



The Scribe

A publication of the Medical Society of Metropolitan Portland

INFORMED CONSENT

Substance and signature

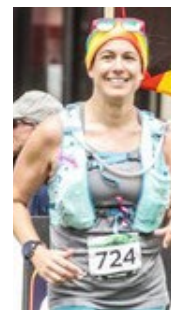


The Doctors Company outlines how an established physician-patient dialogue can prevent patient disappointment from ripening into a claim.

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OFF HOURS

Running for her life



Long-distance running, triathlons keep Lalena Yarris, MD, on her ideal path.

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August 2020

OHSU develops virtual ICU, coordinates with other hospitals to measure bed, ventilator capacity

By Cliff Collins
For The Scribe

If Oregon's intensive care units become inundated during the COVID-19 pandemic, the state's academic health care center is implementing new strategies to bolster hospitals' ICU teams.

Oregon Health & Science University had been planning to launch a virtual ICU effort and expand telehealth capabilities even before the new virus arrived, said **Marshall K. Lee, MD**, medical director for adult critical care telemedicine and assistant professor of anesthesiology and perioperative medicine.

But with initial projections in the spring that the COVID-19 outbreak might overwhelm ICU bed capacity in Oregon, OHSU moved to accelerate its work previously underway to implement a virtual ICU, he said. Now, all 90 ICU beds at OHSU Hospital, **Hillsboro Medical Center** (formerly Tuality Community Hospital) and **Adventist Health Portland** – both OHSU Health partner hospitals – are connected through audiovisual equipment and a comprehensive, secure

data platform, Lee said.

"We finished the proof of concept for our virtual ICU in late 2019. When the COVID-19 crisis hit, we knew we had to act quickly as the virtual model might be needed for hundreds of Oregonians," said **Joe E. Ness, MHA**, senior vice president and chief operating officer of OHSU Health.

The virtual ICU model employs either in-room or mobile audiovisual equipment. A team stationed at OHSU's Center for Health & Healing 2 on the South Waterfront can collaborate with the patient's care team to track patients' vital signs; view ventilator and key laboratory data; engage in two-way communication to round on patients; and assess patients, track progress and recommend treatments.

"What is really exciting about the VICU model is that it allows telemedicine providers to see data in real time and work jointly with the bedside team to optimize patient care," Lee said.

Intensivist physicians provide virtual ICU services during the night for Hillsboro and Adventist ICUs, as both hospitals have ICU physicians on-site during the day. In addition, the OHSU

team covers virtual ICU services day and night to a growing number of hospitals across the state, including **Columbia Memorial Hospital** in Astoria, **Santiam Hospital** in Stayton and **Bay Area Hospital** in Coos Bay.

OHSU worked with GE Healthcare in building a platform called Mural to develop the virtual ICU model, said **Christine Bartlett, MSN, NP**, OHSU director of adult critical care nursing. Mural helps clinicians identify changes in patient status and comprehend the patient's clinical picture in real time. Bedside monitors securely send patients' data, processed through proactive algorithms to help clinicians identify patients who are at risk for

deterioration, including patients who may be on extended mechanical ventilation support due to COVID-19.

Not surprisingly, one challenge to implementation is technological: Bartlett noted that hospitals use different models of equipment, including electronic medical records, all while trying to "integrate data feeds in real time." The goal is to be able to "see data uniformly," Lee said.

When ICU rooms being reserved for patients with COVID-19 went unused in the spring, OHSU took the opportunity to retrofit them with virtual ICU technology.

See **VIRTUAL ICU**, page 15

"The VICU gives us an additional ability to serve Oregonians by supporting local care teams and making collaborative decisions for the benefit of the patient. As we learn how our new normal looks with COVID-19, **leveraging technology to connect clinicians across our state has never been more important.**"

– **Matthias Merkel, MD, PhD**,
OHSU Health senior associate chief medical officer for capacity management and patient flow

FOCUS ON MEDICAL EDUCATION



Laura Byerly, MD, talks with a patient during a virtual visit. Oregon Health & Science University was among the health care organizations that markedly expanded telehealth amid the COVID-19 pandemic. In the medical education arena, the pandemic has created challenges and opportunities. Among the opportunities: the need for telehealth to be integrated as a competency taught to medical trainees, physicians who train residents say.

For more on the novel coronavirus' impact on medical education, please turn to the focus section, which starts on page 8.

Photo courtesy of OHSU/Kristyne Wentz-Graff

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MSMP Senior Physicians Group

TOPIC: Retirement Communities and Care Facilities

10–11:30 a.m., Friday, Sept. 25
(fourth Friday of the month)

Cost: Free for MSMP members and their spouses

If you are a **senior physician** member, we hope to see you at our next Zoom meeting!

If you are a senior physician member, we hope you will join us for our next meeting. Meetings are led by MSMP President Mary McCarthy, MD, and held on the fourth Friday of each month, live via Zoom Conference.

Though meeting topics are generally spontaneous and determined by those in attendance, for our September meeting, we will be discussing retirement communities and care facilities. We hope you can join us; spouses are also welcome!

TO REGISTER: www.MSMP.org/Events • Janine@MSMP.org



COVID-19 resources from the Oregon Medical Association

The Oregon Medical Association (OMA) has been tremendous about compiling up-to-date information to keep you informed on COVID-19 (novel coronavirus).

➔ Check out their resources page at www.theOMA.org

NEW WELLNESS LIBRARY CONTENT

"Physician Burnout, Interrupted"

With the COVID-19 pandemic, medicine is at a crisis point. Health care professionals are responding with an astounding display of selflessness, caring for patients despite the risk of profound personal harm.

Our efforts are recognized and applauded. During this interlude filled with uncertainty, there has been a sense of altruism and urgency that has unexpectedly catalyzed the restoration of some elements of autonomy, competency, and relatedness.

Indeed, the whole medical system, including hospital administrators and insurers, among others, has rallied to support the caregivers. *But will these positive changes be sustained?*



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Laura Byerly, MD, leads Virginia Garcia center through challenges, successes

By Melody Finnemore
For The Scribe

Laura Byerly, MD, credits her fifth-grade science teacher, Mr. Tyler, with igniting her interest in becoming a physician. “He did all kinds of neat science stuff with us. He had this plastic man and you could take all of his organs out. I thought that was really cool,” she says.

Byerly also liked her pediatricians and remembers telling her mom and dad she was going to be a doctor when she grew up. “I had no idea what I was talking about at the time, but I stuck to my guns.”

She moved to Oregon from Maryland in 1979 to go to Reed College and earned her bachelor’s degree in anthropology. She earned her medical degree in 1990 from Oregon Health & Science University School of Medicine, where she also did her family medicine residency.

“During medical school, I just decided I needed to go where a doctor was needed,” she said, adding she remembers seeing flyers from the National Health Service Corps that highlighted areas where physicians were in demand. “I didn’t even think about internationally because I could see plenty of places in the United States where they needed doctors. Virginia Garcia was always on that list.”

Byerly did one rotation at **Virginia Garcia Memorial Health Center** and another in Enterprise, Ore., before joining Virginia Garcia in 1994. She says her residency at OHSU and her family medicine practice at Virginia Garcia introduced her to caring for people who didn’t have insurance or Medicaid coverage and notes she has never had a “middle-class practice.”

“It’s been really fascinating to work with the Latino community, many of whom are immigrants who don’t have an understanding of modern medicine. I’ve had a delightful medical career in terms of the people I was serving and there were positive interactions most of the time,” says Byerly, who is certified by the American Board of Family Practice and also speaks Spanish and some French.

“In my practice, I particularly liked taking care of little kids. I also enjoyed

“Most of our patients are not political and are not thinking about the impacts of policies. They’re mostly just trying to figure out how to get by. Most migrant workers are thinking, ‘If I get this virus, am I going to be able to work?’”

