



# Family Physicians of Oregon

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- Postpartum LARC: New Opportunities in Oregon
- The Keys to Success at the Providence Hood River Rural Training Program
- My Rural Scholars Experience
- Match Day 2017



OREGON ACADEMY OF  
FAMILY PHYSICIANS

MAKING HEALTH PRIMARY

THE OFFICIAL MAGAZINE OF THE  
OREGON ACADEMY OF FAMILY PHYSICIANS



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# Family Physicians of Oregon

Oregon Academy of Family Physicians  
1717 NE 42nd St.  
Suite 2103  
Portland, OR 97213  
503.528.0961  
503.528.0996 (fax)  
Web site: [www.oafp.org](http://www.oafp.org)

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### About the cover:

Hopefully, by the time everyone receives this issue, spring will have arrived in Oregon!



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David Brown, President • [dbrown@pcipublishing.com](mailto:dbrown@pcipublishing.com)  
For Advertising info contact  
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[ddoddridge@pcipublishing.com](mailto:ddoddridge@pcipublishing.com)

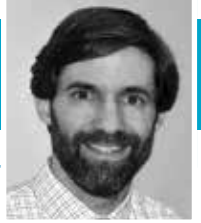


OREGON ACADEMY OF  
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## ● PRESIDENT'S MESSAGE



DAN PAULSON, MD

# Change

*“The only way to make sense out of change is to plunge into it, move with it, and join the dance.”*  
Alan Watts, British philosopher and writer.

So much has been changing in primary care in recent years that I have trouble remembering how things used to be done. In my clinic we have basically accepted that change is the new norm. I don't know how many times I have thought that I would like to hit the pause button for just a couple of months so that we could let some of the changes settle and get more comfortable with them. But that has never happened so I have found some comfort and wisdom in this quote from Alan Watts.

In my clinic and in most of the clinics across the state, changes have been frequent and substantial. The past five to six years have seen the coming of Oregon's Patient-Centered Primary Care Home (PCPCH) program and revised versions of this. We have seen Meaningful Use come and go. Over 60 Oregon clinics participated in the four-year Comprehensive Primary Care Initiative (CPCi) and more than 150 have signed up to participate in its successor, CPC+. We have all dealt with the implementation of the Affordable Care Act (ACA) and its expansion of the Medicaid population. This population is now managed by the 16 Coordinated Care Organizations (CCOs) spread across the state, and the CCOs have brought other changes and challenges for primary care. In many clinics, behavioral health has now become an integral part of the clinic and the care that we provide every day. I haven't mentioned PQRS, MACRA, MIPS, Alternative Payment Models, risk stratification, bundled hospital payments, transitions of care payments, electronic health records . . . but I think we all know what I am talking about.

Throughout all of these changes the major challenge for me has been to keep patients and quality of care at the forefront. As we struggled to understand the complexities and requirements of each of these many programs and changes, and to incorporate them into the routines of our clinic, I have stopped often and asked “How does this benefit my patients?” The answer has not always been clear and at times we have had to adjust our processes to be sure that there was a benefit for the patients. But the care we provide now in my clinic is better than before because we have behavioral health providers working beside us, interacting with us daily and helping us meet the needs of our patients. As we have tracked various quality measures, we have seen improvements in things like colon cancer screening rates, adult immunization rates and depression screenings and referrals to treatment. We are doing a better job of following up with patients who have been to the ED or have been hospitalized to be sure that their subsequent needs are being met. I have more support staff working with me than I have ever had and they are more engaged and invested in the wellbeing of our patients than ever before.

Along the way there have been exasperating challenges as well – different quality measures for each insurer; quality measures that don't improve patient care; EHRs that can't extract useful data; EHRs that make documentation more cumbersome; excessive documentation requirements; and increased overhead because of increased staffing. I'm sure we could all add several more to this list. However, when I look at where we are now compared to five years ago, I still think that the overall outcome is more good than bad, and I do not want to go back to “the good old days.”

I have generally been supportive of the ACA, not so much because it is such wonderful legislation (it isn't) or because it solves all of the problems in our health care system (it clearly doesn't) but mostly because it has done what it was intended to do. More Oregonians – 95% – have health insurance now. Oregon's CCO model covers one in four residents of the state (one in three in many rural areas) and this model has shown that it can hold down costs and improve quality. Patients with "pre-existing conditions" can now get insurance; patients do not have to worry about loss of care if they hit an arbitrary lifetime limit; and patients have less risk of bankruptcy secondary to high medical bills. Preventive care is covered better and more consistently than in the past. Behavioral health care is more available than it has ever been in my career. While there is plenty of room for criticism and there are many things that can still be improved, the ACA is still better than what it replaced and better than anything that has so far been proposed as an alternative.

I have no doubt that the coming years will continue to bring more change to medicine and primary care. With each of these changes I will ask myself the same question I have asked many times, "Do these changes improve the health of my patients and my community?" The goals that I support include insurance coverage for all Oregonians, improved health outcomes for patients, a more productive and healthy workforce in both our communities and in our clinics, a more cost-effective health system with less administrative redundancy and less complexity. For the changes that will inevitably come in the future, I will support those that meet these goals and oppose those that fail. For I have become more comfortable with change and I am willing to "move with it" and to "join the dance" as long as we are meeting the principal goal of improving the health of our patients and communities.

## ● FROM THE HILL



JENNIFER DEVOE, MD, DPHIL, CHAIR OF THE FAMILY MEDICINE DEPARTMENT, OHSU  
IN COLLABORATION WITH SONJA LIKUMAAHUWA-ACKMAN, MPH AND HEATHER ANGIER, MPH

After the passage of the Affordable Care Act (ACA), I was elated to see many patients on my panel gain access to health insurance and get the health care that was unaffordable and inaccessible for years. I remember the 25-year-old with cystic fibrosis who was so excited to tell me about his new job – he had gained coverage on his parents’ plan which helped him improve his overall health and get a better job (with great coverage!). I rejoiced when a 55-year-old grandmother was finally able to receive comprehensive treatment for her depression and return to volunteering at her grandchild’s school, and it was heartwarming to hear from the 40-year-old single mother who told me that re-gaining Medicaid relieved her worries about staying healthy to raise her boys. A decade ago, she brought me to tears when after losing her coverage, she asked me, “How am I going to raise my children if something happens to me and I cannot get health care?”

