MEDICAL SOCIETY OF METROPOLITAN PORTLAND

The Scribe

A publication of the Medical Society of Metropolitan Portland

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Study: Utilization remains lower in Oregon, but prices higher

By Cliff Collins
For The Scribe

Oregon may be known for its progressiveness in health care, but a new report shows it in a less-flattering light in total costs of care.

Compared with Utah, Colorado, Minnesota and Maryland, Oregon ranked right in the middle of the five states as average for total cost. The study found that prices in the Beaver State in 2015 were higher than the average for comparable populations, but that the state recorded lower use of resources, referred to as utilization. This places Oregon as neither above nor below the average, with the price and utilization components offsetting each other.

The newly released report, **"Healthcare Affordability: Untangling Cost Drivers,"** assesses Oregon's population covered by private health insurance, and thus it does not include people enrolled in Medicare or Medicaid. Like other recent studies, this one showed that health care costs vary widely among states. The considerable differences in the cost of health care in the five states examined are largely driven by local patterns of resource use and pricing, according to the report.

The biggest variation among the five states was for inpatient care. Hospital prices were 16 percent higher in Oregon and Colorado, compared with 12 percent below average in Maryland and 14 percent below average in Utah.

Increasing consolidation among Oregon providers — such as mergers and affiliations between health systems and expanded employment of physicians — and the large number of insurance carriers in Oregon's market may be relevant in placing Oregon only equal to the benchmark. In this report, the term "benchmark" refers to the average derived from comparing the five states.

"High prices could be attributed to the influential negotiating power between providers and health plans; areas with a high degree of provider consolidation, or with limited competition, often have higher prices," according to **HealthInsight Oregon**, which participated in the report produced by the Network for Regional Healthcare Improvement, a national nonprofit representing regional health improvement collaboratives.

The report noted that although total costs of care vary across regions, the reasons for that also vary. In some areas, costs are high due to physician practice patterns and utilization of services; in other regions, pricing is the principle driver of high costs. Reaching affordability requires addressing all aspects of cost.

"We have done a good job in Oregon in terms of utilization, but there are still opportunities to improve utilization," said **Mylia Christensen**, executive director of HealthInsight Oregon and **Oregon Health Care Quality Corp.** Using studies such as the current one shows provider variability, indicating that some physicians still administer too many antibiotics or X-rays, for example, she said.

"We've seen clinics and providers dig deep in the data and start making practice changes."

– Mylia Christensen, executive director of HealthInsight Oregon and Oregon Health Care Quality Corp.

MYLIA CHRISTENSEN

Keeping focused on all of the factors driving health care costs is important, Christensen said. Health care spending consumes one of every six dollars in the economy. "The price tag is not sustainable."

She added that the report offers reliable and actionable information on cost drivers that can enable health care stakeholders to make the changes needed to bring down the cost of care.

"We've seen clinics and providers dig deep in the data and start making practice changes," Christensen said. Health plans and hospitals are thinking about how the data could be used to support collaboration toward improvement. In addition, policymakers, consumers and purchasers have requested and encouraged public reporting of provider and clinic cost and quality data.

MEREDITH ROBERTS TOMASI, MPH

"There is tremendous interest in this benchmark report in Oregon. Legislators see it as an important source of information as they consider how to create a higher-value health care system for our state," said **Meredith Roberts Tomasi, MPH**, senior director of affordability and transparency for HealthInsight Oregon. "We're excited

*See **AFFORDABILITY STUDY,** page 10*

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.

MARY McCARTHY, MD

'Tireless' advocate for mental health care honored

When Henry Grass, MD, thought about who should receive a professional award named after him, **Mary McCarthy, MD**, immediately came to mind. The Oregon Psychiatric Physicians Association recently presented her with its Henry J. Grass Access Award for her "tireless and career-long efforts to expand quality mental health care in Oregon," said OPPA President Jonathan Betlinski, MD.

"Mary is someone who, when she sees a need, likes to step in and step up and do what she can to help meet that need. She has been that way for much of her career. I actually heard about Mary before I moved to Oregon," he said.

Among the many reasons the OPPA honored McCarthy, she has been an active voice in several professional associations, including serving on the MSMP Board of Trustees, as president of the OPPA and as a member of the Oregon Medical Association Executive Committee. She also has been active in public education efforts such as a campaign to educate people about Vitamin D and how to reduce Vitamin D deficiency.

McCarthy, who earned her medical degree with honors from Oregon Health & Science University in 1982 and completed her residency there, also is a member of the Oregon Wellness Program Executive Committee. The statewide coalition works to improve physicians' access to mental health counseling.

