reflect the sweeping changes in the attitudes and perceptions towards marijuana use in the United States, NYU Langone Medical Center recently noted in a news release about a study on demographic trends among older cannabis users in America.

A common misperception is that widespread marijuana use is limited to younger generations. However, Baby Boomers have reported higher rates of substance use than any preceding generation, it noted.

"Given the unprecedented aging of the U.S. population, we are facing a never-before-seen cohort of older adults who use recreational drugs," said Benjamin Han, MD, MPH, a geriatrician and health services researcher at the Center for Drug Use and HIV Research and in the Division of Geriatric Medicine and Palliative Care at NYU Langone Medical Center.

"With the increased availability of legalized marijuana, there is an urgent need to understand the prevalence of its use and also its effects among older generations," Han said. "The paucity of knowledge in this area constrains the care for a changing demographic of older adults with higher rates of substance use."

To address this, Han and his team led a study, "Demographic Trends among Older Cannabis Users in the United States, 2006–2013." Published in *Addiction,* the study sought to determine the trends in the prevalence and patterns of cannabis use and attitudes towards cannabis use, and determine correlates of use among adults older than 50.

Researchers evaluated responses from 47,140 adults aged 50 and older in the United States through a secondary analysis of the National Survey on Drug Use and Health from 2006–2013. The survey provides national data on the use of tobacco, alcohol, illicit drugs and mental health in the United States.

The authors found a 71 percent increase in marijuana use among adults aged 50 and older between 2006 and 2013. Adults 65 and older had a significantly lower prevalence of marijuana use compared with those ages 50–64, but prevalence of use increased two and a half times over eight years. Overall, prevalence was higher among men than women through all years.

"We found only five percent of these older adults felt using marijuana once or twice a week was a great risk to their health," said Joseph J. Palamar, PhD, MPH, a researcher affiliated with the Center for Drug Use and HIV Research and an assistant professor of population health at the NYU Langone Medical Center. "I thought the perception of low risk was fascinating because, typically, we think of older generations as drug-adverse and perceiving most drugs to be risky. But apparently very few Baby Boomers

CONTINUES

Research: Palliative care boosts quality of life, reduces symptoms

People with serious illness who receive palliative care have a better quality of life and fewer symptoms than those who don't receive palliative care, according to a study by University of Pittsburgh School of Medicine researchers.

The study, published in late November in the *Journal of the American Medical Association*, was described as the first meta-analysis of the effect of palliative care as it relates to patients' quality of life, symptom burden and survival.

The study took a broad approach and looked at the philosophy of palliative care, according to the university. Researchers conducted a systematic review of 43 trials of palliative care interventions, including 12,731 adults with serious illness and 2,479 of their family caregivers. They also performed a meta-analysis to investigate the overall association between palliative care and three outcomes often linked with that care: patients' quality of life, symptom burden and survival.

"Taken all together, this is a very compelling message," said Dio Kavalieratos, PhD, assistant professor of medicine in the Section of Palliative Care and Medical Ethics in Pitt's Division of General Internal Medicine and the study's lead author. "People's quality of life and symptoms improved; their satisfaction with their health care improved – all during what is likely one of the most difficult periods of their lives."

Researchers also determined that palliative care was associated with improvements in advance care planning, patient and caregiver satisfaction with care, and lower health care utilization. There was mixed evidence of improvement with site of death, patient mood, health care expenditures, and caregiver quality of life, mood or burden.

"Historically, palliative care has overwhelmingly focused on individuals with cancer, but anyone with a serious illness, be it cancer, heart failure, multiple sclerosis or cystic fibrosis, deserves high-quality, individualized care that focuses on reducing their suffering and improving their quality of life," Kavalieratos said. "We need to find ways of integrating palliative care concepts in patients' usual care experiences so it isn't a luxury, but a standard part of health care for those living with serious illness."

Over the past five years, much attention has been paid to the idea that palliative care improves patients' survival, Kavalieratos said. Although some individual studies had shown that, the association didn't play out when multiple studies were pooled together in the meta-analysis.

