

Family Physicians of Oregon

VOL XIX • NO 3 • SPRING 2015

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- OAFP Proposing Payment Reform Legislation
- Chronic Pain Management
- New Family Medicine Residency Program



Oregon Academy
of Family Physicians



THE OFFICIAL MAGAZINE OF THE
OREGON ACADEMY OF FAMILY PHYSICIANS



VOL XIX • NO 3 • SPRING 2015

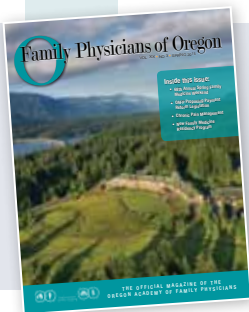
Family Physicians of Oregon

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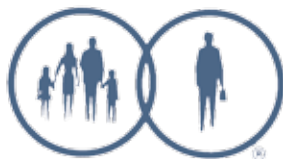
About the Cover:

The 68th Annual Family Medicine Weekend will take place at Skamania Lodge, in the scenic Columbia River Gorge, just 45 minutes from Portland. Here's your chance to learn, connect, and rejuvenate with your colleagues and your family members. Don't miss this must-attend event – April 16-18, 2015 (ALSO Refresher Course April 18-19).

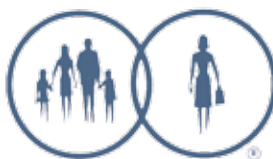


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Oregon Academy of Family Physicians



EDITION 33



LIZ POWERS, MD

Making the Case for Payment Reform

I'm used to our patients bringing in medical bills to review with our billing specialist. We all know that our current system of charges and payments is confusing. It took me some time, though, to realize that one of my patients, let's call him Greg, was bringing ALL of his mail to his care team visits. Greg comes once a week to have his medications put in a pill box. Greg suffered a STEMI about six months ago and has a new complex regimen of medications. His trouble adhering to medical treatment is complicated by the fact that he is illiterate and, hardest of all, his wife and sole support system, died nine months ago of metastatic cancer. Now Greg relies on the care team at our clinic for help with much more than his medical conditions.

Greg's needs were clearly more problematic than I could address in an office visit and were not amenable to treatment with medications. However, he was able to connect with our behavioral health coach regarding his complicated grief reaction. With her help, over time, he was able to get back out in the community. He's lost some weight and I see him biking everywhere, wearing the helmet our clinic gave him as a Christmas present. Being a patient-centered medical home means the clinic is set up to provide Greg with the care he needs to improve his health above and beyond what has historically been deemed "medical treatment" – including helping him read his mail.

Winding Waters Clinic was recognized as a Tier 3 PCPCH on October 1,

2011. Our first attestation was both a reflection of what our practice could provide for patients and a roadmap for the future. Providers and staff connected around the "why" of the changes. We've continued to make changes since then always asking the question, "Is this in the best interest of our patients and our community?" We had a site visit from the Oregon Health Authority on October 8, 2013 that highlighted our accomplishments. Our clinic strengths include authentic co-located team-based care with physical space and workflows designed to maximize efficiency, team-based care and patient engagement. We have a Patient Advisory Council that is involved with clinic improvement activities and our waiting room and exam rooms highlight shared decision-making activities and resources.

Patients and providers alike have benefited from our PCPCH transformation. We measure staff engagement monthly using an anonymous survey. Last month our clinic average was 8.9 on a 10-point Likert scale. In our 2013 CAHPS survey, we were above Oregon's average for access, communication and shared-decision making. Our score on office staff (*office staff are helpful and treat patients with courtesy and respect*) was 99.2%!

Our emphasis on a broad definition of health (including underlying social determinants) allows us to see patients in a life context instead of addressing isolated medical issues. In turn, this expanded definition of health fostered

opportunities for community partnerships. Recognizing that a healthy start for our kids leads to a healthier, stronger and more equitable community, we have partnered with a local agency, Building Healthy Families (BHF), in an effort to integrate parent education and early literacy into practice-wide systems. With some creative thinking we've been able to add additional parent education and services without cutting into visit time and without overburdening staff. The front desk receptionist scrubbing charts for the day pulls a pre-prepared bundle of age-appropriate well-child materials so it awaits patient and physician. When the child and family arrive, BHF staff and clinic staff work together to administer the Ages and Stages Questionnaire (ASQ), a developmental and social-emotional screening, to all children up to 60 months. Staff flag providers, as well as families, if a child might benefit from additional support. These efforts are paying off when we measure outcomes that matter. From 2013 to 2014 our CAHPS scores on child prevention (*parental education around health behaviors and injury/accident prevention*) increased from 40% to 63% and our scores on child development (*parental education around physical and emotional development*) increased from 46% to 72%.

As I visit practices around the state, I have seen other creative ways that clinics have transformed to enhance how they care for patients in a PCPCH setting.

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Some are using community health workers to provide more care in the home setting; others are using group visits as an alternate way to get patients more engaged in their health and health care; and a number of practices have staff dedicated to tracking patients through transitions of care (from ER/hospital setting to nursing facility to home) to maximize good outcomes for patients when they are most vulnerable. All of these value-added activities are currently uncompensated. At professional meetings and site visits alike, I run into other physicians who echo my own uncertainty about being able to expand, or even sustain, the changes we've made so far, without meaningful payment reform.

In my practice we get some per-member, per month (PMPM) payments from our CCO. These payments currently amount to 3% of our monthly revenue, while CCO

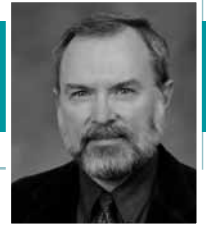
patients are 27% of our practice. The cost of our care team currently amounts to 16% of our monthly overhead. We need to receive care management fees from all payers and the payments need to be enough to support the value-added services the care team provides in order to continue to deliver the best care possible.

I get really excited when I think about what enhanced payment from all payers would allow us to do. For example, grant funding recently allowed us to embed behaviorists in our clinic and hire a nurse care manager (we're one year into the three year project). The initial focus of the grant was on diabetes, and it's clear that we've gotten better at taking care of people with diabetes. Our monthly scorecards show that we've significantly improved our pneumococcal vaccination rates and our measurement of HgbA1c values. We've also improved diabetes control across our clinic population, increasing those with con-

trolled diabetes (HgbA1c <8) from 68% of our diabetics to 84% of our diabetics. And to top it off, the 150 patients working with our behaviorist have collectively lost more than 600 pounds in the last six months! More importantly, we are connecting with our patients on things that matter. When comparing our 2013 and 2014 CAHPS survey results, our scores on patient self-management (*involving patients in decisions regarding prescription of medications*) increased from 41% to 47% and our scores on adult behavioral health (*addressing stress, mental health and substance abuse issues*) increased from 36% to 58%.

I'm motivated by the changes I've seen in my practice and in other practices across the state. Collectively we need to continue to push for payment reform to fund the work we are doing to assist in our creative transformation and to support our patients in their pursuit of optimal health.

● FROM THE HILL



JOHN SAULTZ, MD, CHAIR OF FAMILY MEDICINE, OHSU

It is hard to believe that I have been the family medicine department chairman at OHSU for over 16 years and this is the sixtieth "From the Hill" column I have written. Over the years, I have used the column to share news about our department, accomplishments of our faculty, and concerns about our specialty. Everything our department has accomplished can be tied directly to our partnership with Oregon's family physicians, many of which are graduates of our medical school or residency programs. OAFP members have taught our students, worked with us on research projects, and helped us to provide an important voice for health reform in our state and nation. In turn, we have tried to represent our specialty well in the academic world. Together, we have made Oregon an admired national model for excellence in family medicine.

