MEDICAL SOCIETY OF METROPOLITAN PORTLAND

# The Scribe

*A publication of the Medical Society of Metropolitan Portland*

## The opioid crisis

Amy Kerfoot, MD, a MSMP Board of Trustees member, is a leader in efforts to address the epidemic.

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OFF HOURS

## Driven by curiosity

Varied interests, including stained-glass art and cheese-making, keep things interesting for urologist Jeffrey Woldrich, MD.

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PHYSICIAN PROFILE

# 'Widening the bench'

## *Alisha Moreland-Capuia, MD, wears several hats, saying society benefits from physicians involved in myriad policy work*

**By Melody Finnemore**
*For The Scribe*

When Alisha Moreland was 9 years old, she was inline skating with her siblings and friends in Portland's Sabin neighborhood when she had a serious crash and broke her right femur. The accident forced her to spend several weeks in the hospital.

"I was struggling in the hospital to communicate with people who didn't look like me. It felt very isolating and lonely," she said. "I thought, 'I'm 9 and I'm not feeling comfortable,' and I wondered if anyone else felt that way. I felt invisible and I wanted to be treated not just like a broken leg, but as a whole person."

Now known as **Alisha Moreland-Capuia, MD**, she went on to earn a bachelor's degree from Stanford University and her medical degree from George Washington University School of Medicine. She completed her residency in general adult psychiatry at Oregon Health & Science University in 2013 and did a fellowship in addiction psychiatry with the Portland VA the following year.

Moreland-Capuia became the first African-American Oregonian to become a licensed and board-certified psychiatrist. Calling the achievement "simultaneously fascinating and sad" because it happened so recently, she added, "It was a huge accomplishment and it meant a lot, not just to the African-American community but many communities here in Oregon."

Inspired by Dr. Ben Carson's book "Gifted Hands," Moreland-Capuia initially wanted to become a pediatric neurosurgeon. However, marriage and motherhood during medical school made her realize she was going to have to find a means of ensuring balance in her life. Psychiatry not only provides an opportunity to work with the brain, but she also can be involved in policy work and other social aspects of health care, she said.

Moreland-Capuia wears several hats, including as physician, scholar, educator and orator. She is an assistant professor of psychiatry in OHSU's School of Medicine and executive director of the university's Avel Gordly Center for Healing.

"I feel privileged and honored to get to work alongside great people, and I love the fact that I get to work with individuals and families and actually witness people get better," she said. "The art and practice of science translates to so many other areas and across other disciplines, and that has been one of the wondrous highlights of working at the Avel Gordly Center."

A former appointee to the Governor's Council on Alcohol and Drug Abuse Programs, Moreland-Capuia was appointed to the Oregon Health Policy Board Healthcare Workforce Subcommittee in 2016 and hopes to increase diversity in medicine and health care delivery in Oregon.

The several boards she serves on include the Oregon Historical Society and I Have a Dream Oregon. She also is a former appointee to the Community Oversight Advisory Board (COAB), which oversees the Department of Justice's mandated reform for the Portland Police Bureau. Moreland-Capuia co-chaired the board's

*See **PHYSICIAN PROFILE,** page 9*

*Photos courtesy of Alisha Moreland-Capuia*

**"One thing that's really important to me is having balance.** I'm a better physician, person, mother and wife when I'm involved in the community. It inspires me to do the work."

*– Alisha Moreland-Capuia, MD*

## 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: ELDER CARE

# *Can walking and talking about the past sustain brain health?*

## OHSU study explores if blending physical activity with social engagement staves off memory loss

**By Cliff Collins**
*For The Scribe*

A small local study is examining whether combining physical activity with social engagement and reminiscing can help African-Americans maintain cognitive health and stave off decline.

According to the National Institutes of Health, a growing body of evidence suggests that the prevalence of cognitive impairment or Alzheimer's disease may be two to three times higher among older black Americans than in older non-Hispanic whites.

Medical scientists don't understand all the reasons why this may be so. Studies have found that, compared with the general population, the increased risk of dementia is 50 percent to 150 percent greater in people with type 2 diabetes. According to the American Heart Association, African-Americans are disproportionately affected by diabetes, as well as by obesity and hypertension. And the Alzheimer's Association notes that because African-Americans are more likely to have vascular disease, they also may be

*See **SHARP STUDY,** page 6*

*Focus groups revealed that participants shared a sense of purpose in being in the study, not just for their own individual health, but also for the opportunity to preserve community memories for future generations.*

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# The Scribe

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1221 SW Yamhill St., Suite 410
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Ph 503-222-9977 Fax 503-222-3164
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## Required OSHA Training and Advance HIPAA Compliance

**9 a.m. – 12 noon, Friday, Feb. 23**

**800 SW 13th Ave, Portland**
**First floor downtown conference room**

**Cost: $75 for MSMP members and their staff;**
**$95 for non-members**

*MSMP is proud to present our OSHA and HIPAA training, tailored for members and led by Virginia Chambers, CMA (AAMA).*

OSHA annual training is **required.** The ONC, OCR and AHIMA recommend HIPAA annual training. Attendees will receive a certificate of participation that can be presented to their employer for credit.

**QUESTIONS: Sarah@MSMP.org • REGISTER: www.MSMP.org/Events**

## Physician and Medical Assistant Team Workshop

*Presented by MSMP in partnership with OHSU Division of Management*

**8 a.m. – 12 noon, Friday, April 13**

**1221 SW Yamhill St., 4th Floor, Portland**
**Yamhill One Conference Room**

**Cost: $100 for MSMP members and their staff;**
**$150 for non-members**

MSMP and OHSU Division of Management invite you to attend our Physician and Medical Assistant Team Workshop. This team-building event will focus on providing physicians and their medical assistants with relational development skills as well as the applicable tools and strategies to collaboratively set a shared vision for the future while promoting provider wellness, building high-functioning teams and reducing staff turnover.

