

# Family Physicians of Oregon

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- Taking it on the Road: Seven Years Later
- Match Day Results
- Time for Goodbye's



OREGON ACADEMY OF  
FAMILY PHYSICIANS

MAKING HEALTH PRIMARY

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OREGON ACADEMY OF FAMILY PHYSICIANS



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# Family Physicians of Oregon

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### About the cover:

*Drs. Nathan Defrees, Weston Baker and Matthew Sperry have come a long way since their days as first-year medical students. Read about their story on pages 12 – 13.*



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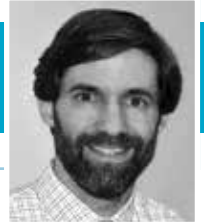
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EDITION 45



DAN PAULSON, MD

# Many Thanks

Serving as OAFP president and as a board member has been a rewarding experience. It is an honor to represent our Academy and all of the family physicians in Oregon. I have also enjoyed working with a very talented and dedicated board of directors who represent the wide diversity of our profession. And yet as much as I have appreciated representing and working with the family physicians of the state, there is one other person who makes this organization strong and effective. That is our executive director, **Kerry Gonzales**.

Kerry has been with the OAFP for the past 27 years and has been an exemplary executive director. Even before I joined the board, I had been impressed by how she ran our CME conferences and how she made all members feel welcome. Her leadership skills were evident to me from the start of my time on the board, making new members to the board feel welcomed and included. She had a good understanding of the issues and knew how to explain them to the new members like me who were just learning about their roles on the board. Over time I saw the depth of her understanding as she provided the level of information needed by the entire board to make good and

...as much as I have appreciated representing and working with the family physicians of the state, there is one other person who makes this organization strong and effective. That is our executive director, Kerry Gonzales.

informed decisions. She has shown many times how well she understands the state of Oregon and the health care climate here. She has always been able to connect board members with others in the community so that our voice was heard in the most positive of ways, leading the Academy to have a strong and respected voice in the state.

Kerry has connected with physicians across the state to identify future leaders in the Academy, sometimes reaching out to physicians as potential leaders long before we had thought of ourselves in this way. She has not only been able to identify this potential in people but she also helped to cultivate the leadership potential in new board members so that when it became our turn to step into the role of vice president or president, we were ready to do this. Kerry's knowledge of the state and her connections across the family medicine community continues to

bring new and talented physicians into leadership roles in the OAFP.

There are many other responsibilities for an executive director that are essential to making the organization function effectively—managing a budget, identifying current and future needs, managing staff, organizing conferences—all of which Kerry does effectively and with seeming ease. Yet something else that makes Kerry stand out is her ability to communicate the mission of the OAFP. She has been able to grasp this mission (health and vitality for all Oregonians) and articulate it across all settings and contexts, often more effectively than physicians. She is deeply dedicated to patient-centered care and understands how to support family physicians as we work to improve the health of our communities. Her passion for family medicine has helped keep me inspired and invigorated to do the work of the OAFP even as I am buried in the day to day work at my clinic.

I know that my admiration for Kerry is shared by others. I have spoken with many of the past presidents of the Academy and other board members who share my feelings. I have seen Kerry interacting with other state chapter executives at national meetings and see how much respect they have for her. Many people have shared personal experiences of how Kerry has touched their lives both professionally and personally. Hearing these stories has helped me see why she has had such a successful career. Beyond all of her professional excellence, Kerry cares deeply for people. She has built many strong and lasting personal relationships through the years which make those around her feel valued and inspired to give more. This is a quality that I will always carry with me as I aspire to be that same kind of a leader.