"As a field, we need to develop new methods of studying how palliative care impacts people with serious illness and their caregivers. These methods should not burden patients and caregivers who participate in this research, but also need to be rigorous enough to capture what's going on at this critical point in people's lives." ■

consider marijuana use risky. But after all, this was *the* generation who was there, in the late 1960s, when the counterculture revolution exploded marijuana into mainstream popularity."

The researchers note that the majority of self-reported marijuana users indicated they first started using before age 18. This means that most of the current users either continued use or have begun using again more recently. Research is needed to determine whether this is related to changes in local, state and national acceptance.

"Personally, I don't think we need to be very alarmed about most older people who are using marijuana," Palamar said, "as our results suggest that only four percent started use after age 35. It is probable that most older users are at least somewhat experienced and are hopefully at reasonably low risk of harming themselves or others after use."

The results, however, give the researchers reason to believe the population may be at a particularly high risk for adverse health outcomes, as the concurrent use of multiple substances (marijuana, prescribed prescription drugs and even self-prescribed illicit drugs) all used in combination may make older adults further vulnerable to poor physical and mental health outcomes and certainly can impact their care, the news release noted.

"For years we've been worried about the potential effects of marijuana on the developing brains of teens, but now we may need a bit more focus on their grandparents, who are increasingly more likely to be current users," Palamar said.

"Older people may use marijuana for a variety of reasons – including medical reasons – however, we need to make sure they are not using in a hazardous manner since older adults may be vulnerable to its possible adverse effects. One particular concern for older users is the risk of falls while using marijuana. However, this has not yet been studied," Han added.

This study underscores the need for further research on marijuana use and its effects on this population. More importantly, the research dispels the myth that older adults do not use recreational drugs. It is the researchers' hope that their study encourages cannabis use questions to become a part of older adults' care plan screenings. ■

AGING HOMELESS, *from page 1*

requirements," such as for accessibility.

Adequate "housing is an essential component of overall health and daily function," said **Glenn S. Rodriguez, MD**, a past president of the **Medical Society of Metropolitan Portland** and a longtime family physician who specialized in geriatric patients.

Studies have been scarce and statistics vary across the country, but the estimated overall number of people over age 50 living on the streets increased 20 percent from 2007–14, and now make up 31 percent of the nation's homeless population, according to the Department of Housing and Urban Development.

Kennedy said the nation has experienced a dramatic demographic shift in the homeless population. University of California, San Francisco data showed that in 1990, just 11 percent of that metropolitan area's homeless were over 50, but now half are that age or older. The situation also is compounded in the Portland metropolitan area, because affordable housing is scarce, waiting lists for it are long and housing is expensive, he pointed out.

Nationally, between 2008 and 2014, programs offering health care to the homeless saw a 50 percent jump in the number of patients older than 50, according to a study reported by Kaiser Health News. The research found that many of those in their 50s and 60s were newly homeless.

Devoe, who practices primary care at

MEG DEVOE, MD

WILL KENNEDY, DO

Central City Concern's Old Town Clinic, said the clinic sees about 5,000 patients annually who are either very low income or facing homelessness. "People who have been homeless tend to have significant chronic diseases earlier in life. Chronically homeless tend to get sicker earlier in life and die earlier." She said their average life expectancy is estimated to range between age 40 and 65.

Kennedy, who practiced in Columbus, Ohio, before moving to Portland in 2010, said that the Midwestern city did not suffer from a housing crisis and had adequate single-level housing for seniors who lived independently. When he began working at CareOregon in 2014, he was struck by two things: the local housing crunch and its effect on the elderly and others, and the "rich" number of resources in the Portland area available to help vulnerable people.

But in conjunction with the breadth of resources was a "significant disconnect" by providers and people in the community in their awareness of available resources to assist those facing housing problems, he observed. "There are many organizations doing great work for vulnerable people, but they're not necessarily connected." There is "fragmentation" and a lack of connectedness with the provider community, Kennedy said.

"The health care sector definitely has a role to play," Rodriguez said. "We've probably done a better job of articulating the problem than solving it."