The workshop will be led by Steve Kinder, MPA, and Jessica Walter, MA, from OHSU Division of Management.

**QUESTIONS: Sarah@MSMP.org • REGISTER: www.MSMP.org/Events**


## MSMP Board of Trustees Nominations

***The deadline for nominations is March 23***

The MSMP Board of Trustees will consider recommendations for positions on the new Board, commencing May 8, 2018. 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. 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 Board meets monthly except for July and August. Conversations are lively, direct, diverse and important.

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 23.***

## Medical Student Award Nominations Needed

MSMP is pleased to accept nominations for our Annual Medical Student Award, paying tribute to a medical student who embodies our mission to create the best environment in which to care for patients.

We are looking for a student who displays professional knowledge, skill, judgment, mentorship and compassion, strong community involvement and strives for wellness to meet the highest standards of service.

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

***Nominations must be submitted by March 23.***

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# Amy Kerfoot, MD, a MSMP Board of Trustees member, is a leader in efforts to address Oregon's opioid epidemic

**Amy Kerfoot, MD**, a member of the Medical Society of Metropolitan Portland's Board of Trustees, has long been active in addressing the opioid epidemic, including serving on the Oregon Medical Association's Opioids Task Force and Gov. Kate Brown's Opioid Epidemic Task Force.

Kerfoot, who practices occupational medicine with Northwest Permanente, recently shared with *The Scribe* more about her involvement in helping address Oregon's opioid epidemic, why a multidisciplinary approach is crucial in this effort and how physicians can do their part. A link to a radio interview Kerfoot did with Salem radio station KYKN on these topics is available at MSMP.org.

***THE SCRIBE: You've been involved in addressing the opioid epidemic at least since your residency. What prompted your interest then and your continuing work now?***

**KERFOOT:** As an OHSU preventive medicine and public health resident, I was fortunate to find a trusted professional mentor and rotation supervisor in Dr. Paul Lewis, the tri-county health officer and an alumnus of the preventive medicine residency. Paul presented an overview of the issues he was working on where a resident could both learn and add value. Work on a regional opioid coalition was one of the options, and one that included nearly every sector of the community. A few years later, it is an issue that continues to consume our communities and cause great suffering and economic loss each year. As I've moved from resident to attending physician, the opportunities to serve have become more numerous, but directly build on the foundation of exposure I got during residency. I was asked to serve on the governor's task force on behalf of the OMA, likely a result of the relationships I'd built during residency. My role on the governor's task force is to represent the interests of OMA members (practicing physicians) on a multidisciplinary task force with a legislative focus.

***How does the work of the OMA and Gov. Brown's task forces complement each other?***

**KERFOOT:** The OMA's opioid task force has been in existence for several years, and is focused on the work practicing physicians need to do in order to appropriately treat pain in their patients, but also safeguard the safety and well-being of patients, their families and the community. It is very focused on the medical community as stakeholders. The governor's task force, on the other hand, is more diverse. It includes members of state government, treatment organizations, law enforcement, public health and patient advocacy groups. My role as a representative of the OMA is to be sure that the physician voice is included. We want to make sure that any legislative actions don't inadvertently make it more difficult for physicians to provide high-quality, efficient care for patients with pain, and also those with an opioid use disorder. This allows us to most effectively contribute to the efforts to address the crisis here in Oregon.

***The governor's task force has members from multidisciplinary backgrounds and organizations. What are you learning from them and what legislative solutions, such as bolstering Oregon's prescription drug monitoring program (PDMP), are being discussed to help address the issue?***

**KERFOOT:** I was really fortunate in a public health/preventive medicine residency program to be exposed to the full complement of stakeholders in the opioid epidemic. That's the coolest thing about public health – its reach across many social institutions. My work on the task force, however, has given me a greater appreciation for the work that our lawmakers and law enforcement officials do on the issues that aren't necessarily medical in nature but still impact our communities. As for the work of the task force, we're really just getting started. We've submitted a bill for the short 2018 legislative session that carves out some attention for broader use of the PDMP, some pilot projects to support peer mentoring linking overdose survivors to treatment and to better understand the barriers to insurance reimbursement of opioid use disorders. It's a start. We are having conversations around more ambitious measures for the 2019 session. The meetings are open to the public, so any interested party can attend, or review the minutes on the state's website.

***How do the task forces' efforts dovetail with the work you are doing at Kaiser?***

**KERFOOT:** Kaiser has had a highly effective opioid oversight committee for several years now. The work of physician leaders, pharmacists, pain specialists and support staff has been very effective in reducing overall opioid prescribing (in keeping with Centers for Disease Control and Prevention guidelines), while supporting the needs of both patients and providers. Many members of this Kaiser committee have been involved in regional public health efforts. Kaiser is an active stakeholder in these efforts. My job has really just been as a liaison between the discussions at the governor's task force and the Kaiser committee, as well as the government relations team. The work doesn't directly overlap, but it's complementary.

***What feedback did you receive after your participation in a panel presentation for the Strategic Economic Development Corporation (SEDCOR) in Salem?***

**KERFOOT:** I heard what a huge impact the opioid epidemic has had on all communities across Oregon. It hurts businesses. It hurts families. Employers want to know what they can do to help employees with problems, and how to minimize the risks to their employees and to their own families. Nearly every person in the room had a personal story for how the epidemic had touched them. I got positive feedback on the explanation of how a substance use disorder is a chronic medical disease (like diabetes), and will therefore require long-term treatment, sometimes with medication. Destigmatizing addiction is a really important part of what the medical community needs to do.