Kerry is retiring this year and is leaving the Academy in a very strong position. We have an active and engaged board of directors with many new leaders ready to carry forward our mission. Our reputation in Salem and across the state is strong because we have a history of being solid advocates for policies that improve the health of our patients and our communities. We have durable connections across the state and in the many different work settings of family physicians. Kerry deserves credit for helping to create and maintain this. Her steady leadership, keen eye for future leaders, and dedication to the enduring success of the OAFP made sure that she leaves us in good hands to continue our work. These qualities were evident once again in her well thought out succession plan. Kerry notified the

board in advance of her retirement so that we could implement a smooth transition. As we sought and reviewed applications, interviewed candidates on the phone and in person, and hired her replacement, the wisdom of the process that Kerry put in motion became very clear to me. With great skill, Kerry made all of us involved feel included and heard, giving us a wonderfully difficult choice between several well-qualified candidates. Kerry is justly proud of the OAFP and the work we do and she has made certain that she leaves us in good hands for the future.

So I think that I speak for family physicians and supporters of family medicine throughout Oregon and beyond when I say, with deep gratitude and great appreciation: Thank you, Kerry.



JOYCE HOLLANDER-RODRIGUEZ, MD AND JENNIFER DEVOE, MD, DPHIL,  
CHAIR OF OHSU FAMILY MEDICINE DEPARTMENT

## Family Medicine's Role in Population Health: Beginning the Journey at Cascades East Family Medicine Residency

As family physicians, we are trained to approach every patient in the context of family, and every family in the context of community. Working to improve the health of communities we serve is not a new concept. It is with pride in the family medicine discipline that we look back at our decades of pioneering work, including further developing Community Oriented Primary Care concepts,<sup>1,2</sup> building communities of solution,<sup>3,4</sup> and transforming primary care through the creation of patient-centered primary care homes.<sup>5,6</sup> This revival of our vision and purpose is central to the current Family Medicine for America's Health efforts as outlined by Puffer, et al: "Central to the notion of focusing on patient-centered care is the understanding that individual patients are a reflection of the communities in which they live, and by better understanding and harnessing the unique relationships among patients, families, communities, and those professionals dedicated to promoting health, we can work together to achieve better care and better health." With this community orientation as a central guiding light for our discipline, it has been exciting over the past several years to hear of growing interest in population health. But what do large health systems, hospitals, payers, accountable care organizations, coordinated care organizations, patients and the public all mean when they talk about population health? Do they mean population health management, public health, community health, or clinical population medicine? Or, all of the above? These questions made us ponder: What is our role in population health? And, how do we want to define, develop, and implement our population health work?

At a recent gathering of faculty and residents from the Cascades East Family Medicine Residency in Klamath Falls, Oregon, we spent time focused on the questions surrounding population health and what it means for us as family physicians and for our family medicine teams. We discussed and reviewed five major questions: 1) How do we define population health? 2) Why do we care about it? 3) Who are our partners in this work? 4) What tools do we use to approach these issues? and 5) What skills do we need to do this well? We then reflected on the ways we apply population health to the clinical realm within our family medicine practice, how we incorporate it into the curriculum of our residency, and how we use it to approach the needs of our community.

### What is population health?

The terminology around population health is confusing because a variety of similar terms are used differently, depending on the setting and the user. For example, when a family physician talks about improving population health, the population with which we are working may be our own patient panel, everyone who is seen within our practice, or everyone within the broader community we serve. A payer, such as an insurer or Coordinated Care Organization, may talk about improving population health and mean only their members or the enrolled population. And finally, when we work to address the needs of our broader community and improve gaps in care, we might aim to reach out to the populations that are not enrolled in a health plan and are not regularly accessing primary care.

In an effort to define the term, Kindig and Stoddart described population health<sup>8</sup> as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." This emphasizes the importance of health outcomes, not just health care delivery. It is important to note that by viewing population health as the health of populations, this solidly fits within the purview of family physicians and primary care teams. If we are not working to improve the health of groups of people, then what are we doing? We cannot relegate this task to payers or the public health system; we have unique skills to address the health of populations and can collaborate to play an active role in this work.

### Why do we care?

Most dominant health care delivery and payment paradigms focus on clinicians interacting with individual patients and do not easily support the activities necessary to improve the health of populations and communities. The continuity relationship of the physician-patient dyad is one of our key defining characteristics as family physicians, and this unique aspect of our discipline is what drew many of us to this profession. We must hold true to this important tenet and recognize its value<sup>9,10</sup> while also understanding the ways in which our health care system is falling short in efforts to improve the health of our

communities.<sup>11</sup> The people of our nation, our state, and our counties are leading shorter lives, are in poorer health,<sup>12</sup> and are paying increasing amounts of money for health care with diminishing returns on their investment.

