MEDICAL SOCIETY OF METROPOLITAN PORTLAND

The Scribe

A publication of the Medical Society of Metropolitan Portland

OFF HOURS

Battle of the Doctor Bands

MSMP's fourth annual fundraising music competition, which will feature HomeBrew, Tight Junction and Pink Hubcaps, is fast approaching. Read about the groups that will rock the house June 15.

– Page 6

PHYSICIAN PROFILE

'Amazing opportunities'

Providence emergency physician Jamie Schlueter, MD, applies her sports medicine expertise on the international playing field.

– Page 12

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

MSMP'S 133RD ANNUAL MEETING

Medical community celebrates advocates for underserved populations, physician wellness

By Melody and Barry Finnemore
For The Scribe

The **Medical Society of Metropolitan Portland's 133rd Annual Meeting** celebrated individuals making a profound difference in the community, including a key physician wellness supporter and an attorney providing free civil legal services to low-income Oregonians who work in the state's farming industry. The May event also offered an analysis of the health care policy landscape by a key architect of the Oregon Health Plan.

Dick Clark, CEO of The Portland Clinic, received MSMP's Presidential Citation in recognition of his continued support of the medical society's growing Physician Wellness Program, and for "exhibiting exemplary leadership and skills and a willingness to serve the medical community."

The Portland Clinic's **Megan Madden, MD**, accepted the award on behalf of Clark, who was out of town. Madden read remarks by Clark, who said he humbly accepted the award on behalf of Portland Clinic colleagues, whose support allows him to serve MSMP.

During MSMP's Annual Meeting, Nargess Shadbeh, JD, received the Rob Delf Honorarium Award for her work to improve the lives of Oregon's migrant and seasonal farmworkers. *Photo courtesy of Wiley Parker*

Clark was lauded by MSMP for going "above and beyond" to engage with the medical society, for serving on the wellness program's steering committee and for providing "inroads" to the health care community to help increase support for MSMP.

Lydia Villegas, MD, MSMP's Board of Trustees president, presented the third annual Student Award to **Justin Lee**, noting his investment in community health, social justice and underserved patients. Among other accolades, Lee, an Oregon Health & Science University student, was praised for his efforts to teach his medical school peers, including improving professional training systems and programs for students of color and from diverse backgrounds. *(For more about Lee and his accomplishments, please turn to page 4.)*

Other students nominated for the award were Monique Hedmann, Claudia Lopez, Nattaly Greene, Katie Lebold, Elizabeth Kinsey and Ranish Patel.

MSMP Trustee **John Evans, MD**, presented the Fifth Annual Rob Delf Honorarium Award and honored Delf, the respected and longtime MSMP leader who passed away Feb. 14 at age 73. "He was not only our CEO, he was our friend and mentor as well. It's safe to say his memory will live on for a very long time," Evans said. He presented the award to **Nargess Shadbeh, JD**, director of Oregon Law Center's Farmworker Program. The Delf award is given to those who exemplify MSMP's ideals through work projects or activities that improve community health or the practice of medicine.

Shadbeh, who has devoted her legal career to serving and improving the lives of Oregon's migrant and seasonal farmworkers, said she was honored that the medical society shared with her and hard-working farmworkers an award named for a "special person" in Delf, who appreciated collaboration.

Shadbeh said collaboration between disciplines is a natural approach to complex issues, citing a partnership with health providers and migrant farmworkers to identify through focus groups and surveys in indigenous languages two main concerns regarding occupational health and safety among farmworkers: pesticide

*See **ANNUAL MEETING,** 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.

LEGAL & ECONOMIC FOCUS

Area experts urge caution on consumer genetic tests

By Cliff Collins
For The Scribe

On the topic of home genetic testing, the horse has already left the barn, so physicians had better be prepared for questions and concerns from patients.

In April, the federal **Food and Drug Administration** approved the first direct-to-consumer tests that provide genetic risk information on an individual's genetic predisposition to 10 diseases or conditions.

In announcing the approval for the company, 23andMe Inc., the FDA's Jeffrey Shuren, MD, said consumers now have direct access to certain genetic risk information, but he emphasized the importance "that people understand that genetic risk is just one piece of the bigger puzzle; it does not mean they will or won't ultimately develop a disease."

That distinction could be lost on patients who worry that they have specific diseases in their family that prompt them to take the at-home tests, according to several local specialists.

"Knowledge is power, but knowledge that you don't know how to use can be stressful," observed **Therese M. Tuohy, PhD**, a genetics counselor with Legacy Health.

"I think patients are going to have a hard time interpreting these reports," said **Joseph F. Quinn, MD**, a neurologist and director of **Oregon Health & Science University's Parkinson Center and Movement Disorder Program**. In addition, physicians – including most neurologists – are not accustomed to evaluating relative risks, he said. "The primary care doctors are going to get a lot of calls (about this), and

JOSEPH F. QUINN, MD

*See **HOME GENETIC TESTS,** page 10*

The Scribe

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"Connecting Physicians in Community"

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The Scribe is published monthly by the Medical Society of Metropolitan Portland, 4380 SW Macadam Ave, Ste 215, Portland, OR 97239.

Join us for Walk with a Doc

7 a.m., Friday, July 14

4380 SW Macadam Ave., Portland

Meet us on the waterfront bike path. Look for 'Walk with a Doc' signs.

Join MSMP for 'Walk with a Doc' with Dr. Donald Girard.

This event brings local physicians and community members together to allow for discussions on health and healthy lifestyles while getting 30 to 60 minutes of physical activity.

This walk is appropriate for all ages and fitness levels!

No need to register, just show up! Snacks and water will be provided.

Walk with a Doc

2nd Friday of each month at 7 a.m.

4380 SW Macadam Ave.

Meet on the waterfront bike path. Look for 'Walk with a Doc' signs.

Battle of the Doctor Bands

7 p.m., Thursday, June 15 *(doors open at 6 p.m.)*

Lola's Room at the Crystal Ballroom

The bands have been chosen!

- HomeBrew
- Pink Hubcaps
- Tight Junction

Whether you take a spin on the dance floor or listen from the sidelines, join us in this musical experience! Our celebrity judges include Steppenwolf drummer **Ron Hurst**; renowned concert pianist **Michael Allen Harrison**; and longtime Portland air personality **Dave Scott**.

Please turn to page 6 to read more about our three bands.

Tickets are just $10 and can be purchased at *www.MSMP.org*.

MMFO grants up to $500 for health care-related projects

Deadline: Friday, June 30, 2017

The second quarter mini-grant application deadline of June 30, 2017, is quickly approaching. The mini-grant program funds project requests (up to $500) that support activities which improve health education and the delivery of health care to the community.

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

Welcome our newest MSMP Members!

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

- **Physician Wellness Program**
- **Battle of the Doctor Bands**
- **Continuing Education**
- **Annual Meeting Speaker Event**
- **OSHA/HIPAA Courses**
- **Scribe Newspaper**
- **Little Black Book**

Join today at MSMP.ORG

Attention: Medical students

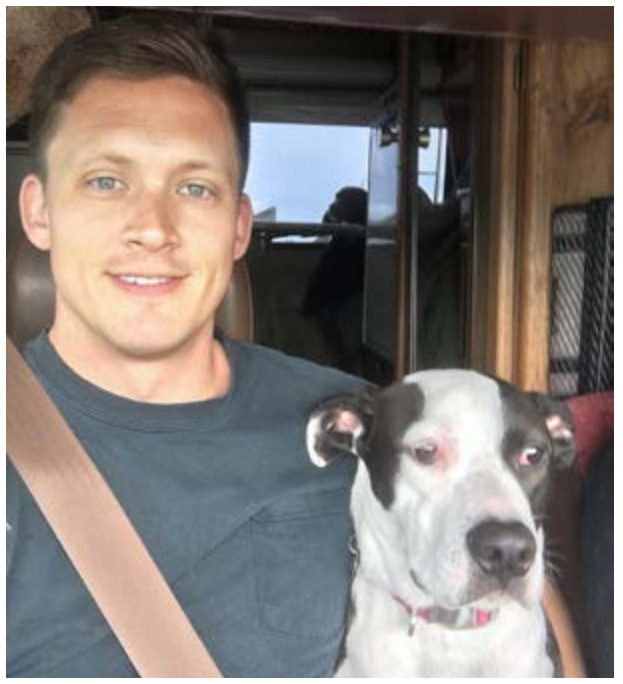
If you have a story idea, we would love to hear it!