Across Oregon, primary care teams are seeing the impact of health insurance expansions and other ACA policy reforms. Since the ACA took effect, 95 percent of all Oregonians now have health care coverage and Oregon’s uninsured rate has dropped from 17 to 5 percent.<sup>1</sup> Many of us are communicating with policy makers and community leaders about further changes we believe are necessary to improve access to health care and improved population health.

Coupled with our personal experiences and patients’ stories from health care’s front lines, Oregon’s family medicine community is studying the impact of policy change on patients’ and families’ access to care. In partnership with OCHIN ([www.ochin.org](http://www.ochin.org)) and the amazing community laboratory OCHIN has built, researchers in the Oregon Health & Science University (OHSU) Department of Family Medicine discovered:

- Individuals who gained Medicaid in Oregon’s 2008 Medicaid expansions, also known as the “Oregon Experiment,” had an increased rate of primary care visits and preventive services, as compared to those who remained uninsured.<sup>2,3</sup>
- A higher percentage of Oregon community health center (CHC) patients who gained Medicaid quit smoking compared to those who remained uninsured.<sup>4</sup>
- After the ACA Medicaid expansions were implemented in 2014, CHCs in Medicaid expansion states saw a dramatic drop in the

I’d like to see continued momentum towards transforming the health care system and partnering with communities to eliminate health disparities and improve population health. This momentum comes from us as advocates. Our experience matters, our work makes a difference, and our stories amplify the voices of those in our communities who are afraid to speak up or who are not being heard.

number of uninsured patients seeking primary care services, while CHCs in states opting out of the expansion continued to see high rates of uninsured patients.<sup>5,6</sup>

- Over time, patients with partial or no health insurance coverage are less likely to receive preventive services compared with those who have continuous coverage; with no evidence of a dose-response relationship (i.e., more time covered is not necessarily better than less time covered if the coverage is not 100% continuous).<sup>7</sup>
- The percent of a clinic’s patients with continuous health insurance influences how well the clinic performs on quality metrics (e.g., A1c testing, influenza immunizations and lipid screening for diabetics); thus, this information should be factored into an adjusted performance rating and all efforts should be made to increase insurance rates in the population.<sup>8</sup>
- Even when uninsured patients are able to access primary care, they are less likely than insured patients to be able to access many preventive services and more likely to be overdue for recommended services.<sup>9-11</sup>
- There is a causal link between coverage for parents and their children. A child with an uninsured parent is less likely to have health insurance, even if their child qualifies for child-only coverage.<sup>12,13</sup>
- Family income is the characteristic most strongly associated with a family’s lack of full-year health insurance.<sup>14</sup>

As someone with a history of being vocal and passionate about the need for drastic health policy reforms, I do not subscribe to health insurance as the complete solution to fixing our unsustainable health care system.<sup>15</sup> I admit to being a skeptic about the ACA and some important features it was lacking, such as strict cost containment and a public insurance option. However, as we continue the work to discover the best cures for the American epidemic of “uninsurance” and finding new treatments for our nation’s “inequitable access to care” disease, there is increasing evidence that the ACA health insurance expansions are a step forward.

So, where do we go from here? I’m ready to move beyond asking the question about whether or not health insurance matters. (For those not ready to move beyond this point, consider asking them the following two questions: 1. Are you willing to drop your health insurance policy immediately and go without health insurance indefinitely? 2. Are you willing to enroll in a study where you are randomized to either receive health insurance or go without health insurance forever? If the answer to either or both of these questions is “no,” then we can keep moving forward toward insuring every person in this country).

I assert that health insurance matters *and* so does primary care. The combination of insurance and a usual source of care (USC) are associated with the highest rates of preventive health care, compared to having either insurance, or a USC, or neither one.<sup>16,17</sup> We have important work ahead of us to continue building the 21<sup>st</sup> century community classrooms that will inspire young people to choose careers in primary care and the community laboratories to improve our ability to transform primary care delivery, to assess the impact of policy changes on patients and communities,<sup>18</sup> and to discover how to best organize and pay for primary care in order to achieve the quadruple aim.<sup>19</sup>

Rather than repealing the ACA and going back to an era where patients lose health insurance coverage, I’d like to see continued momentum towards transforming the health care system and partnering with communities

to eliminate health disparities and improve population health. This momentum comes from us as advocates. Our experience matters, our work makes a difference, and our stories amplify the voices of those in our communities who are afraid to speak up or who are not being heard. It is up to us to continue sharing these powerful stories and our experiences and to keep moving forward.

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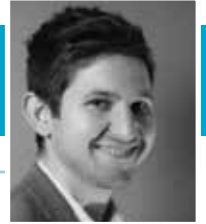
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# PUBLIC POLICY AND LEGISLATIVE AFFAIRS

DOUG BARBER & SAM BARBER, OAFP LOBBYISTS



Bills to restructure Oregon's health care workforce incentives and increase spending on primary care dominate OAFP's legislative agenda during the 2017 session.

## **Workforce Incentives**

HB 3261 continues legislators' work to restructure how they look at programs and budgets for:

- Loan repayment
- Loan forgiveness
- Rural Medical Tax Credit
- Scholars for a Healthy Oregon
- Rural Malpractice Subsidy

In 2015, legislators created a new Health Care Provider Incentive Fund. Their goal was to put all of the incentives in one place so they could better understand their impact on the state budget. Now they are trying to figure out exactly how the fund would work and key legislators aren't in agreement.