One of the strategies being followed by CareOregon, which serves about 150,000 Oregon Health Plan members in the metro area through Health Share of Oregon, is "to be a convener, a middle man in that," said Kennedy. "When providers call us, we're definitely fluent in trying to find resources. Part of our work is to try to make connections."

Strategies for solutions

CareOregon and Central City Concern each have embarked on projects to address community housing needs.

In 2014, CareOregon formed an LLC with three housing agencies and several service-delivery organizations to support CareOregon members in low-income housing, said **Rose Englert**, CareOregon's senior business leader of Community Health Innovation Programs.

Called **Housing with Services**, the pilot project encompasses 11 federally subsidized independent housing properties aimed at helping 1,400 low-income seniors and adults with disabilities living in downtown Portland. The project sends social workers to support residents' medical or mental health needs and to try to prevent residents from ending up going to emergency rooms, she explained. The coordinated care and integrated health and social services delivery model is

GLENN S. RODRIGUEZ, MD

ROSE ENGLERT

challenging to set up and run because so many players are involved, Englert said. But residents' feedback has been positive so far.

"We're seeing a lot of good results the last two years," she said, adding that a full evaluation will be conducted to determine outcomes and whether the program saves money overall.

Central City Concern is trying to identify people who are at risk of losing their homes avoid hospitalization, Devoe explained. "One of the things we are experimenting with are flexible funds for nontraditional health care," said Devoe. If someone has housing and cannot come up with a month's rent, and thus is in danger of losing that housing, the agency may pay that rent. "That's a new concept for health care."

Central City Concern also is running a test program with what it calls its Summit Team. The organization's leadership recognized that about 5 percent to 10 percent of its most medically complex patients use a disproportionate amount of medical care. So, it established a multidisciplinary care team modeled as if it were an ambulatory ICU, she said. The team's low patient-to-staff ratio allows patient visits of as long as an hour.

"There is no one way into homelessness, and no one way out," Devoe stressed. Many patients have mental health, substance abuse or chronic disease problems, and some have all three, she said.

Another need the agency identified is for palliative care and end-of-life care. "With the housing shortage, people living on the street often are asked to go to a nursing home" for this type of care, she said. These individuals "tend not to do well" in nursing homes; they may be younger than typical nursing home residents and have behavioral problems. They need coordinated care to help them "walk through the stages of grief" and "restore dignity," she said.

Devoe said that after implementation of the Affordable Care Act, most of Old Town Clinic's patients are covered under Medicaid or Medicare. According to Central City Concern, in 2013, the year before the ACA brought Medicaid expansion in Oregon, 47 percent of Central City Concern's patients were uninsured; by 2015, only 11 percent lacked coverage.

Rodriguez said the state has funded some innovative efforts to include housing, but "that's less likely to happen now" with the change of administrations and the budget crunch in Salem.

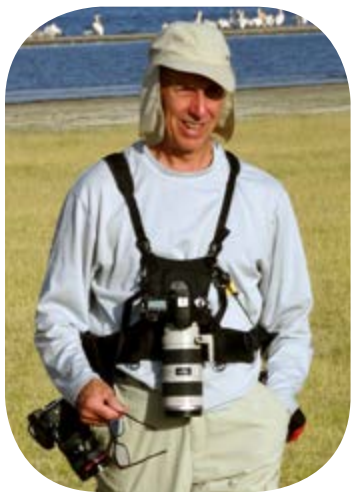
In addition to these respective programs, CareOregon and five local health systems committed $21.5 million to Central City Concern's earlier announced effort to improve health by addressing the housing crisis. The partnership with Central City Concern, called **Housing is Health**, will add 382 new housing units at three locations, one of which will include a medical clinic and housing for 176 people.

Also, one of those health systems, **Kaiser Permanente**, announced in January that it is awarding $2.27 million in grants to seven nonprofit agencies across the region. Each will receive $325,000 over three years to support programs that engage community health workers and peer counselors in helping people with mental illness and addiction disorders find and retain housing.