***What did you take away from the recent American Medical Association legislative strategy conference, and what policies are being considered at that level to combat the opioid epidemic?***

**KERFOOT:** One of the most stunning takeaways from the conference was just how much more difficult it is to legislate effective solutions in states that did not expand Medicaid under the ACA. Without going into politics, it's impossible to treat a massive public health problem when a significant portion of the population in need cannot access effective treatment. It made me grateful that Oregon has tried to prioritize the needs of public insurance beneficiaries in meaningful ways.

I was also impressed with what a significant difference our geography makes. Citizens in rural parts of the state can't always access care without the assistance of telemedicine provisions. Lastly, it was inspiring to see presentations from leaders who have created effective programs in their respective states. These ideas will certainly help the task force in shaping solutions that work in Oregon.

***Pain is such a complex issue. For so many patients, they naturally want relief from their chronic pain, and many seek pain medication. Providers, also naturally, want to help their patients feel better and return to optimum health. To what degree is this issue an additional source of stress for physicians, and is this part of the medical community's conversation about the opioid crisis?***

**KERFOOT:** Part of what helped fuel the opioid crisis was the aggressive marketing to physicians and patients that opioids were the answer to every imaginable kind of pain. "Pain as the fifth vital sign" helped fuel a sense of entitlement to being pain free, and to receiving liberal quantities of opioids. Unhappy patients could retaliate by giving low physician feedback survey scores, which punished their clinicians.

After more than a decade of escalating addiction and overdose deaths, the conversation has shifted. Physicians naturally want to ease the suffering of their patients, but there is a better understanding that pain is complex and multifaceted. Each patient has factors that create his or her experience. The best treatment is directed at those different

*See* ***OPIOIDS IN OREGON,*** *page 9*

# Large Portland construction firm among companies opening employer-owned clinics

**By Melody Finnemore**
*For The Scribe*

Like many employers, Hoffman Construction Co. executives watched the company's health insurance costs rise while several of their employees grappled with injuries, chronic health problems and other illnesses. Many employees were being treated at urgent care clinics rather than seeing a primary care doctor who could consistently track their health. Neither the company's leaders or its employees were particularly satisfied with the quality of their health insurance or care, which was growing more expensive and less convenient by the year, says Dave Drinkward, Hoffman's executive vice president.

"We looked at it from the standpoint of what can we do as a company to have a meaningful impact on our employees, first and foremost, but also from a business standpoint. Healthy, happy employees are more engaged and more productive than those who aren't," he said.

As Hoffman's leaders talked to their peers around the country, they learned more about employer-provided health care models that are gaining proponents. The company developed its own health care clinic, which opened last June at 400 S.W. Sixth Ave. After a nationwide search, Hoffman hired Seattle-based Vera Whole Health to staff and manage it. **Phyllis Gilmore, MD**, and **Allie Quady**, a certified health and wellness coach, see primarily Hoffman employees at the clinic.

Drinkward noted that some companies they surveyed chose to hire their medical staff directly or have a health clinic within their corporate offices. Hoffman chose its model because many of its employees work in the field rather than the headquarters, and a separate clinic also provides greater patient confidentiality. In addition, joining Vera's network means that employees can use Vera's clinics in Seattle, providing them with more options for care.

"Vera combines an urgent care model that is quick and efficient, but the doctor knows the employees and can have a holistic idea of what each person's health condition is. That model is pretty attractive," he said. "We see that as the gateway to health, being able to see someone who knows you and understands your issues and can advocate for you."

**Lindsay Leeder**, a nurse practitioner and clinical consultant for Vera, has visited the Portland clinic several times and said the employer-owned clinic model is more prevalent along the East Coast and Midwest and is gaining popularity on the West Coast.


LINDSAY LEEDER

In addition to Oregon and Washington state, the 10-year-old company has clinics in Idaho, California, Arizona and Alaska. Leeder said her conversations with physicians in each region have a common theme: "We can all see, as providers, how confusion about cost can create barriers to access to care."

Vera's clinics differ from urgent care clinics in several ways, she noted. The clinics are one-stop shops that include medication dispensaries and allow patients to take care of everything in one visit. The wait time for patients is five minutes or less. And while urgent care clinics treat an immediate problem, Vera's primary care clinics integrate holistic care and health coaching.

"The ability to work in a model where we're encouraged to be a navigator for people is really rewarding," Leeder said.

She added that while the national average meeting time between patients and physicians is about seven minutes, Vera's appointments are at least 30 minutes and sometimes longer, depending on the reason for the patient's visit. Longer patient meetings allow the physicians to build stronger relationships with their patients, understand their health concerns better, and develop a comprehensive treatment and prevention plan with them.

"We find that people are more committed to activate that care plan and put words into action," she said.

**Hoffman Construction Co. established an employer-owned health care clinic in downtown Portland, where its employees can receive urgent care, long-term treatment plans for chronic conditions, health coaching and medications in a one-stop shop model.**

*Photo courtesy of Vera Whole Health*

Hoffman's Drinkward admitted he was a bit unsure at first about how the health coaching component of the clinic would resonate within his company.

"It's really taken off with our employees," he said. "I can't tell you how many stories I've heard from employees who say, 'I was kind of skeptical at first, but I tried it and now I've lost 30 pounds,' or 'I've started running again.' They love it." ■

> "We looked at it from the standpoint of **what can we do as a company to have a meaningful impact on our employees**, first and foremost, but also from a business standpoint.
>
> Healthy, happy employees are more engaged and more productive than those who aren't."
>
> *– Dave Drinkward, Hoffman Construction Co.*

# Scribe Focus

## 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'll focus on Pain Management.**

## *SHARP study,* from page 1

at greater risk for developing Alzheimer's.

