MEDICAL SOCIETY OF METROPOLITAN PORTLAND

The Scribe

A publication of the Medical Society of Metropolitan Portland

FOCUS ON

Elder care

OHSU expands aging-in-place research to retirement homes.

– Page 7

OFF HOURS

Rollin' along

Amanda Risser, MD, MPH, becomes "Rogue One" on the roller derby track.

– Page 10

INSIDE

Serving the Portland-area Medical Community Since 1884 www.MSMP.org February 2019

Health plan stability identified as key legislative goal

By Cliff Collins
For The Scribe

With the start of a new legislative session, health care interests are turning their attention to a biennial concern: full funding of the Oregon Health Plan.

Both organized medicine and the state's hospital association consider financial stability of Oregon's Medicaid program a top priority. This is especially true as the state's share of the cost begins to tick up slowly and the federal portion shrinks. For that and other reasons, the OHP faces a $933 million deficit heading into the 2019 session, according to the Oregon Health Authority.

The OHP's success so far is reflected in its dramatic progress in the number of Oregonians now covered by health insurance: 94 percent at the end of 2018.

Gov. Kate Brown has proposed several steps to make up the funding shortfall, noted **Courtni Dresser**, government relations director for the **Oregon Medical Association**. These include continuation of and an increase in the hospital assessment tax, and renewal and expansion of the current tax on insurance premiums. The governor also proposed a hike in the tax on tobacco, plus expanding that to include vaping products.

Photo: Zev Eccles

COURTNI DRESSER

Dresser said the OMA supports a cigarette and vaping tax increase. "We are excited to see that happen," because, if passed, it would accelerate the continued decline in the number of smokers and thus promote public health improvement, bring in more money for the OHP and, including with the addition of vaping products, help quell a new generation's adoption of vaping and becoming addicted to nicotine.

DAVE NORTHFIELD

Dave Northfield, director of communications for the **Oregon Association of Hospitals and Health Systems**, said fully funding the OHP also is a top priority for his organization this session.

"One thing that's a positive: In Oregon, there's broad agreement that that's a good thing for the state, given that we have 1 million," or about one-fourth of Oregon's population, now covered by it, thanks to Medicaid expansion. In addition, "The state's obligation to fund Medicaid has grown over time," he said. "That's where we are now: The federal portion of Medicaid funding is shrinking, by design."

Another key focus for the OMA is Senate Bill 139, on which OMA has been "proactively working for over a year with our coalition partners, including patients," Dresser said. The bill relates to utilization, and would impose restrictions and reporting requirements for utilization management of health services by commercial insurers, coordinated care organizations and the OHP.

The purpose, she said, is to increase transparency so that patients and providers clearly understand why an insurer denies coverage of a service when a prior authorization is requested by the provider.

In terms of expectations for the session, Dresser foresees continued scrutiny on drug pricing transparency, including a focus on the role of pharmacy benefit management in price increases.

The hospital association anticipates

*See **LEGISLATIVE SESSION,** page 11*

Oregon's 2019 Legislative Session

Jan. 22 to June 30

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*.

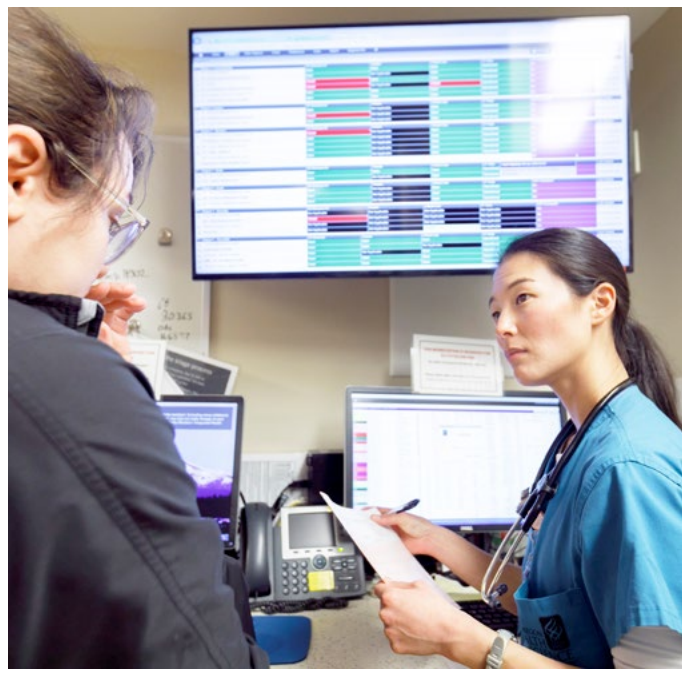
We welcome your feedback, and appreciate your readership.

Thank you.

Novel medical exchange

➢ Capt. Misha Ownbey, MD, an emergency medicine physician, works a shift in the Oregon Health & Science University Emergency Department as a participant in the Army Military Civilian Trauma Team Training. OHSU is one of only two U.S. hospitals participating in the program, also called AMCT3, which pairs 10 Army medical personnel with civilian trauma medical staff.

While military medical personnel are trained to provide complex battlefield trauma care to soldiers wherever the need arises, they sometimes spend years providing health care at traditional military hospitals. This new program allows these highly skilled physicians and nurses to maintain proficiency in trauma care while also keeping pace with their rapidly changing military and medical professions.



Photos courtesy of OHSU/Kristyna Wentz-Graff

➢ (Left to right) Trauma surgical critical care registered nurse Michelle McClenathan, Lt. Col. Nick Jaszczak, MD, and Samuel Ho, MD, confer during morning rounds in OHSU's ICU as part of the Army Military Civilian Trauma Team Training. ■

27 million

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The Scribe

February 2019 • Volume 37, No. 2

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

"Connecting Physicians in Community"

1221 SW Yamhill St., Suite 410
Portland, OR 97205
PH 503-222-9977 FAX 503-222-3164
www.MSMP.org

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

Student and Resident Event

Planning for Your Future as a Physician: Private Practice vs. Employed

6:30 p.m., Thursday, Feb. 21
Lucky Labrador Public House
7675 SW Capitol Highway, Portland

All you can eat pizza and salad buffet and one beer on us!