Ideas include:

- Appropriating a pot of money to the Oregon Health Policy Board (OHPB) so its Workforce Committee can figure out how best to spend it in support of Oregon's health care workforce;
- Giving legislative direction to the OHPB on which programs the state wants funded but giving OHPB flexibility on how much to spend and where; or
- Requiring the OHPB to develop a spending plan and bring it back to the 2018 legislative session for approval.

Also in the mix is the Rural Health Tax Credit. Legislators want to better understand how the tax credit fits with other incentive funding. However, because of the way Oregon's state budget is constructed, different committees handle tax credits and workforce incentive funding.

## **Primary Care Payment Reform**

In 2015, the Legislature passed SB 231, which created the Primary Care Payment Reform Collaborative to develop recommendations to "direct greater health care resources and investments toward supporting and facilitating health

care innovation and care improvement in primary care." Evidence shows that increased primary care spending results in better quality care, better health outcomes and fewer high cost emergency room visits and hospitalizations.

The Collaborative brought together providers, commercial insurers, Coordinated Care Organizations (CCOs), hospitals, the Oregon Health Authority (OHA) and other stakeholders to discuss the SB231 goals and collaborate on solutions. This diverse group produced consensus recommendations which have been supported by the Oregon Health Policy Board.

This session, SB 934 seeks to implement those Collaborative recommendations by:

- 1) Requiring CCOs, OEBC, PEBB and commercial insurers to increase investment in primary care (as defined in SB 231) until they reach the benchmark goal of 14.4% of their global budget or total premium.
- 2) Instructing OHA to adopt by rule penalties for CCOs that fail to reach this benchmark.
- 3) Requiring insurers who fail to meet the benchmark to submit to the Department of Consumer and Business Services, along with their rate filing, "a plan for increasing the spending on primary care as a percentage of premiums by at least one percent each plan year."

This bill also extends the Primary Care Payment Reform Collaborative through 2023 to support continued health care innovation, collaboration and care improvement.

The Collaborative met in early March to discuss the bill and its intent. Many members voiced support for the bill, though some payers had reservations. Providence, PacificSource and CareOregon were particularly concerned with the methodology the OHA uses to calculate the spend on primary care. They also voiced that payment targets need to account for the complexity of the insurance market and Medicaid market. For example, they mentioned new requirements for coverage of procedures and pharmaceuticals, as well as understanding the difference in risk between populations.

Look for continuing information on these efforts on the OAFP website --<http://oafp.org/advocacy-update-archive/>.

# Postpartum Long-Acting Reversible Contraception: New Opportunities in Oregon



VALERIE J. KING, MD, MPH AND MOIRA RAY, MD, MPH

Long-acting reversible contraceptives (LARC), defined as intrauterine devices (IUDs) and implants, are 20 times more effective at preventing pregnancy than contraceptive pills, patches or rings (Winner, 2012) and are associated with significant reductions in the numbers of unintended pregnancies and abortions (Peipert, 2012; Winner, 2012). The use of LARC methods has increased in the U.S., but stood at just 12% of reproductive age women in 2012 (Daniels, 2015). However, opportunities exist to expand access to and use of these highly effective contraceptives.

Beginning January 1, 2017 LARC devices are reimbursed by Oregon Medicaid when provided immediately postpartum. Provision of LARC in the immediate postpartum period may aid women in optimal birth spacing and to avoid short interpregnancy intervals that are associated with adverse obstetric and neonatal outcomes including preterm birth, low birth weight and small for gestational age infants (Bigelow, 2015). LARC devices are safe and effective and are more cost-effective than any other contraceptive method. For example, one cost-effectiveness analysis found that over two years, placement of a postpartum IUD was associated with a savings of \$282,540 per 1,000 women (Washington, 2015).

A 2015 Cochrane systematic review summarized the results of four randomized controlled trials that included 243 women (Lopez, 2015). Women were twice as likely to be using IUD contraception six months after delivery if they received it immediately postpartum compared to waiting for routine six-week postpartum placement (Lopez, 2015). While post-

placement expulsion was more common over the first six months among women in the immediate placement group (16.8% vs. 3.1%), they were still more likely to actually be using an IUD at six months postpartum (80.8% vs. 67.4%) (Lopez, 2015). Economic evaluations have shown that LARC is cost-saving (not just cost-effective) and expulsion rates would need to reach more than 38% in order to favor delayed insertion (Washington, 2015).

Medicines360 (<http://medicines360.org>), a nonprofit women's health pharmaceutical company, developed the Liletta® IUD to decrease the cost

of these devices for lower-resource settings. Medicines 360 offers Liletta® to 340b pharmacy benefit participants at approximately \$50 per device and about \$500 for other purchasers. Currently available economic evaluations have not been conducted using costs comparable to the Liletta® IUD, so savings may be even greater if this device is used, particularly by 340b providers.

Offering immediate postpartum insertion of long-acting reversible contraception (LARC) is supported by the Centers for Disease Control and Prevention (CDC) (CDC, 2015), the American Academy

In November 2016, the Oregon Health Evidence Review Commission (HERC) strongly recommended coverage for postpartum LARC by the Oregon Health Plan. . . . CMS guidance gave multiple examples of ways Medicaid programs could work to eliminate administrative, reimbursement, logistical and training barriers to increase access to LARC. The HERC coverage guidance also summarizes ways that clinicians and health systems can overcome these barriers in Oregon.



of Family Physicians (AAFP) (AAFP, 2016), the American College of Obstetricians and Gynecologists (ACOG) (ACOG, 2016), the American Academy of Pediatrics (AAP) (AAP, 2014), and the Centers for Medicare and Medicaid Services (CMS) (CMS, 2016). LARC is safe for the majority of women, including those who are breastfeeding, according to the CDC's latest Medical Eligibility Criteria (CDC, 2016). While implants can be placed at any time prior to discharge from the hospital, IUDs need to be inserted within ten minutes of placental delivery, or intraoperatively prior to uterine closure after cesarean delivery.