But multiple factors – both biological and social – likely are involved. Better understanding is hampered by the fact that nearly all clinical research on Alzheimer's so far has studied whites.

"The lack of high-quality biologic data on large numbers of racial and ethnic minorities poses critical barriers to progress in understanding whether the mechanisms and processes of Alzheimer's disease operate the same or differently in racial and ethnic minorities and, if so, how, particularly in the high-risk African-American population," according to a 2014 *Health Affairs* paper, "Alzheimer's Disease In African-Americans: Risk Factors And Challenges For The Future."

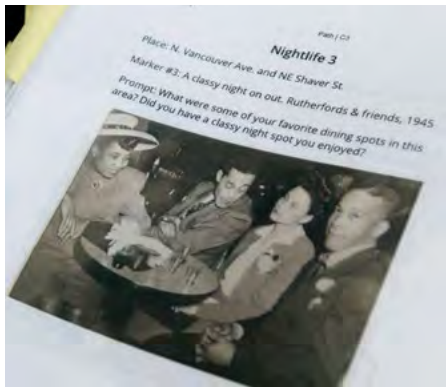
"There is a large and diverse literature on cultural beliefs and perceptions of disease and aging, inequities in health care access, life-course influences, and social and cultural variations in care-giving experiences, and these factors likely intersect with biologic mechanisms in currently unknown ways, resulting in these health disparities for Alzheimer's disease."

The authors add that, "given the complexity of the disease and the fact that no single factor has accounted for observed disparities, multi-interdisciplinary collaborations that can integrate multidimensional layers of data (such as biologic, social, life course, environmental and policy) will be necessary to move the field forward and address one of the most urgent public health problems of our time."

**Oregon Health & Science University's Raina Croff, PhD**, a medical anthropologist and an assistant professor of neurology, is following that recommendation in addressing various approaches to this disparity. Her study, now in its second year, is called **Sharing History through Active Reminiscence and Photo-Imagery**, or SHARP. The objective is to sustain or improve cognitive health for African-Americans age 55 and older.

**RAINA CROFF, PhD**

The study, which lasts six months, includes seven groups of three participants, all of whom have each spent at least 10 years living in North or Northeast Portland. Some still live there, while others who used to live in those neighborhoods drive in from Gresham, Fairview, Beaverton and other outlying areas to join the walks. Groups walk one-mile courses three times a week through neighborhoods that once were predominantly African-American. Groups can select from 72 "themed" walks, such as for nightlife, fashion and beauty, social change, food, politics and experiences with the police, Croff said.




**An example of the "memory prompts" used in the SHARP study.**

**Vickie Naylor, Bernadine Clay and Donna Maxey read a "memory prompt" while participating in the Sharing History through Active Reminiscence and Photo-Imagery, or SHARP, study in September.**

*Photos courtesy of OHSU/Kristyna Wentz-Graff*

"The unifying theme I'm looking at is the interaction between culture and health, how culture impacts health," she explained.

Participants employ "memory markers" before beginning the walks, three more times at different study intervals, and one time at the end. A smart tablet device prompts them with news clippings, photographs, advertisements or artifacts such as political campaign buttons tied to certain locations along the routes – the site of a school, church or a civil rights march, for example.

"I was looking at culture as a primary driver of health," said Croff, a Portland native who was raised in both the north and east parts of town and later went away to study cultural anthropology and archeology in West Africa.

In the SHARP study, "I was interested in having people walk through physical spaces and talking about their memories with one another, as opposed to sitting in a room and being asked about it."

The goal is to test whether physical exercise, combined with active reminiscence and social interaction of folks who remembered the way the neighborhoods used to be, can forestall memory loss. The study includes primarily cognitively healthy people, plus about one-third who are experiencing memory loss or mild cognitive impairment. At the end of six months, researchers will follow up with a test to determine whether the program improved or maintained participants' cognitive health.

Croff generally chose "upbeat, celebratory" historic scenes for the material used with the tablets. However, she acknowledges that the walks take place in a "gentrified area, which can make it hard to remain positive."

One enrollee, Donna Maxey, recalled the devastation her family suffered when they lost her childhood church that once stood on the current site of Veterans Memorial Coliseum. Her family's home and her father's barbershop were located where Interstate 5 now bisects the area. Many of the longtime families have scattered.

On the other hand, those enrolled in the study tell Croff they believe that, by participating, they are part of something positive. Croff found through focus groups that participants shared a sense of purpose in being in the study, not just for their own individual health, but also for the opportunity to preserve community memories for future generations. They felt they are getting something for their own health "while contributing to our community health," she said.

Participants' observations and narratives are recorded during their walks, on a tablet device and on a backup digital recorder. The tablet automatically starts recording once participants log in at the start of their walk, so the entire walking conversation is recorded.

The SHARP study is supported by funding from the Alzheimer's Association, the National Institute on Aging, and the Edward R. Roybal Centers for Translation Research in the Behavioral and Social Sciences of Aging. The original study design was developed through a pilot project supported by the Centers for Disease Control and Prevention.

Croff hopes the walking program will help participants maintain and even improve their cognitive health, but she said determining which of the three elements of the study made the most difference may be difficult, because the combination of all three may be the key.

She said similar studies may be applied in the future to other minority communities, as well as to people who have Alzheimer's disease. ■

## *Study: Phone calls more effective than text messages as patient reminders*

Live phone calls significantly outperform text messages and letters as a way to remind patients to complete and return at-home screening tests for colon cancer.

The study, in the *Journal of General Internal Medicine*, included more than 2,700 patients who receive care in safety-net clinics and who were overdue for colon cancer screening. Colon cancer screening is recommended for everyone ages 50 to 75.