Do you or someone you know enjoy a hobby or activity that you would like to share? *The Scribe* regularly features Medical Student Perspectives, a focus on how medical students create balance between personal and professional development, as well as self-care and wellness.

Please contact Scribe editors Barry and Melody Finnemore at *Scribe@MSMP.org* or 360-597-4909. Thank you for your interest in *The Scribe*!

'A tremendous responsibility and incredible opportunity'

Justin Lee, recipient of MSMP Student Award, eyes family medicine, promoting social justice and equity



2017 MSMP Student Award recipient Justin Lee and his dog, Wally, on a recent trip. *Photo courtesy of Justin Lee*

By John Rumler
For The Scribe

Justin Lee, the recipient of this year's MSMP Student Award, already has racked up an impressive variety of medical experiences at home and abroad, and plans to apply that experience as a family doctor caring for underserved populations.

"Justin is as committed to primary care as any student I've ever seen, and his commitment and advocacy occurs so much outside of the classroom. He does everything in **such a selfless manner that sometimes understates his incredible talent** and passion for family medicine." – *Ryan Palmer, EdD, OHSU*

Lee, a fourth-year medical student at Oregon Health & Science University, grew up in North Portland and attended Grant High School. He says he decided to become a doctor "somewhere between watching Dr. Mark Greene on the television series 'ER' and, as an impressionable high school student, observing an OHSU cardiothoracic surgeon perform an open heart surgery."

He is a Gold Humanism Honor Society member, a Swindells Scholar and speaks Spanish fluently. Lee served in the Oregon Rural Scholars Program and as Action Team Lead for OHSU's Health Equity Circle. He held the position of behavioral health assistant at the OHSU Richmond Clinic, and served as a persistent pain manager at the Old Town Clinic, among other roles and activities.

"I believe deeply in the value of providing high-quality behavioral health care, while also reducing the stigma and barriers to accessing that care," Lee says.

Ryan Palmer, EdD, assistant professor of family medicine at OHSU, met Lee three years ago, first in the Family Medicine Interest Group and later in the Oregon Rural Scholars Program.

"Justin is as committed to primary care as any student I've ever seen, and his commitment and advocacy occurs so much outside of the classroom," Palmer says. "He does everything in such a selfless manner that sometimes understates his incredible talent and passion for family medicine."

After graduating high school in 2005, Lee attended Davidson College in North Carolina. Upon completion, he served in the Peace Corps in Peru from 2010 to 2012, calling it one of the most formative experiences of his life.

Lee lived with a host family on the coast in northern Peru in a town of about 2,000 people. His work focused on community health, educating and training a rural population on issues ranging from maternal/child nutrition, sanitation and sex education to dengue and malaria prevention.

He also taught English to middle schoolers, started and coached a youth soccer team, and traveled throughout the country serving as a translator for several U.S.-based medical missions, one for a group of plastic surgeons, another for a team of ophthalmologists.

"My time in Peru was an amazing and enriching experience for which I am supremely grateful. It was also very difficult for me. While I had deep and meaningful relationships with my host family, friends and other Peace Corps volunteers, I had a lot of time alone and isolated."

Lee also spent 12 weeks at a clinic in John Day, where he worked with physicians in clinical, hospital and emergency department settings and saw patients as a med student. "I was imbedded in a small community and got a good taste of what it would be like to live and practice medicine in a rural community," he says.

At the Old Town Clinic, Lee worked with a multidisciplinary team developing education, programs and protocols for improved pain care. He also piloted a pain case management model of care-incorporated education with behavior health skills.

"I got to do big-picture, systems- and programs-level thinking as well as one-on-one skill development and learning with patients," he says.

At the Richmond Clinic, which is also focused on an underserved population, Lee was engaged in supervised one-on-one counseling/behavioral health interventions on a full spectrum of primary care visits, including substance abuse, anxiety, depression, persistent pain, parenting problems and others.

Joan Fleishman, PsyD, an assistant professor at OHSU, met Lee two years ago at the Richmond Clinic as he sought her out as a mentor to learn more about addressing behavioral health conditions in a primary care setting. "Justin's thirst for knowledge is ferocious and his dedication to serving marginalized and underserved populations is palpable," Fleishman says.

"My experience at the Richmond Clinic was so valuable, to learn and practice skills in a supervised setting," Lee says. " I will carry that knowledge and skill-set lens with me in my future practice."

Many medical students are drawn to higher-paying specialties in cardiology, neurology or as research scientists, which contributes to a shortage of family doctors. According to a 2016 report by the American Association of Medical Colleges, by 2025 there will likely be a shortage of between 14,900 and 35,600 primary care physicians in the nation.

"I want to practice family medicine because I believe that the work is challenging, interesting, important and rewarding," Lee explains. "The power that comes with being a physician is a tremendous responsibility as well as an incredible opportunity to be an advocate for social justice, equity and kindness - with individual patients and in the community/society at large. These are all things I strongly believe in."

Laurie Francis, MPH, senior director of innovation at the Oregon Primary Care Association, met Lee more than three years ago, she says, when he "gently and repeatedly cajoled" her into participating in the origination of a structural competency course.

She describes Lee as an amazing listener, very introspective, exceedingly thoughtful, and able to translate philosophy, learning and ideas into action.

"I'm certain he will be an excellent physician, team player and leader in a health care world that requires significant change to improve health for all," Francis says. "Justin's skills, intuition and drive are a rare combo and he gives me lots of hope for the next decade in medicine."

Frances Biagioli, MD, professor of family medicine at OHSU, nominated Lee for the award. "Justin is an ideal nominee, based on his continued investment in community health, social justice, and serving the underserved," she wrote in her nomination. "He also teaches his medical peers as an instructor for family medicine simulated clinical assessments. He has a bright future as a physician committed to community practice and as such is an exemplary nominee."

Lee's immediate goal is to finish his final year of medical school in 2018 and to enter a family medicine residency program. Down the road, he aspires to be a full-scope family physician either in a rural or urban underserved setting.

"I hope to continually be involved in medical education, teaching and public health, health equity, social justice work and advocacy," he says. "I'd be potentially interested, later on, in leadership and policy work as long as I can still have time practicing in a clinical setting." ■

Physician wellness 'very close to my heart'

Dan Rubin, PsyD, joins medical society's growing program

Dan Rubin, PsyD, recently joined the **Medical Society of Metropolitan Portland** as a wellness counselor with its growing Physician Wellness Program.

DAN RUBIN, PsyD

Among other things, Rubin, a clinical psychologist, was a founding member and teacher for Mindful Medicine, a Portland nonprofit that offers evidenced-based mindfulness and compassion training to physicians and other health care professionals.

In addition to Rubin, the Physician Wellness Program's counseling team includes Beth Kaplan Westbrook, PsyD, and Rebecca Martin-Gerhards, EdD. Rubin recently shared with *The Scribe* a bit about his background (he comes from a physician family), the impetus for working with providers through MSMP's Physician Wellness Program and how he enjoys spending his off hours.

What led you to a career in psychology?
I got into psychology for a few reasons, but mostly because I benefited from psychotherapy when I was a teenager and young man struggling with depression. I was inspired to become a healer and help people, just like my therapists helped me.

What motivated you to begin working with medical professionals, and what was the impetus for you to begin working with MSMP's Physician Wellness Program specifically?
Well, my father and brother are both physicians, so some of my favorite people are doctors! Growing up around medicine and healing has been a big part of my life. During graduate school, I did an internship working with medical residents. When I began my private practice, I started a consultation group for docs that ran for six years and also began to teach workshops on wellness and mindfulness for physicians. I love working with physicians and physician wellness is something very close to my heart. Working with the PWP is another way I can work towards healing our healers, so it's a real privilege and joy for me to be involved.

Burnout, stress and depression are among the challenges health care providers face. What tools and strategies do you help them develop to address those and other challenges?
Being a physician is difficult, and the demands on the profession are increasing. There is always more to do, and less time to do it in. There's constant speed and pressure, and very little time to process emotions, reflect, connect with peers and just catch one's breath. Physicians are almost always in survival mode, and this chronic stress wears them down. The doctors I work with often describe feeling like they have become cogs in a machine, and they want their humanity back. So, I teach mindfulness, compassion and communication skills to help people slow down, get out of their heads and become reengaged with their values, and learn to shift out of surviving into what I think about as "alive-ing."