Over the years, I have received surprisingly few responses to these columns. Occasionally I receive an email from someone who has read them, but the *Family Physicians of Oregon* has received only one formal reply in the form of a letter to the editor. So it is hard to know who reads these columns or the degree to which they are useful. Much has changed during these 16 years. There are now two medical schools in Oregon. We have added positions to the residency programs and new residencies are being planned in our state. Oregon family physicians have adopted the patient-centered medical home and are working with Coordinated Care Organizations to care for more patients than ever before. More of us are employed by health systems and more of us have restricted our

As I look back at 16 years in my current role, I often think about those that came before us. The risks they took and the obstacles they overcame were far bigger problems than we face today. They gave us a dream of what family medicine could be and I remain as inspired by that dream as I was 35 years ago.

scope of practice when compared to traditional, full-scope practice. And the pace of change continues unabated.

OHSU has changed a lot during these years as well. Today, we have far less state support and depend far more on our own clinical practices and grant writing skills. There is dramatically less support for rural training and we struggle to maintain a strong primary care focus in the school of medicine's curriculum. Much of what our department has accomplished has been due to our own initiative and the strength of our partners in the community. In spite of these challenges, we still attract students from all over the nation based on their belief that this is the best place to learn about family medicine. Recruiting to our residencies and our faculty has never been stronger.

Healthy organizations have a strong commitment to their missions and build a culture of excellence around that mission. They do not complain about problems, they solve them. Today, our discipline has plenty of problems. But we are also far more equipped to deal with them than ever before. Family physicians fill positions of leadership in almost every health care organization in our state. And yet,

something seems amiss. It seems harder and harder to remember the core values that got us to this point. Every decision in our health care system seems to make it harder to care for patients and our voice sometimes seems drowned out by the white noise that rules the world of health policy. Our zeal for better population health creates uncertainty about which of our core values should endure and which are out of date. On our best days, we feel connected to the patients and communities we serve. On our worst days, we wonder why we are doing this for a living.

In spite of what people might tell you, the solutions to today's challenges in health care do not lie at the level of state government or in the lofty offices of health plan and hospital leaders. The solutions lie in the communities we serve. If it sometimes feels to us like our voice is being lost in the fray, imagine how much less of a voice our patients and communities have. Every year, our patients are faced with higher out-of-pocket costs and more administrative hassles from their health plans. Local businesses are worried about how to afford health benefits for their

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employees. Health reform is putting more people into the health care system and this is a good thing. But the delivery system is not up to the growing demand and this affects every family physician in our state. All of this is very stressful for us. You might think those of us at the medical school are protected from much of this. I don't think this is the case, but it might be easier for us to be optimistic because we are exposed every day to the energy and altruism of our students and residents. Nothing about our health care system inspires me much these days, but everything about these young people does. Their hope is contagious. The talented young faculty we have recruited to the department also inspire me. They look at family medicine today as a canvas on which to paint and they think of better ways of doing things every day.

As I look back at 16 years in my current role, I often think about those that came before us. The risks they took and the obstacles they overcame were far bigger problems than we face today. They gave us a dream of what family medicine could be and I remain as inspired by that dream as I was 35 years ago. The question to ask is this, "Have we lived up to their example?" At the very least, it seems like we owe it to them to preserve and protect the dream and pass it along to the next generation with as much passion as they did.

Many of the founding generation of our specialty are no longer with us. But you can feel the same enthusiasm when you meet with today's young people. When you come to our annual meeting this spring, many of them will be there. You should take some time to talk with them. Hope is a good thing and the dream is still alive.



DOUG BARBER, OAFP LOBBYIST

Groundbreaking Payment Reform Legislation Being Proposed

“Multipayer support will ensure that practices are compensated for the work they are doing to provide coordinated care, and supported in achieving better outcomes through a robust and shared primary care home approach.”

That was the promise in the Multipayer Agreement, signed in November 2013 by ten health insurers (including Cigna, Aetna, Moda Health, PacificSource, Providence, Kaiser Permanente and Regence Blue Cross Blue Shield), some CCOs (including CareOregon, Health Share and the Umpqua Health Alliance), and Oregon’s major provider organizations (Oregon Medical Association, Oregon Nurses Association, Oregon Association of Hospitals and Health Systems, Oregon Pediatric Society, along with the OAFP).

But that promise has been unfulfilled.

A few insurers and CCOs have implemented payments to support care coordination and the other non-reimbursable services provided by Patient-Centered Primary Care Homes (PCPCH). But those payments are not widespread nor are they significant enough to support the additional personnel (such as nurses, medical assistants, care coordinators and behavioral health specialists) that PCPCHs have hired to deliver high-quality care.

Consequently, the OAFP is working with **Sen. Elizabeth Steiner Hayward** (D-Portland) to introduce PCPCH payment reform legislation. “Clinics across

the state have made substantial gains implementing programs in their offices that promote health in our most complex patients. Passage of this bill would allow these practices to continue these programs without interruption,” Steiner Hayward said.

The original plan was to specify a payment floor of \$6, \$8 and \$12 PMPM for Tier 1, 2 and 3 PCPCHs respectively. Those numbers were based on the actual cost of providing PCPCH care in OAFP clinics around the state (see the following article on OAFP’s PCPCH cost estimator).

After several meetings with a variety of providers and insurers, the legislation was changed so a new multipayer stakeholder group would develop one or more reimbursement methods “that will direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in PCPCHs.” One of those methods would be a PMPM payment for patients attributed to a clinic or provider.

Key Elements of SB 609:

- Establish a learning collaborative (the new multipayer stakeholder group).
- Require innovation payments to PCPCHs for non-reimbursed services

including risk-stratified care management and care coordination.

- Require reports from providers to insurers about how innovation payments are used.
- Have the collaborative establish quality and outcome benchmarks for evaluating the effectiveness of the innovation payments.
- Apply to all insurers and payers including commercial insurers (whether or not they participate in the collaborative), OEBC & PEBB, the CCOs, and third-party administrators.

OHA Introduces a Similar Bill

The Oregon Health Authority (OHA) introduced SB 231 that would create a Primary Care Transformation Initiative designed to “increase the resources dedicated to primary care” in Oregon. Their primary care payment reform committee would:

- Develop up to five payment methodologies that are an alternative to fee-for-service and support patient-centered care.
- Align financial incentives with the health care quality improvement goals of carriers, purchasers and consumers of health care.

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- Provide technical assistance to PCPCHs in each community.
- Develop an evaluation plan for the initiative.

CPCi Shows Better Outcomes and Cost Savings

Medicare's experiment with innovation payments to clinics for PCPCH services is showing promising results.

A recent report on the first year (through September 2013) of Medicare's Comprehensive Primary Care initiative (CPCi) found that, "CPC has generated enough savings in Medicare health care expenditures to nearly cover the CPC care management fees paid by CMS for attributed Medicare fee-for-services beneficiaries."

The report found that this initiative reduced Medicare A and B costs by \$14 PMPM. This comes primarily from fewer hospitalizations, reduced use of ED and decreased specialist visits. The report concludes, "Impacts were nearly large enough to offset CMS's monthly care management fees, which average \$20 PMPM."¹

PCPCH Research is Promising

Peer-reviewed research in 28 studies found better health outcomes at lower costs for patients in PCPCHs. The findings include:

- Cost savings of \$120.69 PMPM in North Carolina.
- 29.7% reduction in ED visits and 28.5% reduction in hospitalizations at

New York-Presbyterian.

- 25% reduction in high-cost imaging services in Colorado.

Now it's Oregon's Turn

The OAFP and OHA bills will give the 2015 Legislative session two options to consider for boosting PCPCH payments in Oregon. Hopefully, the process will result in a new structure to encourage PCPCH financial support.

The OAFP will continue to provide updates regarding this legislation on our website, in *Family Physicians of Oregon* articles, and in blast emails. Stay tuned!

¹Mathematica Policy Research. "Evaluation of the Comprehensive Primary Care Initiative: First Annual Report," January 2015.

Supporting the PCPCH Model of Care

In regards to the Patient-Centered Primary Care Home (PCPCH) model of care, there are some things we know for certain: that a successful PCPCH delivers care in a unique way; that a fee-for-service payment structure is not the best way to capture all that is performed in a PCPCH; and that it costs an office more to practice as a PCPCH. But what we don't know for sure about PCPCH is how *much* more it costs to practice this way and how exactly this money is expended. We need to be able to answer these questions for payers, patients and legislators.