"As we looked at the challenges facing people with mental illness in our community, we heard repeatedly that lack of stable housing is the most critical need," **Andrew McCulloch**, president of Kaiser in the Northwest, said in awarding the grants. ■

CareOregon and five area health systems have committed $21.5 million in a partnership with Central City Concern to improve health by addressing Portland's housing crisis. Called Housing is Health, it will add 382 new housing units at three locations, one of which will include a medical clinic and housing for 176 people (pictured right).

A FOCUS on photography



Randy Pitts, MD, began taking photos as a hobby when his children played sports. His subjects and locales have expanded since then. He's pictured here in Tanzania.

Photo above by Ken Panck

All others courtesy of Randy Pitts, MD

Family physician finds rewards in capturing a range of images

By John Rumler
For The Scribe

After a busy day at his family medicine practice, **Randy Pitts, MD**, often winds down by photographing landscapes, individuals or events.

"I find I'm greatly rewarded in trying to create a photo that's visually pleasing, compositionally sound, colorful, and is an image that is different in some regards to what may have been done by others," he says.

Pitts was born in Cincinnati, Ohio, and grew up traveling around the country, East Coast to West Coast, because of his father's job at National Cash Register. "My dad fought in World War Two in the South Pacific in the Marines and was the official photographer for his division," he says with a touch of pride.

Pitts originally considered a career as a dentist or surgeon but chose a family practice instead. "I wanted the freedom to work in any city or country and not be tied to a hospital doing one certain type of work. I felt that a family practice would provide a variety of experiences and give me opportunities to explore different medical problems and treatment options."

In 1983, Pitts took over a small practice in Hillsboro and ran it for 28 years before joining The Portland Clinic's Beaverton location.

Although Pitts acquired his first camera, a 35-mm Canon A1-D, when he was an intern at the University of Oklahoma, he had neither the time nor the finances to fully enjoy it. His entry into photography came in the early 1980s, when he began taking pictures of his three children's sports adventures in elementary school, high school and eventually college.

As his kids started playing collegiate basketball, Pitts felt he had to substantially raise the bar with his photography. "It was a great incentive for me to hone my skills. It was also a sheer pleasure and the opportunity of a lifetime to document our two sons and daughter playing sports at that level."

As his kids graduated, Pitt's passion for taking photos evolved and broadened from sports to include landscape and wildlife, wedding and childbearing, nighttime, underwater and event photography. He's also transitioned from using manual cameras to shoot prints and slides to now using digital photography exclusively.

Although he owns dozens of lenses, Pitt's favorites include a 100-400 L-IS-2, a 100/2.8 macro, a 70-105L, a 50/1.4 and a 50/1.8, a 70-200/2.8L-IS-3, a 10-24 wide angle, and a 7-14 fish-eye lens. All of his lenses are Canons. After going out on a photo shoot, he'll upload the digital photos to one of his laptops, filing them meticulously according to date, location and subject. He uses Photoshop and Lightroom for post-processing.

He experiments with neutral density and polarizing filters, magnification filters and other more unique opportunistic filters for special purposes. Pitts uses tripods, both large and small, as well as a photographic beanbag, which, he said, works particularly well for long exposures.

Along with his wife, Cynthia, Pitts takes local hikes and visits nearby refuges to take photos. The couple also enjoys getting out as early as 4 or 5 a.m. to photograph urban scenes in downtown Portland.

As Pitts has grown in sophistication with both his equipment and skills, he's focused more on the lighting and composition of his subjects. "I consistently try to develop the composition and general photograph that would give the observer the feeling of 'wow!' although I am still at the lower end of that curve," he wryly observes.

Several of his photos adorn the walls of his home and office, but Pitts has not yet staged a show or displayed his work in galleries, which is a shame, friends say.

Computer/technology consultant Keith Haines has known Pitts for more than a dozen years and helped him with both his business and personal computer issues, especially helping organize thousands of photos. He describes Pitts as "always smiling, laid back, and an easygoing type of person."

Over the years, Haines has seen Pitts in the various roles of doctor, small business owner, father, friend and artist. He says Pitts is modest and able to poke fun at himself, and describes his photography as "as good as anything out there." He adds that Pitts is still excited and eager to learn new photography skills.