The OPPA also honored **Ajit Jetmalani, MD**, director of OHSU's Division of Child and Adolescent Psychiatry and a leader in establishing the Oregon Psychiatric Access Line for Kids (OPAL-K).

"He's a great person and I felt really privileged to be included in that with him," McCarthy said. "It was an honor to receive the award the first year it was named after Henry Grass." ■

The Scribe

May 2018 • Volume 36, No. 5

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

"Connecting Physicians in Community"

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The Scribe is published monthly by the Medical Society of Metropolitan Portland, 1221 SW Yamhill St., Suite 410, Portland, OR 97205.

The Scribe reaches further into our community

Last month, MSMP increased our readership by nearly 3,000 digital readers of *The Scribe* through distribution of our full-color digital flipbook, which was previously circulated to members only. Our end goal was to increase exposure for the positive work done by our members and exemplify their humanitarian efforts.

As a result, one community partner conveyed, "We see tremendous value in the opportunity to read what MSMP members are relating to and become even more invested in their storyline." This further emphasizes MSMP's mission with *"Connecting Physicians in Community."*

The Scribe is our flagship publication and is distributed monthly in both digital and print format to physicians and physician assistants throughout Multnomah, Clackamas and Washington counties. *The Scribe* features articles written by and about physicians and medical students, advancements in medicine and wellness, and also promotes upcoming MSMP events and educational opportunities.

Learn about opportunities to promote your business – download our Media Kit (*www.MSMP.org*) or contact *Sarah@MSMP.org* to learn more.

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

1 – 4 p.m., Wednesday, Sept. 12

1221 SW Yamhill St., Suite 410, Portland
MSMP Conference Room

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

OSHA annual training is required and 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

MSMP and MMFO combined Annual Report

Medical Society of Metropolitan Portland and Metropolitan Medical Foundation of Oregon are proud to share with you our very first combined Annual Report.

The 2017 calendar year was one of growth and optimism, and the pages of this report provide a mere snapshot of some of the outstanding accomplishments of our members and employees – and the impact of their work in health care, wellness and beyond. Only through your continued membership and support can we continue to enhance the value of membership.

Catch all of last year's highlights in our Annual Report at *www.MSMP.org/Annual-Report.*

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As a thank you for your continued support and membership, we are excited to share this invitation from adidas providing you access to the Employee Store to share in the employee discounts!

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'The physician must first listen'

Fourth-year medical students describe process of honing ethical, professional communication

By John Rumler
For The Scribe

As they prepare for their residencies, fourth-year medical students at Oregon Health & Science University are learning to improve their communication skills and enhance their proficiency in what OHSU describes as the ethical aspects of information sharing in emotional situations with patients and their families.

The curriculum, which includes videotaped interactions with professional actors as "standardized patients" and required reading of journal articles, patient narratives, case reports and other resources, culminates in an examination. *The Scribe* interviewed two students who have experienced this new learning, **Lucas Meuchel, PhD**, a 2018 MD candidate who will begin a residency in anesthesia and critical care medicine at OHSU this fall, and **Sophia Hayes**, also a 2018 MD candidate pursuing an internal medicine specialty.

Photo: Megan Thruston

Sophia Hayes

Photo: Lacey Meuchel

Lucas Meuchel, PhD

THE SCRIBE: What have you learned about the effectiveness of non-verbal communication skills such as eye contact, effective gestures, active listening skills and body language, as well as compassionate verbal communication that relates information in a way laypeople can understand?

HAYES: I lean heavily on the adage that "knowledge speaks while wisdom listens." I think this holds true particularly when communicating with patients. There is often a substantial difference between the information that a physician needs to make clinical decisions and the information that a patient needs to construct his or her illness narrative and to meaningfully engage in their medical care. To figure out that difference—and to tailor it to each patient—the physician must first listen. And not simply listen but do so in a way that conveys an appreciation for the unique suffering and experience of each patient.

MEUCHEL: Through this session and prior clinical skills exams designed by Dr. Sullivan, we've learned that active listening and open body language are critical to connecting with our patients. We are also taught to be mindful of the layperson's medical literacy and to match our communication appropriately. Compassionate verbal communication plays a significant role in establishing effective dialogue, and our instructors have focused on our being cognizant of all of these elements in patient-provider interactions.

What specific techniques or approaches from the coursework seem to be most effective in your experience?

HAYES: The techniques that I have found most useful are selecting an appropriate setting for difficult conversation so that there are ample privacy and time; eliciting the patient's/family's/loved one's understanding of the situation; clarifying the details of the situation without using medical jargon; and allowing for pauses in the conversation so that the patient can absorb the information.