In November 2016, the Oregon Health Evidence Review Commission (HERC) strongly recommended coverage for postpartum LARC by the Oregon Health Plan (OHP) (Ray, 2016). This recommendation applies to Medicaid coverage in Oregon and is meant to be useful to private insurers as well. A guideline note was added to the OHP's Prioritized List stating that, "Long-acting reversible contraceptives (implant or intrauterine device) are included . . . in all settings, including (but not limited to) immediately postpartum and postabortion (OHP, 2016)." In addition, the HERC sent a letter to all medical directors in Oregon (HERC, 2016), calling attention to recent CMS guidance clarifying contraceptive coverage and recommending strategies to reduce barriers to use of LARC (CMS, 2016).

The HERC's letter specifically asked that Oregon's Medicaid medical directors work to eliminate administrative barriers that impair access to postpartum LARC as they implement the coverage recommendation. Barriers cited include issues with reimbursement, both of the device itself and professional or facility fees. Given that most in-hospital births are paid with a global charge it will be key to either include LARC costs or to allow separate billing. Currently, it is difficult to bill two distinct services on the same day to many insurers. Reimbursement rates, even if they do cover the cost of the device, may be lower than

the clinician or facility actual cost. When the LARC device is provided via a pharmacy benefit it can create billing problems if a device assigned to a particular woman is not placed and prior authorization requirements can create additional barriers. Hospitals and health systems may not provide adequate inventory of devices or clinician and training to assure timely and high quality services. There may also be no defined mechanism for reimbursing LARC removal, replacement or re-insertion when these services are subsequently required. Although these barriers do exist in Oregon, the CMS guidance (CMS, 2016) gave multiple examples of ways that Medicaid programs could work to eliminate administrative, reimbursement, logistical and training barriers to increase access to LARC. The HERC coverage guidance also summarizes ways that clinicians and health systems can overcome these barriers in Oregon (Ray, 2016).

One barrier for family physicians may be having the appropriate skills to provide this service. Placement and related care for IUDs and implants involves training on insertions, removals and side-effect management. While contraceptive implant training in the postpartum period does not require any additional special skill compared to insertion at other times, providers may need additional training in order to effectively provide postpartum IUDs. Initial training for immediate postpartum or post-cesarean IUD insertion is available from an online CME course from the University of Washington (available at <http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larcimmediately-after-childbirth>). In October 2015, the Oregon Coordinated Care Organization (CCO) Health Share sponsored a LARC training event open to all providers, not just those serving Medicaid enrollees, by the Bixby Center at the University of California, San Francisco. The Bixby Center also offers a free one hour online introductory course on IUDs and

implants (<http://beyondthepill.ucsf.edu/online-training>) and links to other LARC resources. ACOG's LARC Program (<http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/LARC-Clinician-Education-and-Training>) maintains a list of training resources, including those provided by manufacturers of LARC devices and others.

The OAFP encourages family physicians in Oregon to notify staff if they are having difficulty regarding training, reimbursement, health system logistics or other issues involved in the provision of immediate postpartum LARC devices. The OAFP would be happy to connect you to experts who can give you advice and to help organize training sessions at our conferences.

The work for the Oregon HERC's coverage decision on the timing of LARC was done by three of OAFP's family physician members along with their colleagues: **Moira Ray, MD, MPH** (Assistant Professor of Family Medicine, Department of Family Medicine at OHSU and Clinical Epidemiologist at the Center for Evidence-based Policy); **Valerie King, MD, MPH** (Professor of Family Medicine, Department of Family Medicine at OHSU and Research Director at the Center for Evidence-based Policy); and **Cat Livingston, MD, MPH** (Assistant Professor of Family Medicine at OHSU and Associate Medical Director, Oregon Health Evidence Review Commission.)

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# The Keys to Success at the Providence Hood River Rural Training Program

ROBERT GOBBO, MD, PROVIDENCE HOOD RIVER RURAL TRAINING PROGRAM RESIDENCY DIRECTOR, PETER BENZIGER, MD AND MATT SPERRY, MD

**Bob Gobbo, MD**, Residency Director at the Providence Hood River Rural Training Program (PHRRTP), understands the importance of providing a community-based family medicine training program that produces physicians interested in and capable of providing obstetric care upon graduation. He has found the keys to improving the success rate in this specialty includes residents who are mentored and supervised by experienced family medicine faculty preceptors in the clinic and labor and delivery setting.

Ideally, residents who will graduate with obstetrics competency should log at least 80 vaginal deliveries during their residency and experience greater autonomy in decision-making during their OB rotations. Gobbo noted, "The PHRRTP residents also assist and many perform 20 – 30 cesarean deliveries prior to graduation. They must also log at least 10 continuity deliveries during their second and third year where they participate in the prenatal, delivery, postpartum and well child care of the patient and her newborn. Thus far, it has been our program's experience that residents are involved in approximately 20 continuity deliveries prior to graduation."

In addition to One Community Health's primary care practice in Hood River, the residents also see patients weekly at the Providence Women's Clinic, which has a

staff of four OB/Gyn's who have been very supportive of having PHRRTP residents participate in their patients care. Each resident, during their third year, must also do a one month High Risk OB rotation, which is currently at Legacy Emmanuel Hospital in Portland.

**Peter Benziger, MD**, graduated in 2016 from the pioneer residency class of the PHRRTP.

Dr. Benziger wished to train in a rural residency program as he wanted to begin his career in a small town and felt that training in a rural community would be the most relevant and applicable to his career aspirations. He saw his dream of practicing as a rural family medicine doctor come to fruition when he recently began working at Columbia Gorge Family Medicine in Hood River.

Because of the necessity in frontier medicine for physicians to be prepared to take care of critically ill patients, rural residents need to be competent on the wards, in the ICU, in the emergency room, on labor and delivery and in the clinic. "I realized that gaining multiple exposures to procedures -- including deliveries, lines and codes -- and having responsibilities in these different settings, is very valuable. Being a part of a rural residency prepared me for the jump to the real world," said Benziger.