—Laura Byerly, MD



when I was talking to people and you could see the light go on in their eyes when they understood, ‘This is what I need to do to take care of myself,’” she says.

Now medical director at Virginia Garcia Memorial Health Center, Byerly says she enjoys administrative tasks that have included advising colleagues on how to implement and use electronic health records in the most effective way possible.

“I really have become a data geek over the years and the electronic health records is a big part of that,” she says, noting it was more difficult to track performance with paper records compared to EHRs. “The data shows where we need to make improvements and where we’ve gotten results. That has been a really fun and unexpected part of my work that I never would have thought of when I first started.”

Byerly says she considers her biggest administrative responsibility as having the biggest impact for the most people and constantly defining how to provide better care for patients. She notes that Virginia Garcia Memorial Health Center was already implementing a metrics tracking process before coordinated care organizations were established, so its system was prepared when Medicaid began requiring that tracking.

“It’s been so wonderful to watch

us, once we started to get those data quality reports, make those improvements and it has really impacted our culture and morale,” she says. “The whole transformation has been really exciting.”

Social justice a priority

Virginia Garcia Memorial Health Center faced another transformation of sorts with the COVID-19 pandemic. Providers immediately moved to telephone visits when possible, but providers’ experiences have varied depending on where they are located within Virginia Garcia’s service areas. As an example, staff in its McMinnville clinic have had less exposure to patients testing positive for COVID-19 and, therefore, less anxiety than those in the Cornelius clinic, which has had the majority of positive cases.

“In the first part of the pandemic, people were clamoring for testing and we couldn’t get that going fast enough,” Byerly says. “Some within the Hispanic population wanted to get tested right away. That group is being hit harder and we know that is because more people are living in less space because of less expensive housing and they have jobs where you cannot separate and are an essential worker.”

Noting that the battle against social injustice has been a key priority

during her entire career, Byerly says addressing systemic racism and ensuring all of Virginia Garcia Memorial Health Center’s 55,000 patients receive high-quality care is essential, particularly during the pandemic.

“More of our population is testing positive and I’m going to push for more testing and tracking. All along we’ve been more liberal in who we would let get a test in order to find more cases and get people to be careful sooner in the process. It was an attempt to do something we had some control over,” she says.

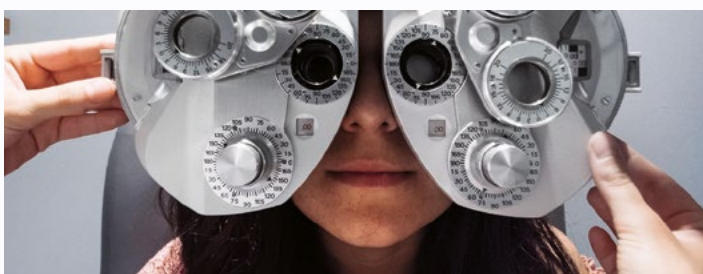
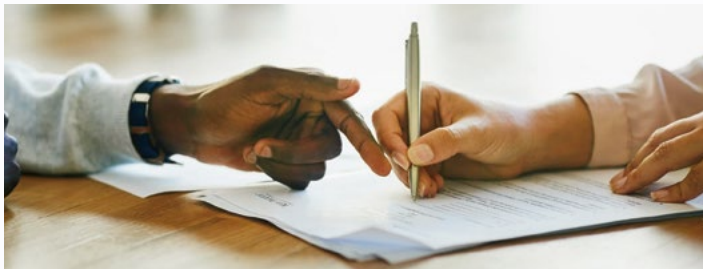
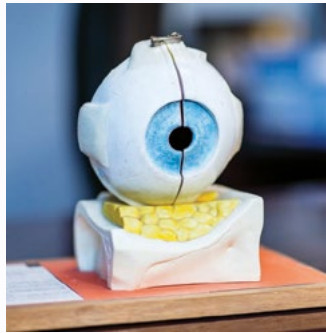
Virginia Garcia Memorial Health Center is partnering with Washington County to expand testing in the field to farmworkers and others who must continue working but don’t have the time or access to go to a health clinic.

“It’s discouraging that we aren’t further along in that path,” she says. “Most of our patients are not political and are not thinking about the impacts of policies. They’re mostly just trying to figure out how to get by. Most migrant workers are thinking, ‘If I get this virus, am I going to be able to work?’”

Outside of her job, Byerly relies on music for relaxation and fun. She enjoys playing the guitar and meeting with her marimba group (by Zoom these days). She also plays music and sings with her partner, Ken Ward. ■

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Informed consent

Substance and signature

By Robert Morton
The Doctors Company



For decades, consent documents have helped protect physicians against the claims of dissatisfied patients. Times have changed, however, and modern medicine requires a more complex and complete acknowledgment of both the patient's and the physician's rights and responsibilities to each other.

True informed consent is a process of managing a patient's expectations; it is not just a signature on a document. Achieving an accurate diagnosis requires the patient to provide accurate information to the physician. The physician must then provide sufficient information to the patient so that he or she can make a reasonable and informed decision regarding a comprehensive plan for medical or surgical treatment. This physician responsibility cannot be delegated.

A successful exchange of information between the doctor and the patient accomplishes two things. First, when the physician explains diagnoses, treatment alternatives, expected outcomes and potential risks to the patient, it demonstrates that the physician recognizes the patient's rights and will remain responsive to them. Second, it shifts the decision-making responsibility from the physician alone to a mutual responsibility of both physician and patient. At its best, informed consent should protect and inform the patient and the doctor.

Litigation often results from a discrepancy between the patient's expectations and the outcome of treatment. Informed consent cannot eliminate malpractice claims, but an established rapport between the patient and the physician based on robust exchanges of information can prevent patient disappointment from ripening into a claim.

Physician-patient dialogue

Avoid medical jargon when discussing diagnoses, treatment plans, risks

and expected outcomes with the patient. Define and explain medical words and concepts using simple pictures and analogies. If there are alternative treatment options, discuss them in detail. Also, outline the recovery process and the expected short- and long-term effects on the patient.

Identify any uncertainty and risk involved with a specific treatment plan, including the probability factors, if possible. Discuss reasonable assumptions the patient may make about the treatment plan. Whenever possible, supply reading materials and the consent document for the patient to take home and discuss with his or her family.

Encourage questions. Questions provide a better understanding of the patient's comprehension of the information and facilitate the dialogue between the patient and the physician. If time permits, consider scheduling a second visit with the patient to review the consent form, clarify expectations, and ensure patient comprehension of the proposed treatment – especially with elective procedures.

Documentation

Documentation is another key component of the informed consent process that cannot be entirely delegated to a nurse or another member of the health care team. If the doctor-patient discussion proceeds successfully and the patient requests treatment, the doctor is required in some jurisdictions to write a note in the patient's record. Additionally, the consent document must include the patient's name, doctor's name, diagnosis, proposed treatment plan, alternatives, potential risks, complications and benefits.

To some extent, physicians who use an informed consent document can protect themselves further by including a statement to the effect that the form only covers information that applies generally and that the physician has personally discussed specific

factors with the patient. The consent document must be signed and dated by the patient (or the patient's legal guardian or representative). Many consent forms also require a physician signature.

Consent forms should include statements to be signed by the patient and the physician. The patient attests that he or she understands the information in the treatment agreement. The physician attests that he or she has answered all questions fully and believes that the patient/legal representative fully understands the information. These statements help defend against any claim that the patient did not understand the information.

Some states have specific requirements for informed consent forms, procedure-specific disclosures and legal standards for disclosure of risks. For example, Texas maintains lists of procedures and attendant risks and hazards through the [Texas Medical Disclosure Panel](#). Check your state for requirements.

Informed consent in special situations

The informed consent process for same-day surgery patients may occur in the physician's office before scheduling the procedure. That will allow the patient time to think about the information, ask questions and make an informed decision.