MEUCHEL: Finding an appropriate setting for discussions with patients and families, delivering small amounts of information and checking frequently for understanding, allowing space and time for emotion, soliciting questions frequently, and providing contact information or connecting with additional resources.

What helps you to be focused, centered and poised as a communicator in the midst of difficult life events?

HAYES: I certainly don't feel centered and poised in the moment! For me the key, though, is to think about communication as storytelling. A good story only has the details that are absolutely necessary to move the plot forward. And, in the end, I try to remember that suffering is a messy thing, and that the conversations about illness and suffering rarely go according to plan. If I go in with a general sense of what I would like to convey, but let the patient drive the conversation forward, the end result is something much closer to "patient-centered" communication.

MEUCHEL: In terms of patient interactions, I think placing myself in the position of the patient and/or family member helps a lot. I try to narrow my focus onto that one single interaction and really be in the moment with them. We have learned frameworks for delivering information that are helpful in keeping the conversation focused.

Also, I keep in mind the significance of the encounter – often we are immersed in a patient's care, thinking through the data or procedure for the majority of our day, processing changes as they happen, whereas the patient or their family has mostly been waiting, building concern and stress. This one encounter is a collision of the objective and clinical data with their emotions and expectations, and this forces me to stop and focus on effective and efficient communication.

Beyond that, communicating with the members of the health care team is critical. Knowing that my colleagues are equally informed and taking care of our other patients enables better focus on the current encounter. In addition, having another provider facilitate the interaction can be invaluable, as they often have additional experience and can provide further reassurance.

Since communication is a lifelong skill, how do you plan to keep your skills at a high level, even in the midst of a busy, stress-filled day?

HAYES: The mentors I have learned the most from about effective communication are the ones who define communication broadly. Every interaction with a patient, no matter how brief, is an opportunity to build rapport, establish trust and convey empathy. I hope to remember that each

See **MEDICAL STUDENTS,** *page 10*

"It's helpful to have a framework to work with, but in the end, patients don't want canned conversations. They want and need their providers to lean in, sit in the discomfort and simply be humans."

– Sophia Hayes

Podiatrists offer tips for providers to prevent foot pain from standing on the job

By Melody Finnemore
For The Scribe

Providers work long hours, many of them while standing on the job. That can easily take a toll on feet, causing symptoms that include plantar fasciitis, tendinitis, venous insufficiency in the lower legs, stress fractures of the metatarsals, muscular pain of the feet, ankles and lower legs, and shoe-induced pain from underlying deformities such as bunions and hammertoes.

Several local podiatrists offered their tips for helping to prevent aches and pains providers often experience.

Janson Holm, DPM, FACFAS
Foot & Ankle Department at The Portland Clinic

Many foot and ankle problems can be avoided by simply staying flexible. The key muscle group to focus on is the triceps surae (gastrocmenius and soleus). Simple calf muscle stretches will minimize the pressures on the foot that can lead to plantar fasciitis and metatarsal stress fractures, as well as many of the types of tendinitis in the foot and ankle.

It is important to try to vary your activities throughout the day – intermittent breaks from standing and walking go a long way to reduce stress and fatigue on the foot and ankle. Choose shoes that provide support and stability over shoes that are made of soft materials for cushion.

For the days that you know you will be on your feet a lot, knee-high compression stockings will reduce fatigue and swelling, and protect the veins from developing insufficiency.

Derek McCammon, DPM, FACFAS
Advantage Orthopedic & Sports Medicine

Proper shoe choice cannot be emphasized enough. The need for proper length, width and toe box depth is paramount. The use of over-the-counter foot orthotics or custom orthotics frequently help alleviate many of these pains. I also frequently recommend knee-high compression socks for those of us standing in a dependent position for prolonged periods of time.

Clifford Mah, DPM
Cascade Foot & Ankle Specialists

Number one is Achilles (tendon) stretching and wearing good supportive shoes when you stand on concrete. If you stand a lot, non-medical-grade compression stockings can be helpful. The stretching part is probably the most important.

Daniel Byrd, DPM
Blue Mt. Foot Specialists and president of the Oregon Podiatric Medical Association

The top three items to prevent foot pain and problems are good shoes, good shoes, good shoes. Function over fashion is the most important rule. There are

*See **FOOT PAIN,** page 10*

Scribe Focus
Emergency Medicine

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. In June, we'll focus on Economics & Legal Issues.