If those of us who are practicing in a PCPCH can't provide this data, then insurance companies and other payers will set their own amounts and will choose arbitrary fees that undervalue our care. (*Case in point, some insurance companies are paying less than \$2 PMPM*). We know this is too low, but what is the right amount?

With the help of some of the PCPCH clinics in Oregon, we have developed a worksheet for clinics to use to illustrate the services provided and to quantify the staff time needed to perform these services. From the practices that have completed this form to date, we have determined that it costs approximately \$8 PMPM to \$18 PMPM to provide PCPCH care. We recognize the difference in costs related to a specific practice vary widely based on practice location, PCPCH tier level, as well as the types and services provided.

In order to be credible with legislators and payers, we need help collecting information from your clinic regarding how much it costs to provide PCPCH care. In addition, it is also important to be able to document services you provide that are currently unbillable (such as a care coordinator or a behavioral health specialist).

We are asking that you complete the PCPCH Cost Estimator Tool on page 13. If

you or your staff needs help filling it out, just ask; we are happy to provide assistance.

As you fill out the form, remember to include any services your clinic provides that are currently paid for by your IPA, CCO or through grant funding. If you know your CCO (or another entity) is paying for some of the services you provide, but don't know the cost details, please make a note and we will do some additional research to find these answers. Also, when completing the Cost Estimator Tool, feel free to provide a range, instead of an exact dollar amount or number of hours.

To ensure that the proposed payment reform legislation passes so that you can be compensated for the work you are doing to provide the best care possible in a PCPCH setting, it is crucial that we have this beneficial information from as many of our clinics as possible. Please send in your completed Cost Estimator Tool to kg@oafp.org as soon as possible. Thank you for your help in this matter!

PCPCH COST ESTIMATOR TOOL

The staff at Winding Waters Clinic in Enterprise developed this cost estimator tool to help articulate how much it costs to maintain their PCPCH status. The FTE equivalents provided below reflect what their clinic is using; your numbers will probably be different but you may find the information below as a useful starting point.

Context of calculations:

- Clinic Size: _____ # of active patients
- # of Annual Visits: _____
- Provider Patient Care FTEs: # _____
- Outsources the following: (examples: billing, IT): _____
- Utilizes this EHR: _____
- Clinic hours of operation _____ hrs./week
- Average of _____ hrs of staff time/week

There are four basic areas that will either need additional resources or would be newly created for an organization (not including IT):

- Engaged Leadership
- Continuous Quality Improvement (QI)
- Care Coordination
- Patient Care Management

Engaged Leadership:

- 2.5 FTE (\$ _____/month)
 - Clinician Champion: 0.5 FTE (\$ _____/month)
 - Practice Administrator or Office Manager (Executive Level) 1 FTE (\$ _____/month)
 - Department Managers (Front Office/Back Office) 1 FTE (\$ _____/month)

QI:

- 0.25 FTE (\$ _____/month)
 - 1 hr. meeting/month (staff from each department plus management) (\$ _____/month)
 - Average 3 hrs./week working on projects, preparing for meetings (\$ _____/month)
 - 4 hrs./month coordination of QI efforts with Patient Advisory Council (\$ _____/month)
 - Administering and interpreting CAPHS surveys quarterly (\$ _____/month)

Care Coordination:

- 6 FTE (\$ _____/month)
 - RN and Behaviorists: 2 FTE (\$ _____/month)
 - *Patient Centered Interactions*
 - Care Team: 4 FTE (3.5 clerical staff, 0.5 RN) (\$ _____/month)
 - *Care Coordination*
 - Referral/order tracking
 - Medication management (med reconciliation, refills management)

- Phone/patient portal message triaging (RN/Medical Assistant)
- Clinical quality and population health data collection and sharing
- Community outreach

Patient Care Management:

- 6.5 FTE (\$ _____/month)
 - Medical Assistants: 3 FTE (\$ _____/month)
 - *Proactive care*
 - Chart scrub/huddles
 - Preventative health discussions
 - Shared Decision Making
 - Front Office: 2 FTE (\$ _____/month)
 - *Enhanced Access*
 - Recalls – outreach for chronic and preventive health care needs
 - Patient Portal Management
 - Open Access Scheduling
 - Front Office/Data: 0.5 FTE (\$ _____/month)
 - *Empanelment*
 - Panel management
 - RN Care Coordinator: 1 FTE (\$ _____/month)
 - *Organized Evidence-Based Care*
 - Sub-population management (chronic care model)
 - Updating and implementing evidence-based standard care across PCPCH

Included in these calculations are only the NEW tasks (or new positions if new hire needed) required on an ONGOING basis to cover overhead of a highly-functioning PCPCH. Not included in this calculation is the increased overhead cost associated with expanded hours of operation. Also not included in these calculations are the up-front costs of transformation.

OVERALL FTE INCREASE = 15.25 (\$ _____/month)

0.5 FTE clinician

1 FTE high-level mgmt

1 FTE mid-level mgmt

1.5 FTE behaviorist

2 FTE RN

3 FTE MA

6.25 FTE clerical/front desk

**OVERALL expected increase in cost/month/pt = \$ _____
(PCPCH/care mgmt – does NOT include E+M fees)**

ATTEND THE MOST IMPORTANT MEETING
FOR FAMILY PHYSICIANS IN 2015!

OAFP'S 68th ANNUAL SPRING FAMILY MEDICINE WEEKEND

SKAMANIA LODGE, STEVENSON, WA

APRIL 16-18, 2015 • ALSO REFRESHER COURSE APRIL 18-19

This year's meeting will be held at Skamania Lodge, in the scenic Columbia Gorge, just 45 minutes from Portland and once again we are joining two meetings together: the Oregon Academy of Family Physician's (OAFP) annual Scientific Assembly and the Oregon Rural Practice-based Research Network's (ORPRN) annual convocation. This collaboration offers important and timely clinical and practice enhancement education for both groups. Please join us!

ORPRN CONVOCATION

What is ORPRN?

Established in 2002, the Oregon Rural Practice-based Research Network (ORPRN) is a statewide organization of primary care clinicians who work with community partners and academicians to promote knowledge transfer and conduct research to reduce health disparities. ORPRN's research principles include grounding research and practice redesign implementation in the real world of busy primary care practices and their community settings. ORPRN is headquartered at OHSU, and has regional offices staffed by four Practice Enhancement Research Coordinators (PERCs).

THURSDAY, APRIL 16

12:00 PM

Poster Session and pre-Convocation Networking time with snacks (Enter drawing)

1:00 PM

Welcome – Albert Thompson, MD, Chair, ORPRN Steering Committee

1:10 – 4:50 PM

Walking the Ledge – Dangerous Ideas and Innovation in Primary Care

1:10 PM

Primary Care for Patients with Complex Health Care Needs: Lessons from LEAP – Keynote Speaker, Michael Parchman, MD, MPH

2:00 PM

Behavioral Health Integration in Primary Care Practices – Elizabeth Waddell, PhD

2:45 PM

Oral Health and Community-Oriented Primary Care – Eli Schwarz, DDS, MPH

3:30 PM

Break

3:45 PM

Interactive Exercise – Danger and Finding the Truths, Trends, and Unique Ideas – ORPRN Practice Enhancement Research Coordinators

4:15 PM

Are You Ready? Linkages Promoting New Models of Payment and Relationships – L.J.Fagnan, MD; David Dorr, MD, MS; Ronald Stock, MD, MA

4:50 PM

Prize drawing (must be present to win)

4:55 PM

Closing Remarks – Sandra Dunbrasky, Chair ORPRN Steering Committee

OAFP FAMILY MEDICINE WEEKEND

FRIDAY, APRIL 17

7:00 – 8:00 AM

Coffee and continental breakfast in the exhibit hall. *The OAFP is 100% free of any pharmaceutical company funding or support. Please drop by and thank our exhibitors for supporting family physicians.*