Hospitalized patients must be informed as far in advance of the procedure as practicable. If time permits in an emergency in which the patient is unable to provide consent, the physician must contact a legally authorized representative to obtain an informed consent. If the nature of the emergency does not permit time to contact a legally authorized representative, consent is implied. Consent may be waived under emergent conditions that threaten life, limb, eyes and the central nervous system. If the patient is incompetent or otherwise cannot consent, the physician

is legally bound to obtain informed consent from the incompetent patient's authorized representative, except in an emergency. This type of consent should be thoroughly documented in the medical record.

Additional tips and suggestions:

- Develop and use procedure-specific forms that the patient can sign when the informed consent discussion takes place.
- Obtaining consent from the patient after a sedative or sleep-inducing medication is administered is not recommended. However, when a change in the patient's condition requires a change in treatment, secure the patient's consent. Thoroughly document in the medical record the facts and conditions surrounding the need for the revised consent.
- Additions or corrections to the consent form must be dated, timed and signed by both parties.
- Any member of the health care team may sign as a witness to the patient's signature, although this serves only to verify that it was the patient who signed the form. The witness does not obtain consent or verify the patient's competency to give consent.
- A patient's questions or obvious lack of understanding about the procedure should be referred to the attending physician as soon as possible.
- Translate consent forms to the most common non-English languages that you encounter in your practice, and verify that the form is translated correctly.

Patient safety measures

Every physician should develop his or her own style and system for the

Leading teams in times of uncertainty



Coach's Corner

By Shandy Welch, FNP

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

informed consent process, making it easier to avoid omissions and, more importantly, ensuring consistency of application.

Do not speed through the process. Give the patient and the family time to absorb and comprehend the information. Preprinted materials are extremely helpful for patient understanding and will serve as a trigger for other questions.

Assess the patient's level of understanding just before documenting the process. One way of doing this is to ask the patient to repeat back to you his or her understanding of the information you have communicated. This will increase the likelihood that you will be able to manage the patient's expectations effectively.

If you and your patient have completed the informed consent process and your patient declines your recommendations, see our article on "[Informed Refusal](#)" for further guidance. You can also contact the Department of Patient Safety and Risk Management for assistance. Contact us at patientsafety@thedoctors.com or 800-421-2368. ■

Robert Morton, CPHRM, CPPS, is assistant vice president with The Doctors Company's Department of Patient Safety and Risk Management.

This article is part of The Doctors Company's "Reopening Your Practice" series. To read more tips for reopening your practice, and for other resources, please visit www.thedoctors.com. To read prior articles in this series in The Scribe's May, June and July editions, please visit <https://msmp.org/The-Scribe>.

We are all navigating new territory, and doing our best to move our work and teams forward despite the uncertainty moment to moment. There are certainly tactical moves and processes to change, but I would argue it all pivots on one thing: **the perspective and attitude you bring to the table.**

As a leader, it is *you* who sets the tone and drives the team to see change as opportunity or chaos. It is *you* who approaches the problem, feels and acknowledges the fear, and uses that as awareness and motivation rather than a barrier or defeat.

HERE ARE SOME KEYS TO SUCCESS:

1. SHOW UP. This is not a time to work from behind a desk and rule from afar. Connecting, in whichever way is most personal, is imperative. Ideally in person; if not, Zoom; if not that, a phone call, etc. The personal disconnect can itself take down a team. Imparting creative ways to stay connected and engaged is vital to your future success.

As a leader, you can influence and lead by example. Set aside 30 minutes each day to reach out to a co-worker. This does not have to be a direct report – it may be better if it is not. No agenda is needed, just connect on a human level and hear their story. Connection, or lack thereof, is a common theme these days. Integrate ways to keep you and your team engaged with each other. Once a week, end work early and go to a park together, commit to a Zoom social hour and integrate unexpected joy. The key is not to add this on to their day; honor this as "paid work time" and schedule accordingly. Keeping your team connected will save you in the long run.

2. CLARIFY YOUR "WHY": Now is a great time to pull back and re-engage around "why" the work

you do is so important. What is the mission or vision you are trying to serve, and why does it make a difference? It is these conversations that will spark the compassion and unify your team - the common bond that brings you all together. The conversation that results will be one of energy, focus and will allow your team to prioritize the work ahead.

3. ASSESS YOUR "HOW": When times are chaotic, it is easy to lose focus and neglect the small details that create excellence. Inspire accountability and curiosity to challenge the process. Once you have established your "why" and energy is building, look at each element of your business and ask yourselves, "Does this action/process/support or get me closer to my greater vision?"

Many times, you will find elements or people that are creating value but, honestly, their contribution no longer aligns with your primary goal nor serves an important purpose. In medicine a golden rule is, don't order a test/lab unless it will change the treatment or diagnosis. If done routinely, it is an excellent way to ensure integrity and focus.

This is where many get stuck. If you are really serious about creating a high-performing team, you now need to have a difficult discussion, and most people would rather avoid that discussion, so they stop here. This leads to redundancy, resentment, expense and certainly a slow disintegration of your team.

Avoiding having difficult conversations is something I see all the time. This is a skill and talent that takes intentionality and practice.

IN THE MEANTIME, CONSIDER THIS:

- Are you physically and emotionally showing up each day with an attitude and perspective that will empower your team and encourage creativity and optimism?
- Can you commit to two hours each week in which you dedicate to connecting with your staff?
- Challenge yourself to find three processes that your team performs and critically look at whether or not they serve a greater purpose.

RESOURCES FOR MORE DEPTH:

- **Andy Stanley Leadership podcast:** "[Revisiting Creating High-Performance Teams, Part 1](#)"
- **How to Be Awesome at Your Job podcast:** Episode 552: "[The Foundational Principle that Separates Good Leaders from Bad Ones with Pat Lencioni](#)"
- **The 4 Disciplines of Execution:** Chris McChesney focuses on the "how" to get things done. ("[The 4 Disciplines of Execution: Achieving Your Wildly Important Goals](#)" by Sean Covey, Chris McChesney, Jim Huling. Free Press: 2012.)

To reach Shandy Welch with topic ideas for this column or for assistance through MSMP's Physician Wellness Program, please email shandywelch@gmail.com. Her weekly newsletter can be found at www.fresheyes.solutions



Medical students, school leaders adapt to meet COVID-19 challenges

By John Rumler
For *The Scribe*

The COVID-19 pandemic, and the accompanying turmoil, stress, and uncertainty, hit **Oregon Health & Science University** administrators, faculty and students fast and hard, forcing rapid changes.



Photo: OHSU

GEORGE MEJICANO, MD, MS

"We had to adjust very quickly and faced a steep learning curve," says **George Mejicano, MD, MS**, senior associate dean for education in OHSU's School of Medicine. "It was a little bumpy at first, but it has settled down and things are going a lot smoother now."

OHSU's normal classes and in-person clinical rotations were suspended from March 13 to June 28 under its phase I transition plan. Mejicano and OHSU administrators are finalizing the phase II transition plans, which likely will be frequently tweaked and updated as the COVID-19 crisis evolves.

In March, as the rates of infection and deaths caused by the pandemic began rising around the nation, OHSU pulled all students from clinical rotations and switched classroom education, didactic and small-group discussions to remote learning. Also, wherever possible, virtual simulation methods were used to continue clinical training. Also, the university's research mission has been curtailed, with the exception of research specifically related to the diagnosis, treatment and prevention of COVID-19.

On June 29, OHSU's clinical rotations, with added COVID safety precautions, resumed. Remote learning will continue into the fall for the incoming class of 2024 as well.

Board certified in internal medicine and infectious diseases, Mejicano is a professor of medicine in the division of diseases and served on the Centers for Disease Control and Prevention's Board of Scientific Counselors from 2003-2004.