Students and residents: Listen and learn from our panel of practicing physicians who will discuss their experience in opening their own practice versus joining a well-established practice or health system. There will be an opportunity for Q&A following the discussion. Stay tuned for our special panelist announcement.

No cost to MSMP student and resident members. Not a member? Join us for free at *www.MSMP.org/Join-us*!

Registration is required at *www.MSMP.org/Events*. Families are also welcome.

Student Award nominations needed

The deadline for nominations is Feb. 27

MSMP is pleased to present our annual Student Award, paying tribute to a student who embodies our mission to create the best environment in which to care for patients. We are looking for a medical student or physician assistant 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* to complete a nomination form. Nominations must be submitted by Feb. 27.

MSMP's 135th Annual Meeting
6:30 – 8:30 p.m., Tuesday, May 7

LOCATION: **The Nines Hotel**
525 SW Morrison St., Portland

Join your colleagues for an evening of savoring food and spirits amidst the ambiance of live music during our **135th Annual Meeting** as we celebrate recent accomplishments and what to look forward to in the upcoming year.

Our featured discussion is entitled: *Innovations in Heart Health: High Tech to High Touch,* led by Jamie Beckerman, MD and Manish Mehta, MD.

REGISTER IS REQUIRED; PLEASE VISIT: www.MSMP.org/MSMPs-Annual-Meeting

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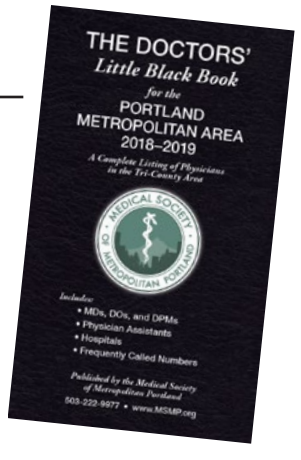
You can also explore our complete list of cost-saving advantages and exclusive group member benefits today at *www.MSMP.org/Group-Member-Benefits*.

Feature your services in *The Doctors' Little Black Book*



The Doctors' Little Black Book is one of the most unique publications for the health care industry in Portland, with a complete listing of all metro-area physicians and physician assistants including their specialties.

Our handy, pocket-sized guide also includes a list of hospitals and frequently called numbers, and is distributed to physicians and clinics in Clackamas, Multnomah and Washington counties. Advertising in the *Little Black Book* provides visibility and marketing to the medical community year-round.

FOR ADVERTISING RATES: www.MSMP.org/The-Doctors-Little-Black-Book

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Dr. John Barry transplanted his 2,500 kidney in an early December procedure for transplant patient Mary Gale.

Photo courtesy of Mary Gale

Career milestone

OHSU's John Barry, MD, drawn to medicine by personal experiences, surpasses 2,500 kidney transplants

By Barry Finnemore
For The Scribe

Two deeply personal experiences led **John Barry, MD**, to pursue a career in medicine, and kidney transplantation in particular.

Barry, an Oregon Health & Science University professor of urology and surgery who recently performed his 2,500th transplant operation on Marquam Hill, said he became interested in medicine because of a local general practitioner who cared for Barry's family when Barry was a child. Dr. Robert Page, always neatly dressed in the physician's white coat and a white shirt and tie, made house calls and helped Barry and his loved ones get better.

Page, Barry recalled, was intelligent, a terrific communicator and kind.

"I thought he was in a noble profession," Barry said in a recent interview.

The other experience occurred when Barry was a third-year medical student. He'd occasionally visit the medical ward at the University of Minnesota hospital. He'd pull patient charts and read them "like a novel," seeking to learn as much as he could. There he ran across a familiar name – a diabetic childhood playmate whom Barry hadn't seen in 15 years who, it turned out, needed a kidney transplant.

His friend died before he got the needed procedure, and is buried next to Barry's grandparents at Hillside Cemetery in St. Charles, Minn.

The experience, so profound Barry becomes emotional talking about it today, prompted Barry to focus his career on transplantation. "I saw a need," he said simply.

An OHSU faculty member since 1973, Barry has held numerous leadership roles on the hill, including as kidney transplantation director from 1976 to 2009 and leading the Division of Urology and Renal Transplantation from 1979 to 2008. He's also been president of the American Urological Association (AUA), the American Board of Urology, the American Association of Genitourinary Surgeons and the AUA's Western Section, among other organizations.

He's particularly energized by the collaborative nature of the specialty and by his many opportunities to give ailing patients a new lease on life.

Barry, born in the Mississippi River city of Winona, Minn., and raised in three small towns, was an accomplished football player in his youth, learned to surf in his 60s and continues to surf today, and was the oldest of two boys. His dad worked several jobs, including as an automobile dealership parts manager, auto mechanic, Chevrolet service manager, mail carrier and, after earning a college degree in his 50s, an auto mechanics instructor at a trade school. Barry's mom, in addition to working in the home, opened a shop that sold children's clothes and wares and, together with Barry's dad, worked at a gas station.

Barry, who also served in the Air Force, said his parents were children of the Great Depression who taught their own kids "to achieve so you are ready when opportunity presents itself."

A longtime member of the Medical Society of Metropolitan Portland, Barry took time in mid-January to share with *The Scribe* his thoughts on the transplantation field's evolution, a couple of his most challenging cases and what energizes him about his work.

The Scribe: After experiencing the loss of your childhood friend who needed the transplant, what were your thoughts at the time regarding the specialty?

Barry: Transplantation then was almost a primitive treatment. I became interested in it just as it was beginning to become a recognized and accepted therapy for end-stage renal disease.