ED preparedness helps ensure optimal patient care, staff support during flu season

This year's flu season not only caused suffering for many patients, but it also presented challenges for area health systems and their providers. ***Julie Watkins-Torry, MD,*** *medical director of Adventist Medical Center's emergency department, discussed with* The Scribe *how her department prepared for and managed the spike in care and the lessons learned that will be helpful during future health emergencies.*

The Scribe: How did Adventist prepare for this most recent flu season, and how did the severity of the season compare to previous flu seasons?

For all emergency departments, including Adventist Health Portland, flu season is an annual challenge to the emergency department resources given the increase in patient volume. Each year, we prepare in a few ways: 1) ensuring that our staff are as healthy as possible by supporting an annual influenza vaccine campaign for our provider teams. Staff that are unable to receive the vaccine are required to wear masks to protect themselves from acquiring influenza. 2) We reinforce hand hygiene principles and universal precautions to prevent the spread of infectious diseases. 3) We reinforce staff education regarding applying masks to patients who present with a cough and/or influenza-like symptoms. 4) We also do our best prior to the start of flu season to ensure that we are fully staffed in order to optimize our processes.

The severity of the flu season this year was the worst in 10 years in regards to the number of patients experiencing the flu, the severity of illness, as well as the morbidity/mortality. Influenza is particularly challenging for patients who have underlying medical problems which are often exacerbated by influenza, such as diabetes, pulmonary disease and heart disease.

In what ways did this flu season prompt Adventist to change or strengthen its protocols, or employ unique processes, when accepting and treating patients with the flu or other highly contagious conditions?

Our emergency department is fortunate to have optimized up-front processes that allow our patients to be evaluated in a timely manner and start their workup and care within the first 20 minutes of arrival. These existing processes that we utilize year-round enabled our department to weather the storm of flu season and continue to provide high-quality, expeditious care to all of our patients. We are proud to be able to say that our time-to-provider is the shortest in Portland and that is due to a concerted effort from our nursing and provider team working together to expedite their evaluation and care.

While we are fortunate to have 32 beds in which to see patients, our patient volume (135 to 165 patients per day) often exceeds this bed availability. We, therefore, have four dedicated rooms for "rapid medical evaluation," or RME. This provides a private space in which a provider and a patient can have an initial conversation about the patient's medical issues, have an exam performed and the provider is able to formulate an initial care plan. Thus, even in high-volume times, such as the 197-patient day during the height of flu season, patients are able to be seen, have their labs and imaging studies ordered, and be given an initial dose of medication to treat their symptoms, such as treatment for pain, fever or nausea.

If we did not have this system to expedite care, our patients at times would have to wait three to six hours to be seen by a provider, have their workup started and receive relief with medications. This would not be safe care.

Because of our high volumes during flu season, we did see an increase in the amount of time patients waited in the waiting room between their initial evaluation by a provider and being roomed. This placed an increased strain on our nursing staff to be updating vitals and reassessing patients in the waiting rooms at appropriate intervals. Our nursing staff, therefore, implemented rounding in the waiting room on an as-needed basis.

What were the lessons learned from this experience, and how will they be applied to other situations?

There were many lessons learned.

1) Surge capacity planning – have processes in place and be ready at all times to implement them.

2) Influenza is a family affair: Our staff receive the flu vaccine, practice excellent hand hygiene and wear masks, but they are also exposed to influenza at home from their school-aged children and their family members, and are often tasked with being the caregivers for their children, spouses and loved ones should they fall ill with the flu. Thus, staffing shortages from "sick call" are not always avoidable even with the best planning.

3) During flu season providers must think harder and longer to tease out influenza from other medical issues. Influenza infection can co-exist with other medical problems, such as asthma or COPD exacerbation, diabetic ketoacidosis, heart failure and pneumonia. Influenza itself can cause severe life-threatening conditions, though usually does not. Also, a patient with influenza and sepsis present very similarly – fever, fast heart rate, signs of infection. Influenza usually requires symptomatic treatment and gets better on its own, while sepsis requires aggressive life-saving treatment.

4) Burnout is a known phenomena for health care providers, and the additional strain on providers during times of higher patient volume needs to be considered, addressed early and often, and a priority for leadership.

Essentially, flu season is tough on patients, and strains existing systems of care and the health care providers. At the same time, it strengthens our systems and processes by demanding process improvement to better accommodate patient volume surge.