The patients were sent test kits by mail, and 10 percent mailed back their completed tests within three weeks. Those who did not were assigned to one of seven reminder interventions. These included a phone call from a clinic outreach worker (a live call), two automated calls, two text messages, a single reminder letter or a combination of these strategies.

The live phone call intervention was most effective, resulting in 32 percent of patients completing and returning their test kit within six months. The text message intervention was the least effective – only 17 percent of patients in this group completed and mailed back their test.

"We knew that these patients are not as text savvy as younger patients, but we didn't expect text messaging to do so poorly compared to the other strategies," **Gloria Coronado, PhD**, lead author and cancer disparities researcher with the Kaiser Permanente Center for Health Research, said in a news release. "Text messaging is a relatively inexpensive way to send patient reminders, but for this group it was also relatively ineffective."

Patients received the various reminders in their preferred language. Phone calls were the most effective strategy for all patients, but English speakers were more likely to respond to the single live phone call, while Spanish speakers were more likely to respond to the combination of a live call and two automated calls.

"The phone calls may help to build trust, or confianza, which is an important value and motivator for care-seeking among Hispanics," said **Ricardo Jimenez, MD**, co-author and medical director of Sea Mar Community Health Centers in Seattle, where the study took place. ■

# Richer advance care planning conversations among needs amid 'silver tsunami'

**By Barry Finnemore**
*For The Scribe*


SHANNON JACKSON, MD

From the need for richer advance care planning conversations with older adults who still are independent to growth in programs that bring care into the homes of frail and homebound patients to the various care facilities that serve older people, much is evolving with respect to elder health and wellness.

**Shannon Jackson, MD**, a geriatrician with the Providence Senior Health team, offers providers her perspective on these and other issues below:

***The Scribe: What are some common health challenges among older patients that you are seeing in your practice? For example, to what degree is the flu impacting your patients and your practice this year?***

**JACKSON:** As everybody knows, this has been a rough flu season, especially for children and frail elders. We are still seeing multiple senior care facilities in the Portland area with residents testing positive for influenza. Something I found interesting was this small study by Jing Yan et al., picked up by the general media and published online recently in the Proceedings of the National Academy of Sciences titled, "Infectious Virus in Exhaled Breath of Symptomatic Seasonal Influenza Cases from a College Community." The implication of this study is that aerosolized influenza virus can be passed through simply breathing or speaking, especially in close quarters. A person doesn't have to be coughing to spread infectious particles.

Although the CDC doesn't currently recommend masking for asymptomatic persons, my take home after reading this study is to consider recommending preventive mask wearing to my patients at high risk for influenza complications when in tight public spaces such as airplanes, buses and in medical clinic waiting rooms during flu season.

***A couple years ago we published a story about osteoporosis among men, and how more emphasis should be placed on prevention and education about a condition affecting many men that often is thought of as predominantly a women's disease. What are some health challenges that may be under the radar among the public but that more men and women should be aware of as they age?***

**JACKSON:** I think there is great need to have richer advance care planning conversations with older adults who are still independent in activities of daily living and all or most instrumental activities of daily living. I like to open the door to these discussions by using the Institute for Healthcare Improvement (IHI) "What Matters?" format. I would recommend to all of us who see a variety of seniors at different stages of function and cognition they consider documenting a "what matters" conversation in the chart of each patient. This gets well below the surface of filling out a POLST and helps you as a clinician align with the patient's hopes and fears. Here is a link with some short and intuitive videos about why these conversations are so important and how to start them as a preventive care/advance care planning visit with adults of any age: *www.ihi.org/Topics/WhatMatters*.

Providence is participating in a grant from the IHI and the John A. Hartford Foundation to develop and test clinical interventions that pivot around four important domains in care of our aging "silver tsunami" population: mobility, mentation, medication and what matters. Unless you are a pediatrician, we are all asked to step up and become experts in care of older Americans. As you are having an advanced care planning appointment with your senior, I would challenge you not only to document what matters to your patient, but also your recommendations to them on how to stay mobile, mentally active and recommend stopping high-risk medications, ideally with the help of a clinical pharmacist. Look for validated resources surrounding these 4Ms to be coming out from IHI by 2020.

***Is there a recent study or are there trends concerning geriatrics that have caught your attention and prompted you to take a different approach to treatment?***

**JACKSON:** Yes, there is a lot of growth right now for programs that bring care into the homes of frail and homebound patients. Housecall Providers is the longest-running, home-based, primary care program in the Portland area, but we have seen Kaiser, Providence and some of the larger senior housing companies such as Marquis and Avamere hiring medical providers who round on patients at home or in facilities. There remains a continuous tension on how to do this efficiently, especially as our nation and our health care systems are just starting to shift away from fee-for-service billing to a population health model.

I'd say that to a general practitioner audience, buckle your seat belt! During the next 10 years we will see even more change on nursing facility rounding, ED care coordinators trying to discharge people out of the ED to a hospital-at-home or rehab-at-home strategy, and facility-based providers at assisted-living facilities, adult care homes and memory care units that

*See **ELDER CARE,** page 10*

# DRIVEN BY C·U·R·I·O·S·I·T·Y

## Stained glass, cheese-making and robotic surgery keep things interesting for Jeffrey Woldrich, MD

"I think there are some parallels between stained glass and surgery.

The technical and practical aspects of both appeal to that part of me that has always been curious about how things work."

– Jeffrey Woldrich, MD

**By Jon Bell**
*For The Scribe*

He's a married father of a 2-year-old daughter, a trained sculptor and a self-taught stained-glass artist. He dabbles in cheese-making, loves to cook and calls himself an amateur charcutier. A self-described Francophile, he's also a travel junky who explored Asia with his father for three months after college and who'd love to visit Angkor Wat, the historic temple complex in Cambodia.