My internship was at the State University of New York, which was six months of surgery – 36 hours on, 12 hours off – and six months of medicine, where I was on-call in the hospital every third night. It was very intense, but when I finished I felt like a doctor.

How has transplantation evolved and advanced since you first began practicing?

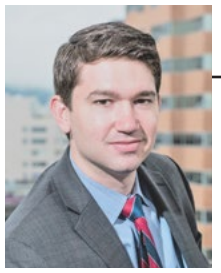
Barry: There've been technical changes in suture material and antibiotics; an acceptance of brain death as the death of an individual so organs can be removed and live on in someone else; the development of protocols to make the donation of kidneys safe; histocompatibility testing; the development of cross matches so immediate rejection does not occur; advances in immunosuppression, and improvements in kidney preservation so we can keep kidneys for a day or two before we transplant them.

Now, (the field) is an example of what a team effort in medicine can do for planning treatments and being certain that a treatment plan can be carried out. A transplant candidate now has the advantage of screening by transplant nurse coordinators, a half day of education, followed by a visit with a nutritionist, screening by a financial counselor, a visit with a social worker, a history and physical examination by a transplant nephrologist or transplant surgeon, and a medication review with a pharmacist. Patients also have to be cleared by a dentist because there cannot be infections in the mouth due to immunosuppression.

It's a great example of interdisciplinary medicine, practiced for decades in the field of organ transplantation. We've been doing it at OHSU since the late '60s, early

*See **JOHN BARRY, MD,** page 11*

Ensure compliance with Oregon Equal Pay Act



By Grant Engrav
For The Scribe

Major changes have been made to Oregon's pay equity laws that affect every medical clinic that employs one or more employees performing work in the state. The Oregon Equal Pay Act of 2017 (EPA), which took effect Jan. 1, 2019, seeks to prevent discriminatory hiring and compensation practices within Oregon workplaces. Although Oregon law already prohibited gender discrimination in the payment of wages (e.g., paying men more than women for comparable work), the EPA now specifically forbids employers from discrimination against employees in the payment of wages on the basis of other protected class categories in addition to gender.

Of the many changes the EPA makes, there are two main changes to highlight. First, the law prohibits a prospective employer from inquiring into the wage history of a prospective employee. Second, the law prohibits an employer from paying an employee a higher wage than other employees who belong to a protected class, which includes: race, color, religion, sex, sexual orientation, national origin, marital status, veteran status, disability or age. This means that you cannot pay married employees more than non-married employees for comparable work. Likewise, employees of one race cannot be paid more than an employee of a different race for comparable work, and so on and so on.

The only factors that can be considered when justifying disparate pay among an employee of a protected class and one who is not is as follows: a seniority system; a merit system; a system that measures earnings by quantity or quality of production, including piece-rate work; workplace locations; travel, if travel is necessary and regular for the employee; education; training; experience; or any combination of the factors described above if the combination accounts for the entire compensation differential.

The prohibition against inquiring into the wage history of a candidate is a significant change, particularly for medical offices that frequently employ highly compensated employees. Simply stated, it is no longer permissible for employers to ask what salary or wage an applicant earned at a previous employer. Even if a candidate volunteers their wage history during an interview, that information may not be used to decide whether or not that person will ultimately be hired. However, *after an offer has been extended to a candidate*, an employer may still permissibly request or seek confirmation of past wage history.

An employee alleging pay equity discrimination under the EPA will be able to file a complaint for getting paid differently based on their protected class with either the state Bureau of Labor and Industries (BOLI) or by lawsuit.

Amounts owed to employees due to unlawful wage disparities under the EPA are considered unpaid wages. It is important to note that the EPA applies to *all* compensation types including wages, salaries, bonuses, benefits, fringe benefits and equity-based compensation. Because the EPA applies to all compensation types, penalties for violations may be higher than an employer would otherwise expect depending on each employer's offered benefits and compensation schedule.

Violations of the EPA are penalized harshly and carry with them the potential for large losses via damage awards to Oregon plaintiffs. Penalties can include liability for unpaid wages, compensatory damages, punitive damages, attorneys' fees, injunctive relief and any other equitable relief a court may deem appropriate. Because the changes made in the EPA present a veritable "damages buffet" to would-be plaintiffs and their respective attorneys, Oregon employers can expect to be sued more frequently and should plan accordingly. One consideration to be aware of are the "safe harbor" protections built into the statute.

Moving forward

There are many components of Oregon's EPA and you should consult with an attorney to understand how they affect your specific business. However, here are a few action items and suggestions to consider:

- **Conduct a pay equity analysis.** Employers are advised to conduct a pay-equity analysis to assess and correct any wage disparities amongst employees who perform work of comparable character. By conducting a pay-equity analysis and fixing unlawful disparities where you find them, you may be able to take advantage of the safe harbor protections discussed above. If the analysis is performed with the

*See **OREGON EPA,** page 11*

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. In March, we'll focus on Pain Management.

Social interaction proves to be best medicine to prevent mental health issues among seniors

By Melody Finnemore
For The Scribe

Anxiety and depression affect up to 20 percent of seniors, with anxiety as the most common mental health problem for elderly women and the second most common for men after substance abuse, according to the national Geriatric Mental Health Foundation.

In a pair of issue briefs released by the Healthy Aging Program at the Centers for Disease Control and Prevention and the National Association of Chronic Disease Directors, an estimated 20 percent of people age 55 and older experience some kind of mental health concern. In addition to anxiety and depression, these include severe cognitive impairment and mood disorders such as bipolar disorder. Mental health issues often factor into cases of suicide, and older men have the highest suicide rate of any age group.

Depression in older adults can lead to impairments in physical, mental and social functioning and complicate the treatment of other chronic diseases. Older adults with depression visit the doctor and emergency rooms more often, use more medication, rack up the highest outpatient charges, and stay longer in the hospital, the CDC states.