The nature of living in a society with an aging population, and epidemics such as diabetes, heart disease, obesity, drug addiction, poverty and homelessness, means that the health care dollars to go around are being stretched more and more to provide care for sicker patients with fewer resources. Therefore, health care facilities are running on all cylinders with as few resources as possible. Flu season and other times of patient volume surge challenge such a system and require creative problem-solving to ensure optimal patient care while ensuring that our staff and providers are also supported, as we are often asking them to work harder and faster to ensure that patient care is not compromised. ■

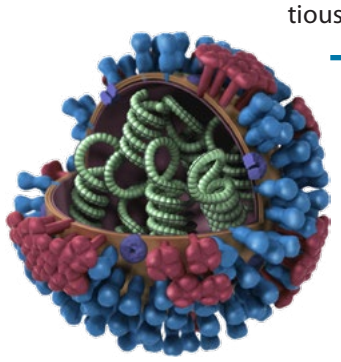

Image: CDC/Douglas Jordan. Illustrator: Dan Higgins

Flu season is tough on patients, and strains existing systems of care and the health care providers. **At the same time, it strengthens our systems and processes** by demanding process improvement to better accommodate patient volume surge.

Online extra! Don't miss this article!

Dan Bissell, MD, emergency medicine physician at Legacy Salmon Creek Medical Center and president and CEO of Northwest Acute Care Specialists, discusses the most recent flu season, the model Legacy EDs utilize to screen and treat patients with the flu, and the importance of regional cooperation in responding to surges of patients, regardless of the emergency.

To read this interview with Bissell, please visit *www.MSMP.org/MembersOnly*.

MSMP MEMBER EXCLUSIVE

Drug shortages among issues to be addressed by Oregon ACEP delegation

A delegation of **American College of Emergency Physicians Oregon chapter members** will head to Washington, D.C., later this month to lend their voices as the national organization advocates for and educates lawmakers about a trio of issues.

When the delegation attends the 2018 Leadership & Advocacy Conference May 20–23, its primary focus will be drug shortages. Emergency department drug shortages are on the rise, increasing by 435 percent between 2008 and 2014. Ninety percent of hospitals experienced drug shortages in the last half of 2010, and 80 percent said the shortages had resulted in a delay or cancellation of patient intervention, according to an ACEP news release.

A survey by the American Hospital Association found that nine in 10 anesthesiologists reported experiencing a shortage of at least one anesthesia drug. Two-thirds of hospitals surveyed had experienced a shortage of cancer drugs, 88 percent were short on pain medications and 95 percent experienced a shortage of anesthesia drugs for surgery.

The immediate cause of drug shortages can generally be traced to a manufacturer halting or slowing production to address quality problems, triggering a supply disruption. Other manufacturers have a limited ability to respond to supply disruptions due to constrained manufacturing capacity, the news release noted.

Although drug shortages have persisted, the U.S. Food and Drug Administration has prevented more potential shortages in the last two years by improving its responsiveness. ACEP praised recent legislation that allows the FDA to require that drug shortages be reported to it with at least six months notification. However, emergency physicians still bear the brunt of the problem.

"The doctors themselves don't have control over the price or the amount of drugs that are produced, but they face this backlash if they have to tell a patient or a patient's family, 'We don't have this drug,'" said Liz Mesberg, executive director of the Oregon ACEP chapter.

The second issue at hand is reauthorization of the Pandemic and All Hazards Preparedness Act (PAHPA). Enacted in December 2006, the act amended the Public Health Service Act to establish an Assistant Secretary for Preparedness and Response within the Department of Health and Human Services; provided new authorities for several programs, including the advanced development and acquisitions of medical countermeasures; and called for the establishment of a quadrennial National Health Security Strategy. Congress temporarily reauthorized PAHPA last October.

"We have quite a lot of members who are involved in emergency preparedness so we are quite interested in that," Mesberg said.

Opioids are the third focus this year's Oregon delegation, which includes Mesberg and two resident delegates. ACEP is co-sponsoring two bills related to clinical policy on opioid prescribing.

Emergency department drug shortages are on the rise, **increasing by 435 percent** between 2008 and 2014.

"Oregon has made some progress in addressing the opioid epidemic, so we're in a good position to talk on the national level about how we've been able to accomplish some of the successes we've had," Mesberg said.

The delegation plans to meet with Sen. Jeff Merkley and Sen. Ron Wyden. A blizzard during last year's event hampered meetings, but the Oregon delegation had the opportunity to speak with Rep. Greg Walden for nearly two hours about issues related to opioids, she said. ■

Report: Oregon above national average for health security

Oregon is above the national average for health security, with an overall health security level of 7.3 in 2017 compared to the national average of 7.1.

An annual assessment of the nation's day-to-day readiness for managing health emergencies improved significantly over the past five years, though deep regional differences remain. The Robert Wood Johnson Foundation has released the 2018 National Health Security Preparedness Index, which found the United States scored a 7.1 on a 10-point scale for preparedness, nearly a 3 percent improvement over the last year, and a nearly 11 percent improvement since the index began five years ago.