*Third year resident Matt Sperry, MD and new physician, Peter Benziger, MD*

"It was important for me to train in obstetrics and attain obstetric competency as part of my residency training as I believe obstetrics is truly the lynchpin to family medicine. Being involved in the delivery experience is a privileged moment that is one of the most rewarding things about my job."

Benziger understands that providing OB services to his patient panel will be both physically and emotionally challenging, but believes he will be able to strike a comfortable work-life balance due to a strong group of colleagues that support him.

**Matt Sperry, MD**, a third year resident at PHRRTP, agrees that obstetrical training is very important for family physicians. "Whether or not a physician plans to

## SAVE THESE DATES

For more information, contact Kerry Gonzales at the Oregon Academy of Family Physicians  
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### 71ST ANNUAL SPRING FAMILY MEDICINE WEEKEND & ORPRN CONVOCATION

Scientific Assembly & Congress, April 12 -14, 2018  
OAFP/Foundation Auction, April 13  
Embassy Suites Hotel Downtown Portland

continue to practice obstetrics or not upon graduation, the training to know and understand what our patients go through is invaluable,” said Sperry. Sperry also mentioned that many physicians are unsure what their future practices will look like, so getting thorough training in obstetrics is important should they decide later that they wish to include obstetrics. “I find that the continuity of seeing pregnant women for prenatal visits, delivering babies and then seeing the whole family afterwards allows me to provide patient -tailored and centered care, and is extremely rewarding for myself as a clinician. I think that longitudinal experiences like this are key to preventing future burnout.”

Sperry continues, “Practicing obstetrics is an interesting thing. As a physician, when everything is going well I sometimes feel somewhat superfluous. After all, women have been delivering babies without our help for thousands of years. The nurses on the labor and delivery floor are extremely competent and can largely run the show without me. I do have one large advantage, however, especially as a family physician, and that is the continuity I have with my patients. I know them and they know me. Many of them knew me before they became pregnant and over the 10-15 prenatal visits preceding their delivery we have gotten to know each other much better. In contrast to everyone else on the labor deck, I am the person they are expecting to see. I was reminded of this recently when I was called in for a delivery in the middle of the night.

My patient was in her early twenties and this was her first pregnancy. I had been delivering her prenatal care and we knew each other well. She had arrived in spontaneous labor and progressed along at a normal labor curve without intervention; this was an uncomplicated pregnancy and delivery. At least that’s how the nurses and I viewed the situation. To the patient, however, this was a major life event, fraught with potential complications. Even

though she was in extremely good hands with the nurses who were managing her early labor, when I arrived she said out loud “Oh thank God you’re here.” Not because I’m a particularly talented physician or labor coach, but because I’m the person she knows and trusts. To me, this is what makes my practice rewarding. It is a huge privilege to be present for our patient’s life-changing events -- birth, extreme sickness and death -- as a family physician I get to attend to my patients for all of these.”

Dr. Gobbo has been pleased with his resident’s experiences in the rural program and the mix of obstetrics, emergency and adult medicine inpatient care they are managing has proven to produce clinicians with a deeper skill set to care for patients in all clinical areas of the hospital and ambulatory setting. “Both Matt and Peter are outstanding clinicians and are well respected by the clinical and nursing staff and practice evidence- based and safe obstetrical practice.”



LYNN ESTUESTA,  
OAFP/FOUNDATION EXECUTIVE DIRECTOR

## How Your Foundation Dollars Are Being Spent

As a Foundation focused on the needs of the next generation of family physicians, the programs we support are helping to ensure that the pipeline of family physicians can and will continue for years to come and be able to offer the finest medical care and access for all Oregonians.

With the funds raised at our annual auction and donations throughout the year, we provide educational, networking, scholarship and mentorship opportunities to our medical students and family medicine residents.

For the past 20+ years the OAFP/Foundation has championed hundreds of family medicine students and residents in their journey to work in rural and underserved communities throughout our state. I am asking you to help us to continue doing so.

Currently, through your donations we support the following programs: the Laurel G. Case Award for Rural Experiences, the Mary Gonzales Lundy Award, the Oregon Rural Scholars Program, and the Rural Discovery Medicine Program.

The goal of the Laurel G. Case Award for Rural Experiences, named after the first Family Medicine Department Chair at OHSU, has always been to allow medical students the opportunity to live and work with a rural family physician. With the recent changes to the

curriculum, students no longer have time between their first and second year of medical school to take advantage of this life-changing opportunity. However, with the help of the OHSU Family Medicine Department, this experience will now be open to all OHSU medical students as an elective. We understand the value of getting students out in the field, working in clinic, in the hospital, helping with procedures

and getting a taste of the continuity of care provided in a rural family medicine setting and we will continue to support the Department and the preceptors willing to mentor these students.

The Mary Gonzales Lundy Award, named after Mary Lundy, the former OAFP Executive Director, is awarded to an outstanding fourth year medical student who is entering a Family Medicine Residency. This year, we were fortunate to have fifteen excellent candidates apply for this award and we were thrilled to be able to honor two students – **Rita Aulie** and **Bryan Wu** – with this prestigious award.

The Oregon Rural Scholars Program (ORSP) was developed as a way to combine primary care training, rural medicine and continuity learning for students with a particular interest in being a medical professional in a rural area. The good news is that 56% of the ORSP graduates entered a family medicine residency program (compared to 8.5% of medical school graduates nationally.) To date, over 80 students have been selected to participate in this program and we want to do all we can to encourage those numbers to grow. Students learn about life as a rural doctor, rural population health, attend skills workshops and rural clinical case presentations, and participate in rural-focused journal

With the funds raised at our annual auction and donations throughout the year, we provide educational, networking, scholarship and mentorship opportunities to our medical students and family medicine residents.

*continued on page 18*

clubs and a community project. Each student participates in a twelve-week rural clinical experience and receives enhanced mentoring from faculty, community faculty and peers, as well as early exposure to the rural family residency program in Klamath Falls. The Foundation currently supports the ORSP program by providing travel stipends for students to attend their annual ORSP weekend retreat in Klamath Falls. (See p. 22 “My Rural Scholars Experience” to read more about the ORSP program.)