In an interview with the National Alliance on Mental Illness, Dilip Jeste, MD, past president of the American Psychiatric Association, noted that over the next two decades the number of older adults diagnosed with anxiety, depression and other mental health issues is expected to increase as the Baby Boomers age. This will be, in part, because of the higher incidence of depression, anxiety and substance use disorders among people born after World War II than in those born earlier. Other reasons include decreasing social stigma, resulting in a larger proportion of older people being diagnosed with and treated for mental illness.

However, depression is not a normal part of growing older, the CDC states. While depressive disorders are a widely under-recognized condition and often


JULIE COHN, MD

are untreated or undertreated among older adults, in 80 percent of cases it is a treatable condition.

Julie Cohn, MD, a physician specialist in geropsychiatry with **Legacy Medical Group—Geriatrics**, said she sees an increasing trend of mental health issues within the aging population and has experienced firsthand that psychosocial interventions involving companionship are more effective than medications.

"Very often I'll make recommendations like going to the senior centers and other programs in the community that increase interaction, any kind of social group that may not be medical," she said.

Cohn said it's sometimes challenging for patients to do this because where they live may make it difficult to expand their social network. "Sometimes it's very hard for a patient if they don't have a car and may not be able to drive, or if they want to stay in their home and don't want to live in assisted living," she said, adding seniors may also have difficulty accessing certain places that do not accept their insurance.

Cohn said the geriatric specialists in her clinic and the patients' primary care physicians are collaborating more closely regarding patient care. The result is increased awareness about the connection between cognitive health and the need to screen for dementia, as well as addressing the process of adjusting to aging and the accompanying loss of independence.

"Most people tolerate aging very well, but depression is not screened for as well in older adults," Cohn said.

Recent studies have shown that tablets and other devices that allow seniors to video chat also are positive tools in reducing isolation and depression and helping them stay connected to friends and family. One study led by **Alan Teo, MD, MS**, an associate professor of psychiatry


ALAN TEO, MD, MS

at **Oregon Health & Science University** and a researcher at the **VA Portland Health Care System**, found that of four online communication technologies, video chat appeared to show the most promise in staving off depression among seniors.

Teo and his team of researchers compared video chat, email, social networks and instant messaging with people 60 and older and gauged their symptoms of depression based on survey responses two years later. The results were published in the *American Journal of Geriatric Psychiatry*.

"Video chat came out as the undisputed champion," Teo said in an article posted on OHSU's website. "Older adults who used video chat technology such as Skype had significantly lower risk of depression."

Data were obtained through the Health and Retirement Study supported by the National Institute on Aging of the National Institutes of Health. Since 1992, the nationwide study has surveyed seniors every two years. The researchers said video chat's appeal isn't necessarily surprising because it engages users in face-to-face interactions rather than having them passively scrolling through a Facebook feed, for example.

"I still maintain that (in-person) interaction is probably best of all," Teo said in the article. "However, if we're looking at the reality of modern American life, we need to consider these communication technologies. And when we do consider them and compare them, our findings indicate that I'm better off Skyping with my dad in Indiana than sending him a message on WhatsApp."

The study's co-authors are **Sheila Markwardt, MPH**, a staff biostatistician at OHSU, and Ladson Hinton, MD, professor and director of geriatric psychiatry at UC Davis Health. ■

Online extra! Don't miss this article!

MSMP MEMBER EXCLUSIVE

Joel Amundson, MD, enjoyed being a pediatrician in a large practice, but he felt like something was missing. He became intrigued by a micropractice model some of his friends and colleagues were doing where the physician is a solo practitioner. Amundson decided to launch a hybrid practice in which he and **Meredith Dunn, MD**, also a board-certified pediatrician, operate Dr. Joel's Clinic in Northeast Portland as an equal partnership.

Amundson shares his thoughts about the practice model, including its benefits and challenges, in this month's Members Only online feature at ***www.MSMP.org/MembersOnly.*** This is part of an occasional series.

OHSU expands aging-in-place research to retirement homes

By Cliff Collins
For The Scribe

Research being done at **Oregon Health & Science University** aims to apply OHSU-developed technology toward helping retirement community residents maintain independence.

The objective of a recent study funded by the National Institutes of Health was to determine whether providing care staff at retirement communities with digital objective data voluntarily collected about their residents could, over time, reduce the need for higher levels of care, said principal investigator **Jeffrey Kaye, MD**, professor of neurology and biomedical engineering and director of the **OHSU Layton Aging and Alzheimer's Disease Center**.

Called Ambient Independence Measures for Guiding Care Transitions, the study incorporated technology used in a separate, ongoing project at OHSU's **Oregon Center for Aging and Technology**, which runs both studies and for which Kaye also serves as director.

The center has spent more than a decade researching ways to allow aging in place, testing technologies that allow seniors to live independently for as long as possible and avoid having to go to nursing homes. In 2016, Kaye and colleagues at OHSU launched a multisite, nationwide study funded by the NIH and the Department of Veterans Affairs called Collaborative Aging Research Using Technology.

During the past four years, the OHSU center conducted the Ambient Independence Measures for Guiding Care Transitions study applying this same concept to work with retirement facilities. OHSU sought to provide administrators and staff with data from their residents gathered over time. The technology drew from "data collected using a platform we've developed over several years," Kaye said. "It allows us to place in homes devices measuring function and activities" of daily living as the resident moves about in different rooms.

The system employs an array of passive infrared sensors, each about the size of a doorbell, placed throughout a resident's living space to assess changes in walking speed, computer use, sleep, how often the resident leaves the unit, and overall activity; this can include a monitor in the resident's vehicle if he or she still drives. Included is an electronic pill box, as well as a scale capable of measuring and transmitting the person's weight, body fat and pulse, in addition to the room temperature.

The system compiles voluminous data that can help medical practitioners and caregivers track health and well-being.