These skills are all about "re-humanizing" good human beings who also happen to be overworked and overwhelmed physicians. These skills are pragmatic and don't take too much time to practice. Plus, there is nothing like good, old-fashioned therapy where you can talk about your emotions, frustrations, and experiences and get useful feedback from an objective and caring professional who understands what you are talking about. This is what I offer.

What do you appreciate most about working with MSMP's program?
MSMP does excellent work supporting physicians. It's an honor to be part of a team of good, talented people who share my values around healing our healers.

How do you enjoy spending your time when you're not in the office?
When I'm not working, I like to hang out with my wife and 5-year-old twins, play music, daydream and read lots of science fiction. ■

HealthInsight, Q Corp: Merger to more effectively meet needs of patients, providers

HealthInsight Management Corporation, **HealthInsight Oregon** and **Oregon Health Care Quality Corporation** (Q Corp), which last August announced they would explore options for a closer organizational relationship, said recently that their governing boards approved a merger of the two organizations and their operations in Oregon.

HealthInsight and its Portland-based affiliate, HealthInsight Oregon (formerly Acumentra Health), have partnered with Q Corp in health care quality improvement and transformation initiatives nationally and in Oregon for a number of years.

Leaders of both organizations studied an array of long-term partnership models and recommended the merger.

"This merger will strengthen and leverage the activities of both organizations not only in Oregon, but across HealthInsight's four-state region of Oregon, Nevada, New Mexico and Utah," said **Mylia Christensen**, executive director of Q Corp and HealthInsight Oregon. "Collectively, our organizations have significant strengths, and this formal affiliation will enable broader and deeper engagement, delivering services to stakeholders as collaboratively and efficiently as possible."

The boards also approved the creation of a new research and development unit to be housed within HealthInsight Oregon. Staff from HealthInsight and Q Corp will work together in this unit to develop and test innovative programs and approaches and to pursue new and diverse revenue sources.

"This is an exciting time of growth and opportunity for HealthInsight and Q Corp," said **Marc Bennett**, president and CEO of HealthInsight Management Corporation. "This merger will enable us, working together, to more effectively meet the needs of patients and providers across the region."

The organizations will work together during the next few months to finalize a governance and leadership plan, realign corporate structure and staffing, and finalize integration, according to an announcement. Christensen will remain executive director of both HealthInsight Oregon and Q Corp and will partner with executive staff in each state to leverage and scale existing and new programming across the region.

As part of the restructuring, HealthInsight also has created a separate corporate entity, HealthInsight Assure LLC, to provide independent direction and governance of the company's External Quality Review (EQR) contracts and related quality assurance lines of business. The new organization will draw on HealthInsight's experienced staff to perform its work for state Medicaid agencies. HealthInsight Oregon has conducted the EQR for Oregon under contract with the state Medicaid agency since 2005. ■

Battle of the Doctor Bands brings new, familiar faces fourth time around

By Jon Bell
For The Scribe

If the third time's a charm, what does that make the fourth?

Music fans at this year's **Battle of the Doctor Bands** will find out when the **Medical Society of Metropolitan Portland**'s fourth annual fundraising bash turns it up at Lola's Room on Thursday, June 15.

MSMP has lined up three doctor-based bands for the annual showdown, which finds local musicians putting on a show, raising funds – this year for **MSMP's Physician Wellness Program** – and having a great time.

Here's a look at who will be taking the stage at this year's Battle of the Doctor Bands.

Tight Junction

Irvan Bubic, a first-year medical student at Oregon Health & Science University, and a handful of other musical medical students had been informally jamming on the weekends when one of their professors caught wind that they were in a band. The professor invited them to play at an event this past February called GIM Live PDX, a night out celebrating all things internal medicine.

Though they hadn't really considered themselves a real band – they'd only been playing since the start of the school year – the group of about 10 or so accepted the gig.

"And that's how we transitioned from being just a fun, social kind of jamming group to being a little more serious," said Bubic, who played drums in various bands throughout college at the University of Montana.

The group, called Tight Junction after the medical definition for the areas of two cells that have joined together to form a nearly impenetrable barrier, evolved from the early weekend jams into a more focused cover band to prepare for the February gig. The members, all medical students, play everything from guitar and bass to horns and strings. Their set list for the event featured songs from Fleetwood Mac, Michael Jackson, Lauren Hill and Alabama Shakes. They closed with a version of "Bad Case of Loving You (Doctor, Doctor)," a song made popular in the late 1970s by Robert Palmer.

"We just tried to play anything that would get the crowd going," Bubic said.

Since then, the band has been further honing its sound and direction, which Bubic said is a fusion of blues, rock, big band and even rap. They've been working on some original material to play at the Battle of the Doctor Bands, though Bubic noted that the group has made sure to keep their studies at the forefront.

"We practice as often as we can, but we all agree that school comes first," he said, "but we still want to put on a good show."

In addition to Bubic, the band's lineup includes **Monique Hedmann**, vocals; **James Carey**, guitar; **Pedro Abdala**, guitar; **Connor Eagleton**, guitar; **Ryan LeBuhn**, bass; **Dennis Shi**, keyboard; **Ian Straehley**, trombone; **Emma Felzien**, saxophone; and **Samantha Ing**, violin.

HomeBrew

They were part of the very first Battle of the Doctor Bands – and now they're back again.

HomeBrew, an 11-member band that for close to 15 years has been rocking out to a mix of classic R&B, blues and dance music, will be back on stage at the MSMP's event in part because they all simply enjoy playing in front of live audiences.

"We thought it would be fun," said bassist **Gary Oxman, MD**, "and when the invite went out, we just thought we'd give it a shot again."

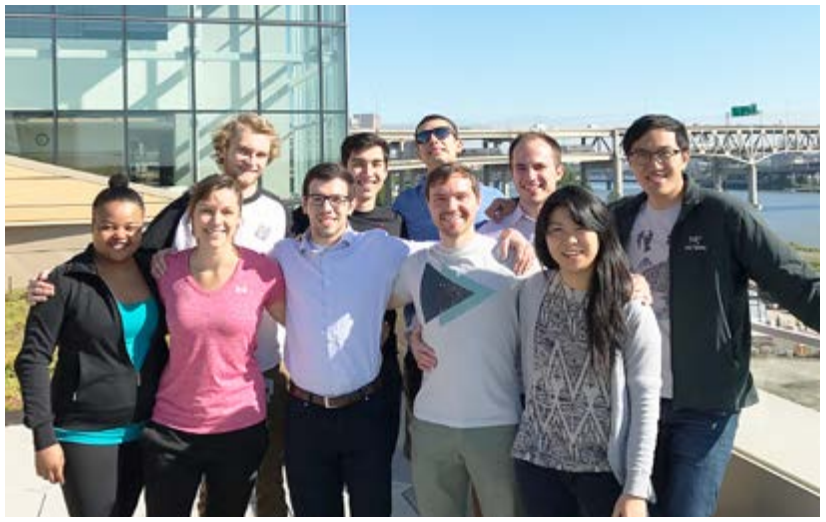
The band, which entertains guests at weddings and other live events about once a month, usually plays songs from artists such Sam & Dave, Etta James, Van Morrison and the more contemporary blues singer Susan Tedeschi. This year's Battle of the Doctor Bands, however, requires some original material, something that Oxman and his bandmates were glad to accommodate.

The group is not entirely steeped in medical backgrounds, but there are several members who are. Oxman was a family physician who also served as the Multnomah County Health Officer for more than 25 years before retiring in 2013. Others include blues harp player **Bruce Goldberg, MD**, the former director of the Oregon Health Authority; **Mark Loveless, MD**, on lead guitar and vocals; **Darren Coffman**, director of the Health Evidence Review Commission, on trombone; and drummer **David Panzer, DC**, who is a chiropractic physician.

Since their first appearance in the battle, HomeBrew has had some personnel changes. Its current lineup also includes **Maria Blum**, lead vocalist; **Chris Frimoth**, keyboards, vocals and guitar; **Doug McCleary**, keyboards; **Dick Zimmerman**, tenor sax; **John White**, baritone sax; and **Gabe Labovitz**, trumpet.

The band initially took its name from some of the members' interest in brewing up their own beer, but Oxman also noted that it represents the idea of melding many different elements together into a new whole.

As for the upcoming MSMP event, Oxman said they're all looking forward to it. "It was a lot of fun before," he said, "and we know it will be again."