"Randy's got an incredible eye for taking photos and capturing different scenes and images that are quite unusual. His stuff is extremely high-quality and he has enough material that he could easily do a series of coffee table type of photography books."

While Pitts has taken photography classes and workshops, he's learned a great deal from studying books and magazines and, most of all, from his friends.

Ken Panck and Pitts met about 35 years ago and have spent countless hours taking photos together, including frequent trips up the Columbia River Gorge to photograph landscapes and flowers and taking a journey to East Africa to capture a variety of wilderness images.

While Panck specializes in birds and wildlife, he says Pitts is always looking to expand his repertoire. "Randy is constantly pushing the envelope, experimenting

with different lighting and lenses and subjects until he gets the shot he wants. He's got a keen eye for composition and is uncanny at coming up with unusual photos."

A retired electrical engineer who owned a plastic-injection/die casting business, Panck says his friend is highly skilled, yet humble, good natured and self-deprecating. "We share lots of ideas, especially on equipment and subjects, and are planning another trip, this time to South Africa. Randy is highly skilled and should have his own website to showcase his art, but I think he's too humble." ■

Glenn Snodgrass, MD, former Medical Society president, passes away

Glenn Snodgrass, MD, who practiced neurology and served as president of the Medical Society of Metropolitan Portland's predecessor organization, passed away Dec. 5. He was 86.

Dr. Snodgrass, who was president of the Multnomah County Medical Society in 1979, was closely involved in health care-related legislative matters during his time as a medical society leader, his wife, Joyce Snodgrass, said.

Dr. Snodgrass practiced medicine until he was 81, the last several years as an interviewer in the worker's compensation arena. He co-owned a practice with three other providers in the Rose City for many years.

Dr. Snodgrass was born in 1930 in Hutchinson, Kan. He was drawn to a career in medicine because of an aptitude for science and a desire to help people, his wife noted.

He graduated from medical school at the University of Kansas, served in the military and completed his residency in neurology at the University of Kansas. He worked for a time as a neurologist in Richland, Wash., and also headed the neurology department at a veterans hospital in Kansas City. He moved to and started practicing in Portland in 1963.

Dr. Snodgrass was a talented photographer, taking mostly cityscapes and landscapes, and developed pictures in his own lab, his wife said. They enjoyed traveling and, together with family, completed a vacation cabin on Harstine Island, west of Tacoma, that the family still owns. Dr. Snodgrass had learned do-it-yourself skills from his father, Joyce Snodgrass said.

In addition to Joyce, he is survived by three children, Elisa Davidson (Douglas), Steven Snodgrass, and Julia Bascom; and grandchildren, Jeremiah and Jessica Davidson, Alix Snodgrass, and Lilly, Georgia and Rose Bascom. ■

FAMILYCARE, *from page 4*

"Providers love it. They know the staff by name because they work with that same group; they don't get transferred. We try to make it as seamless as possible for providers."

Port teams "help quite a bit," said **Helen Albelo**, who is responsible for referrals and authorizations for **Rose City Urgent Care & Family Practice**, which has offices in Portland, Gresham and Milwaukie. "We don't get the runaround."

The clinic's assigned Port team answers questions and follows up with patients. She pointed out that, by contrast, she recently spent an hour on the phone with another insurer before she finally reached someone who could answer her question. With FamilyCare, Albelo can get quick responses as to whether a member is covered for a certain benefit. If a member needs referral to specialty care, the Port team finds resources that are closest to the patient's home, she added.

"This is a very good program," Albelo said. "I wish there were other programs like it with other insurance companies, because it would help us and their members."

T.J. Gray, DO, a veteran family physician with **Mountain View Medical Center** in Hillsboro and Forest Grove, said one of the values of the Ports team that serves his practice is the help it provides in caring for patients with complex cases and with special needs such as for mental health, cardiology or HIV care referrals. The fact that each Port team's members sit together in FamilyCare's office enhances care coordination for the clinic's patients, he said. "There's a lot to being in the same proximity to each other."