8:00 – 8:15 AM

Welcome and introductions

8:15 – 9:15 AM

Our Moment in History: The Importance of Family Medicine Today – John Saultz, MD

9:15 – 10:15 AM

Family Medicine for America's Health – Reid Blackwelder, MD, AAFP Board Chair

10:15 – 10:45 AM

Break. *Please visit the exhibit hall where mixed in with our excellent exhibitors will be table after table of auction items.*

10:45 – 11:45 AM

Small Groups – Choose one:

1. Top 10 Herbal Remedies to Recommend – Melissa Hemphill, MD
2. New Drugs, 2015: The Good, the Bad and the Worthless – Bill Origer, MD
3. The Transformational Potential of Direct Primary Care – Erika Bliss, MD
4. Not Just a Discharge Summary: The Role of PCPCH in Transitions of Care – Jessica Flynn, MD

12:00 – 2:00 PM

Lunch time options. Pick up a box lunch and choose from the following options:

- Guided hike on the 1.75 mile Lake Loop Trail (easy). Dress for the weather. We will go rain or shine!
- Social Media – What it is and why you should use it – Melissa Hemphill, MD
- Round table discussions: Topics include: practical tips and up-to-date information on ABFM board certification; Early Discussion and Resolution update; international medical work; new physician issues, and more.

2:00 – 3:00 PM

Small Groups – Choose one:

1. SBIRT in the Clinic: Making it Work – John Muench, MD
2. HIV Screening and Primary Care Pearls – John Nusser, MD.
3. Preventive Medicine for Adolescents – Johanna Warren, MD
4. SAM Study Hall, Pain Management – Josh Reagan, MD. *This workshop will last the rest of the afternoon. Take and pass both the written part of the exam and the clinical simulation. Receive 13 hours of CME after you pass.*

3:00 – 3:30 PM

Break – Snacks in the exhibit hall.

3:30 – 4:30 PM

Small Groups – Choose one:

1. Fact or Fad: What's New in Nutritional Therapy – Matthew Riley, MD
2. Addictions 101 for Primary Care – Ariel Singer, MPH
3. The Power of Science + Art: Pairing Data with Patient-centered Care Strategies to Begin Achieving the Triple Aim – Evan Saulino, MD, PhD
4. Physician Portraits – John Muench, MD
Review and discuss a series of fine art portraits that highlight physicians at work. We hope to better understand the evolving role of the physician-professional in society, to better understand our own reaction to popular perceptions of the physician in historical context and to improve our ability to interpret the emotional content in fine art paintings in ways that might better inform our own doctor-patient encounters.

5:30 – 9:00 PM

OAFP Foundation "Place Your Bets on the Future of Family Medicine" Dinner and Auction



SATURDAY, APRIL 18

7:00 – 9:15 AM

Congress of Members. Breakfast will be served. *This one session will be both Opening and Closing sessions of Congress. All OAFP members are welcome. Watch www.oafp.org for Resolutions we will be discussing.*

9:15 – 10:15 AM

1. Joint Injection Review – Ryan Petering, MD
2. Opening Doors: Providing Quality Care to LGBTQ Patients – Carol Blenning, MD, Maliheh Nakhai, MD
3. **OAFP FOUNDATION-SPONSORED WORKSHOP**
Adverse Childhood Experiences (ACES)/Trauma-Informed Care in the Primary Care Setting – Teri Petterson, MD
Increase your knowledge about the impact of Adverse Childhood Experiences (ACES) on lifelong health and functioning of your patients. Develop a framework to identify and address ACE's within your practice and identify strategies for creating a more trauma-informed clinic and system.

10:15 – 11:15 AM

TOWN HALL – Update on the Oregon Legislative Session and Issues that Affect Family Medicine – Senator Elizabeth Steiner Hayward, OAFP Lobbyist Doug Barber

11:30 AM – 12:30 PM

Small Groups – Choose one:

1. Pediatric Preventive Care – TBD
2. Patient Engagement – Liz Powers, MD
3. Lipid Guidelines: Making Sense of ATP-IV – Maureen Mays, MD

12:30 – 2:00 PM

CELEBRATION LUNCH – *Installation of officers and surprise announcement of the Oregon Family Doctor of the Year.*

2:00 – 3:00 PM

Musculoskeletal Exams – Hands-on workshop – Ryan Petering, MD

2:00 – 6:00 PM



Advanced Life Support in Obstetrics (ALSO) Refresher course – REGISTER SEPARATELY. **This Refresher Course is half the time of a regular ALSO Course** and will extend your certification by another 5 years. You may only take the Refresher before your ALSO certification expires.

SUNDAY, APRIL 19

8:00 AM – 12:00 PM

ALSO Refresher

If you're interested in attending this year's ORPRN Convocation and OAFP Annual Spring CME Weekend, there's still time to sign up. You can register online at our website – www.oafp.org -- or by mail or FAX. We look forward to seeing you in April!

ORPRN CONVOCATION



Walking the Ledge . . . Dangerous Ideas and Innovation in Primary Care

“An idea that is not dangerous is unworthy of being called an idea at all.” – Oscar Wilde

What is a dangerous idea? In football it might be deciding to pass instead of run when it's second and goal with two timeouts and 26 seconds left on the clock. In health care, innovation and new models of care may be viewed as dangerous. Innovation starts at the margins of medical practice, with a few early adopters willing to take the leap with ideas like giving patients full access to their health records, bringing a behaviorist into the team, or forming a patient and family advisory council to join the practice's quality improvement committee.

Join us as we step into new and often uncharted territory during the ORPRN Convocation which will be held on Thursday, April 16, 2015, from 12-5 PM in partnership with the OAFP's Annual Spring Family Medicine Weekend at Skamania Lodge in Stevenson, Washington.

ORPRN Convocation Presentations:

Primary Care for Patients with Complex Health Care Needs: Lessons from LEAP

Keynote Speaker: Michael Parchman, MD, MPH

Behavioral Health Integration in Primary Care Practices

Elizabeth Waddell, PhD; Rural practice staff and clinic-community members

Oral Health and Community-Oriented Primary Care

Eli Schwarz, DDS, MPH, PhD

Interactive Exercise – Danger and Finding the Truths, Trends, and Unique Ideas

ORPRN PERCs

Are You Ready? Linkages Promoting New Models of Payment and Relationships

L.J. Fagnan, MD; David Dorr, MD, MS; and Ronald Stock, MD, MA

Faculty Bios:

David A. Dorr, MD, MS, Department of Informatics and Clinical Epidemiology earned a BA in Economics and an MD from Washington University in St. Louis. He completed an Internal Medicine residency at Oregon Health & Science University, and earned a Master's in Medical Informatics and Health Services Administration from the University of Utah. He developed the Integrated Care Coordination Information System (ICCS), a population management system connected to multiple EHRs and other data sources that does risk stratification, complex care management, quality measurement, and reporting.

L.J. Fagnan, MD, ORPRN Director, received his medical degree from the University of Oregon Medical School and joined the United States Public Health, Indian Health Service and practiced in Bethel, Alaska, for three years. He completed his family medicine residency training in Boise, Idaho, at the University of Washington Family Medicine Residency of Southwest Idaho. In 1977, Dr. Fagnan founded Dunes Family Health Care, in Reedsport, Oregon, which was funded as one of thirteen model rural practices with the Robert Wood Johnson Foundation's Rural Practice Project.

Michael Parchman, MD, MPH, is Director of the MacColl Center for Healthcare Innovation within the Group Health Research Institute (GHRI). He was Director of the Primary Care Practice-Based Research Initiative and a senior advisor for Primary Care at

the Agency for Healthcare Research and Quality (AHRQ) in Rockville, Maryland. His work has focused on improving outcomes for patients with chronic illness in small primary care practice settings. Dr. Parchman is co-investigator on the Robert Wood Johnson Foundation-supported project, "Primary Care Teams: Learning for Effective Ambulatory Practices (LEAP)."