One of the biggest shifts, Mejicano

says, is the emergence of telehealth as a crucial go-to option. "It's changing how we teach and how we take care of patients. We've been able to successfully adapt it clinically as well as educationally."

The advantages of remote interactions are impossible to ignore, Mejicano says. "It eliminates transportation expense, it saves time, students can interact well with Zoom and, above all, it is safe. It's here to stay."

Another big change, according to Mejicano, is that previously OHSU students experienced a simultaneous blend of clinical and didactic education, but to increase efficiency and save time, they are now separate entities. "We've pulled out the didactic pieces that were sprinkled throughout the process and consolidated them and created a more pure clinical experience for the students and also more pure didactic experience."

But not everything translates well to Zoom and virtual learning. The anatomy lab, which has been closed to students, is an example. "It's fine for students to watch the dissection process, but there really isn't any replacement for actually performing dissections yourself."

OHSU administrators were to decide this month whether it will be possible to reopen the anatomy lab.

The biggest challenge during OHSU's adaptive process, Mejicano says, was constantly monitoring safety and the tenuous supply chain of PPE, especially medical grade N-95 respirators, which are reserved for clinicians and patient care.

"It isn't just us at OHSU, those masks are in demand at other hospitals and medical schools as there just aren't enough to go around."

Chris Gaulty, MD candidate, MS4, was rotating in the pediatric ED when he and his cohorts were abruptly pulled from their clinical rotations. In the weeks before, Gaulty heard frequent comments from the nursing staff about how they were having difficulties arranging child

care. One RN mentioned that, because she worked in the hospital, her child care provider was wary of going to her home for fear of catching the virus.

So, with the extra time Gaulty suddenly had on his hands, he worked with fellow fourth-year medical students Emily Lane and Audrey Tran to organize a free child care service provided by student volunteers from the School of Medicine, including nursing, dentistry and pharmacy students.

"It involved spending a couple of hours each day on the phone or computer, coordinating between student volunteers and front-line health care workers," Gaulty says. "We provided child care for about 200 families over eight weeks and learned a lot doing it."

Gaulty was born in Ohio shortly after his parents immigrated from the Philippines. His mom worked as a chemical engineer for Proctor & Gamble, taking international assignments to Japan, China and Singapore. After completing high school in Beijing in 2011, Gaulty moved to Portland, graduating from Reed College in 2015 and entering medical school in 2017.

"Overall, I'd say one word to describe how fourth-year medical students are feeling is 'helpless,'" he says. "We understand and support taking every precaution to defend against this pandemic, but sometimes this means we're treading water in a growing sea of student loans."

Gaulty, who will apply for an emergency medicine residency this fall, says his first experience working in an ED was with **Ramine Yazhari, MD**, at Randall Children's Hospital at Legacy Emanuel during his second year.

"We cared for a wide range of patients, some with simple medical problems and others in very critical condition. We treated about every age and organ system imaginable, and I would come home from each shift buzzing about all the different pathologies we saw and the complex

decisions we had to make," Gaulty says.

His short-term goal, Gaulty says, is to learn as much as possible from his emergency medicine sub-internship and to be active on a new student/faculty committee (formed in OHSU's School of Medicine) that will expand education on how to combat health care disparities and systemic racism. Gaulty's medium-range goal is to match to an EM program that fits his interests and values while, for the long term, he sees himself pursuing a fellowship in medical education, ultrasound or perhaps pediatric emergency medicine.

"I think the right path will become clear as I progress through residency. Wherever I end up, I aspire to be a worthy mentor to medical students, particularly those who are underrepresented in medicine."

The first in his family to study medicine, Gaulty says his learning experience – like all OHSU students – has been significantly altered by the pandemic, yet he is confident that his class will still graduate in time for him to start his residency in 2021.

"Thankfully, the OHSU School of Medicine curriculum administrators quickly created virtual electives, allowing many of us to resume progressing towards our degrees."

For example, Gaulty did a virtual point-of-care ultrasound rotation where he completed online modules and "live" sessions over Zoom. He and other students learned the basics of ultrasound physics and technique, as well as how to interpret ultrasound images of the heart, lungs, abdomen and other anatomical landmarks.

As OHSU clinical rotations resumed, Gaulty returned to his in-person clinical rotations in the ED and says he is much more comfortable doing point-of-care ultrasound. "We weren't able to physically practice doing ultrasound, but learning the 'cognitive' skills of interpreting the images made it much easier to hit the ground running in person."

But due to safety measures, the



“I want to be on the front lines taking care of people when they need help the most, even when it’s scary. The aspect of the pandemic that really motivates me is the fact that people of color are being disproportionately impacted. As a child of immigrants, my desire to practice medicine has never been more urgent.”

—OHSU medical student
Chris Graulty

Photo: Luis Valenzuela

situation in the ED is a bit different, at least for now. At present, students are not permitted to see patients who have tested positive for COVID-19 or those with symptoms. In the ED, that means Graulty and other students are getting fewer chances to directly evaluate patients presenting with respiratory viral symptoms.

Medical student testing disrupted

For medical school undergraduates at OHSU and around the nation, the pandemic has wreaked havoc on the mandatory United States Medical Licensing Examination (USMLE) testing, Graulty explains. Between March and April, undergrads normally take the USMLE Step 2 Clinical Skills exam, a practical standardized-patient exam that requires flying to a testing center (the closest for OHSU students is in Los Angeles). That exam has officially been suspended for between 12 to 18 months, he says.

The \$1,300 testing fee Graulty and thousands of other students were charged has not been refunded, despite the fact that the exam has been suspended for over four months. For students on a tight budget, many existing on student loans, that is a big chunk of money that could go to rent or meals.

As for the USMLE Step 1 and Step 2 Clinical Knowledge exams, Prometric, the testing company contracted by the National Board of Medical Examiners, has been canceling many test dates at random, Graulty says. “After weeks of constantly studying, some students have had their exams canceled within hours of the start time. You can imagine the

enormous frustration and stress the USMLE testing has created for a great many students.”

This also creates extra work for residency program directors, who will now have to carve out time for their residents to complete the examination (a pass/fail standardized patient exam that is passed by approximately 95 percent of MD students trained in U.S. medical schools) during the intern year.

In addition, the upcoming residency application cycle will be unlike any

other, as students will be conducting residency interviews virtually. “We’ll be deciding on residency programs without ever having visited any,” explains Graulty. “Program directors are working creatively to show applicants their facilities and introduce their current residents, but applicants will be making important, lifetime decisions with a lot less information than they would normally have.”

Meanwhile, Graulty says he would prefer if students could physically practice procedural skills, but the virtual format has some benefits. “We are able to have more people participate since we’re not constrained by space, and we can go through more simulations in the time we have.”

Currently, the rate of COVID-19 infections and deaths are spiking in many states, particularly Florida, California and southwestern states which, Graulty says, puts even more urgency on his desire to practice medicine.

“I want to be on the front lines taking care of people when they need help the most, even when it’s scary. The aspect of the pandemic that

really motivates me is the fact that people of color are being disproportionately impacted. As a child of immigrants, my desire to practice medicine has never been more urgent.”

Of all the students at OHSU, Mejicano says, the incoming class of 2024 will face the biggest challenge, given that, with safety measures in place including remote learning, it will be more difficult for students to bond as a learning cohort. “The other classes have formed many friendships and created a supportive, interactive learning community. It will be harder for new students, who are unfamiliar with each other and with OHSU, to do that and it will take longer,” he says.

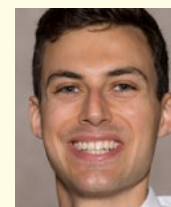
Despite all of the uncertainty caused by COVID-19, Graulty is hopeful that, in the long run, medical schools and residency programs will be better off for all of the innovating during the pandemic. “I think that the medical students who trained in the midst of this pandemic will become some of our most resilient and determined physicians.” ■

Medical, public health students help with contact tracing

Students from **Oregon Health & Science University** and **Portland State University’s School of Public Health** have received hands-on experience with contact tracing, working with state and county health officials to help track and slow the spread of the novel coronavirus.