Oh, and **Jeffrey Woldrich, MD**, is also a general urologist – with a particular interest in robotic surgery – at The Portland Clinic.

"I (always) knew I was going to be a doctor," Woldrich said, "but I simply have lots of interests."

That would be an understatement.

Always curious about how things work, Woldrich grew up intrigued by science but knew early on that medicine, not scientific research, would be his calling.

"Medicine was a natural fit because it was practical and more social than basic science," he said.

Though he knew as early as middle school that he wanted to be a doctor, Woldrich studied art and semiotics – the study of signs and symbols and their use – at Brown University. While there, not only was he able to take all of his pre-med classes, but he also studied art history in Paris and did some medical research in southern India. After college, he went to medical school at the University of California, San Francisco, then did trauma surgery in a community hospital in El Salvador for several months before a urology residency at the University of California, San Diego. He later moved to Oregon and joined The Portland Clinic.

In a recent interview for *The Scribe*, Woldrich shared a little more about his art, his inspiration and his failed attempts – so far – to make a good aged cheese.

### How long have you been a glass artist and how did that start?

I actually taught myself how to make stained glass from a book and made my first window during medical school. It's in my parents' bathroom today. As I have become more interested in glass art, I have also started working with a kiln and have recently been using traditional stained-glass painting techniques. Similar techniques were developed in Gothic stained-glass windows, which let you make much more complicated images than you can by simply cutting pieces of glass and then leading them together. Each window takes months to make, both because it is time consuming, but also because I am a dad and surgeon with plenty of time commitments.

### What is it about glass art that you enjoy?

Coming from a sculptural background, there is a real interest in the physicality of materials – their physical properties, histories and associations. Glass is an amazing material in this regard. I really enjoy the way light interacts with glass. Each window is constantly changing based on the surrounding environment, and since the weather is always changing here, they are well suited to the Pacific Northwest. I also like the strange properties of glass – it seems like a solid but actually is an extremely viscous liquid. That is why you can actually coax it to break in the shapes you want by scratching the surface of the glass, thus breaking the surface tension. It has to be respected because it is very easy to cut yourself. Finally, I like the history of this as an ancient art form. This was one of the premier artisan careers in centuries past, obviously less common today. It's cool to feel connected to artists from the distant past. I love that there are stained glass windows in European cathedrals that are so old that the glass is gradually flowing downward because of gravity and so the pieces are getting thicker on the bottom than on top. They are thinking about flipping the windows upside down so that they start to flow the other way!

### Does your interest and pursuit of that at all relate to or merge with your medical practice?

I think there are some parallels between stained glass and surgery. They have a similar active problem-solving process and you have to be careful you don't cut yourself. The technical and practical aspects of both appeal to that part of me that has always been curious about how things work. It's probably why I am also the handyman in our house.

### Do you have a favorite glass art piece you've done?

I made two stained-glass windows designed to overlap for friends during residency. Mine are usually pretty abstract but have a starting point. I made kind of an art deco window that was based on raindrops on the street, and another with a starting point of bubbles in a glass of champagne.

### You're somewhat of a foodie, too?

I really enjoy cheese and cooking, which is why I started trying to make cheese. I can make a very nice soft unaged cheese of various kinds like goat and cottage cheeses. My experiments at aged cheeses have not been so successful . . . I really like the stinky, gooey cheeses out there, so I hope to refine this skill over time.

### All these pursuits, plus a career in medicine and being a dad, no doubt keep you busy. But are there any other pastimes you've wanted to try that you might someday?

I'd like to learn how to garden. So far, I have a long track record of dried-up houseplants to argue against my green thumb. ■

*Photos courtesy of Jeffrey Woldrich, MD*

**PHYSICIAN PROFILE,** *from page 1*

Mental Health Subcommittee and said the experience taught her myriad lessons, from understanding the traumas experienced by both community members and the police to how to try to affect change in a large bureaucracy through mutual respect and honest communication.

"It's easy to see it as a big, bulky, untouchable process, but the system is intimately attached to people and systems don't change if people don't change," she said. "If the goal is change, we need to extend grace and, yes, we acknowledge the elephant in the room, but we also need to be who we are and be that respectfully.

"(COAB) could potentially be a wonderful model for what we do as a country moving forward…and it would continue to hold people accountable even when the leadership changes so people don't forget or destroy the process because of politics or other motivations," Moreland-Capuia added.

When asked why she believes it's important to be involved in local matters related to medicine, public health and education, she noted that physicians are multidimensional and it "widens the bench" to have medical professionals involved in all types of policy work.

"One thing that's really important to me is having balance. I'm a better physician, person, mother and wife when I'm involved in the community. It inspires me to do the work," she said.

A key part of her life's balance involves the Capuia Foundation, which she co-founded with her husband, Daniel Capuia, whose family is from Angola. They lost nearly everything during Angola's civil war and lived in a refugee camp for more than 10 years. The United Church of Christ sponsored the family to come to Portland in 1990; Daniel and Alisha met during high school and married while she was in medical school. When the civil war ended, Daniel's father was invited to return to Angola as an advisor on how to rebuild its infrastructure. Daniel and Alisha co-founded the Capuia Foundation to help in these efforts, with a focus on improving economic conditions through health care, education and agriculture.

The family used its own money and gathered donations, including from OHSU, to build, staff and supply a health clinic in Angola that took nearly a decade to develop. Daniel, Alisha and their three children, ages 16, 11 and 7, visit twice a year. Moreland-Capuia works in the clinic and sees about 200 patients for free each time. Her services range from giving shots, drawing blood and using a hand-powered centrifuge to performing breast exams and any other services that would be provided by a primary care clinic.