Kaye said two sets of participants agreed to be involved in the project, which wrapped up last summer: residents in seven retirement communities in the Portland metropolitan area, and the staff in those facilities. Both had to consent to be part of the research. Residents in these centers all were living independently on their own. The idea was to help them continue to do that as long as possible, he said.

The results of the research were mixed. Enormous amounts of information were accumulated – three years of continuous data for each individual, with little if any dropout – so the project overall went well, Kaye said. An unexpected stumbling block, however, turned out to be the facilities' staff members: "The challenge was, staff at each facility didn't look at the data enough," he said. "They didn't use the data enough to" determine whether residents needed to make changes in their living situations in order to avoid a higher level of care.

At the study's conclusion, the OHSU team diplomatically interviewed staff members to discern the reasons for this lack of use. The salient points OHSU discovered from interviewing staff members were lack of time and the fact that surveilling data was not a designated part of workers' specific job descriptions.

"When we started this project, we met with staff, and they were very excited," Kaye said. "We had them tell us what the data dashboards should look like." But when the project actually got going, "their time and attention were reduced to little or nothing. It wasn't like a priority in their day-to-day jobs. They are trained to put out fires, to handle crises." Their attention was focused elsewhere than to the proactive measures that researchers hoped workers could put into practical use.

Nonetheless, when Kaye presented findings from the project at an Alzheimer's disease conference last July, "there was a lot of interest" from health care managers in having this type of data, according to Kaye. "It's hard to argue that having proactive data captured over time is not a great thing. But the reality of how that would exactly work hasn't been considered." The use of the data has to be "fully integrated" into the workaday world of residential facilities from the beginning in order for this to be effective, he said.

"The NIH and VA are still very interested in this area of research," but the only way to find out if it is successful in helping the growing aging population avoid preventable health problems and nursing home care is to continue to do research using these technologies, Kaye said.

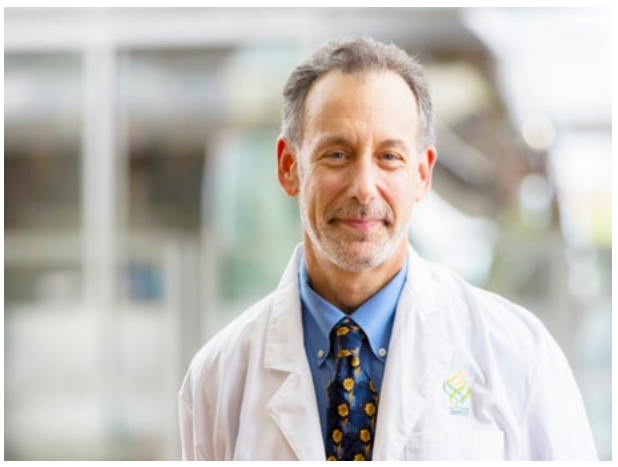
All the technology development for both projects has been performed at OHSU, although "much of it comes from components available elsewhere. It's designed to be accessible to the open-source community so researchers can build on it." He noted that this is important to the federal government, because "too much proprietary holding of data and methodology" takes place, he said. The fact that "people hold onto this" makes use of findings less successful than it could be. "An explicitly open-source platform allows people to more rapidly innovate using different sets of motion sensors."

Kaye and his OHSU center colleagues feel optimistic about the potential for improving peoples' lives. The continuing NIH-VA research in peoples' own homes is "now a major project across the U.S.," he said.

Its initial phase placed sensors and devices in 240 households, including low-income octogenarians in Portland, African-Americans and other minorities living in Chicago and Miami, and veterans living in rural areas of the Pacific Northwest. The hope is that when this demonstration project concludes in 2020, it will determine how to use data to help seniors stay as healthy as possible and remain independent. The eventual future intent is to expand to more than 10,000 homes.

Only in the last five years or so have people come to the realization that this sophisticated type of technology potentially can be used in the health care setting to optimize care, Kaye said.

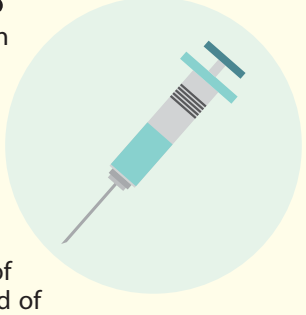
"There is so much to learn in this area," he said. Of the research he added: "We're very proud to have it in Oregon and at OHSU. It's become a whole new world, and we're very excited to be part of it." ■



"There is so much to learn in this area. We're very proud to have [this research] in Oregon and at OHSU. It's become a whole new world, and we're very excited to be part of it."

– Jeffrey Kaye, MD

Boost Oregon offers resources about vaccinations



The measles outbreak that has affected Clark County, Wash., and spilled into Oregon has put vaccinations back in the spotlight.

The nonprofit **Boost Oregon** provides a forum for parents to provide community-based education about vaccines to other parents. In addition, the organization trains physicians on effectively communicating with parents who are hesitant to vaccinate their children. Boost Oregon teaches providers the various reasons parents may hesitate to vaccinate their children and how to respond compassionately and effectively.

As reported in *The Scribe* in late 2018, the Metropolitan Medical Foundation of Oregon recently awarded a $2,000 Catalyst grant to Boost Oregon, whose board of directors and medical advisory board are made up of several pediatricians and other physicians. MMFO's grant funding supports several community workshops in Portland. The workshops are led by pediatricians and provide a safe space for parents to bring their concerns and questions about vaccines and get evidence-based answers.

Boost Oregon's website, *www.boostoregon.org*, offers several resources, including booklets for providers and their practices, and information about workshops and trainings. ■

Team physician Karl Kaluza's career focused on doing right by athletes

Karl Kaluza, DO, his wife and two young sons help the non-profit Night Strike's free medical clinic for homeless people under the Burnside Bridge. *Photos courtesy of Karl Kaluza*

By John Rumler
For The Scribe

At West Linn High School, **Karl Kaluza, DO**, loved taking care of his banged-up teammates and helping get them back into action as soon as possi-ble, even while he participated in five sports himself.