Students stepped in to help after OHSU canceled student clinical rotations in March because of COVID-19. In place of in-person rotations, OHSU created several virtual electives, including a COVID-19 epidemiology course taught by **Paul Lewis, MD**, an associate professor of pediatric infectious diseases in the OHSU School of Medicine. Many students enrolled in the elective, and many more signed up as volunteer contact tracers for Multnomah County.

Teva Brender, a second-year medical student who performed contact tracing with the Clackamas County Public Health Division, said that contact tracing has allowed him to give back amid the crisis.



TEVA BRENDRER

“Through this work, I can tangibly help with the pandemic,” he said in a piece on OHSU’s website. “It feels good to really help out on the front lines as much as I can as a second-year medical student.”

Graduate students, in paid roles, have helped the state follow confirmed novel coronavirus cases through an emergency contract between the School of Public

Health and the Oregon Health Authority. Students also have conducted contact tracing. The school’s contract with the state was extended through summer 2021.



JENNIFER KU

“This work is very important,” said **Jennifer Ku**, a third-year PhD student in epidemiology who coordinates the public health students’ pandemic case management efforts. “COVID-19 is a new disease and there are a lot of unknowns. We’re still learning about the specifics of the disease, and it’s important to trace infected individuals to learn more and plan future steps.”

Jonathan Snowden, PhD, an assistant professor of epidemiology in the School of Public Health and of obstetrics and gynecology in the OHSU School of Medicine, said students are obtaining concrete experience by helping create evidence-based recommendations. “The field of public health is being renewed by this process of collaboratively responding to the pandemic.”

Noted Lewis: “My goal is that the students not only have excellent medical knowledge, but also develop excellent empathy and understanding for their patients and the challenges they face.”

Brender noted the economic challenges that face some who self-quarantine. He said he expects to be more respectful of future patients’ social and economic situations and medical needs. ■

Physician shortage growing, study finds

A study from the Association of American Medical Colleges projects that the United States will face a shortage of between 54,100 and 139,000 physicians by 2033.

The COVID-19 pandemic, the organization said, magnifies the need to address shortfalls in primary care doctors and specialists.

The projections in the sixth annual study, titled “The Complexities of Physician Supply and Demand: Projections from 2018-2033,” are up from last year’s report, which predicted a shortage of as many as 121,900 physicians by 2032. The new study, which advances the calculations by one year, projects shortfalls in primary care of between 21,400 and 55,200 physicians, and in specialty care of between 33,700 and 86,700 physicians, the AAMC said in a late June article on its website.

The study cites two trends that particularly contribute to the shortage: more Americans older than 65, and more physicians reaching retirement age.

Older people generally require more specialty care, the association noted, adding that although the national population is projected to increase by 10.4 percent during the 15 years covered by the study, the over-65 population is expected to increase by 45.1 percent.

Moreover, the study found that more than two in five physicians will be 65 or older within the next decade. Although each doctor’s retirement plans will be affected by numerous factors, the report notes that “growing concerns about physician burnout... suggest physicians will be more likely to accelerate than delay retirement.”

As dire as the numbers are, the association said they don’t reflect the even higher demand for physician services that would exist if access to health care was more equitable nationwide. The projections for future demand on physician services are based on current levels of medical use by all populations, including those with less access to care such as some minorities and people living in rural areas.

“If underserved populations had health care use patterns like populations with fewer access barriers, demand could rise by an additional 74,100 to 145,000 physicians,”

according to the report.

Although the study was conducted prior to the novel coronavirus crisis, it said the pandemic “is likely to have short- and long-term consequences on the nation’s physician workforce.” The impacts could touch medical education, such as interruption of classes and clinical rotation cancellations; regulatory changes; changes in how medicine is practiced, such as greater use of telehealth; and changes in interest in specific specialties.

Michael Dill, the AAMC’s director of workforce studies, said that in addition to training more physicians, a multipronged approach is needed to

address the physician shortage and the resulting care gaps. That approach includes better use of technology, including training doctors and staff on how to use it to improve care and reach underserved populations. Dill noted the rapid and substantial increase in telehealth practices brought on by COVID-19, and expressed hope that providers will continue to use telehealth more than they did before the pandemic to reach those populations consistently.

Also critical to addressing these issues, he said, is expanding the care that doctors and other health care professionals can provide. ■

OHSU aims to boost resident numbers in next decade

Oregon Health & Science University said it intends to boost the number of medical residents by 100 within the next 10 years.

OHSU said it will grow its own residency programs. In addition, the OHSU School of Medicine’s new Graduate Medical Education Statewide office is working with other institutions to help them start their own programs.

“Bringing more medical residents to Oregon is key to bringing more physicians to Oregon,” **Jim Anderson, MD**, professor of diagnostic radiology in the OHSU School of Medicine who also directs the school’s Graduate Medical Education Statewide initiative, said in a piece on the university’s website. “Studies have shown that physicians are more likely to set roots in the same states and cities where they do their residencies. As a statewide institution, OHSU seeks to bring more doctors to Oregon as a whole, regardless of whether they end up working for OHSU.”

OHSU cited new residency programs coming to OHSU Health Hillsboro Medical Center as an early success. Two of those programs, which will train recent medical school graduates in family medicine and internal medicine for three years, have received approval from national accreditors. Hillsboro has proposed a third program that would offer one year of transitional training for new physicians who specialize in certain fields – among them radiology, pathology, dermatology and anesthesiology – so they can later join more specialized residency programs elsewhere, OHSU said.

When fully running around 2024, the three programs could bring a total of 60 medical residents to Hillsboro. The family medicine and internal medicine programs could see their first residents as early as July 2021, and the transitional program could receive residents starting a year later.

“We’re tremendously excited to launch residency programs at OHSU Health Hillsboro Medical Center and to welcome residents who are committed advocates

to those in need, intellectually curious, and eager to bring new energy and ideas in the provision of exceptional care,” said **Brian C. Ricci, MD**, who leads the Hillsboro internal medicine residency program and is also an assistant professor of medicine in the OHSU School of Medicine.

“Residents will be embedded within our community – in our primary care clinics, through the ¡Salud! Health outreach program for seasonal winery workers, with local health care partners – and will hopefully remain here to serve our community for years to come.”

Ricci is working with **Kay Nordling, MD**, who leads the Hillsboro family medicine residency program and is also an assistant professor of medicine in the OHSU School of Medicine, to bring both programs to fruition.

Anderson provides advice and guidance to other health care systems across Oregon on how they might start, grow or advance their residency programs.

“We’re dispelling the myth that health systems have to compete against each other for medical residents,” Anderson said. “Oregon systems are coming together to help the state as a whole.”

OHSU said it also is examining its residency programs with the aim of better serving the state’s rural and underserved communities. For example, some hospital-based programs across the OHSU Health system may add rural rotations for their residents.