A new program sponsored this year by the OAFP/Foundation is the Rural Medicine Discovery Program. Developed by first year medical students interested in getting more students involved in rural practice, this enrichment course takes place in rural communities throughout the state, four to five times per year, with typically 15 students per event. Students have opportunities to spend time with a preceptor, experience recreational opportunities unique to the region and discuss medical school options with high school students. Many a student has already changed their mind regarding where they want to practice upon graduation and this program had plenty to do with it! The OAFP/Foundation is currently funding meals, housing and transportation for this important program.

In addition, the OAFP/F will continue to support the Family Medicine Interest Group by sponsoring lectures, provide scholarships for students to attend national family medicine conferences and fund physician/student networking events beyond the Portland Metro area.

After surveying our chief residents and the resident

directors on the Academy board, we concluded that this group was interested in networking activities across residency programs to share ideas and build opportunities for collaboration. To support these requests and enhance the residency experience, the OAFP/F plans to put into motion the following activities: provide informal resident-faculty gathering opportunities; create a resident-only listserv; and develop a resident forum at the 2018 OAFP Spring Family Medicine Weekend held in Portland. The Foundation is also interested in providing an emergency fund for residents and looking into providing travel stipends for resident rural rotations.

Please keep the Foundation in mind whenever you would like to make a financial contribution to the future of family medicine in Oregon. The board appreciates your donations to the Foundation whether you give during your typical year-end giving, at the annual auction that takes place during the Spring CME Weekend, or if you would like to give a gift in honor of, or in memory of, someone special. You can easily donate online at the OAFP website, or download a donation form -- <http://oafp.org/oafp-foundation/> -- and send it to us at 1717 NE 42<sup>nd</sup> St., Ste. 2103, Portland, OR 97213. Thank you so much for your support.

We would love to hear about programs or opportunities that you believe the Foundation should invest in that would support the expanding needs of the family medicine physician. We look forward to hearing from you. Also, if you are interested in being an OAFP/Foundation board member, please contact Lynn Estuesta at the same email.

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## 2017 OAFP/Foundation Board

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Rick Wopat, MD, Samaritan Family Medicine Resident Clinic, Lebanon

Lynn Estuesta, Executive Director

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## 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**  
**Oregon Academy of Family Physicians,**  
**1717 NE 42nd St., Ste 2103, Portland, OR 97213**

# My Rural Scholars Experience

*I am happy to say that I underestimated the impact this experience would ultimately have on my education, my future career, and dare I say, my soul.*



*Peter visiting Hell's Canyon with his mother, Carol Scharfer, and her dog, Hiker.*

My experience in medical school is not unlike that of my fellow classmates. All of us have unique, often inspiring stories and histories. All of us believe we have a duty to serve others. All of us have failures to overcome and successes to build upon. Where my story differs from many in my class is that I got to have the incredible experience of being an Oregon Rural Scholar.\*

In my first years at OHSU I was active in promoting programs that worked to improve health care delivery to rural areas. As a result, I was rewarded with an opportunity to study medicine in the beautiful, yet relatively remote, northeastern Oregon town of Enterprise.

Prior to trekking out to the Wallowa's, I anticipated working with highly respected health care providers dedicated to improving the health and welfare of the people living in rural communities. I was excited to follow patients for an extended period of time. I was prepared to work hard, learn medicine and see firsthand how rural

communities do more with less. While there, I hoped to integrate into the life of the community itself.

I am happy to say that I underestimated the impact this experience would ultimately have on my education, my future career, and dare I say, my soul.

On the first day of my rural clinical experience, I was immediately accepted as a member of the clinic's team. I use the word "team" purposefully, as that is exactly what it was. This was not simply a place of employment designed with a hierarchy of management and subordinates. This was an environment that actively solicited recommendations from every member of the staff. This system encouraged everyone to take a lead in projects of their own choosing, so long as improved patient care, staff wellness or medical education

*continued on page 24*



was the goal. This team approach created a learning environment that empowered each individual and ultimately improved every aspect of daily health care delivery.

One of the benefits of the Oregon Rural Scholars Program is the ability for students to establish a continuity of care with a number of patients. This was an excellent opportunity to see how various treatments affect patients' lives, how conditions evolve over time and how a relationship of mutual trust and understanding can develop between a provider and the person in their care.

As an example, during my first week I met a young woman that was being closely followed due to concerns for placenta previa. Fortunately, this condition resolved. When her due date neared, she graciously invited me to join her providers in helping her bring her baby into the world. It was an honor to be the first to wish her son a happy birthday. I continued to follow their care for the next few weeks. The last time I was with them was during her son's circumcision. I suppose one could say that I was able to be with this baby from his first health scare to his first elective procedure.

In another instance, I was with a gentleman that came to the office with a complaint of "difficulty seeing things." Prior to his arrival that day, his vision had apparently degraded from an "eagle-eyed 20/20" to "severely blurred" over the course of only a few days. In addition, his eyes were red and very painful. Given this presentation, there was a heightened level of concern that he may have acute angle closure glaucoma. He was understandably worried, so I offered to join him as he went to a specialist to run a few tests that would help confirm or rule out this vision-threatening medical emergency. Long story short, he did not have this condition, and everything ended well. The time we spent together that afternoon resulted in more than a prescription for eye drops. The rapport we developed that day resulted in his re-establishing care with a doctor for the first time in 25 years. I am proud that our discussion even led him to begin the process of quitting smoking.

These relationships built over time had a very profound effect on me. They revealed that time itself is a very powerful healing tool. This lesson observed, learned and lived helped solidify my resolve to practice primary care.

As a Rural Scholar, I was expected to develop and implement a project with the purpose of providing a benefit to the community. My project focused on exposing various barriers that limit a patient's life, to receive quality care. My project had the goal of improving individual care plans, while helping determine potential "hot spots" of need within the county.