"I spent hours in the training room," he recalls. "I loved learning how to tape ankles and serving as an assistant trainer."

Today Kaluza, who specializes in non-surgical sports medicine and family medicine, is the official team physician for the Portland Trail Blazers. He's received numerous honors, including listings in *Best Doctors in Oregon* and *The Leading Physicians of the World*, and served as team physician for the Portland Timbers for six years before joining the Blazers.

"Professional sports was never a goal for me. I just wanted to be excellent at taking care of my patients," he says.

Chris Stackpole, PT, DPT, SCS, CSCS, the Blazers' former director of player health and performance, was on the screening committee when Kaluza first interviewed with the team in early 2016.

"Karl has an extremely unique skill set and such a well-rounded background," Stackpole says. "He's a genuinely caring person who relates very well with others." Stackpole, now with the Los Angeles Lakers, considers Kaluza a good friend and mentor.

Along the way, Kaluza, who also sees patients at Rebound Orthopedics & Neurosurgery in Lake Oswego, has provided care for professional athletes in hockey, roller derby, football, baseball, soccer, basketball, mixed martial arts, figure skating, running, track and field, and dancing.

Kaluza's father was a Navy ENT surgeon, and the family traveled extensively, moving to West Linn in 1995 from a military base in Millington, Tenn. At age 4, Kaluza wanted to be Spider-Man, but after that wore off, he wanted to be a doctor like his dad.

When Kaluza played lacrosse at the University of Puget Sound, he enthusiastically became the de facto team trainer. At the time of his graduation, there were few sports medicine fellowships, but when his wife, Amy, took her emergency medicine residency and fellowship at Michigan State, he was also accepted. After graduating, he stayed a year, teaching medical students and residents, and was named Primary Educator of the Year and also won the Outstanding Family Practice Award.

While his father was his biggest influence, Kaluza has benefited from too many mentors to mention, he says.

"I am not original or creative, so I am especially thankful that such fantastic physicians gave their time and knowledge to train me. I would not be half of the doctor that I am without them," he said. "I had a mentor make this very simple for me. You do the right thing for the athlete, every time, over and over. Sometimes that is forcing them to sit out against their will. Other times it is helping them play through some discomfort. Beyond doing the right thing for the athlete, I don't have a formula."

Kaluza's father wasn't big on advice, Kaluza says, but he took one of his suggestions to heart, and is very glad he did. "My dad told me to make an ally of the nurses and to listen to them because they would save me from, literally, grave mistakes," Kaluza says. "He was right. They've saved me more times than I can count."

Before serving as team physician for the Portland Timbers between 2010 and 2016, Kaluza provided primary care for Timbers and Portland Beavers' athletes alongside Sports Medicine Oregon. When the Timbers joined Major League Soccer, they offered him the position of team primary care physician.

Kaluza's two favorite experiences with the Timbers were working their raucous and much-anticipated inaugural home game upon joining MLS, and working the MLS All-Star Game.

As the host team provides medical care to both home and visiting teams in the MLS and NBA during the preseason and regular season, Kaluza attends all home games. He travels with the Blazers for international, summer league and post-season games.

While caring for athletes in various sports is more similar than different, Kaluza says, some injuries are more likely to occur in certain sports. "Runners get more lower extremity stress fractures, fighters get more concussions, everyone gets ankle sprains and experiences pre-competition anxiety to a degree." From an injury-risk standpoint, Kaluza thinks bull riding, motocross and cage fighting are the most dangerous.

His relationships with athletes are largely professional. He is more likely to form friendships with coaching and management staff, but he could not resist going to some Flint Generals hockey team parties. "Those are a very fun-loving group of guys."

At Blazers games, Kaluza is on high alert. "An athlete can collapse and die during competition or even practice," he says. "When I am working a game, it is definitely not a relaxing experience, as I may need to jump into critical life-saving mode at a second's notice."

Realizing that medications and surgery can be effective options, Kaluza's area of expertise is solving and preventing problems without either. "This allows me to serve patients in a way that is a bit unique compared to some of my peers."

Over the years, Kaluza has developed a referral network of about 25 specialists. Some are sports oriented, but the group also includes ophthalmologists, dentists and women's pelvic health care experts.

"Having a list of preferred specialists for almost everything imaginable is a benefit of serving in the same community for a long time."

Kaluza, his wife and two young sons also help the non-profit Night Strike's free medical clinic for homeless people. Located under the Burnside Bridge, it serves as many as 1,000 people a month, providing meals, blankets, clothing, haircuts, foot washing and prayer, in addition to medical services.

"The issue of homelessness in Portland is complex, worsening and sad," Kaluza says. "I encourage everyone to play a role, even if only offering a kind smile to our homeless."

Retired RN Janey Pinneo is Kaluza's neighbor and also knows him through church and mutual friends, and from volunteering at Night Strike.

"Karl is a kind, non-judgmental person who demonstrates unconditional love for the people he cares for," she says. "One evening I witnessed him taking his shoes off to give to one of his clients who needed better ones." ■

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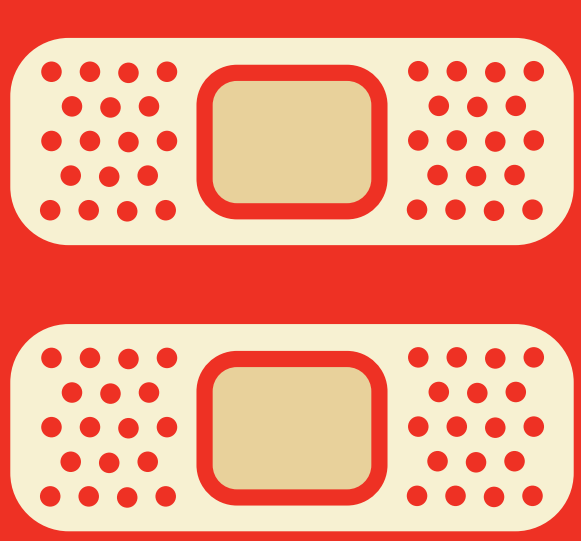

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Photo by Bill Zingraf

Amanda Risser, MD, MPH, (in the solid gold helmet) became a rough and tumble blocker on the High Rollers roller derby team after she and some friends from her residency class at OHSU went to watch a bout put on by the Rose City Rollers.