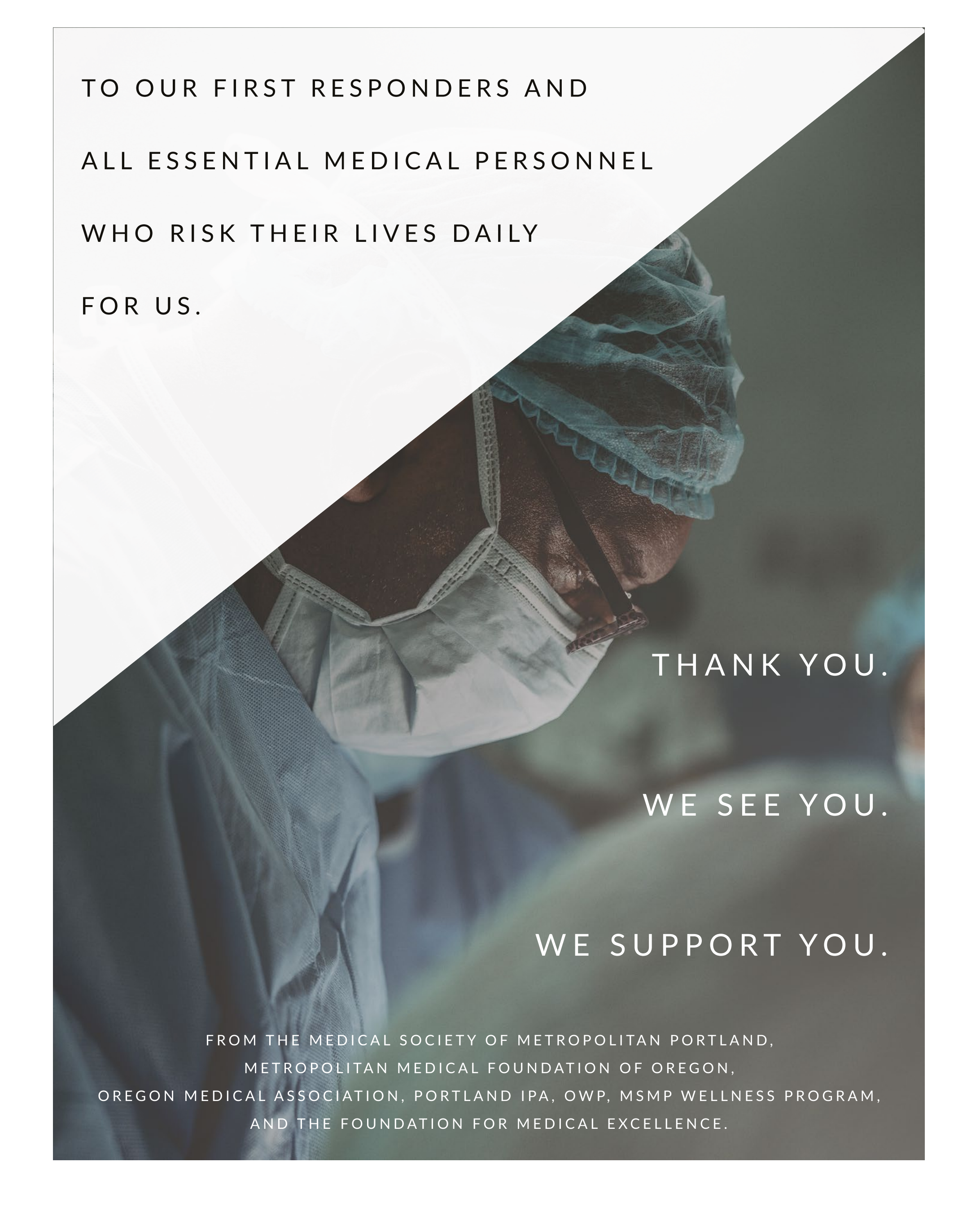
Also, OHSU is working with the University of California, Davis, on a \$1.8 million American Medical Association-funded project to bring hundreds of medical students and residents to train under faculty and community physicians in rural and underserved communities in Oregon and northern California. Some of that project’s residents may end up working at Hillsboro Medical Center, OHSU said. ■

For more on the OHSU/UC, Davis, project, please see page 6 of the August 2019 Scribe.



▶ LEARN MORE

Read about two Oregon Health & Science University-related programs that aim to improve health care access in rural areas and among underserved communities in the August 2019 issue of *The Scribe*.



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Pandemic forces residency programs to shift gears

Leaders see both positive, negative impacts of coronavirus on training

By Cliff Collins
For The Scribe

Those responsible for training new physicians are hard-pressed to think of any aspect of it that has not been affected by COVID-19.

"The pandemic has certainly caused all sorts of changes," said



CHRISTOPHER E. SWIDE, MD

Christopher E. Swide, MD, associate dean of graduate medical education and professor of anesthesiology and perioperative medicine at **Oregon Health & Science University**. "It's been a huge impact."

At the outset, residency and fellowship training programs were hit by government mandates to limit elective procedures and hospital bed censuses to prepare for a possible influx of coronavirus patients. These cutbacks greatly increased the difficulty of obtaining core requirements.

"All our didactic education is all virtual," said Swide. "There are no more case conferences," and not being able to "do hands-on" training constitutes "a different experience for the educational environment."

What's more, "traditional rounding as a team had to be changed," he explained. To ensure physical distancing, not as many people can be in a patient's room at a time, which

means not as many residents or medical students can round together in a patient room. This could limit a resident's ability to mentor medical students, and limit senior residents' abilities to mentor interns. Doctors must leave the room to do charting and transfer-of-care orders, too.

OHSU's 200 residents and 100 fellows also face "the anxiety of being exposed" to the virus, as well as uncertainty about what the future holds for their careers. "The very different learning environment adds anxiety to the long hours" and traditional stress of residencies, Swide observed.

"Things have very much changed, not just for residents – everybody in health care is subject to extreme stress up and down the system," Swide added.

With primary and secondary schools not being held in person, new doctors also are subject to the same challenges as others in society in terms of child care and family stress, he noted.

"We certainly are trying to do all we can do, but there's a lot of stuff we cannot control," he said.

Residents get placed in different sites all around Oregon and other states, and "these are sites we have to oversee," Swide said. OHSU must inspect sites and monitor bed censuses and local outbreaks that might impact personal protective equipment supplies.

All overseas travel has stopped, so global health trips are suspended indefinitely, although OHSU allows some domestic trips for fellowship training experiences such as at tribal and rural health care sites. "Our residents don't attend meetings anymore, they are virtual only, which is different from the experience you would get" from being able to meet and hear international experts and develop personal relationships, Swide said.

The Accreditation Council for Graduate Medical Education has modified its standards to support virtual care of patients, which now make up a "significant number" of patient visits, Swide said. Residents are aware of budget gaps for OHSU and other hospitals, including faculty pay reductions, and "understand the impact on the system and wonder how things can go on. The unpredictability is something all of us feel."

Planning required rotation blocks is difficult when everything is in flux, including pressure on emergency departments. The American Board of Medical Specialties has been "flexible" in relation to residents' requirements, he said.

"Everything is getting delayed," including licensing tests, which can be a disadvantage, because residents naturally prefer to take exams as close as possible to when they complete their residencies, he added.

"The House of Medicine has certainly stepped up to try to help," including on the issue of potentially extended training for residents, Swide said. "We certainly can see that (becoming necessary) going forward if things are continuing to be impacted. If there is a surge this winter," no one can predict the effect that will have on residencies, he said.

He and other graduate medical education deans around the country hold weekly Zoom meetings to discuss "how we can help each other," Swide said. "Five, six months into this, we can't know the long-term impact of all of this."

"None of us want this pandemic," but the medical community also should not overlook the positive aspects that have surfaced as a result, Swide observed.

One of those is that "virtual is a real winner here," he said. "The need of virtual health is only going to increase," and it should be fully integrated as a competency taught within our educational environment, he said. How to employ it is "a skill and art to itself," as is educating patients about how to use it.

Swide cited another positive example: A few OHSU medical students graduated early so that they could help out, and "there are a lot of inspirational stories of residents and fellows" who have gone above and beyond to assist with the pandemic.

"I want to say, you can be proud of the next generation of physicians," and the selfless approach they are taking toward their patients despite the risks to themselves, Swide added. "They're doing the best they can" under difficult circumstances, and "we're doing what we can to help them."

How DOs' training is affected

In Lebanon, Ore., **Western University of Health Sciences College of Osteopathic Medicine of the Pacific—Northwest** faces similar but different circumstances.