"People walk for hours to get there and they can't come back next week, so we have to do things on-site and treat them right then. It has been amazing and all of it has been with the purpose of uniting a community that has only been out of war for 15 years," said Moreland-Capuia, who plans to return in August.

She shared the story of one family who walked more than 20 miles to the clinic, where Moreland-Capuia examined the family's sick son and, after testing, diagnosed and treated him for malaria. Three weeks after his visit, the boy was reported to be doing well.

"There are multiple stories like these that keep me motivated to do the work and continue to work to build a strong primary care infrastructure in Angola.

"The work is life changing. My children are kind, compassionate, giving and empathetic as a consequence of bearing witness to the level of 'give' in Africa," she noted. "We are only as good as we serve. I am a firm believer in serving the global community – our humanity depends on it."

Moreland-Capuia said her energy to accomplish so much personally and professionally stems from a single-minded focus on the task at hand. She shared her perspective on owning one's power during the Strength Through Stories conference held at OHSU in December.

"People think about power in terms of dictating and people don't want to talk about it but everybody wants it. Power comes from inside and looks different for everyone. It becomes less about how we wield our power and more about using it to overcome and share it," she said. "True equity comes when all the power structures that have been in place since the founding of our country become less about having power over others and more about sharing it." ■


**Alisha Moreland-Capuia (fourth from left) and her husband, Daniel (far left), co-founded the Capuia Foundation with Estevao Capuia (second from right) and established a health clinic in Angola. During their visits, Moreland-Capuia works in the clinic and sees about 200 patients for free each time. Her services range from giving shots, drawing blood and using a hand-powered centrifuge to performing breast exams and any other services that would be provided by a primary care clinic.**

*Photo courtesy of Alisha Moreland-Capuia*

**OPIOIDS IN OREGON,** *from page 4*

elements (trauma history, mood disorders, social and economic factors, level of fitness and daily activity, metabolism of medications) and that treatment shouldn't be based solely on a medication. It's certainly hard to see your patient suffer, but our training teaches us how to sit with patients as they navigate these situations, and to help steer them toward pain treatment that is in the interest of long-term health and well-being.

These conversations aren't always easy to have, so employers should support physicians in having them. This means having good alternatives a patient can access, and a system designed to make it easy for physicians to effectively treat pain without solely relying on opioids. This is the type of work that the Kaiser opioid oversight committee has done, and the results have been positive for the organization and for the members it serves.

***What, in your view, is the physician's role in combating the opioid epidemic, and how can a physician's employer help support this role.***

**KERFOOT:** The physician needs to manage pain as something to be mitigated to the point that a patient can function, while setting expectations that pain free isn't always realistic or safe. Opioids should be a last resort (not first-line), and should be used in the smallest quantity for the very shortest period of time. For most acute injuries, that's a few days. Pain may persist beyond that, but non-opioid strategies need to take precedence.

The physician also needs to help destigmatize addiction. This means recognizing it (screening for it) and speaking up when a patient appears to be developing a problem. It also means bringing in a multidisciplinary team to treat all aspects of the illness. Like other chronic illnesses, relapses (like a flare-up) may be expected, and it should be managed without judgement, but also while expecting accountability. ■

**ELDER CARE,** *from page 7*

see your patients most or all of the time in the community. You will probably be challenged to work frequently with teams beyond home health to care for high-risk populations.

***To what degree have your patients embraced health monitoring devices, and in what instances have those devices helped them and helped you as a practitioner in caring for them? Do you have advice about the use of these devices, or instances where caution should be taken?***

**JACKSON:** I have seen some real success with the congestive heart failure and atrial fibrillation applications that interface with heart failure/home health teams. Many of my patients have a smart watch or iPad where they track vital signs, or blood glucose values, effectively. I love the diabetes disease management program at Providence where our PharmDs download blood glucose values from the patient and then make recommendations and place those recommendations in the chart.

My truth as a geriatrician (definition: curmudgeonly luddite) for mostly frail, homebound patients is that a paper diary of a patient's bowel habits, urinary incontinence patterns, behavioral concerns, pain and other symptom record is like gold. I can truly say that a good caregiver with a seven-day diary about the patient's complaints and PRN medication use is more valuable in my practice than any device.

***What are some health issues you'd like general practitioners to be aware of when they are treating older patients?***

**JACKSON:** I thought I would give an update about what I'm seeing in the community regarding different types of facilities and their general cost, and ability to care for patients with functional deficits.

An independent living facility (ILF), also known as senior housing, typically provides one or two meals per day, light housekeeping and some transportation to clinics and non-medical events. Otherwise, patients manage medications, some cooking and grocery shopping, and scheduling independently. There are agency nurses and caregivers who can be hired for additional cost at these facilities to help with medications. Typically, this level of care would not be appropriate for a person with memory impairment, or in need of ADL (activities of daily living) support, unless they can hire privately additional caregivers to support them in their apartment.

An assisted living facility (ALF) is designed to help mostly with instrumental activities of daily living such as cooking, cleaning, medication administration, appointment coordination and transportation. They often can offer some personal care assistance such as bathing and, at times, dressing. Many assisted living facilities have hair salons, and some have regular foot care and RN appointment days. Assisted living also typically has an attached clinic where, at the minimum, there are nursing hours, and some now have a provider (often PA/NP) who will be available to the residents of that community for clinic visits. Assisted living facilities range from bare bones studio apartments to having more than one restaurant with several beers on tap within the building. The cost varies widely but ranges, at minimum, from $3,000 to $7,000 per month. There are requirements for the PCP to sign medication list and treatment plan orders intermittently, usually done by fax to your office. This level of care is typically not sufficient for a person who is unable to transfer out of bed or out of a wheelchair independently, or who needs a specialized diet with feeding support or dementia-related behaviors such as wandering or agitation.