This year's competitors, clockwise from top left:
HomeBrew, Tight Junction and Pink Hubcaps

MSMP's Fourth Annual Battle of the Doctor Bands

Where: Lola's Room at the McMenamins Crystal Ballroom

When: 7 p.m., Thursday, June 15; doors open at 6 p.m.

Judges: Ron Hurst, drummer for Steppenwolf; radio personality Dave Scott; and pianist and composer Michael Allen Harrison

Sponsors: The Doctors Company, Finity Group LLC and Providence Health & Services

All ages welcome

Pink Hubcaps

Santana. Ritchie Valens. The Beatles. Pink Hubcaps.

OK, that last group might not fit squarely in the same realm as the others, but they'll be glad to rock out some songs by those other artists and put on a good show at this year's Battle of the Doctor Bands, just as they did last year.

"We had such a good time," said **Elizabeth Stephens, MD**, a specialist in endocrinology at Providence Health & Services and the singer for Pink Hubcaps. "It surprised us how great it was to perform as a group at the lovely Crystal Ballroom venue at Lola's Room. It was a great experience for all of us."

The band consists of Stephens on vocals, her husband, **Peter Mortola**, on guitar, and her 11-year-old son, **Noah Mortola**, on drums. Their neighbor, **Mark Molchan**, an artist and musician, plays bass.

"We literally all live on the same street," said Stephens, who has been singing for fun at least since her days in medical school at Vanderbilt University, where she sang in an a cappella group. Her youngest son, Riley, is 9 years old and plays piano, but he has yet to be convinced that he should join the group.

"Not yet," Stephens said, "but maybe soon."

Until then, the Battle of the Doctor Bands audiences will have to enjoy the current lineup of Pink Hubcaps at this year's battle, where they're planning some classic rock covers and an original or two in the same vein as the greats.

"We'll be doing some different elements but in the same style," Stephens said. "It's going to be fun." ■

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Scribe Focus
Legal & Economic Issues

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, look for our Men's Health & Wellness Focus section.

PSU researcher describes intersections between health care, economics

Rajiv Sharma, PhD, is an associate professor at Portland State University who specializes in health economics and micro-economics. He has collaborated extensively with physicians, and has advised public agencies on health and economic issues. He previously worked as a health economist/core investigator in the Research Enhancement Awards Program at the Portland VA Medical Center.

Sharma's research interests include access and disparities in health care, cost-effectiveness analysis of medical interventions, and the patient-physician relationship and medical decision-making. He has led the Longitudinal Access to Physicians Study (LAPS) since its inception in 2013. LAPS audits primary care physicians nationally to assess the effects of state and federal policies on access to health care. The study is funded by the National Institutes of Health.

He recently shared with *The Scribe* some of the findings from his research and current economic issues that are impacting the medical community. His responses have been edited for clarity and brevity.

How did you become interested in health economics?

I lived in several countries growing up, including India, the former Yugoslavia around the time of (President Josip) Tito's death, Pakistan during the Soviet occupation of neighboring Afghanistan, and Germany at the time of the fall of the Berlin Wall. Observing their vastly different levels of economic development and standards of living created a deep interest in understanding the causes of these differences and led me to study economics.

Health and health care are interesting because they are fundamental to the well-being of people, not just in the sense of their physical and mental health but also for economic development. Premature mortality and illness are destroyers of human capital – a person's accumulated skills perish with them. Healthy people and societies are more productive and this increases their wealth directly. When they live longer and are healthy longer, people invest more in education and skills since they can enjoy the benefits of the investments over a longer period of time. The higher productivity creates wealth that can, in turn, further improve health through better nutrition, mitigation of risks and improved health care. This creates a positive, self-reinforcing cycle that can be transformative. Unfortunately, this can also go into reverse where declines in economic circumstances feed into declining health and create a vicious downward spiral.

What are some specific health and economic issues you have collaborated and advised physicians and public agencies about?

Most of my collaboration with physicians has involved analyses where we assess interventions for their cost-effectiveness.

Please describe what you've discovered through your research on this topic.

For many chronic conditions, the costs in lost productivity far outweigh the costs of direct medical treatment. While this is well-known among those who read cost-effectiveness analyses, it receives insufficient attention in policy circles because these costs are not included in agency budgets or insurance payments. These costs are dispersed through the economy and are borne by patients, their families and sometimes by employers.

What economic issues are most pressing for the medical community now?

There is a great deal of uncertainty regarding the repeal of Obamacare and what may replace it. The impact of a repeal would be especially large for physicians and health systems serving low- and middle-income populations. According to CBO estimates released recently, the Trumpcare bill passed by the House of Representatives will decrease the number of insured by 23 million, or about 7 percent of the U.S. population. Funding for Medicaid is especially hard hit under the bill. Hospital finances have improved since 2013 because the insurance expansions of Obamacare have led to decreases in uncompensated care, and it is likely that a repeal would reverse many of the gains.

> "Health and health care are interesting because **they are fundamental to the well-being of people,** not just in the sense of their physical and mental health but also for economic development....**Healthy people and societies are more productive and this increases their wealth directly.**"
>
> *– Rajiv Sharma, Portland State University*

Why did you choose to focus your research on access and disparities in health care?

Even in a rich country like the United States, there are large socio-economic, racial/ethnic and regional disparities in health and health care. Some disparities are getting worse. A recent article in *JAMA Internal Medicine* finds differences between U.S. counties of up to 20 years in life expectancy at birth. For comparison, that is about the same magnitude of difference as between Japan and Haiti. An analysis by one of my students finds that socio-economic determinants of health are becoming substantially more important as predictors of differences in mortality between U.S. states. Improved access to regular health care mitigates some of the disparities, and, consequently, I find it important to study access, disparities, and how they are affected by policy choices.

How did you come to lead LAPS and what has that experience been like for you?

My PSU colleague Arnab Mitra, Miron Stono from Oakland University in Michigan, and I began this research in 2013 to examine the effects of the insurance expansions of the ACA on access and disparities in access. At the time, there were worries that the influx of newly insured patients would create a surge in demand that would swamp physician practices.

What are some key points of your paper that was published in 2015?

The key findings were that disparities in access to primary care were much larger when race/ethnicity, sex, and insurance type were all considered together than in studies that focus on one or two of these dimensions. Medicaid patients were less likely to be offered new patient appointments with primary care physicians than people with Medicare or private insurance. In contrast, self-pay (uninsured) patients were as likely to be offered appointments as patients with Medicare or private insurance. This last finding suggests that the well-known disparities for uninsured patients are likely to be driven by financial factors rather than by primary care physicians' unwillingness to accept new uninsured patients.

What are some results of your research since then?

Additional findings are going through the peer review process, and are not regarded as final until they have completed this vetting process. In addition to looking at changes since the insurance expansion, we have examined how access and disparities differ between states that did and did not expand Medicaid. We have also examined how access for patients who indicate a need for preventive care due to smoking or weight concerns compares to access for patients with no specific health needs. And yes, my team and I think that this research is important to assess the effects of future policy changes including the possible repeal of Obamacare. We are seeking additional funding to continue this work. ■

The first paper from this study, "Insurance, Race/Ethnicity, and Sex in the Search for a New Physician," was published in Economics Letters *in 2015 and is available at the Portland State Library.*

The do's and don'ts of financing for medical practices

By Jack Caynon, Susan Ford and Thomas Stilley
For The Scribe

To contend with an ever-evolving, fast-paced and often disruptive health care landscape, every medical practice, from the smallest to the largest, must understand how to obtain and use financing. However, you shouldn't try to take on this process alone when your ultimate focus is to provide excellent medical care for your patients. Instead, build a team of trusted advisers and lenders to assist you in evaluating available financing options, and explain why and when you should use a particular option in plain English. A great professional team will do much of the legwork and aid in your decision-making about which funding vehicle is right for your practice.

Build your team

The first thing to do is to hire a competent practice administrator (PA). Your PA can coordinate the financing process for your practice; however, the final decision on entering into a financing arrangement should always be made by the practice's owners, particularly when they may be required to personally guarantee any loans. The other members of your team should include a reputable accountant and a lawyer, both of whom have experience working with medical practices and their financing needs.