Eli Schwarz DDS, MPH, PhD, is Professor and Chair of the OHSU Department of Community Dentistry, and has a DDS and a doctoral degree from University of Copenhagen, Denmark, and a Master's degree in Public Health (cum laude) from Hadassah Medical School, University of Jerusalem. He is a founding fellow of the Hong Kong Academy of Medicine and a fellow in the specialty of Community Dentistry in the Hong Kong College of Dental Surgeons. He is also a fellow of the American College of Dentists and a fellow of the Royal Australasian College of Dental Surgeons.

Ronald Stock, MD, MA, is a geriatrician, clinical health services researcher and Associate Professor of Family Medicine. A graduate of the University of Nebraska College Of Medicine, Dr. Stock completed his residency and faculty development fellowship in Family Medicine at the Medical University of South Carolina and University of North Carolina-Chapel Hill and has a Certificate of Added Qualifications in Geriatric Medicine. Ron is the Director of Clinical Innovation at the Oregon Health Authority's Transformation Center.

Elizabeth Waddell, PhD, ORPRN Practice Transformation Director, contributes to leadership and curriculum development on multiple practice transformation projects that focus on integration of primary and behavioral health care. She received a PhD in Sociomedical Sciences at Columbia University and then completed a postdoctoral fellowship in NIDA's Behavioral Sciences Training Program in Drug Abuse Research.

For more information about the ORPRN Convocation on Thursday, April 16, visit <http://www.ohsu.edu/xd/outreach/oregon-rural-practice-based-research-network/news-and-events/convocation.cfm>.

Health is Primary

By now, you've probably been hearing quite a bit about *Health is Primary*, a three-year communication campaign launched during the 2014 Academy of Family Physicians Assembly in Washington, D.C. that advocates for the values of family medicine, demonstrates the benefits of primary care, and drives patient activism. The goal is to create an America where *Health is Primary*. This communication piece is part of a larger effort by the newly formed Family Medicine for America's Health (FMAH), which is represented by the following family medicine organizations:

- American Academy of Family Physicians
- American Academy of Family Physicians Foundation
- American Board of Family Medicine
- American College of Osteopathic Family Physicians
- Association of Departments of Family Medicine
- Association of Family Medicine Residency Directors
- North American Primary Care Research Group
- Society of Teachers of Family Medicine

You may have more questions than answers regarding this campaign, and what, if anything, it has to do with you and your everyday practice. Read on as we answer the most frequently asked questions.

What is Family Medicine for America's Health?

Family Medicine for America's Health is a new collaboration between the nation's eight leading family medicine organizations to drive continued improvement of the U.S. health care system and demonstrate the value of true primary care.

Their goal is to transform the family medicine specialty to ensure that we can meet the

nation's health care needs and, ultimately, improve the health of every American. A five-year strategic effort, focused on furthering the evolution of the patient-centered medical home, will be complemented by the *Health is Primary* communications campaign to advocate for primary care. Through this campaign, America's family physicians will join forces with patients, employers, policymakers, community leaders, and other key stakeholders to demonstrate how primary care keeps people healthy, improves population health and reduces health care spending; in other words, meet the Triple Aim.

What will the *Health is Primary* campaign do?

Health is Primary will educate and encourage patients to increase the physician-patient partnership and provide patients with actionable information about how to improve their health through exercise, nutrition, prevention, and chronic disease management. The objective is to arm patients with information that will help them understand what primary care is and how to get the most from their medical home.

Are there specific health topics the campaign is focused on?

During the course of the campaign, *Health is Primary* will drive consumer engagement initiatives focused on important health issues, including, in its first year, nutrition and fitness, chronic disease management, immunizations, and smoking prevention and cessation. They will expand this focus to include other key issues in years two and three of the campaign.

Beyond a media campaign, how do family physicians plan to deliver on their campaign promise to make health primary?

The *Health is Primary* communications campaign coincides with a five-year strategic implementation effort by Family Medicine for America's Health, which will work simultaneously to transform the specialty and deliver on the promise of primary care. The strategic effort will focus on shifting to comprehensive primary care payment, furthering the evolution of the patient-centered medical home, advancing the use of technology, and ensuring a strong primary care workforce. To accomplish these efforts, a volunteer workforce will be established in six major areas: Practice, Payment, Workforce Education and Development, Technology, Research and Engagement.

Why is family medicine undertaking this effort now?

FMAH believes our health care system is at a tipping point. During the last decade, they have seen a major transformation, from the development of patient-centered medical homes to the passage of the Affordable Care Act. Now that health care reform is underway, family physicians across the country are ready to harness the renewed focus on prevention, population health, and reducing health disparities to build a robust primary care infrastructure that reflects the values of family medicine and puts patients at the center of care.

What should you be doing to help to foster awareness of *Health is Primary*?

For now, just understanding the intent of *Health is Primary* is all you need to know. As we hear more from Family Medicine for America's Health regarding how to transform perceptions and behavior surrounding health care in America, we will keep you posted. In the meantime, if you'd like to know learn more, go to healthisprimary.org.

AN OUNCE OF PREVENTION



WHERE HEALTH IS PRIMARY.

 **Health is Primary**

BROUGHT TO YOU BY AMERICA'S FAMILY PHYSICIANS



American Academy
of Family Physicians



Patients with access to primary care are more likely to receive preventive services and timely care before their medical conditions become serious – and more costly to treat.

Family doctors work with their patients to keep them healthy. We want to ensure that all patients have access to and use regular preventive care.

Let's make health primary in America.

Learn more at healthisprimary.org.

 **HealthIsPrimary**

#MakeHealthPrimary



FOUNDATION NEWS



“PLACE YOUR BETS ON THE FUTURE OF FAMILY MEDICINE” ANNUAL FOUNDATION AUCTION & DINNER APRIL 17, 2015 5:30 PM

Come join us on Friday, April 17 at the Skamania Lodge where auction items will be on display and up for bid all day long. Then, beginning at 5:30 head to the ballroom for an evening of wine, dinner and camaraderie! You'll have a chance to purchase some great goods and services, chat with old colleagues, meet with new, and support the Foundation's efforts to provide scholarships for medical students, research funds for residents, respite for rural physicians, top-notch ethics lectures and educational opportunities for all members.

With the proceeds from last year's auction, the Foundation was able to provide the Laurel G. Case Award for Rural Experiences to fourteen OHSU medical students

between their first and second year who had the opportunity to live and work with a rural family physician this past summer. In addition we awarded Mary Gonzales Lundy scholarships to Dean Defrees and Ilana Hull, fourth year medical students who matched in a family medicine residency. To encourage physician involvement in the community, we supported presentations in over fifty fourth and fifth grade classrooms throughout the state who participated in the Tar Wars anti-tobacco education program. Medical supplies were also purchased for the FMIG-supported Health Equality Week screening fair. The Foundation is also sponsoring a workshop at the upcoming Annual Spring Family Medicine Weekend entitled, "Adverse Child-

hood Experiences (ACES)/Trauma-Informed Care in the Primary Care Setting." Dr. Teri Pettersen, a metro area pediatrician, will speak on the short- and long-term effects of trauma and the effects of said trauma on the individual, their family, and their community.

With your help at this year's auction – either by providing cash, product, service or bidding on items – the Foundation can continue to support and expand on funding these worthwhile causes. Email us today at mail@oafp.org or call at 503-887-6910 to donate an item or service. The foundation is a 501 (C) 3 charitable organization and all donations are tax deductible. You can download a Foundation donation form at <http://oafp.org/fundraising-auction/>.



SAVE THE DATE

**68TH ANNUAL FAMILY
MEDICINE WEEKEND**
 Scientific Assembly & Congress
 April 16 – 18, 2015
 OAFP/Foundation Auction, April 17
 ALSO Refresher Course, April 18-19
 Skamania Lodge, Stevenson, WA

For more information, contact Kerry Gonzales at the
 Oregon Academy of Family Physicians
kg@oafp.org • www.oafp.org • (503) 528-0961 • Fax (503) 528-0996



A CHRONIC PAIN MANAGEMENT JOURNEY

“Dealing with pain is a life skill that we must all learn if we are to live on happily.” – Keith A White, MD

This statement is true not only for our patients, but for the physicians who treat chronic pain patients as well. The standards of care are forever changing. It is imperative to develop practice guidelines and skills in order to appropriately treat chronic pain patients and keep ourselves happy in practice.