Larger communities have systems designed to serve huge numbers of people. These systems are often burdened by too many moving parts and personnel separated by location, position, title and red tape. Because of this, a student project rarely has the opportunity to move past the planning stage.

On the other hand, in a rural community, a smaller population means individuals often have multiple roles to fill. This has the benefit of allowing for a more streamlined approach to community management and



*OHSU Family Medicine Resident, Rachel Sircar, MD, and third year medical student, Peter Engdall, visiting Russell Ford's glass blowing shop.*

improved communication between various persons and organizations. This approach succeeds in mitigating many of the issues that delay well-meaning projects in more populous areas. This rural environment was perfect for a project such as mine, to move beyond the design stage and to actually being initiated.

This ability to see firsthand how one student project can positively affect the greater good was an unexpectedly uplifting aspect to my Rural Scholar experience.

Working in a rural clinic for three months doesn't seem like a long time. Yet, during that time, I not only received a top-tier educational experience, but I was warmly embraced by the community. I was invited to share dinners with the families and friends with whom I worked; got to know shop owners, restaurateurs and fellow sports fans; and cheered from the sidewalk as some of my newest friends walked in the Christmas parade. In one instance I even got to see the daughter of one of our doctors drive a dog sled team down the city streets. I was a member of the clinic's touch football team; helped harvest turkeys for Thanksgiving; watched local artists blow glass, sculpt and make pottery; I even joined the local pickleball league. In short, I went to Enterprise as a stranger and left there a person honored to call it my home.

Now, when asked, "How was your Rural Scholar experience?" I find myself smiling widely. It was incredible! I experienced the practice of medicine from some of the most inspiring medical professionals (doctors, P.A.s, nurses, counselors and medical assistants) one can find in any part of the country. I also dedicated time to a project that I believe will truly have lasting benefits to both the clinic and the community.

During my three month tour, I was five hours outside of anything that could be considered a metropolitan city; 45 minutes away from the nearest movie theater and over an hour away from the nearest Walmart. Some have described this area as "the middle of nowhere." I argue against that notion. For it was there, in the foothills of the Oregon Alps, that I found myself living in a rich and vibrant community. My time there

filled me with a newfound sense of purpose, once again excited by the future that awaits me.

It was there in rural Oregon that I found myself. More importantly, I discovered the doctor I wanted to become.

My experience in medical school is not unlike others. The day-to-day grind of learning how to practice medicine often makes a vision of the future obscured within the opacity that is medical school. However, my experience in Enterprise as a Rural Scholar has given greater clarity of what my future may bring. It revealed to me how I can have a fully realized career of serving my community through the practice of medicine, even in the most rural of locations.

I would like to thank the amazing and beautiful people at Winding Waters Clinic and Wallowa Memorial Hospital for the incredible opportunities they provided me and the kindness and knowledge they shared. Special thanks to my incredible preceptors: Kathryn Mayhew and Kathy Siebe, physicians **Elizabeth Powers, Keith DeYoung**, Annika and **Geoff Maly**, Kenneth Rose and the legendary Scott Siebe. You are all exemplary role models for me and the entire profession.

\*The Oregon Rural Scholars Program is developed as a way to combine primary care training, rural medicine and continuity learning for students with a particular interest in being a medical professional in a rural area. This program was a way for an OHSU student to fulfill requirements needed to demonstrate their intent to practice in a rural community, which would make them eligible for various grants, scholarships and loan repayment programs. This program is working to expand offerings to family, internal medicine, pediatrics and surgery, as well as interprofessional learning experiences with PA and NP students.

*The OAFP/Foundation supports the Oregon Rural Scholars Program by providing travel stipends to the scholars attending their annual rural retreat in Klamath Falls. If you are interested in supporting this program financially, please contact Lynn Estuesta, OAFP/Foundation at [mail@oafp.org](mailto:mail@oafp.org) or go to the OAFP website and donate online at <http://oafp.org/oafp-foundation/>.*



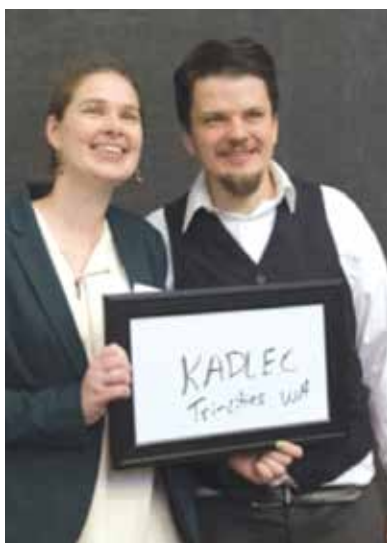
*Peter surrounded by the his Winding Waters flag football teammates -- Team Rushing Rapids.*

# Match Day 2017

On March 17, twenty family medicine students entered the Collaborative Life Sciences Building on OHSU's waterfront and opened the most important envelope in their career to date – the Match Day envelope which revealed where they would be spending the next three or four years of their lives completing their residency training. Sighs of relief, tears of joy and cheers of adulation filled the jam-packed hall. Fourteen percent of the graduating class matched in Family Medicine (41 percent of the class choosing a primary care residency –including family medicine, internal medicine and pediatrics) and six FM graduates will be training in Oregon. Congratulations!