ROLLIN' ALONG

Amanda Risser, MD, MPH, becomes 'Rogue One' on the roller derby track

By Jon Bell
For The Scribe

By day she is **Amanda Risser, MD, MPH**, an assistant professor of family medicine and a physician who specializes in addiction medicine and maternity care at Oregon Health & Science University.

But by night – at least on some evenings between January and June – she is Rogue One, a rough and tumble blocker on the High Rollers roller derby team. It's a sport and an identity that Risser picked up about eight years ago after she and some friends from her residency class at OHSU went to watch a bout put on by the Rose City Rollers, the primary roller derby league in Portland.

"We went out as a group one night, a ladies' night kind of thing, and I was sitting next to a classmate who could tell how excited I was about watching it and how engaged I was in the game," Risser said. "She said, 'I don't see any reason why you can't do this yourself.' I thought it was so unattainable, but I also thought, 'What do you have to lose?'"

Since then, Risser has become a roller derby regular, competing and practicing with the High Rollers, spending two seasons with one of the Rose City Rollers' all-star traveling teams and even becoming coach of her daughter's roller derby team.

"One of the things I love about it is just the camaraderie of the team," Risser said. "I have a lot of significant and meaningful friendships with people on my team. I'm one of the older people on my team, but I have a lot of millennial friends, so I'm connected to a lot of different ideas. And all of the folks in it just have become part of my family and community."

Steeped in service work

Long before she was blocking for a jammer on the High Rollers – jammer is the term for the point-scorer in roller derby – Risser was a youthful roller skater growing up in Houston. The daughter of two doctors who did a fair amount of work with marginalized and underserved populations, Risser was all but predisposed for a life in medicine.

She left Texas after high school to study anthropology and Spanish at the University of California, Berkeley, and about two years in decided that she wanted to have a career in medicine. In addition to her upbringing – and a service trip to Latin America in high school – Risser had also been influenced by volunteer work she did for a free clinic at UC Berkeley.

"I think it was really satisfying to be engaged in research and work that bettered people's lives, like my mom did," she said. "That was something that I sought out – service-oriented work, since I had grown up steeped in that activity."

Risser went on to earn her MD from Stanford University in 2002, then did a residency at OHSU in family medicine and public health and preventative medicine in 2006. She's been at OHSU since then, practicing largely in areas related to addiction, including caring for babies of opiate-dependent mothers.

"Addiction is a disease that just has so many public health implications," Risser said. And, she added, it's only getting worse.

"I think we're certainly practicing in the midst of a public health crisis," she said.

Going 'Rogue'

Almost immediately upon testing the roller derby waters, Risser was hooked. She started at the beginner level but moved up quickly.

"I got really excited," she said, "and just took every opportunity to learn more and skate more."

Risser first competed in the Fresh Meat program, which is for competitive skaters looking to get drafted onto a team. A year after she started, in November 2012, the High Rollers drafted Risser, and she's been with them ever since. She also tried out for and landed a spot on the Rose City Rollers all-star B team, called Axles of Annihilation. The all-star teams – there is an A and B team – travel around the country and play other teams from all over.

The Rose City Rollers' A team, Wheels of Justice, actually won the World Flat Track Derby Association Championship in November, the third time the team has won the sport's highest honor.

When she was on the all-star team in 2016 and 2017, Risser said she was training about 12 hours a week – not an easy regimen to maintain alongside a family and a busy medical practice. She now is back with the High Rollers, who practice once a week and have a weekly bout. Her roller derby name, Rogue One, comes from Star Wars, though Risser said she and her son came up with it out of an obscure comic book, long before the 2016 movie of the same name came out.

In addition to the camaraderie and athleticism that roller derby have brought into her life, Risser said she truly enjoys the sport. As a blocker, it is her role to help the jammer score points, but the position has both defensive and offensive capabilities. Roller derby, she said, is exciting and complicated and takes a lot of strategic thinking and teamwork.

Risser said a highlight from her roller derby career thus far, aside from coaching her daughter's team and competing with the all-stars, was a season during which she was team captain. That year, the High Rollers went undefeated except for a single bout.

"The cool part was that we weren't the flashiest, we didn't have the most standout names," she said. "It wasn't about having the best skaters, but having the right skaters. It was that idea, like in that movie 'Miracle,' that if you turn toward teamwork and dedication to each other and to the sport you can really achieve awesome things."

At 44, Risser knows she's among the older players on her team, but she's undaunted by that. In fact, she's got her sights and hopes set on possibly returning to the all-star team once her kids are a little older.

"I loved being on the travel team, so that would be fun to try again," she said. "We'll have to wait and see if I can pull it off." ■

LEGISLATIVE SESSION, *from page 1*

continued emphasis by government-paid health care in moving away from fee-for-service and toward more value-based payments. Northfield said that if phase 1 of OHP emphasized expanded access, phase 2 will focus on payment reform, rewarding quality and outcomes rather than fee-for-service and quantity. Medicare has helped spur on this movement, offering financial incentives and penalties to encourage avoiding readmissions as part of this payment reform.

Within the hospital category known as the community benefit requirement, although he said there was no currently proposed legislation on the matter at the time of this writing, the association's goal is to create uniform financial assistance policies across the whole state, including charity care for patients earning under 200 percent of the poverty level.