The index analyzes 140 measures – such as percentage of bridges that are in good or fair condition, number of pediatricians and flu vaccination rates – to calculate a composite score that the foundation said provides the most comprehensive picture of health security available. The scores indicate the ability to protect the health security of Americans from incidents such as newly emerging infectious diseases, growing antibiotic resistance, terrorism and extreme weather conditions at the state and national levels.

- Oregon's overall health security level reached 7.3 out of 10 in 2017, a 10.6 percent increase from 2013.
- Oregon's largest improvement occurred in the Environmental & Occupational Health domain, which increased by 34.5 percent between 2013–17.
- Health security levels in 2017 declined in no domains.
- Health security levels in 2017 significantly exceeded the national average in two domains: Community Planning & Engagement and Environmental & Occupational Health.
- Health security levels in 2017 were significantly below the national average in one domain: Countermeasure Management.
- The state's highest health security level in 2017 occurred in the domain of Incident & Information Management, with a value of 8.7.
- The state's lowest health security level in 2017 occurred in Healthcare Delivery, with a value of 5.2.

Originally developed by the CDC as a tool to drive dialogue to improve health security and preparedness, the index is a collaborative effort funded by RWJF involving more than 30 organizations. State health officials, emergency management experts, business leaders, nonprofits, researchers and others help shape the index. ■

For more information, please visit https://nhspi.org/states/oregon.

Paddling's powerful draw

Addiction medicine physician relishes treacherous whitewater runs

Stephen Cameron, MD, was first introduced to kayaking while watching the Olympics when he was 11. His interest grew into competitive kayaking. He's written a book about paddling technique, and he served as a coach for the Costa Rican Olympic team. *Photos courtesy of Stephen Cameron*

By Jon Bell
For The Scribe

Bored at his Portland home one day as an 11-year-old, **Stephen Cameron, MD**, turned on the television to take in some of the 1972 Summer Olympics in Munich, Germany.

What he saw was the Olympics' first-ever canoe/kayak slalom races, which found paddlers racing down a manmade whitewater course called the Augsburg Eiskanal, vying for gold. They raced through gates, much the way slalom skiers do.

"I was just strangely fascinated by it," Cameron said.

After a subsequent canoeing trip with his family and the Oregon Kayak & Canoe Club on an upper stretch of the Willamette River, Cameron was hooked. He became an avid kayaker, and by the 1980s, Cameron was a serious racer. He made the U.S. Whitewater Slalom Team and would have been on the Olympic team in 1984 had the event been offered in the games, but it wasn't.

And 13 years after he'd first caught the Olympic kayak slalom in Germany on TV, Cameron himself was paddling a kayak down the Augsburg Eiskanal, an artificial whitewater river, in the 1985 ICF Canoe Slalom World Championships.

Along the way, Cameron also worked as a private river guide in places such as Chile and New Zealand. He competed in the World Cup twice, wrote a paddling technique book called "Performance Kayaking" that came out in 1990 and remained in print for 20 years, and he coached the Costa Rican sprint and slalom team for the 1992 Olympics.

"We didn't do great," Cameron said, "but we didn't really expect to."

But kayaking can be a tough go as a career, even if you're filling in the gaps with stints as a river guide. Cameron was also winding down his undergraduate studies, heading toward a degree in biology and psychology from Hampshire College in Massachusetts in 1987.

"It was a lifestyle that was exciting," Cameron said of his boating exploits, "but it's not sustainable. I kind of came to a crisis and needed to figure out what I was going to do."

'An unspoken trust'

The son and grandson of doctors – his father was a psychiatrist and his grandfather helped start what is now the Legacy Devers Eye Institute – Cameron decided to follow in their footsteps. He graduated from the University of Washington School of Medicine in 1992 and started working early on in primary care and urgent care. But while working for a stint in Juneau, Alaska, he was asked if he wanted to pick up a few extra shifts in addiction medicine. He did, and he ended up enjoying it. Addiction medicine has been his specialty ever since. Today, Cameron is with Ascension Medical Group, a recovery-focused practice in North Portland. (The clinic's name was officially changed to AMG at the beginning of May.)

"I think people come in actually wanting to get better," he said about his enjoyment of the practice. "Even if they are squirrelly when they come in, they come in with reasons to get better, which is not often the case in primary care. Modern medicine is really a lot about compensating for people's poor lifestyles. With addiction medicine, it's people generally wanting to get better."

Cameron said new medications are improving the field of addiction medicine – opiate blockers like naltrexone, for one – but there's also been a shifting mindset in the field that has helped advance it, as well.