Financing, when to use it and how to obtain it

Financing can help your practice deal with many issues, such as a temporary disruption in cash flow caused by transition from one biller to another, or the need to cover the startup costs of a new physician. Or, your practice may need to purchase an expensive piece of equipment or fund major repairs to your facility. It is helpful to analyze these issues by considering whether the need for financing is short or long term. If the need is short term, a line of credit may be an appropriate option. A line of credit is a loan that works similarly to a credit card. A lender will agree to make funds available to the practice up to a predetermined amount.

If the need is more long term, such as the purchase of equipment that can be depreciated, consider leasing the equipment instead or financing it through the equipment supplier rather than using a line of credit to purchase it.

Finally, if your facility needs repair or renovation, have your lawyer negotiate these items with your landlord, or negotiate for tenant improvement allowances in your lease before you sign it, or upon renewal.

When should you *not* use financing? In general, don't use financing to pay salaries, bonuses, or 401K contributions for your employees. Except for unanticipated temporary cash flow shortages, using credit to persistently cover a lack of revenue does not solve the problem but simply kicks the can down the road. Cash flow issues should be immediately addressed with your accountant and possibly a business consultant to prevent more serious problems from arising.

Have your team help you find the right lender

Now that you have formed your team and determined the appropriate financing vehicle, your PA should assist with winnowing the number of lender candidates down to three or so. Then, a representative group of physicians should meet each candidate to determine if the lender has the experience and temperament to work with the practice.

Although the lending relationship is important to the practice's operations, always remember it is a commercial relationship, not a fiduciary one. The lender will attempt to obtain the most favorable terms for itself, while your accountants and attorneys will always seek to protect your interests first. With this in mind, you should always have legal counsel review loan documents, equipment leases, facility leases, and employment agreements to protect your legal and financial interests.

Create a budget and stick to it

Engage your PA and accounting firm to create a budget for the practice. As part of the budgeting process, you should forecast your cash flow needs to determine when and if you may need to supplement them with your line of credit.

Once you have a budget, meet with your practice members to approve the budget and obtain their commitment to abide by it. Practice members should be held accountable to the budget for the practice to be successful. This is an important tool to keep your practice on the right path to financial success and to withstand unexpected events and disruptions practitioners face in today's health care arena. ■

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HOME GENETIC TESTS, *from page 1*

understandably are not going to be up to speed" to be able to assess individual patients' risks based on these test results, he said. "It's going to be a challenge" for the profession if a lot of consumers start taking these.

The FDA approved the tests for one company but wants to use it as a model for similar tests by 23andMe and other companies, so more offerings will be coming to market. **Wojciech Wiszniewski, MD, PhD**, a board-certified genetics specialist and OHSU assistant professor, said he expects to see the number of direct-to-consumer genetics tests grow, as well as the number of conditions for which they will be approved by the FDA.

WOJCIECH WISZNIEWSKI, MD, PhD

Wiszniewski said genetics centers and counselors already are seeing more and more patients wanting to be tested for their predisposition to late-stage genetic-related diseases, and couples seeking tests to evaluate risks to their potential offspring. "Our clinics already are busy, and will be even busier in the future."

One reason he forecasts this is that patients are confused about what genetics tests mean and in what instances they should be used. That is his and many other specialists' primary concern. In a clinical setting, which is where he prefers such tests be conducted, "I like to know about the goals of genetic testing," he said. "I try to choose the genetic testing that is optimal" for the particular patient. "People are asking for these kind of tests without knowing what they are and why they are taking them."

Shuren posited that providing information on an individual's genetic predisposition to certain medical diseases or conditions "may help to make decisions about lifestyle choices or to inform discussions with a health care professional."

The 23andMe genetic health-risk tests work by isolating DNA from a saliva sample, which is then tested for more than 500,000 genetic variants. The presence or absence of some of these variants is associated with an increased risk for developing any one of the following 10 diseases or conditions:

- Parkinson's disease
- Late-onset Alzheimer's disease
- Celiac disease
- Alpha-1 antitrypsin deficiency, a disorder that raises the risk of lung and liver disease
- Early-onset primary dystonia, a movement disorder involving involuntary muscle contractions and other uncontrolled movements
- Factor XI deficiency, a blood clotting disorder
- Gaucher disease type 1, an organ and tissue disorder
- Glucose-6-Phosphate Dehydrogenase deficiency, also known as G6PD, a red blood cell condition
- Hereditary hemochromatosis
- Hereditary thrombophilia

Tuohy views the FDA approval as a positive development, one that will raise more awareness among the public about genetic testing. But she said the tests cannot determine a person's overall risk of developing a disease or condition. In addition to the presence of certain genetic variants, many other factors contribute to the development of a health condition. "You could have modifying factors that could lower risk."

"23andMe is great as far as it goes, but it's not comprehensive enough for specialized medical care," Tuohy said. "This is not quality-controlled for medical use." The tests are "very broad and take a shallow dive. They take a snapshot of almost all the genes, but don't dive down too far." For the 10 conditions for which the tests assess risk, they look for a small subset of mutations within those genes. They extract out the heavy-hitting mutations we know are more at risk."

Quinn said patients concerned about their risk for Parkinson's disease would be best served by going to a genetic clinic and counselor. Patients with a family history of the disease are the ones who are most likely to seek the tests, but physicians should explain to them that only a small number of Parkinson's patients possess the two most common mutations associated with the disease: LRRK2 and GBA. About 1 percent of Parkinson's patients have the LRRK2 mutation, and "the association between that gene and the disease is very strong," he explained. But what makes counseling patients challenging is that patients will know they have the mutation, but not whether they will develop the disease, or at what age, he said.

Moreover, if the consumer doesn't know which mutation that's associated with greater risk is in the family, a negative test is not going to be of value, Quinn noted.

According to the FDA, other potential drawbacks associated with use of the home tests include false positive findings, which can occur when a person receives a result indicating incorrectly that he or she has a certain genetic variant, and false negative findings that can occur when a user receives a result indicating incorrectly that he or she does not have a certain genetic variant. "Results obtained from the tests should not be used for diagnosis or to inform treatment decisions," the agency counseled. "Users should consult a health care professional with questions or concerns about results."

In response to the FDA's approval, noted bioethicist Arthur L. Caplan, PhD, of New York University, told NBC News that he is concerned about users' privacy, and how well the testing company can safeguard samples and results. In addition, the **American College of Medical Genetics and Genomics** released a position paper that, among other points, suggested that companies offering these tests should provide better privacy protection of genetic information.

Wiszniewski pointed out that genetic tests are not routinely repeated in the way, say, glucose testing is, which shows variation. Once the genetic tests find a mutation, "it will stay with you forever, and it's important for other members of the family." The direct-to-consumer tests also "might cause anxiety and unnecessary and expensive screening that is not necessarily needed for that particular patient. These are reasons why I'm not enthusiastic about at-home testing."

However, he acknowledged that they do bring some "positive aspects." The tests provide more access to genetic testing, and are less expensive, which may be a consideration if patients' insurance doesn't cover testing in a clinical setting, or requires a lot of out-of-pocket expense.

He advises clinicians to "talk to the patient first. I would like to know patients' expectations and concerns about a particular problem that could be genetic. It's important to review the patient's history and consider ordering genetic testing if there is some evidence or element that would point to a genetic problem."

"There is always tremendous anxiety about giving genetic information to patients" if testing is taken for Parkinson's or Alzheimer's, Quinn said. Even though these tests can show whether an individual is at greater risk than average, they are for diseases for which we do not have cures, and for which we have little or no definitive information about prevention.

When patients with family members with Parkinson's ask Quinn whether they should have genetic testing, "by the time I recite the uncertainty about it, there are very few takers," he said. "I'm not sure it's going to be" an advantage for them to be tested. ■

Health economist wins NIH funds to study bundled payments, racial disparities

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries, costing more than $7 billion in 2014 for hospitalizations alone, according to the Center for Medicare and Medicaid Services. Wide variations in cost and quality characterize these procedures, including problems such as post-surgical infections and implant failures.

These surgeries are also the focus of long-standing racial and ethnic disparities, with black Americans about 40–50 percent less likely than whites to receive hip or knee replacements (also called lower extremity joint replacements, or LEJR). Even when they do receive LEJR, black patients are more likely to have complications leading to readmissions or death, according to Oregon Health & Science University.

Hyunjee Kim, PhD, with OHSU's Center for Health Systems Effectiveness, is using a new National Institutes of Health award to take advantage of a recently established CMS initiative to look at the intersection of payment models and racial disparities. Launched in November 2015, the Comprehensive Care for Joint Replacement (CJR) model is Medicare's first mandatory bundled payment program and has the potential to serve as a prototype for future payment systems. It bundles together treatment costs from the time patients are admitted to the hospital for surgery through the first 90 days of their recovery.