According to Northfield, a statewide definition of community benefit was outlined in a law passed in 2007. He explained that before implementation of the Affordable Care Act, most of the obligation for community benefits – required of hospitals being granted non-profit status – came in the form of writing off care not paid for.

"But with the ACA, that number dropped dramatically," he said. "Now those uncompensated care numbers are starting to creep up again" due to lack of affordability, as insurers raise the amount of co-payments patients must kick in.

The majority of hospitals in the United States operate as non-profit organizations and, as such, are exempt from most federal, state and local taxes, according to an article in *Health Affairs*. This favored tax status is intended to be an acknowledgment of the "community benefit" provided by these institutions.

Congressional scrutiny from 2005 to 2009 culminated in the inclusion of new community benefit requirements in the ACA, the journal reported. These requirements were part of a strategy to address the ACA objectives of preventive care and population health through community health improvement activities.

In the category of behavioral health, including addiction-related treatment, the hospital association is backing a legislative concept to address solutions for emergency-department boarding. If it becomes a bill, it would support development of a task force and pilot project. The association also endorses creation of a statewide crisis support network, including a hotline. It is working with the organization Lines for Life to achieve this, and in which Lines for Life would be the organizer, he said. ■

CCO 2.0

The Oregon Health Authority is currently going through a process to select the coordinated care organizations, or CCOs, that will serve Oregon Health Plan members from 2020–2024.

OHA has released a draft request for applications, which lays out the requirements applicants must meet for the next five years of coordinated care contracts. At its Oct. 15 meeting, the Oregon Health Policy Board adopted final policy recommendations for improvements to the OHP, which the OHA has dubbed "CCO 2.0." (Please see the October 2018 *Scribe* cover story, available at *www.MSMP.org*, for details.)

Part of the board's recommendations were in the area of provider reimbursement. An expectation for CCO 2.0 is to continue moving away from fee-for-service payment to value-based payment. This entails that 20 percent of primary care payment be value-based in the first year of CCOs' new contracts, which launch in 2020, and 70 percent for all providers by the fifth year. The OHA will award new contracts June 2019, and they will take effect beginning Jan. 1, 2020.

Oregon's Medicaid waiver requires OHA to develop a plan describing how the state, CCOs and network providers will achieve an established value-based payment target by June 30, 2022. ■

OREGON EPA, *from page 5*

assistance of legal counsel, it will be protected by the attorney-client privilege.

- **Correct pay disparities.** If disparities exist, an employer should correct those disparities by increasing the pay of the affected employee unless the employer can show that the variance in pay is attributable to one or more of the "bona fide factors" that may be considered under the law. Please note: When correcting wage disparities between employees, employers are specifically prohibited from reducing any employee's pay in attempting to attain equity.
- **Update hiring materials.** Employers should update all pre-employment forms given to job applicants, interview questions, as well as any hiring instructions or communications given or made to third-party staffing agencies. All mentions of prior wage history should be removed.
- **Provide training to HR and hiring managers.** Employers should review the requirements of the EPA with all employees responsible for hiring and payment of employees to ensure compliance.
- **Post notices in every establishment where employees work.** Every employer is required to post a notice relating to the Oregon EPA in their business. A template is available from BOLI.

Grant Engrav is co-founder of Portland's Engrav Law Office. He can be reached at grant@engravlawoffice.com.

JOHN BARRY, MD, *from page 4*

'70s. It's like a football team: If the quarterback doesn't have 10 other players around him doing their job, it doesn't get done.

What inspires you in your work every day?

Barry: When you do a kidney transplant, you sew in the artery, sew in the veins and take off the vascular clamps, and this cold, gray, lifeless thing turns pink. You hook it into the bladder, and a person's life has changed. It's magic.

It happened again yesterday; I'm now up to 2,502 transplants.

Can you talk about a particularly challenging case, and your thoughts on it today?

Barry: There are two cases. One was in 1969, when I scrubbed on my first transplant as a resident at OHSU. I was second assistant. Dr. Russell Lawson was primary surgeon, and Dr. Walter Derrick was the chief resident. The patient was a boy getting his third transplant, this one from his mother. This one was successful. He lived on with normal renal function for many years. He was only 4 years old, and what made it challenging was his size and the fact that he was receiving an adult kidney. It was unusual for that time. That was transplant number 31 for OHSU's program, and number one for me. I don't recall it being anything other than amazing.

The other case was 15 or 20 years ago, and I was the only faculty surgeon available that day for the donor and recipient surgeries. I did the donor kidney removal first, flushed the kidney and put it on ice. Then we brought the recipient in; this was his third kidney transplant. We had to find a place in his body to put it. We decided we were going to put it high up in the abdomen, and we were going to sew it to the splenic artery. But in the time from his angiogram to the operation, the artery had clotted, so we took out his own kidney on the left side and sewed the kidney transplant in place. Because of the disease in his native renal artery, his kidney transplant artery clotted. We removed the kidney transplant, closed the first wound, repositioned him and put the transplant in the right side.

The transplanted kidney didn't work for three weeks, then it took off, and he had nearly normal renal function for several years until he died of heart disease. The reason I remember it was because the two surgeries took a total of 14 hours.

A piece about your milestone transplant and career, posted on OHSU's website, mentions notes you've received from and connections you've made with transplant patients through the years. What do those connections mean to you?

Barry: It means I'm doing the right thing for a career. It means that what I do is worthwhile.

It sounds like you have no plans to step away from medicine soon.

Barry: I set up criteria for that. My criteria are, number one, if I don't generate enough income to pay for my keep. Number two, if I don't meet standards of care – specifically mine – which are quite high. And number three, I don't interfere with the administration of the Department of Urology or the Division of Abdominal Organ Transplantation, because I've given up my administrative duties. I will give advice, if asked; otherwise, I keep my mouth shut. I don't want to be a "shadow boss" because it diminishes the role of the real boss.

And number four, if it's no longer magic for me. If any one of those happen, I'll quit. All good things have to come to an end sometime. ■

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