John T. Pham, DO, vice dean and associate professor of family medicine, explained that the school, known by its shorthand name of COMP-Northwest, does not have a residency program, train residents on its campus or, unlike OHSU, have its own hospital. Instead, COMP-Northwest places its graduates into residencies in hospitals across Oregon and Washington and many other states.

Medical students who graduated May 29 were given virtual instruction during their final two and a half months of school, said Pham, who

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Telemedicine is here to stay and part of our responsibility to prepare our physicians is to teach students how to do that without losing that personal touch.

– John T. Pham, DO,
vice dean and associate
professor of family medicine,
COMP-Northwest



is a former member of the board of trustees of the **Medical Society of Metropolitan Portland**.

COMP-Northwest faculty did everything they could to prepare graduates to enter residencies during a pandemic, including providing them with COVID-specific training such as how to don and doff PPE, proper hand-washing and general sanitation procedures, he said. This effort partly was to relieve hospitals receiving residents from having to take the time to do this training, and so that the school can reassure hospitals that their graduates are prepared.

COMP-Northwest also “made the call” to delay for two and a half weeks sending third-year medical students to clinical rotations to allow hospitals more time to orient their new interns, Pham said. The school places about 100 graduates each year into residencies.

In terms of training medical students, the pandemic has been “very

disruptive” to normal procedures, he noted. “The curriculum, didactic part is pretty easy” to adapt to using virtual instruction, but osteopathic medicine includes training in manual manipulation, which requires hands-on training that is challenging in terms of safety with COVID-19, he pointed out.

The way COMP-Northwest has approached it is to bring in “small pods” of students at a time to work on clinical skills, according to Pham.

Having to adapt to this “hybrid model” has not been simple for students, but “they know we’re trying to do the best we can in a tough situation,” he said. Teaching by virtual is different, but medical students today are technology savvy and are “resilient,” he said.

“Telemedicine is here to stay,” Pham said, and “part of our responsibility to prepare our physicians” is to teach them “how to do that without losing that personal touch.” ■

MSMP MEMBER EXCLUSIVE



Don't miss this article!

Health care leaders talk about HB 4212 which, among several other measures related to the COVID-19 pandemic, will require a broad range of health care providers to collect data on race, ethnicity, preferred spoken and written languages, English proficiency, interpreter needs and disability status. The bill passed during the Legislature’s recent special session.

To read more, please visit www.MSMP.org/MembersOnly.



Photo: M.O. Stevens, Wikimedia Commons

Funds to enhance training to treat people with substance use disorder

Oregon Health & Science University was among 44 centers nationwide awarded federal funds to enhance training of health care professionals to treat people with substance use disorder.

The university, which said the funds marked the first federal investment for expanding the addiction medicine workforce, noted that the Oregon Addiction Medicine Fellowship will receive \$450,000 for each of the next five years to expand OHSU’s existing training program. It will result in intensive addiction medicine training experiences for physicians in community health centers such as Portland’s Central City Concern, in rural communities, among Native Americans and for adolescents with addiction.

“Right now, less than 15 percent of people who need addiction treatment in the U.S. receive it,” fellowship program director **Todd Korthuis, MD, MPH**, said. “Part of that is due to a workforce shortage. There is just not enough expertise integrated into our health care system to meet the need. The Oregon Addiction Medicine Fellowship trains physicians from multiple specialties to integrate addiction medicine skills in diverse health care settings.”

The funding includes training experiences for physicians in areas where substance use disorder is especially acute. It also supports program coordinator positions at OHSU.

The need is acute. OHSU pointed out that, according to a 2017 estimate by the U.S. Substance Abuse and Mental Health Services Administration, Oregon ranks last among states in access to addiction treatment.

Nationwide, *The Washington Post* reported in early July, federal and state officials were reporting alarming spikes in drug overdoses – what it called a hidden epidemic within the coronavirus pandemic. Suspected overdoses nationally, not all of them fatal, increased 18 percent in March compared with the same period last year, 29 percent in April and 42 percent in May, based on figures from the federal Overdose Detection Mapping Application Program, which collects data from ambulance teams, hospitals and police, the newspaper said.

The Oregon Addiction Medicine Fellowship program started in 2014. Though graduates are qualified to practice as addiction medicine specialists, the program focuses on integrating addiction treatment expertise into a wide range of health care and community settings. The first 12 fellows include five family medicine physicians, five internists, one neurologist and one anesthesiologist. Eight of the 12 have stayed in Oregon, OHSU said.

“The idea is that people tend to stay where they train,” said Korthuis, professor of medicine in the OHSU School of Medicine. “This award advanced one of my long-term visions to increase training for providers in rural Oregon in addition to Portland.”

It reflects a larger university effort to build medical capacity in the state through residency and fellowship programs, OHSU said.

“The addiction medicine fellowship is one example of our longtime and expanding commitment to immerse and train physicians in communities across Oregon,” said **George Mejicano, MD, MS**, senior associate dean for education in the OHSU School of Medicine. “We are gratified to receive this federal financial support in our effort to better meet the needs of underserved communities, especially in an area as urgent as opioid addiction.” ■



By Jon Bell
For The Scribe

Take a look at the photos from just about any 5K, marathon or long-distance running race, and more often than not you'll likely find faces that are focused and strained, exhausted and even pained. Some expressions suggest regret, others hint that this may indeed be the runner's final race.

Not so with **Lalena Yarris, MD.**

Browse through some of her race photos, and whether she's knocking off a 50-mile run on the Pacific Crest Trail near Mount Hood or



cruising along the six-day, 120-mile TransRockies Run in Colorado, Yarris seems always to be smiling. That's because Yarris, a professor of emergency medicine at the Oregon Health & Science University School of Medicine, has found over many years and many miles that she thrives not

only on the community that accompanies long-distance running and racing, but also on the running and training itself.

"Trail running really aligns with my spiritual practice, which is Buddhism," said Yarris, who grew up in Santa Monica and studied biology and literature at the University of California, San Diego. "There's a big emphasis on nature and meditation. Running is not my meditation, but it is meditative. For me, when I run I often do, in a sense, meditate. I focus on the trail and my breathing, I let go of thoughts and time passes. I love to be in nature and having a habit that keeps me moving most days a week."

It's a habit that Yarris has had for much of her life. She was on the swim team and played water polo at UCSD, and while she was in med school at OHSU she continued to swim and run to stay active. It was a classmate of hers who recommended that she turn her swimming and running regimen up a notch and train for a triathlon.

"It was the swimming aspect of triathlon, which has open water swims in mountain lakes, that hooked me," Yarris said. "And once you do it, then you see that it's such a fun and supportive environment. There's music and spectators, I had friends who did them and I really liked how it gave me the ability to push myself, to learn the nutrition and fitness. The triathlon was something totally new to me, so as a novice, I could push myself and grow."

After her first triathlon, Yarris was indeed hooked. She started with the more approachable sprint-length triathlon, which includes an 800-meter swim, a 12-mile bike ride and a 5K

RUNNING FOR HER LIFE

LONG-DISTANCE RUNNING, TRIATHLONS KEEP OHSU'S LALENA YARRIS, MD, ON HER IDEAL PATH

run. She moved up to longer distances – the Olympic distance is a 1,500-meter swim, a 25-mile bike and a 10K run – and eventually found herself volunteering in a medical tent at the granddaddy of all triathlons, the Ironman. Those races feature a 2.4-mile swim, a 112-mile ride and a marathon to finish, all of which must be completed in 17 hours or less.

At the Ironman where Yarris volunteered, she said she witnessed a bit of magic at the finish line as the 17-hour mark approached. All the professionals who'd already completed the race were there, as were all the spectators and other racers who had come in earlier. Everyone was cheering for those who were pushing themselves to their limits to make it across the finish line in time.

"It was the most magical time, right before the 17 hours were up," Yarris said. "I watched that and had this overwhelming feeling of, I want to do this not to compete, but I want to feel what it's like to train for this, to go for it and just put it all out there."