Chronic pain management is a subject most physicians of my generation were not taught. In fact, I believe we were taught not to manage pain. Not long after I finished my residency and started practice, the Oregon Medical Association (OMA) and the Oregon Board of Medical Examiners (now called the Oregon Medical Board (OMB)) offered an afternoon course at the OMA on “Chronic Pain Management.” Those presenting this course included national experts in pain management. The underlying theme was that it was appropriate to use opiates to ease the pain of the dying but it was unethical and medically inappropriate to use opiates to treat chronic pain of any other etiology.

I attended the conference out of interest. I left fearing that I might face an accusation that my prescribing of opiates was inappropriate. There were some physicians in attendance from my community (old birds who had been practicing about as long as I have now) whom I suspected had been mandated to attend in order to remediate their wayward prescribing practices. At the time I had two chronic pain patients who were not dying for whom I was prescribing what (by today’s standards) were considered small doses of opiates on an ongoing basis. One was a woman with a history of several failed back surgeries. She ultimately died of pul-

The key to successful pain management is knowledge of the patient. Here is where family medicine physicians are best suited to the task. Our patients expect us to be their advocates and caregivers for this most serious and disabling problem.

monary fibrosis, having never increased her opiate dose. The other patient was a budding computer programmer with a personal and family history of frequent headaches. He went on to have a successful and productive 30-year career, a stable long-term marriage, and raised two children to maturity. Now retired, he remains my patient, taking a relatively low dose of opiates for his headaches. There were many other patients with chronic pain whom I limited to NSAID’s and other modalities. There were and are very few consultants to refer to in my community.

Since then, the standards of care for pain management have come full circle. The admonition against the use of opiates to treat chronic pain was called into question when the media and our licensing boards exposed the sea of chronic non-cancer pain patients who were not being adequately treated. It was a disgrace that these needy patients’ pain was being ignored when we had powerful opiate pain relievers at our fingertips. We were then encouraged to use opiates and the other modalities available with the major goal of improving the patient’s function (while making certain that we were careful to document function improvement). Pain specialists were fond of

saying that functional improvement was the key to patient success and when well documented, served as protection against any accusation of overprescribing.

Since then the Oregon legislature took action to mandate CME to help teach health care providers the standard principles of pain management and opiate use. The OMB expects us to provide all chronic pain patients with a “Material Risk Notice”¹ which is a detailed, signed, informed consent form regarding opiate use (even though this is no longer required by statute). We are expected to do random urine drug screens on all chronic opiate patients. Increasingly, we are also expected to have a pain contract with all chronic pain patients, laying out the rules imposed and the expectations required of those to whom we prescribe chronic opiates.

The OMB’s sample Material Risk Notice includes a provision listing alternatives to opioids such as medications, treatment and other modalities available to manage pain. This sounds simple to implement, but it takes time and effort to explain all this to our patients, answer their questions, ensure they understand the risks, goals, alternative treatments and additional therapies which may be

necessary to achieve their goals in order to secure their consent while we are also addressing the other issues involved in family medicine such as diabetes, congestive heart failure, COPD, social and psychiatric issues and a panoply of other medical problems which may need to be addressed in an office visit. This has led me to design systems within my practice to ensure that chronic opiate pain patients are identified and the above requirements implemented.

This emphasis on function of pain for patients in treatment provided hope and relief for both patients and their physicians. However, that liberalized opiate prescribing standard did not impose any limits on the amount of opiates prescribed. While the standard gave physicians the ability to prescribe powerful opiates to allay chronic pain, it raised a number of questions we had no answers for. For example:

- 1) Is there an upper limit of opiate use that we should observe?
- 2) Is it appropriate to escalate the opiate doses until the patient is pain free?
- 3) Does every opiate-using patient experience progressive tolerance and dependence if the doses are escalated upward?
- 4) What is the maximum benefit that we can expect from opiates and other modalities?
- 5) What are the other pharmacologic, physical and behavior modalities that should be employed to aid pain patients?
- 6) In which clinical situations would additional medications and modalities be most useful?
- 7) What is appropriate monitoring – urine drug screens, PDMP and pharmacy log checks, pill counts, etc.?
- 8) What is complimentary and safe and what is not in multi-drug combinations (for example: medical marijuana or benzodiazepines)?
- 9) How do physicians best educate patients to participate in their own pain management and rehabilitation?
- 10) Who are and where are the other practitioners that the primary care physician can engage to help patients deal with



their pain, rehabilitate and become more functional?

- 11) Are these resources available both geographically and through the patient's medical insurance?
 - 12) What resources are available to those patients who are uninsured or underinsured?
- The list of questions goes on and on.

In my practice the most difficult challenges are posed by chronic pain patients who:

- Are depressed and may be using opiates and/or other drugs to treat their emotional issues.
- Have secondary gain issues either because of a pending claim following an injury or because they have other reinforcements for playing the sick role and are therefore not engaged to pursue their own wellbeing.
- Have known or unknown propensity for opiate euphoria and addiction.
- Do not have financial resources or insurance and for that reason are unable to access PT, specialists, lab work, more expensive medications (such as MS Contin or Fentanyl patches or gabapentin) or behavioral resources.

These patients tend to view opioid medications as their major pain management tool and are reluctant or unable to access other modalities. It is easy for the physician to slip into this mindset as well. One has to play the role of a resourceful psychologist and

social worker (or engage them, if available) over many visits and sometimes many years to turn the patient towards non-opiate thinking and behaviors and resources.

The practice of chronic pain management impinges on every discipline of medicine and surgery. The key to successful pain management is knowledge of the patient. Here is where family medicine physicians are best suited to the task. Our patients expect us to be their advocates and caregivers for this most serious and disabling problem. We have the type of contact and knowledge of them which gives us the insight to best serve them.

The problems engendered by the focus on function in prescribing opiates together with inadequate education of physicians has caused Oregon to be amongst those with highest U.S. rates of opiate morbidity and mortality. In the past year the OMB was given two presentations on this topic by agencies of the state government. In one, the Oregon State Medical Examiner presented the shocking statistics. Self-administration of other substances, both legal and illegal, with opiates is the leading cause of opiate-related deaths. Chief amongst them is a potent non-prescription drug, alcohol, a substance we are not mandated to screen for. The most common co-morbid prescription drugs are sedatives; chiefly benzodiazepines. As a response to the rising political and public alarm

continued on page 28

STUDENTS SPEAK OUT!

Stories from OHSU students involved in the Family Medicine Interest Group (FMIG)

OHSU's Family Medicine Interest Group (FMIG) has had a busy winter. In November, **John Saultz, MD** addressed a group of more than 50 first- and second-year medical students on the importance of primary care and how family medicine has a large role in designing innovative ways to deliver care that satisfies the Triple Aim. MS1s and MS2s were inspired to hear how Oregon is leading the way in implementing new approaches in providing primary care aimed at improving health outcomes while decreasing health care spending. By being in a state that is piloting alternative payment models and programs that emphasize coordinated care, OHSU students are excited to be able to witness firsthand these new frontiers of primary care delivery.

Additionally, several MS1s, MS2s, and PA students honed their clinical skills with a Heart and Lung Sounds Workshop led by **Scott Fields, MD**. Hearing the difference between mitral stenosis and aortic regurgitation can be difficult for students, so we were fortunate to learn from Dr. Fields. Before the holiday break, FMIG members traveled to the Columbia Care Center with Joe Skariah, DO, where they performed carols and worked on crafts with the residents of the assisted living facility. Students had a wonderful time sharing stories and visiting with the residents. In January, **Ryan Petering, MD** led an ECG Workshop, instructing many MD and PA students on the essentials of ECG reading.



MS1s, MS2s & PAs attend Dr. Scott Fields' Heart & Lung Sounds workshop.