In addition, his eight-provider group is a medical home, and its own care coordinator works directly with FamilyCare's assigned Port care coordinator. Knowing the people at the clinic's Port when questions or authorizations arise "makes it more human for our staff," Gray said. "It's nice to have the same people. I like this model and what they do."

"We strive to have that one-call resolution for our providers and members," said Clark. The Ports' motto is "One call. That's all." The teams aim to answer phone calls within 15 seconds. Medicare requires health plans to answer calls within "a strict 30 seconds 80 percent" of the time for Medicare members, he said. Meeting 30 seconds consistently is challenging, he acknowledged. In order to facilitate fast responses, FamilyCare is acquiring technology that will recognize the phone number of the caller and automatically direct the caller to the appropriate Port, according to Clark.

Citing FamilyCare's annual member satisfaction surveys, he characterized members' response to the Port system as "remarkable," noting that receiving high satisfaction ratings from patients is difficult to achieve for any health insurer, because many members who contact health plans have a grievance and "it's hard to have your members like you."

"Since 2014 we've been saving cards we get from members, handwritten cards about how pleasant their experiences are," Clark said. The company also receives and saves similar notes from providers. In addition, FamilyCare encourages its Port team members to write and mail handwritten thank-you notes to members and providers, especially if someone among either of those groups is "having a bad day," he said. He added that the notes don't include the company's logo, and the effort is not related to branding. "It's so inexpensive in terms of the impact it makes."

Clark said that as far as he knows, no other insurers are using a Ports-type system, and FamilyCare developed it on its own and didn't model it after any others. The program has garnered interest from companies in some other states and countries, and Clark and FamilyCare's chief executive, **Jeff Heatherington**, have talked about it at a conference in Washington, D.C. ■

HEALTH CARE CHARTER, *from page 4*

domains are:

Patient partnership, including care delivery that's "respectful of and responsive to an individual's priorities, goals, needs and values"; a commitment to shared decision-making involving patients and care partners based on best evidence; "effective team-based care" and support for the role of patients as members of the care team; and a commitment to measure outcomes that matter to patients.

Organizational culture, including a commitment to the well-being of "all those who are cared for or work within" an organization; to teamwork via "communication across staff and with patients"; to a health workplace that's "physically and psychologically safe" and provides "tools and incentives for employees to achieve healthy lifestyles"; and to inclusion, diversity and accountability.

Community partnership, including identifying the social determinants of health, such as poor nutrition, and incorporating this knowledge into an organization's work; partnering with government agencies, community groups and others to reduce the root causes of illness and "ensure effective, culturally appropriate care"; a commitment to "advocate for access and high-value care"; and a commitment to "engage generously with community organizations and civic leaders to make innovative, strategic investments that leverage improved community health."

Operations and business practices, including those that "safeguard the privacy of patients and their health information"; a commitment to maintain the executive leadership and training required to sustain ethics and compliance programs that "articulate mission and values, guidelines for observing legal requirements, and standards for the highest ethical focus in addressing the health care needs of diverse populations"; a commitment to improve care models and help other organizations "achieve similar success"; and a commitment to managing conflicts of interest transparently and align incentives with values.

Egener said it's an optimistic time in health care in many ways, noting as a "perfect example" of organizational professionalism the development of the new **Unity Center for Behavioral Health** in Northeast Portland, a collaboration of **Adventist Health**, **Kaiser Permanente**, **Legacy Health** and **Oregon Health & Science University**. Another prime example is the planned development of hundreds of affordable housing units, as well as a health center, as part of a multimillion-dollar partnership involving the Portland nonprofit **Central City Concern** and Adventist Health, **CareOregon**, Kaiser, Legacy, OHSU and **Providence Health & Services**.

"If we're going to improve population health, it will require more than single health systems," Egener added.

He said the Foundation for Medical Excellence plans to maintain a library of projects that embody organizational professionalism, and to recognize annually a project inspired by one or more of the charter's principles. ■

This story is part of *The Scribe*'s ongoing coverage of the development of a charter on organizational professionalism in medicine. Spearheaded by the Portland nonprofit the **Foundation for Medical Excellence**, the recently published charter was created with grants from the **American Board of Internal Medicine Foundation**, **The Commonwealth Fund**, the **American Hospital Association**, the **Federation of American Hospitals** and the **North Shore Long Island Jewish Health System**.