CMS hopes that bundled payments will incentivize better coordination of care by holding hospitals accountable for costs not only of inpatient care but also for care by physicians and post-acute care providers. The program includes about 800 hospitals (including OHSU) in 67 randomly selected metro service areas.

Kim is exploring how the new episode-based payment will affect disparities in utilization and outcomes for LEJR between black and white patients. Her four-year project will assess whether the model will lead participating hospitals to avoid potential LEJR patients with more complex social-service needs – including a disproportionate number of black patients – and whether it will reduce black-white disparities in care quality and outcomes among patients who do get surgery.

Kim's work focuses on how policy and market conditions affect provider behavior, particularly in long-term care, care for elders, and care for patients eligible for both Medicare and Medicaid programs. OHSU noted that she received funding for this project as an NIH new investigator, an unusual feat.

The Center for Health Systems Effectiveness focuses on large-scale, aggregate interactions between different elements of health care delivery systems. Its researchers take a broad economic and policy perspective on service delivery questions, using a quantitative toolkit of large dataset analysis and econometric methods. Its partners include the Oregon Health Authority, OHSU Healthcare, private and public health care purchasers, and other researchers at OHSU and across Oregon. ■

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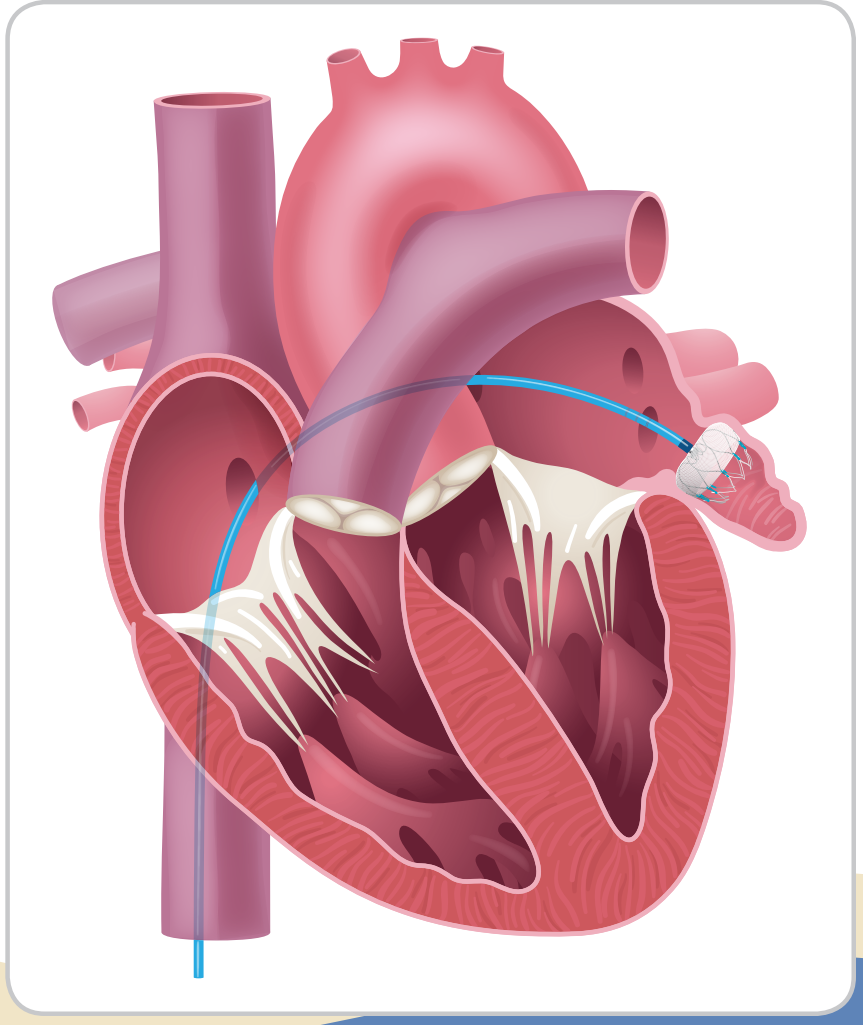

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'Amazing opportunities'

Providence ER physician applies sports medicine expertise on international playing field

By John Rumler
For The Scribe

Providence emergency physician **Jamie Schlueter, MD**, has witnessed the transformation of women's athletics in the United States and been on the scene at some of the most dramatic women's sports heroics in the past several decades. She's worked at international athletic competitions in Canada, England, France, Russia, Argentina, Brazil and Qatar, among others.

Jamie Schlueter, MD, has helped keep top-tier athletes healthy in competitions around the world.

Photos courtesy of Jamie Schlueter

At the Paralympic World Championships in October 2015 in Doha, Qatar, a U.S. seated thrower, Scot Severn, a quadriplegic, fell out of his chair and broke his leg. Working with the prosthetist, Schlueter helped Severn rig his throwing chair to support his broken leg, and three days later he won a silver medal in the shot put. He also won the silver medal for shot put in 2016 in Rio.

Raised in Seguin, Texas, Schlueter's formal sports experiences were limited, as she grew up before Title IX, which paved the way for women's athletic scholarships and more equitable funding. Although it was too late to impact Schlueter, she enjoyed countless hours of informal sports, including back-lot baseball with the boys in her neighborhood and, when she turned 12, Little League softball.

"In junior high we had intramural basketball, which was a bit of a joke," she recalled. "When I got to high school we only had volleyball, which I loved, but I would probably have played football if they would have let me."

Sports medicine is now a wide-open field, but when Schlueter was in high school the only sports medicine doctors were orthopedic surgeons, and the athletic trainers were mostly at the collegiate and professional levels. After viewing a TV special about sports medicine, her father, a pharmacist, told Schlueter it could be a perfect career for her. She went to the University of Texas, becoming a student athletic trainer after catching the sports medicine bug.

Upon graduating with bachelor's and master's degrees, she stayed on with the UT athletic department, where both the women's volleyball and basketball teams won national championships. Schlueter also volunteered at the 1984 Summer Olympics in Los Angeles.

At 36, Schlueter entered the Texas Tech Medical School in Lubbock. It took her a while to find the right niche as a doctor, as she did not have the patience for orthopedic surgery or primary care. However, she felt that emergency medicine would hold her interest while allowing her the freedom to travel to various sports events spanning the globe.

After completing her ER residency at OHSU, she joined Providence Portland Medical Center. "I love the craziness of the ER and I can honestly say that I have never been bored, even for a single minute, during an ER shift. The ER is a fun place to work. It's a team thing. There is no way I could do my job without this great team of nurses and techs."

A natural ability to connect

During her career, Schlueter has experienced many memorable events. Most recently, she worked with the U.S. women's hockey team as it won its fourth consecutive world championship in Detroit last April. The victory was especially sweet because it came only after months of bitter negotiations.

"Despite all of the distractions," Schlueter explained, "the team flew in at the last minute, dominated the tournament and defeated Canada 3-2 in overtime in the gold medal game."

Schlueter joined the medical staff of the U.S. Women's National Hockey Team after she met its staff while working at the 2014 Winter Olympics in Sochi. "I developed a great working relationship with their head team physician, Ally Howe, who brought me on board."

Another highlight was when she was with the Portland Thorns in Rochester, N.Y., in 2013 and Tobin Heath, who was playing injured and had been unable to practice for a week, scored on a long shot past the goalie to win the inaugural National Women's Soccer League championship. In their earlier semifinal against FC Kansas City, the Thorns were down two goals, but rallied to an overtime road victory. "Winning is always good," said Schlueter.

Schlueter divides her time between Providence, the University of Portland, the Portland Timbers, the U.S. Paralympics team and other sports activities. This is the first year she's not working with the Thorns.

With the Olympics, she is able to plan her schedule far in advance. In other situations, she plans her ER schedule every month and fits her sports activities around it. Each role she plays has unique challenges, Schlueter said. She enjoys her post at UP because the athletes are there for four years. "It's easier to coordinate their care, but still, with 10-plus sports and over 200 athletes, there is always something."

Except during the Olympic year, the U.S. hockey team only trains together for a few weeks each year, she explained. "That means that a lot of injuries occur that we do not even get to see until the athletes show up for camp."