Rita Aulie (MS2), Lisa Pearson (MS2), Dacey Storzbach (MS1), and Annie Buckmaster (MS2) perform carols for the residents at Columbia Care Center.



OHSU School of Medicine students met with Senator Elizabeth Steiner Hayward to discuss a bill they recently drafted.

Though it is not an FMIG project, many FMIG members are learning how to effectively advocate for patients by introducing a public health bill during the current legislative session at the State Capitol. These students, in coordination with the OHSU Health Policy Interest Group and OHSU Government Relations, are working on passing a bill that

would allow children to bring sunscreen to school. As the law stands, there is ambiguity as to how schools regulate the administration of sunscreen, or whether students can bring it at all. Because sunscreen has an active ingredient and a drug fact label, it is considered a medication. In fact, some physicians have to write a prescription in order to

allow students to bring sunscreen to school. This bill would exempt sunscreen from the definition of "medication," and specifically allow students to bring to school, while still giving local school boards the flexibility to adopt rules about how and by whom it is administered. This issue is an important one for Oregon, as we have the fifth-highest rate of melanoma in the country and just one blistering sunburn in childhood more than doubles a person's chances of developing melanoma in their lifetime. Last week, eight medical students headed down to Salem and spoke with 18 legislators, including OAFP member, **Senator Elizabeth Steiner Hayward, MD** and many other members of the House and Senate Committees on Health Care. Students hope to have the bill considered in the upcoming legislative session.

Overall, we have had a great winter in which we continue to be inspired and grateful for our wonderful OHSU Family Medicine faculty.

NEW OREGON FAMILY MEDICINE RESIDENCY PROGRAM

In addition to the five existing family medicine residencies throughout Oregon – Cascades East in Klamath Falls, Oregon Health & Science University in Portland, Providence Oregon in Milwaukie, Providence Rural Training Track in Hood River, and Samaritan Health in Corvallis – there is now a sixth family medicine residency located at the Virginia Garcia Memorial Health Center (Virginia Garcia) in Hillsboro.

Beginning in the summer of 2013, Virginia Garcia was chosen as one of six community health centers around the country to participate in the first multi-state medical residency program. The program, funded by a \$4 million federal grant from the U.S. Health Resources and Services Administration (HRSA), focuses on family medicine residencies in at-risk communities in Oregon, Washington, D.C., Arizona, New York, Ohio and Washington. The National Family Medicine Residency at the Wright Center

for Graduate Medical Education partnered with the A.T. Still University's School of Osteopathic Medicine to provide these community-based training opportunities.

This new residency program also signifies a change in the funding model for graduate medical education. Before 2011, all federal medical education funding had to go through either hospitals or medical schools. Since then, through HRSA's Teaching Health Center grant, funding can now be directed at community health centers for doctor training.

The new program is a model for residency programs across the country in that it addresses two of the nation's most pressing health care challenges – the shortage of primary care physicians trained to work with America's most vulnerable populations and the potential changes in federal funding which may leave thousands of new doctors without a place to complete their training.

The program's objective is to create a pipeline of doctors trained to work with underserved rural and urban populations and in team-based practices that emphasize keeping entire communities healthy. With research showing that new doctors tend to practice in the communities where they have done their residencies, there is an obvious need to create opportunities for residents to train in these communities.

Each class has two residents who receive outpatient training at Virginia Garcia's Hillsboro Clinic and inpatient training at Legacy and Kaiser Permanente. **Geoffrey Carden, MD**, site director for the program at Virginia Garcia, said the program will place two new medical school graduates at the clinic every year through 2015. By year three they will have six residents.

Here's a brief introduction to the two interns and two residents currently enrolled in the Virginia Garcia residency program:



Teresa Bair, DO

*University of New England
College of Osteopathic
Medicine, Biddeford, Maine*

Dr. Bair earned a triple major in General Science, Liberal Arts, and Arts and Letters from Portland State University. As a first year intern at

Virginia Garcia Memorial Health Center, she is excited to train in a community health care setting that has an emphasis on serving Spanish-speaking patients. She is particularly interested in health education, women's and reproductive health, manual medicine and patient advocacy.

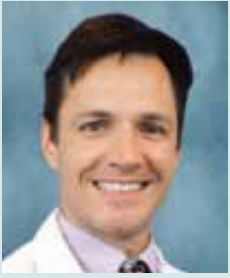


Caitlin Karplus, DO

*A.T. Still University,
School of Osteopathic Medicine,
Mesa, AZ*

Dr. Karplus earned a bachelor's degree in Chemistry at Oregon State University. Growing up in the small town of Philomath, Oregon, Dr.

Karplus saw firsthand the impact a good family physician could have on a community. This experience, along with her years working as a nursing home CNA between college and medical school, led her to believe that a well-established doctor-patient relationship and close continuity of care are important elements of any medical practice. This belief inspired her, in turn, to pursue the principles of community-centered health care in her own career as a doctor.



Bradley Stoker, DO
*A.T. Still University,
School of Osteopathic Medicine,
Mesa, AZ*

Dr. Stoker earned a master's degree in biomedical engineering at the University of Utah and an MBA at the University of California-Irvine.

Before returning to medical school to become a family physician, Dr. Stoker was a junior analyst in New York and the Silicon Valley. While in medical school, he worked in an underserved area with a large Spanish-speaking population. He looks for community-based solutions to serve his patients, and he likes to find ways to improve health care delivery, technology and training. A westerner at heart, Dr. Stoker adores the outdoors of Oregon.



Martin Peters, DO
*A.T. Still University,
School of Osteopathic Medicine,
Mesa, AZ*

Dr. Peters earned a bachelor's degree in International Studies at the University of Oregon.

Throughout medical school and residency, Dr. Peters established an ongoing relationship with two community-based organizations – Adventures without Limits and Health Bridges International. As an outdoor enthusiast, he is almost finished with a Fellowship in Wilderness Medicine and halfway done with a Diploma in Mountain Medicine. Dr. Peters' goal is to combine his interests in foreign language, outdoor adventure, and community development into one fantastic career in Portland.

about prescription drug abuse, diversion and deaths, our Oregon Medical Board and the American Academy of Family Physicians are asking us to become more sophisticated in our chronic pain management practices. To paraphrase Donald Rumsfeld, “We didn’t know what we didn’t know.”

All Oregon licensed physicians received a copy of the winter 2013 OMB Newsletter in which Barry Egener, MD, Medical Director of the Foundation for Medical Excellence wrote the title article “The Pendulum of Chronic Opioid Therapy.”² Here Dr. Egener explains the rationale for the changing standards of care for opioid therapy in Oregon. I agree with much of what Dr. Egener has to say. However, he opines that medical marijuana should not be allowed in combination with opioids. Having seen significant research validating the utility of marijuana in treating chronic pain³ and having a lot of personal experience with this combination, I do not necessarily agree with Dr. Egener on this point. I am not alone. In a recent informal survey of Oregon family physicians, one of four who manage chronic pain patients prescribed marijuana concurrently with opiates. However, given that the OMB’s consultant, Dr. Egener, does not agree with this practice, I feel that it is safer for our licenses if we heed his opinion and suspend the opiate–marijuana combination until there is more consensus on the standard of practice in this regard.

We can all be successful chronic pain managers. Easy-to-implement tools are at hand. There was a superb course “Mission: Pain Management The Patient-Centered Approach” at the AAFP Scientific Assembly last fall in San Diego. This course was full of great resources on all aspects of chronic pain management. It was the most valuable time I have ever spent on this topic. I urge you to access and take this course online at: www.idealcm.com/AAFP/programCMEsd-pain.asp. This course will give you standardized tools for pain assessment, risk assessment, opioid monitoring and clinical pearls.