"We are getting away from the idea of addiction as moral failing and more toward seeing it as a disease," he said. "It certainly behaves like one."

As for his kayaking passion, Cameron, now 57, is still getting after it hard. He tries to get out at least three times a week, often to classic nearby whitewater spot like Canyon Creek north of Amboy, Washington, and out in the Columbia Gorge at Wind River or the Little White Salmon River. And these are not calm paddles at sunset, but challenging, churning runs with class 4 and 5 rapids. The Little White Salmon itself is renowned worldwide for its pristine waters and formidable drops of 20 to 30 feet. Only the most experienced kayakers take on the Little White Salmon.

Cameron said he's had some scary times out on rivers, including the Little White Salmon. During one trip, an expert paddler in front of him, Jenna Watson, capsized after a plunge down a waterfall and got trapped underwater. Another kayaker pulled her out, and Cameron and others tried to resuscitate her to no avail.

"I take it really seriously," he said. "It's still scary to me."

Even so, Cameron said he loves being out in nature and the physicality that's required of kayaking at the level he does it. He also, in a way, likes the rush.

"I do like the adrenaline and the danger factor," he said. "I'm normally very conservative, but I like the focus that the adrenaline gives you. Your problems just go away and it's just the issue at hand."

There's also a deep level of trust and camaraderie that develops between fellow whitewater kayakers. Cameron said you're often required to trust that the information another paddler gives you about an upcoming rapid or stretch of water is completely reliable. Without being able to scout a passage yourself, you have no other choice.

"There's an unspoken trust," he said. "It's almost taken for granted, but it isn't. You're totally trusting, and it just works out."

Having paddled all over the world, in places such as Honduras, Mexico, Chile, Ecuador, Taiwan and across Europe, Cameron said there's not a dream trip or river that is really calling to him. There are a few rivers and creeks down near Eugene – Brice Creek and Quartzville Creek, for example – that he'd like to dabble in, and he's got a multiday trip coming on the Jarbidge and Bruneau rivers in Southern Idaho.

And even though he's heading toward 60, Cameron plans to keep on paddling.

"It's a young man's sport," he said. "I'm typically with guys who are 20 or 30 years younger than me. I'm becoming the old man of the river, but I'm sort of an anomaly." ■

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LEGACY HEALTH

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MEDICAL STUDENTS, *from page 4*

of my patients, regardless of the gravity of their diagnosis, deserves to have their dignity and autonomy respected by the way I communicate with them.

MEUCHEL: Practice is key. As a student, I have tried to push myself into areas that I am unfamiliar with – observing residents and attending physicians obtaining consent for a procedure, going through a treatment plan with the team and then relaying it to the patient, and asking to call consulting services for the team. Gathering feedback immediately following these attempts has helped improve my communication skills significantly, and going forward into residency I plan to continue this process.

What differences did you notice in your own communication skills before, during and after the course?

HAYES: During one of my internal medicine rotations at OHSU, my team allowed me to disclose a terminal diagnosis to a patient's wife. Before the conversation, my attending physician asked me to talk through what I would say. After I had finished, she said, "That's fine, but when you enter the room, forget all of that and just let the patient's wife lead the conversation." That is a skill I continually work on to improve my communication skills. It's helpful to have a framework to work with, but in the end, patients don't want canned conversations. They want and need their providers to lean in, sit in the discomfort and simply be humans.

MEUCHEL: Prior to the course, I thought my communication technique was at least decent; however, during some of the encounters it was readily apparent that I was not effectively connecting with the standardized patients. I had to re-evaluate my approach and focus the encounter, falling back on the AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you) framework we've learned. Afterward, the difficulty in communication I experienced helps prompt reflection on how I need to approach each encounter afresh.

What were your takeaways from watching yourself on video?

HAYES: That I'll never be a movie star! In all seriousness, though, my main takeaway was that body language is as important as verbal language. I appeared somewhat stiff and reserved at times. I can get so focused on what I should say next that I forget to do the simple things like grab a box of tissues or put a hand on someone's shoulder. As awkward as it is to watch myself on video, it was helpful to see those moments where my body language could have been more natural and intentional.

> "I keep in mind the significance of the encounter – often we are immersed in a patient's care, thinking through the data or procedure for the majority of our day, processing changes as they happen, whereas the patient or their family has mostly been waiting, building concern and stress.
>
> **This one encounter is a collision of the objective and clinical data with their emotions and expectations, and this forces me to stop and focus on effective and efficient communication."**
>
> *– Lucas Meuchel, PhD*

MEUCHEL: You watch yourself make mistakes and there is a strong tendency to explain or qualify what you did, so you have to fight that urge and just focus on learning. It is interesting to see the standardized patient's response and how you reacted to it, things you didn't realize you were doing.