The paralympic track team is the most challenging of all her roles, as many of the athletes have serious medical problems related to their impairments. "Wheelchair athletes frequently develop pressure-related problems from spending so much time in wheelchairs and race chairs," she explained.

Also, quadriplegic athletes often have problems related to autonomic dysfunction and many have urinary incontinence/retention and must self-catheterize several times a day, so the threat of urinary tract infections is constant.

In addition, athletes who have lost limbs frequently develop wounds from their prostheses, and those with neurologic impairments are susceptible to seizures. "There is a lot more 'real medicine' with this population," Schlueter said. "The paralympic track team inspires me to no end. It is remarkable when you think about what they go through just to get out of bed every morning, much less compete at the international level."

"Jamie is an **outstanding human who is compassionate, graceful and humble.** She has **great clinical intuition** that allows her to wade through the dramatic aspects of whatever situation she finds her patients in and **focus on their actual injury."**

– Michael Burdick, RN
Providence Portland Medical Center Emergency Department

UP Head Athletic Trainer Richard Bennett met Schlueter in 2009 and the two hit it off immediately, he said. "Jamie started covering some games for us and acting as a consultant, and after a year she became the head team physician for our Sports Medicine Staff."

As such, Schlueter played a critical role in helping create policies and making major medical decisions for the university. Bennett raved about her versatility, advanced skill set and unique multidisciplinary approach. "Jamie is such an amazing person with tremendous energy and enthusiasm for athletics and medicine, and she has so much empathy for student-athletes. She's a huge asset for us."

Nurse manager for the Providence Portland Medical Center Emergency Department Michael Burdick, RN, has known Schlueter for upwards of 16 years. Describing her impact on emergency medicine at Providence, Burdick said, "Jamie brings energy and laughter to an otherwise chaotic and somber environment. She has an innate ability to bring comfort not only to the patients, but also to the staff she works with."

Burdick said one reason Schlueter is able to be so highly successful in sports medicine and as an ER physician is because of her natural ability to connect with all types of people.

"Jamie is an outstanding human who is compassionate, graceful and humble. She has great clinical intuition that allows her to wade through the dramatic aspects of whatever situation she finds her patients in and focus on their actual injury."

While her involvement in international competitive sports brings drama, excitement, travel and endless challenges, Schlueter's home is Providence Portland, where she savors her role practicing emergency medicine. "It's a great hospital and, in reality, most of my sports medicine experiences are volunteer opportunities. I have to keep working at my day job to pay the bills.

"I think of my roles in sports medicine not so much as accomplishments but as amazing opportunities," she added. "The real accomplishments are on the part of the athletes, who completely dedicate their lives to their sport." ■

AHCA an enormous step back in ensuring affordable, quality and equitable care

By Brenda Kehoe, MD
For The Scribe

"It's easy to make perfect decisions with perfect information. Medicine asks us to make perfect decisions with imperfect information," Siddhartha Mukherjee said in "The Laws of Medicine." To that I would add, some politicians strive to make decisions with no information at all. And they tend to succeed in using no information to make bad laws that hurt people.

The U.S. medical care system runs on economics. It is not based on the premise that health care is a right. The privilege of health care is a very expensive one; the U.S. spends 50 percent more than any other country on health care, yet ranks 70th in overall health and wellness. We pay more for intervention than for prevention. Our doctors report a 50 percent burnout rate, and 400 U.S. physicians committed suicide last year alone, nearly double any other profession. We have multibillion-dollar pharmaceutical companies increasing the cost of essential medications astronomically without *any* backlash. Medicare cannot *by law* negotiate drug prices. And all of this despite the fact that of 53,000 applicants to U.S. med schools, most in the top 10 percent of their graduating classes, 21,000 matriculated as medical students in 2016. The average GPA was 3.7. Nearly 95 percent will graduate and go on to practice. These are incredibly intelligent, genuinely compassionate, committed people who have had an average of 26 years of education and provide excellent health care to anyone who can actually get to them. That makes access to care the linchpin of the American health care system, and the reason for its failure.

This system is sick. Who knew that health care was so complicated? We did.

A 2012 study for the years 2002–2008 found that about 25 percent of all senior citizens declared bankruptcy due to medical expenses, and 43 percent were forced to mortgage or sell their primary residence.

The World Health Organization promotes a goal of universal health care: All people should be able to obtain health services without financial hardship, with the expectation of good health, with fair funding and with the outcome of quality, efficient, acceptable, and equitable health care, with continuity.

Towards attaining the goal of improved health, former President Barack Obama signed the Patient Protection and Affordable Care Act (ACA, Obamacare). The basis of the act was as described above, that providers, doctors, nurses, technology, pharmaceuticals and hospitals were not at fault for the poor performance of the medical sector, but that access to those things were at fault.

The ACA was designed to eliminate the discrepancy in health care access by addressing the problem of obtaining, paying for and keeping health insurance. Health insurance coverage would be required by law (the mandate), and insurance companies would be subsidized so that more poor people could afford the premiums. The states were offered, but were not required to accept, federal aid so that they could expand Medicaid coverage; 19 states did not expand Medicaid. In Texas, a person had to be making less than $3,737 per year to get Medicaid, and had to make $11,490 per year to be eligible for ACA subsidies. Everyone in between was uncovered. That amounted to 11 million people in Texas alone in 2012.

In May, Republicans in the House of Representatives voted 217–213 to pass the American Health Care Act (AHCA). That bill is in the Senate, where the expectation is that the Senate will rewrite it.

The AHCA rolls back the ACA's Medicaid expansion, eliminates tax penalties for people who do not have health insurance, and ends taxes on certain high-income people, insurers, drug companies and manufacturers of medical devices. It also provides huge tax cuts for the wealthiest Americans, reducing capital gains tax, repealing a payroll tax and an investment tax that were devised to help pay for the ACA. The AHCA penalizes the poor, the sick and the elderly; it allows insurance companies to charge a 64 year old five times as much as an 18 year old. On May 24, the Congressional Budget Office stated that the AHCA as written would increase the projected number of people without health insurance by 14 million next year and by 23 million in 2026.

The AHCA would require insurers to impose a 30 percent surcharge on people who stop their insurance and then reinstate it when they are sick; allows states to opt out of requiring insurers to provide a minimum set of health benefits such as maternity care, emergency services, mental health care and addiction services; and allows states to opt out of the ACA prohibition of charging higher prices to people with pre-existing conditions. In Oregon, 654,000 people are at risk of losing coverage because of pre-existing conditions alone. States could receive an allotment based on number of Medicaid beneficiaries or a block grant and choose their own options.

The bill allows insurers to offer health plans with higher deductibles and co-payments, a change likely to lower premiums. Customers in states that waive benefit rules may also be able to buy plans not covering as many medical services, like maternity coverage. This will increase the price of insurances that do include maternity coverage.

The AHCA seeks to reduce access to abortion by preventing federal subsidies from going to any health plan that covers abortion. The bill would prevent Planned Parenthood from receiving any federal money for one year. Planned Parenthood is a health care provider that relies substantially on payments from Medicaid and the Title X family planning grant to provide contraception, cancer screenings and other women's health services.

The bill eliminates the ACA's employer mandate, which required large employers to offer affordable coverage to their workers. This means that companies that do not want to cover workers will not be required to do so. Large employers will no longer have the same reporting requirements, and there will be no tax on high-cost employer plans.

Many states would have to roll back their expansions of the Medicaid program that now cover adults without children or disabilities. The bill would also reduce subsidies available for Americans just over the poverty line, the group that benefited most.

The AHCA also cuts funding for state Medicaid programs by $880 billion during the next 10 years. This threatens to affect approximately one-sixth of the American population. People will still have medical emergencies and require hospital care; the ACA made big cuts in how much Medicare pays hospitals, because it was felt that hospitals would make up the difference with more paying customers. The Republican bill does not restore any of the Medicare cuts, so hospitals in poor communities where a lot of people signed up for Medicaid would suffer the most, and so would their patients.

School districts rely on Medicaid to provide essential and costly services to millions of students with disabilities, covering physical therapists to feeding tubes. Medicaid also provides preventive care like visual and hearing screenings, services that would be lost or curtailed with the cuts in Medicaid.