Memory care units (MCU) are often locked wings of either assisted living facilities or long-term care centers. These are basically enhanced assisted living facilities with a secure environment. Often the caregivers assist patients with modified diets, specific behavioral plans, and have additional training on managing common behaviors associated with dementia. These are more expensive, with $5,000 to $8,000 a month being the norm. They have requirements for medication list/treatment plan orders as well, again typically faxed to your office. Many memory care units have the goal of caring for a patient through the end of life, and commonly work with hospice as a patient becomes bedbound.

Adult care homes (ACH) are owned and operated typically by an individual or family who cares for three to five residents in the home. Most commonly, a patient has their own room and bathroom, although there are shared rooms and bathrooms as well. The care homes are licensed by the state, and some are so specialized they care for patients on ventilators.

The most common scenario is for patients in these homes to require significant IADL (instrumental activity of daily living) assistance, and often adult care homes do use mechanical lifts to transfer patients. They administer medications and keep track of medications administered through a MAR (medication administration record). They are instructed on caregiving tasks such as simple wound care and insulin administration by a visiting nurse. The cost varies widely depending on the intensity of services given, but commonly run $4,000 to $7,000 per month in the Portland area. The patients in an adult care home have access to a caregiver 24 hours a day.

There are also communities called CCRCs (continuing care retirement communities) which have either floors or buildings with the range of services on the same campus, going from independent to assisted living, memory care or rehab services. The idea is that patients can move between the levels of care without having to move out of the community.

All of the above facilities work commonly with home health partners coming and going into these facilities to provide care. Skilled nursing facilities and long-term care facilities look about the same to me as they did 10 years ago. ■

## *Online extra! Don't miss this article!*

MSMP MEMBER EXCLUSIVE

JOE ROBERTSON, MD, MBA

Progress through collaboration. That key theme emerged from a recent Q&A with **Joe Robertson, MD, MBA**, Oregon Health & Science University's president for the past 11 years. Robertson, who announced last fall his intention to retire to focus on his health and family, took time recently to share his thoughts on, among other things, accomplishments during his tenure and his plans in the next phase of his career – including a brief sabbatical to freshen his skills in ophthalmic ultrasonography and to advance international relationships that OHSU initiated in the last 10 years.

**To read the Q&A with Robertson, please visit *www.MSMP.org/MembersOnly*.**

## Groups praise passage of Measure 101

The Oregon Association of Hospitals and Health Systems, a key supporter of the Yes for Healthcare coalition that advocated for Measure 101, said that the measure's passage in late January was a "critical affirmation of our collective belief that Oregon is better off with a robust Medicaid program that tends to the needs of patients before, during and after an illness or the birth of a child."

The association's statement, from President and CEO **Andy Davidson**, went on to say that the public's support of the measure "is a recognition that our vulnerable friends and neighbors need access to the lifesaving services that our entire health care system provides. We are proud to have been an integral partner in fighting for these patients and their families."

Hospitals, which the association noted have long advocated for the Oregon Health Plan, will in coming months work with legislative leaders, Gov. Kate Brown and other stakeholders to craft additional, long-term, sustainable funding to ensure the health plan's stability, the association noted. The group represents Oregon's 62 community hospitals.

The Oregon Medical Association also advocated on behalf on the measure and, on its Facebook page, noted that "it can't overstate the importance of each and every vote, not to mention the volunteers who canvassed and called, the legislators who championed and, especially, our physician and physician assistant Oregon Medical Association members who advocated."

It also issued a thank you to voters for "protecting health care access for the most vulnerable Oregonians." ■

## Entities agree to form state's first ACO for children

The 125 pediatric providers of the Children's Health Alliance are organizing with Providence Children's Health and Providence Health & Services to form a pediatric accountable care organization, an Oregon first.

The ACO will provide care for more than 13,000 children in greater Portland whose Medicaid coverage was formerly managed through the FamilyCare Health Coordinated Care Organization, according to a news release.

"The ACO is not only the first in Oregon that focuses exclusively on children – it's one of only a few in the nation," said **Deborah Rumsey**, executive director of Children's Health Alliance. "The goal of the ACO is to build upon high-quality, comprehensive care to achieve more cohesive and streamlined health services."

"We believe this will ensure children, including those with complex care needs, receive comprehensive health services," said **Resa Bradeen, MD**, senior medical director with Providence Children's Health. "The ACO will look to achieve optimal management of their long-term health."

Providence Health & Services serves more than 150,000 Oregon children each year through its clinics, hospitals and health plans. Providence also provides health care coverage for children on Medicaid through Providence Health Plan. The Children's Health Alliance's 22 pediatric practice sites care for more than 140,000 children in the Portland, Salem and Vancouver, Wash., areas. ■

## Study: Flu increases heart attack risk

Chances of a heart attack are increased six-fold during the first seven days after detection of a laboratory-confirmed influenza infection, according to a new study.

Researchers at the Institute for Clinical Evaluative Sciences and Public Health Ontario in Canada found a significant association between acute respiratory infections, particularly influenza, and acute myocardial infarction. The study was published in late January in the *New England Journal of Medicine*.

The risk may be higher for older adults, patients with influenza B infections and patients experiencing their first heart attack. The researchers also found elevated risk, albeit not as high as for influenza, with infection from other respiratory viruses.

"Our findings, combined with previous evidence that influenza vaccination reduces cardiovascular events and mortality, support international guidelines that advocate for influenza immunization in those at high risk of heart attacks," said **Dr. Jeff Kwong**, a scientist at the institute and Public Health Ontario who was lead study author.

The researchers looked at nearly 20,000 Ontario adult cases of laboratory-confirmed influenza infection from 2009 to 2014 and identified 332 patients who were hospitalized for a heart attack within one year of their diagnosis. ■

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