For more about organizational professionalism and for resources such as a link to the charter, please visit the Foundation for Medical Excellence's website at *www.tfme.org* and click on the organizational professionalism tab.

UNITY CENTER, *from page 1*

support for patients after discharge. Through an in-house information and referral service, patients are linked with a host of community organizations such as **Cascadia Behavioral Healthcare**, **Western Psychological and Counseling Services**, **Central City Concern** and many others for comprehensive transitional support services.

Area's first peer support network

An innovative component of the center is its utilization of six peer support counselors who themselves have recovered from mental illnesses and received state certification, enabling them to assist patients as part of their health care team.

Samantha Osborne, supervisor of the peer support program, says it is the first such service to be utilized in a behavioral setting in the metro area. "Part of the role that we play is to support the idea that recovery looks different for every individual, and we're able to come alongside someone and support them in their journey, whatever it looks like." The program includes "peer bridges" that assist patients who've been discharged and help them access support in the community in the first 30 to 45 days.

With an annual budget exceeding $1 million, the center employs 35 doctors and FNPs, 21 of them full time. The 24-hour Psychiatric Emergency Department expects to serve about 47 patients a day, or about 17,000 annually.

> "The Unity Center is an investment that will **dramatically improve the lives of those individuals** and families dealing with a mental health crisis and **lead to a healthier community,"**
>
> *–Marcia Randall, Robert D. and Marcia H. Randall Trust*

In addition, it will care for 4,000 patients yearly on an inpatient basis.

The Unity Center Psychiatric Emergency Service combines emergency care and short-term, inpatient care so patients can be observed for up to 23 hours. Reducing the wait time and giving a person immediate attention has proven to reduce the risk of hospitalization and shows better outcomes according to joint studies conducted by the Cambridge Health Alliance Department of Emergency Medicine, Tufts University School of Medicine, and the Heller School of Social Policy and Management at Brandeis University which were published in E*mergency Medicine International*.

In addition, decreasing crowded emergency departments and improving patient flow will likely improve outcomes. According to the Agency for Healthcare and Research Quality, too-busy EDs result in more opportunities for errors, stress and higher cost, and compromise community trust.

The inpatient facility includes 80 adult patient beds and 22 adolescent beds. There is an on-site pharmacy, chapel, garden, cafeteria and "calming rooms" for patients. The Unity Center's care model is based on Trauma Informed Care, which promotes trust, safety, collaboration, peer support, choice, and the inclusion of cultural, historical and gender considerations.

The center's biggest challenges, Farentinos says, will be maintaining an adequate number of psychiatrists on staff, and to be ready to meet the sudden increase of uninsured mental health patients should the Affordable Care Act be rolled back by the Trump administration. Under Obamacare, 32 million Americans gained access to insurance coverage for mental illnesses. The National Alliance on Mental Illness notes that about 44 million adults in the United States – close to 20 percent – experience mental illness in a given year. In Oregon, about 145,000 adults (18 or older) reported serious mental illness in 2013–2014, according to the *2015 Behavioral Health Barometer: Oregon*, published by the Substance Abuse and Mental Health Services Administration.

"The Unity Center is an investment that will dramatically improve the lives of those individuals and families dealing with a mental health crisis and lead to a healthier community," said Marcia Randall, co-founder of the Robert D. and Marcia H. Randall Trust. ■

Physician Wellness Program

The Medical Society of Metropolitan Portland's Physician Wellness Program provides free confidential counseling removing all barriers that typically prevent physicians from seeking help.

- **Appointments within 24 hours of request, including before or after office hours**
- **No diagnosis is made; no insurance is billed; no electronic record is created**
- **Private setting—counseling in a dedicated, confidential room within the Medical Society offices**
- **Open to all physicians and PAs at no cost**
- **No information disclosed to others without the physician's written consent**
- **No role in disciplinary or fitness-for-duty evaluations**

To schedule an appointment, call our private wellness line at:

503-764-5663

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