The federal government pays subsidies to reimburse insurers for the extra costs associated with plans for low-income people. Last month, Congress declined to approve subsidy payouts to insurance companies beyond May, leaving the decision to President Donald Trump. Not paying the subsidies could destabilize the entire insurance market, resulting in fewer insurance companies willing to cover ACA patients. Subsidy payments to insurance companies amount to $7 billion. Trump and the Republican administration could sabotage the ACA and cause its demise by not releasing those subsidies. Blue Cross and Blue Shield of Kansas City, a nonprofit insurer, announced that it would not offer coverage under the ACA for 2018 because of the insurance market instability despite a balance sheet indicating $1.6 billion dollars in assets in 2015. They will leave 67,000 people in Kansas uncovered. Aetna has already exited most of the ACA markets and is now the only insurer in Nebraska's exchange, but still posted a net income for fourth quarter 2016 of $139 million.

By continuing to keep insurance companies in the loop, by continuing to not offer a public option and universal coverage, **are we failing in our obligation to the health of the American people?** Health care should be a right, guaranteed to all Americans.

In California, SB562 is a proposal to essentially eliminate health insurance companies and guarantee government-funded health care for all California residents, and is moving forward. The price tag is estimated to be about $400 billion. By continuing to keep insurance companies in the loop, by continuing to not offer a public option and universal coverage, are we failing in our obligation to the health of the American people? Health care should be a right, guaranteed to all Americans.

Is the solution to take the insurance companies out of the equation? Can we provide a simpler low-cost or no-cost Medicare option to all consumers, ensuring universal health care access? The "individualist" culture of U.S. citizens has been proposed as the reason that universal health care is not widely accepted, and felt to be the bastion of liberals alone, but recent action in California suggests otherwise. Anything that smacks of "entitlement" is anathema to current U.S. politics. However, the insurance industry has played a key role in holding down debate about universal health care. Insurance companies spent over $100 million to keep private insurers, as opposed to the government, as the key cog in American health care during the ACA debate alone.

Is it possible or reasonable to provide universal health care? At what price? The ACA represented the U.S. health care system's most significant regulatory overhaul and expansion of coverage since the passage of Medicare and Medicaid in 1965, but even it does not provide universal access or universal coverage. The AHCA promises to allow unchecked insurance pricing, does nothing to address astronomical pharmaceutical pricing, and allows built-in discrimination in access to health care by age, health and gender. These barbaric practices were addressed by the ACA, and have not been seen in this country since 2009. The ACA was a huge step forward; the AHCA is an enormous fall backward. How, then, shall we proceed? ■

Brenda Kehoe, MD, an obstetrician/gynecologist, is Secretary-Treasurer and a former president of the Medical Society of Metropolitan Portland's Board of Trustees.

ANNUAL MEETING, *from page 1*

exposure and workplace sexual harassment.

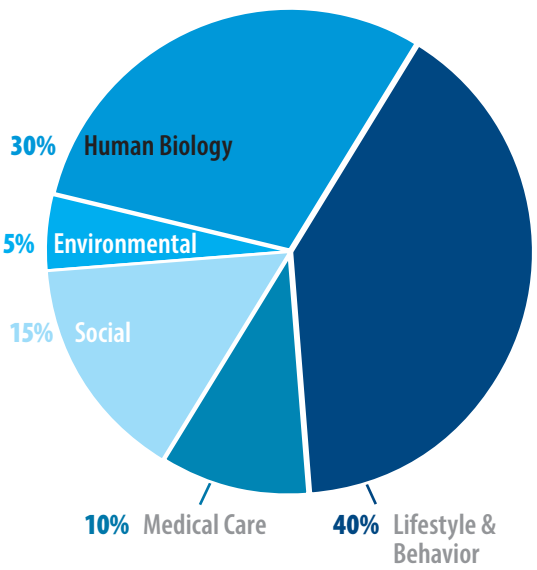
Shadbeh said that strong collaboration across disciplines and with the community resulted in training materials in indigenous languages, aligning with the law center's emphasis on community education. *(For more about Shadbeh and her work, please visit MSMP.org and see the cover story in April's Scribe.)*

Guest speaker **John Kitzhaber, MD**, dedicated his presentation, "Changing Health Care in Oregon: The effects on physician practices, clinics and patient care due to changing health care policies," to medical students, residents and young physicians just beginning their careers. "They are at the cutting edge of changes that are taking place ever more rapidly," he said, adding the next generation of providers has the power to be more proactive than previous generations.

Kitzhaber, a former emergency room physician in Roseburg and Oregon governor, noted the uncertainty caused by potential ACA repeal, insurance market instability, and individuals and families who are one illness away from bankruptcy. He added that the "human element" is missing in the debate, and that health care shouldn't be this complicated or political.

"Instead of asking how can we make insurance more affordable, we should instead ask how we can make Americans healthier. It fundamentally shifts the focus of the conversation," he said.

Figure 1. Health Field Model Influence Factors on Health Status



Source: McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). Health Affairs, 21(2), 83

Kitzhaber pointed to Oregon's coordinated care organizations as models, noting they are meeting quality and health outcome measures. He advocated for increased investment in community services that improve social determinants of health, including reducing adverse childhood experiences, improving early childhood nutrition and education, and supporting new mothers. He posed the question of how the learnings from CCO performance can be applied to the commercial insurance market to achieve lower costs and better outcomes.

"Medicaid isn't just a revenue problem, it's a cost problem. And changes in the model will result in reduced costs," he said. "It's clear that we know it's possible to drive down the cost of care without sacrificing access to care. The question is how to do that."

Kitzhaber challenged medical students and young physicians to explore different models and delivery systems. He read a portion of President John F. Kennedy's speech about the daunting challenges that faced America in its quest to reach and return from the moon, defining the technological and logistical hurdles that included the need for materials that hadn't yet been created.

"We did that and we did it in eight years. Surely, in the same time, we can whittle five to six points off health care costs. I think it's a lot less difficult than going to the moon." ■

CareOregon, Housecall Providers to expand home-based medicine in metro area

Community-based nonprofit Housecall Providers (HCP) became an official member of CareOregon on May 31. The new strategic partnership is designed to increase access to and enhance in-home medical care in the Portland metro area. Becoming a limited liability company in the CareOregon family of health care services will enable HCP to grow and expand its home-based primary, palliative and hospice care.

"Because Housecall Providers has served CareOregon members for years, we knew what outstanding medical care their primary care providers and staff offer," said **Will Kennedy**, CareOregon medical director and an expert in palliative and hospice care. "They bring a unique component to the CareOregon mix as one of Oregon's only standalone medical practices that exclusively sees patients where they live – a vital service for many chronically or critically ill members."

"Our long relationship made CareOregon the ideal choice when we began looking for a partner that could help us grow and strengthen our services," said **Terri Hobbs**, HCP executive director. "We knew they shared our same goals, values and nonprofit status, and would enable us to continue as a unique entity, but with a strong, innovative partner backing us."

HCP offers in-home primary care, palliative care and hospice services to nearly 2,000 homebound patients each year. By remaining a separate community asset, HCP will continue to receive patients through its historical referral sources, such as home health agencies, social workers and adult care homes, while also increasing access to home-based medical medicine for CareOregon members.

CareOregon serves about one-fourth of the state's Medicaid patients. It also offers two Medicare plans.

"I believe one of CareOregon's greatest assets is our ability to work collaboratively with our provider partners to help them improve practice quality and efficiency," said **Amit Shah, MD**, chief medical officer for CareOregon. "We offer providers non-traditional support, such as embedding health plan staff in clinics, individualized pharmacy services and medication management, and a wide range of payment innovations.

"CareOregon works closely with valued community agencies to coordinate food, housing, and mental health needs with acute care needs. Housecall Providers, already part of our network, is an ideal partner because we share the same mission and commitment to caring for underserved populations, while focusing on individuals' unique needs."

Now participating in the fifth year of a national demonstration project, Independence at Home (IAH), HCP has proven that home-based medicine improves quality and efficiency of care for the chronically ill. With the nation's best outcomes in the project, HCP said it has shown its tremendous importance in the future of national health care delivery.

"Through their more than 20-year histories, Housecall Providers and CareOregon have shared a common vision, mission and population," Hobbs said. "Through this partnership, Housecall Providers will bring decades worth of experience delivering home-based medical care to an innovative health plan whose vision is for all individuals, regardless of income or social circumstances, to experience the best health possible. Together, we can improve delivery of home-based primary, palliative and hospice care to metro's most vulnerable population in the face of a rapidly changing health care climate." ■

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