*Audrie Konfe and her daughter open the envelope together to find they will be heading to Ft. Benning, Georgia.*



*Kate Kleaveland is one of two OHSU students placed at the Providence Hood River Rural Training Program.*

*Alissa Goodwin, along with her husband Josh, is thrilled to be heading to Eastern Washington for her participation in the Kadlec Regional Medical Center's program.*



*Roheet Kakaday celebrates his match at OHSU with his family.*



## Congratulations to the OHSU medical students who matched in Family Medicine:

**1) Rita Aulie**

OHSU Cascades East Family Medicine, Klamath Falls, OR

**2) Katherine Berger**

OHSU, Portland, OR

**3) Robin Brown**

University of Utah Affiliated Hospitals, Salt Lake City, UT

**4) Carly Chambers**

Providence Hood River Rural Training Program, Hood River, OR

**5) Alissa Goodwin**

Kadlec Regional Medical Center, Richland, WA

**6) Taryn Hansen**

Group Health Cooperative, Seattle, WA

**7) Roheet Kakaday**

OHSU, Portland, OR

**8) Connor Kitts**

Providence St. Peter Hospital, Olympia, WA

**9) Kate Kleaveland**

Providence Hood River Rural Training Program, Hood River, OR

**10) Audrie Konfe**

Martin Army Medical Center, Ft. Benning, GA

**11) Joshua Lum**

Kadlec Regional Medical Center, Richland, WA

**12) Sheila Miller**

Providence Hospital, Anchorage, AK

**13) Maura Olcese**

Ventura County Medical Center, Ventura, CA

**14) Lisa Pearson**

OHSU Cascades East Family Medicine, Klamath Falls, OR

**15) Jessica Petrovich**

University of Utah Affiliated Hospitals, Salt Lake City, UT

**16) Elena Phoutrides**

Contra Costa Regional Medical Center, Martinez, CA

**17) Will Price**

Camp Pendleton Medical Center, San Diego, CA

**18) Peter Scott**

David Grant Medical Center, Fairfield, CA

**19) Bryan Wu**

Valley Medical Center, Renton, WA

# ● STUDENTS SPEAK OUT!

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

CO-CHAIRS ROSE CHUONG, GREGGORY DALLAS, BRETT LEWIS, EMMA FELZIEN



*OHSU's Family Medicine Interest Group leads. From left to right: Rose Chuong, Emma Felzien, Brett Lewis and Greggory Dallas.*

The OHSU Family Medicine Interest Group (FMIG) is a diverse group of students from all over Oregon and the United States. Some have known that they wanted to be a family physician from the day they decided to go into medicine. Others are still unsure what specialty they want to pursue. However, all FMIG students bring with them an appreciation for primary care and a desire to learn more about what the field of family medicine has to offer. We thought we'd start off the first update of the new year with an introduction to four FMIG members, the new Med20 student leadership team.

**Greggory Dallas** is one of the new leads for FMIG's Lunchtime Talks and Workshops. Greggory is a family medicine enthusiast and rural Oregonian. She has lived, worked and learned in dramatically different contexts — from a Pendleton wheat farm, to Columbia University, to the Peace Corps in Madagascar and now back in Oregon. Along the way, she has seen the importance of access to primary care and she is passionate about supporting her fellow students' explorations of family medicine. In addition to working with FMIG, Greggory is part of the Dean's Student Rural Advisory Group, where she advocates for the integration of rural experiences into the medical school curriculum.

**Brett Lewis** is the other Lunchtime Talks and Workshops lead. Originally from Massachusetts, Brett moved to the West Coast to attend college at UC Berkeley, where she studied public health and anthropology. Before medical school, she worked for the HEAL Initiative, a global health equity fellowship that works in the Navajo Nation and rural communities internationally. Through this experience, she was able to spend several months with a family medicine residency program in rural India, which solidified for her the importance of generalist primary care. To Brett, family medicine doctors seemed the best equipped to address the large range of health needs, the limited resources and the social and structural factors so deeply embedded in the health issues of underserved communities. Since coming to OHSU, she has been further inspired by the family medicine community here and is excited to learn more about all the work being done at one of the lead centers for primary care.

**Emma Felzien** is FMIG's new Community Outreach Coordinator. She came to OHSU with an interest in primary care because she loved the relational aspect of working as a primary care physician. It's a position that allows both the patient and doctor to grow, mature and work together in a nurturing environment. She

is currently in the year-long preceptor experience at OHSU's Gabriel Park Family Medicine Clinic. By being in the clinic every week, she has been able to experience a wide array of family medicine interactions, including well-child checkups, deliveries, long-term diabetic care, mental health concerns and more. She appreciates the eclectic concerns that patients present with in clinic. Emma looks forward to learning more about family medicine, sharing what she learns with her peers and growing with our program here at OHSU.

**Rose Chuong** is in charge of coordinating FMIG's Mentorship program, where she helps link first-year medical students with family medicine residents. She also coordinates the FMIG Listserve. Rose cherishes the longitudinal relationships that primary care providers and patients can establish over time. She has an interest in taking care of patients with chronic diseases and believes that this is best managed when she has the opportunity to see the patient often, learn what is important to them and motivate them to manage their diseases. In addition to the longitudinal relationships, Rose is considering family medicine because it would allow her to work with her favorite age groups: pediatrics, geriatrics and everything in between. She hopes to continue raising awareness of this specialty through FMIG.

This year has brought a lot of change, and with it, a renewed focus on primary care as an essential component of the health and wellbeing of our nation. Med20 FMIG members have picked up where Med19 left off, raising awareness not only for the importance of specialties like family medicine, but also for the variety of exciting people and opportunities in this field. **Joe Skariah, DO**, led a suture workshop, in which students were taught the basics of suturing and were able to practice on pigs' feet. Dr. Skariah also shared his own path into family medicine. Several of the students admitted that they hadn't known much about the different paths one could take within family



*Drs. Brian Garvey and Tim Herrick meet with OHSU FMIG members to discuss the integration of global health and family medicine.*

medicine. The discussion with Dr. Skariah sparked their curiosity to learn more. At an FMIG event about Family Medicine and Global Health, **Tim Herrick, MD** and family medicine resident **Brian Garvey, MD**, talked with thirty medical students about how to incorporate global health into a career in family medicine. In addition to sharing their own experiences and distinct journeys in global health, the pair addressed questions around continuity of care, managing global and domestic practices and the need for those interested in global health to creatively shape their careers by becoming "medical entrepreneurs."

FMIG is looking forward to continuing its momentum this spring with more talks, workshops and opportunities for students to attend local conferences on family medicine and health equity.

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