So inspired, Yarris went on to do just that, not once, but three times. She found a solid coach and trained hard for Ironman Arizona in 2014. She finished in 12 hours, 58 minutes and 41 seconds.

"That first race was my best," Yarris said, "not my fastest, but it was a really good race. I had fun the whole time."

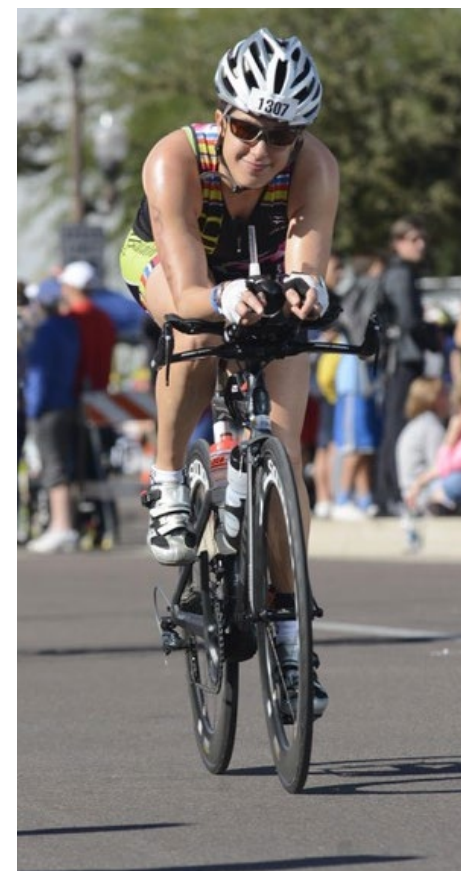
Lalena Yarris, MD, a long-distance runner and triathlete, says the activities allow her to connect with nature and keep her moving. She thrives on the sense of community that accompanies running and racing, and on the training itself.

Photos courtesy of Lalena Yarris

She would return to complete another Ironman Arizona in 2015, and in 2017 she finished Ironman Coeur d'Alene in Idaho, a race renowned for its swim in crystalline Lake Coeur d'Alene.

APPRECIATING LIFE

Yarris has not done another Ironman since Coeur d'Alene, but she said she might still be up for another one in the future. After Coeur d'Alene and a trot in the 2017 Eugene marathon, her focus shifted more toward ultrarunning – broadly speaking, long-distance running that's beyond the 26.2 miles of a traditional marathon – thanks to a friend and a brother who are both into it. One of her biggest races so far was the 2018



TransRockies Run, a 120-mile run that unfolds over six days in the Rocky Mountains. She also ran the 2019 Mountain Lakes 100, which cruises past no fewer than 25 mountain lakes along 100 miles of the Pacific Crest Trail in Oregon.

Training for such races takes plenty of time and dedication, and Yarris juggles a busy schedule to make it happen. In addition to being the mother of three children who range in age from 11 to 18, Yarris is busy at OHSU with her academic work. She's also deputy editor for the *Journal of Graduate Medical Education* and recently became vice chair for faculty development. It's not unusual, then, to find Yarris running the trails of Forest Park for a few hours early in the morning before she heads in to work to give a talk.

Thanks to COVID-19, most of the races that were on Yarris' schedule have now been cancelled. In place of those runs, Yarris and several of her colleagues at OHSU are doing a virtual run of the entire Pacific Crest Trail, the epic hiking trail that runs for more than 2,600 miles between Mexico and Canada. For the five-person team to complete the challenge, each person is running an average of 44 miles per week over three months.

"RUNNING AND RACING REALLY ALLOWS ME TO APPRECIATE EVERYTHING IN LIFE MORE."

— LALENA YARRIS, MD

As for dream races, Yarris said she's fairly open. She's planning to run around Mount Hood this fall on the 41-mile Timberline Trail, and she won a free entry into a future TransRockies Run as part of a promotion to honor health care workers. She'd like to pace her brother in his first 100-miler, and she'll keep swimming, running, practicing yoga and racing triathlons for all the benefits they bring her.

"Running and racing really allows me to appreciate everything in life more," Yarris said. "How good it is to sleep, have a hot shower, good food, the gratitude I feel after finishing a run and having seen so much beauty or a gorgeous sunrise, greeting other runners along the trail. I get exercise, healthy sleep and quiet, contemplative time that really helps me out." ■

Collaborating on bed capacity

The pandemic also prompted OHSU and other health systems in the state to form a statewide network to manage a surge in patient volume.

"In the beginning of the COVID-19 pandemic, we quickly collaborated with health systems across Oregon to create visibility into how we use more than 7,500 hospital beds statewide," said **Matthias Merkel, MD, PhD**, OHSU Health senior associate chief medical officer for capacity management and patient flow. "The VICU gives us an additional ability to serve Oregonians by supporting local care teams and making collaborative decisions for the benefit of the patient. As we learn how our new normal looks with COVID-19, leveraging technology to connect clinicians across our state has never been more important."

OHSU's **COVID Capacity Center** actively monitors real-time hospital data to inform patient intake and care. The center now includes 90 percent of all hospital beds statewide. Enabled by GE Healthcare technology in partnership with OHSU and other health systems, the center began

operations in April and allows health systems to see and react to hospital capacity statewide rather than attempting to manage the surge on a piecemeal, hospital-by-hospital approach.

"This tool will be useful in managing demand for hospital beds any time we have an influx of patients that exceeds one hospital system's capacity," Merkel said. "It will help all Oregonians to avoid decisions being made in silos."

The Oregon Health Authority foresaw the need for better coordination among hospitals, especially between rural and urban areas, and encouraged Oregon health systems to come together to manage an expected statewide surge in demand for hospital beds, staff and equipment such as ventilators, he said.

The COVID Capacity Center includes:

- **Hospital capacity management:** a centralized, statewide look at real-time data, including what regions are seeing an uptick in positive diagnoses and which hospitals have capacity for COVID-19 patient intake; and bed-level

status data for each ICU bed, negative-pressure bed and acute bed, and how many ventilators are being used and how many are available

- **Operational efficiency:** real-time access to data to reduce churn and assist health care workers in critical-care decision-making, such as assigning ICU beds and other specialty beds

- **Data privacy:** removing protected health information to guard patient privacy

Another step toward preparedness

In a related development involving virtual care, OHSU – funded by the U.S. Army and in conjunction with eight other institutions across the country – is establishing an emergency critical care network intended to offer support in the event of a natural disaster that overwhelms local hospital capacity.

"This will allow us to lead the effort in Oregon to connect rural areas to the expertise in our academic health center through easily deployable technology," Merkel said.

OHSU leaders envision developing the platform so that the health system can use it to help manage critically ill patients in remote areas during a disaster.

The initiative would establish the equivalent of intensive care in far-flung locations, be deployed remotely on Microsoft Azure's cloud and leverage Microsoft Teams to facilitate communication among clinicians. The system would enable video as well as continuous, remote monitoring of vital signs from rural hospitals or temporary quarters such as armories or tents, giving those facilities access to specialist surveillance and expertise at OHSU.

The project would expand OHSU's ability to monitor real-time data within its own health system, as well as in its virtual ICU.

"If there's another natural disaster or a pandemic, we'll have this national critical care network available to be used by FEMA or the Department of Defense," said **David Zonies, MD, MPH**, OHSU associate chief medical officer for critical care services, and professor of trauma, critical care and acute care surgery. "We should be able to take care of dozens and dozens of patients simultaneously." ■



Marshall K. Lee, MD, OHSU medical director for adult critical care telemedicine and assistant professor of anesthesiology and perioperative medicine in the OHSU School of Medicine, says the virtual ICU model allows telemedicine providers to see data in real time and to work jointly with bedside teams.

Photo courtesy of OHSU/Jennifer Smith

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