I became very aware that I was speaking rather quickly, and likely not leaving enough space in the conversation for the standardized patient to respond, so I am definitely going to work on slowing down and allowing time for the patient to react and ask questions before moving forward. Of course, the body language is readily apparent; you can't help but notice either how much or how little you gesture or your posture and how these things affect the dialogue. ■

FOOT PAIN, *from page 5*

good shoe stores available, where the staff are knowledgeable and frequently work with podiatry offices regarding foot problems. Therefore, they are familiar with different foot types and what shoes will be best for them.

Whether a person is looking for running shoes or dress/casual shoes, there are shoe stores that will provide good service and appropriate shoes without "up-selling" expensive devices, like insoles or arch supports. These types of devices may be necessary or needed, but even high-quality, over-the-counter arch supports will likely be under $60, and for anything more expensive or custom a person should have their feet examined to determine the exact need and hopefully avoid wasting money. ■

AFFORDABILITY STUDY, *from page 1*

about this."

Oregon also participated in the 2014 benchmark study, released in January 2017. In that earlier report, Oregon's use of health care resources also was lower than average when compared with data from five other regions; however, Oregon's prices were the highest of the five regions – 17 percent above average – resulting in an overall second-highest total cost of care, behind Minnesota. Comparing five regions, analysts found a $1,080 annual difference in the average amount insurers spent per enrollee.

The current report noted that despite considerable population changes in the five states, "year-over-year results were largely consistent. The lack of wide variation in year-over-year results signals stability in the methodology," according to the current report.

The new report broke down price, utilization and total cost by categories: inpatient, outpatient, professional and pharmacy. Cost comparisons were based on data using measures endorsed by the National Quality Forum. "Results showed variability in every category of care except pharmacy pricing, which is largely a result of the influence of a few, large pharmacy-benefit managers and pharmaceutical manufacturers' national pricing policies," according to the report.

HealthInsight Oregon partnered with local commercial health plans to share aggregated cost data with primary care clinics. HealthInsight Oregon also hosted a Cost of Care Steering Committee of 22 stakeholders, including representatives from health plans, providers, consumers and researchers, to guide Oregon's work.

With the publication of the report, the Network for Regional Healthcare Improvement now has two sets of regional cost comparisons. According to Roberts Tomasi, a third report is scheduled for release in fall 2018. Using a standard benchmark helps all stakeholders as they try to understand what factors are behind costs, Christensen said.

"For local medical groups and purchasers, the underlying primary care practice level reports can support individual improvement and the development of value-based payments and benefits," according to the report. "With this in mind, the project is working to expand data analysis to Medicare and Medicaid populations to give practices the most comprehensive view of their patient panels, with the potential to shed light on how costs vary across payers."

Roberts Tomasi pointed out that health care costs are crowding out other investments the community could be making.

"Without data to identify cost drivers, we can't identify the problems and make the changes needed to reduce costs," she said. "We feel it's imperative to have an informed conversation about cost of care and make meaningful information available to all stakeholders. We are proud to have participated in this work and continue to use this report to highlight areas where improvement can be made." ■

Legacy's new leader to join system in late June

Kathryn Correia, who has more than 20 years of experience working with large health systems, will become Legacy Health's next president and CEO in late June.

She served as CEO of HealthEast, a health system serving the east-metro area of Minneapolis, Minn., until 2017 when she led the organization's successful merger with Fairview Health Services, creating the largest health system in Minnesota. Correia then became Fairview Health Services' chief administrative officer, where she has played a key role in Fairview's overall integration, planning, advocacy and philanthropic efforts.

Correia's achievements include initiating the integration of electronic health records systemwide on-time and on-budget; creating the Community Health Network, a joint-venture accountable care organization with independent physicians that resulted in lower cost and higher quality care for patients; and developing the Neighborhood Health Initiative, an innovative model of community health integration that built neighborhood resiliency and increased access to mental health and fresh, local food.

She holds a bachelor's in English and literature from Denison University in Granville, Ohio; a master's of health administration from Ohio State University; and a certificate of health systems management from Harvard. She currently serves her community on several boards and has been recognized as one of the "100 Influential Minnesota Health Care Leaders, Recognizing Excellence" by Minnesota Physician; "100 People to Know" by Twin Cities Business Magazine; and "Top 35 Women Leaders in Health Care" by the Women's Health Leadership Trust; among others.

Correia will succeed **George Brown, MD**, who has served since 2008. ■

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