Like most of us I was unprepared to deal with the intricacies of chronic pain manage-

ment. I have endured a number of unanticipated “learning experiences.” Aided by my colleagues, CME courses, resources put forth by the state Prescription Drug Monitoring Program (PDMP), the OMB and “the school of hard knocks,” my practice has developed a set of guidelines and practices to aid in compliance with current standards of care regarding chronic pain management. Our office staff assists us as a part of the practice team to ensure compliance with these guidelines and practices. Those guideline practices include:

- All chronic pain patients must be identified. This sounds obvious. It is easy when inheriting patients from other physicians who over the years have received regular opiate prescriptions. But there are those long-term patients who would take a few opiate pills here and there for acute exacerbations then began needing regular prescriptions for chronic pain. And there were also those who crept up from acute to chronic pain. A common definition of chronic pain is when pain persists for six months beyond the time expected to resolve from an acute injury. Now, the day before an office visit our staff reviews the chart of each patient and if they fit the definition of a chronic pain patient for whom we do not have appropriate documents in place, these documents are placed loose in the chart to remind us to complete them.
- All chronic pain patients must have a medication contract and a Material Risk Notice. It is time-consuming to discuss and fill these out. Our current practice is to provide these documents to our established patients to read before their next scheduled visit where we will review and complete them. New patients already on opiates and established patients who are starting chronic opiates must have these documents completed before an opiate prescription is given.
- All new pain patients must be screened before being accepted into our practice. Those who use chronic opiates must have a urine drug screen upon presenta-

tion to our office for purposes of applying to become a patient. We ask them to list those who live with them and we call these individuals to ask about the applicant’s medication, alcohol and other drug use patterns; we review medical records from previous physicians and often call prior prescribers; we check the PDMP and we sometimes call past pharmacies. We do all this before accepting the patient into our practice. This process discourages and identifies drug seekers.

- We determine the patient’s mental state and propensity to abuse medication by administering a PHQ9 and Screener and Opioid Assessment for Patients with Pain (SOAPP)* at the first visit.
- Yearly we report the PHQ9 and the Current Opioid Misuse Measure (COMM).*
- Chronic pain management visits are for only that problem. These visits are time-consuming; one must have time to assess the patient’s current level of function, objective findings, therapeutic alternatives and mental and social status. Squeezing in other problems invites cutting corners on pain management.
- We do random urine drug screens. The day before a visit the medical assistant preparing the chart will throw the dice. Those getting a 7 or 11 will be asked to leave a urine sample just before entering the exam room. Any staff member may decide that a urine drug screen is needed at any visit. Often patients behave differently before the office staff than they do the doctor. Staff often have intuitions and see clues that the prescriber will miss.
- Chronic Pain Questionnaire (go to <http://oafp.org/members> to download questionnaire) that we have developed. We also use the Oswestry Low Back Pain Disability Questionnaire (http://www.rehab.msu.edu/_files/_docs/Oswestry_Low_Back_Disability.pdf) at each visit. The Oswestry scale is useful to assess function from many impairments besides back issues.

*The SOAPP and COMM can be found on the “Mission: Pain Management” site referred to earlier.

- Education of the patient. Besides the Material Risk Notice we use a one-page information sheet that sets out what we think we know about opiates. A copy of the Opiate Pain Management Journey can be downloaded at <http://oafp.org/members>. We have the patient read and sign this form and then give them a copy.
- Our pain management contract sets out patient expectations and rules: No missed appointments. No early refills. No medications lost or stolen replaced (except with police report for the latter). Use only one pharmacy. Only one prescriber (me and my PA's). No use for psychological relief. No combination with alcohol or other drugs that we did not prescribe or approve. The consequence of breaking the contract is discharge from the practice.
- Attention to other medical problems at subsequent scheduled visits.
- Pain history: location, intensity, quality, timing, ameliorating and exacerbating factors. Resources named in the AAFP course are the "Brief Pain Inventory," "McGill Pain Questionnaire" and the

"Memorial Pain Questionnaire Card."

- Recognize red flags: Early refill requests, urine drug screens with none of the prescribed medications, other medications or illicit substances, claims that patient cannot give a sample because they "just went." We keep these patients at the office drinking water until they can give us a sample. Lost or stolen or destroyed medications. Spouse or partner who looks "strung out." Frequent trips "out of state" (maybe to sell the drugs).
- Consult pain management experts when any concern arises. Ask the consultant to "get in the saddle" with the patient for awhile so they get the full picture of the patient. It is easy for a consultant to make "cheap shot" recommendations when they have not had to struggle with the patient as you have. Do your best to write a letter to the consultant giving your picture of the patient and stating your questions and issues. It also helps to call the consultant first to give them a thumbnail on the patient; perhaps some things that you might not want to put in print.

This is a brief discussion for a big topic. It is a constant challenge to improve pain management. I wrote this article so that my colleagues might have smoother sailing on their "Chronic Pain Management Journey" than the rough seas of my learning. I am certain that I have left some things out and also certain that I have more to learn.

Keith White, MD, has been practicing at Independence – Monmouth Family Medicine for over 30 years and has been a member of the OAFP since 1978. He recently served on the Oregon Medical Board. He is an adjunct full professor in the OHSU Department of Family Medicine. If you have any questions, concerns, or feedback regarding this article, please contact Dr. White at rhodoc@msn.com.

REFERENCES:

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- ²<http://www.oregon.gov/OMB/Newsletter/Winter%20213.pdf>
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The ALSO Refresher Course has been accepted for up to 16.75 credits by the AAFP.

Go to the OAFP website (www.oafp.org) and register today!

MEMBERS IN THE NEWS

HONORS, AWARDS, AND ACCOLADES



DR. DANIELS

Dorin Daniels, MD, FAAFP, was named Man of the Year by the Ontario Chamber of Commerce and was honored at their annual awards banquet in January. Dr. Daniels is a life member of the OAFP and was the OAFP Family Doctor of the Year in 1983. For almost 60 years, he practiced family medicine in the town of Vale, pre-

cepting medical students until he retired showing them that “small-town doctors practice good medicine and have a good lifestyle.” Upon retirement, he became involved in the Malhuer Country Historical Society and in the Ontario High School’s ASPIRE program where he offers advice to students about life after high school.



DR. LIU

Robyn Liu, MD, MPH, FAAFP, Family Medicine at South Waterfront, and resident

Brian Park, MD, MPH, Family Medicine at Richmond, were appointed to the American Academy of Family Physicians Commission on Health of the Public and Science. Members of the commission work with staff to develop and review evidence-based clinical practice guidelines; recommendations for clinical preventive services, including immunizations; and health of the public policies, including tobacco, exercise and obesity. Both attended the AAFP Winter Commission Cluster meeting in Kansas City in early February where all AAFP commission members come together for discussions and deliberations.



DR. PARK

INTERESTING BUSINESS WE SHOULD ALL KNOW



Dan Crawford, MD, and his wife Kathy, a retired nurse, have spent the past few months in Ebola-stricken Liberia, representing SIM (formerly Sudan Interior Mission). Crawford notes, “It has been inspiring to work alongside the Liberian doctors and nurses at SIM’s ELWA Hospital in Liberia’s capital of Monrovia, who all worked through the EBOLA crisis.”

He has seen few Ebola cases at ELWA but is trying to keep up with an increasing load of severe malaria, typhoid, HIV, and hypertension. Not a novice to medical mission work, Crawford worked for ten years in a jungle hospital in Borneo before returning to the U.S. and working 26 years at South Tabor Family Physicians before retiring in December. Crawford was once again ready to give back to others through a medical mission where he could treat his patients physically, emotionally, and spiritually.

“There have been moments of joy and moments of sadness, often separated by a few seconds. There are many times that we know exactly why we are here and many times that we wonder what possessed us to get on that plane. But we do believe that God called us here and that we are doing what we can.” Thank you to the Crawford’s for their ongoing service to those suffering both near and far.

HAVE AN ITEM FOR “MEMBERS IN THE NEWS?”

Family Physicians of Oregon welcomes short announcements about OAFP members and their clinics. If you have undertaken a practice move, have been the recipient of an honor or award, or just plain have interesting information to share, by all means, let us know! Tell us about your news and we will be sure to print it. Photographs are welcomed. Send submissions to:

LYNN M. ESTUESTA

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