We have work to do to achieve the quadruple aim (better care, better health, lower cost, improved health professional wellness),<sup>13</sup> and transforming primary care to work on a broader scale is a big part of the solution. Changing our mindsets about measuring quality care will be another great step in this direction. This change requires that we recognize the paradox of primary care in showing inferior outcomes at the individual disease level but overall benefit to improving a population's health.<sup>14</sup> How can we shift metrics from comparing ourselves to our endocrinologist colleagues in diabetes care quality indicators, to instead measuring our presence in the community and our overall contributions to the community's health? And, how can we do more to improve the health of the populations we serve?

### **Who are our partners?**

Even as we move into better and stronger practice teams to care for our patients, much health care work is still done in silos. The Folsom Report<sup>3</sup> of 1967 urged primary care physicians to address community health needs and partner with public health systems and others to create communities of solution that would cross jurisdictional lines. Despite the efforts of the community-oriented primary care approach, many of the market forces at work in the United States health care system led to the fragmentation we now see. Family Medicine for America's Health<sup>7</sup> has helped reinvigorate this call to action and create a new vision for the role of primary care in redesigning health care and addressing the health of populations. We should be partnering with everyone and anyone who works to improve the health of groups of people: hospitals/health systems, payers, other primary care providers, the public health system, educational institutions, community organizations, and researchers.

### **What tools do we use and what skills do we need?**

As we move forward in defining relevant populations, launching new efforts to improve population health, and measuring our progress, there are several tools and skills to develop and new team members to recruit and deploy. We are utilizing data to drive decisions for improving our practices and measuring the care we are providing.<sup>15</sup> We can continue along the path toward creating and implementing enhanced primary care delivery models, such as patient-centered primary care homes, with systems to track the health of our patient populations. We can partner with informaticists, epidemiologists, and biostatisticians to create new methods for harnessing and analyzing data from electronic health records (EHRs), insurance claims, and public health data repositories to better understand our population health landscape and how we might be able to impact it. We can also begin to identify and address social determinants of health for individual patients and populations through data collection, new systems of care, new community partnerships, community organizing, and policy advocacy work.<sup>16</sup>

Equipping the next generation of family physicians and primary care teams to continue this work and accelerate our momentum will require many of the unique skills already taught in family medicine residencies for understanding and addressing bio-psycho-social factors impacting health. We should consider adding several additional skills to our training program curricula: community engagement, patient empowerment, community organizing, collaboration and teamwork, relational leadership, informatics, data analysis, and creative problem-solving (to name a few).

### **What are the next steps?**

After a large group discussion about the five questions outlined above, we convened three small groups of faculty and residents to explore opportunities to apply population health in our family medicine practice, our residency curriculum, and our community.

The family medicine practice is the realm where we currently experience the most pressure to incorporate population health management principles. This is particularly influenced by payments for quality markers, risk stratification, and expanded delivery systems like the patient-centered medical home. In a residency practice we need to find ways to engage rotating clinicians (i.e., residents and faculty) in the practice's approach to population health without having these initiatives be dependent on the clinician completing an additional task during their busy day. We want our clinicians to still be directing the care of their patients and panels, but delegating tasks, not just for individuals, but on a practice-wide basis. At our retreat, we selected improved colorectal cancer screening as a key goal and put in place a plan for panel managers to identify care gaps, utilize shared decision-making tools and standing orders, and reach out to patients rather than waiting for them to come to us.

Another tangible approach for incorporating aspects of population health into our clinical practice will be the design and implementation of systems for understanding more about specific neighborhoods in our community and the incorporation of these "community vital signs" into our patient care and population health efforts.<sup>17,18</sup> We are finding new ways to use EHRs to improve risk stratification and documentation of health achievement barriers, which include social determinants of health.<sup>16</sup>

To incorporate population health skills into our curriculum, we outlined new elements that will equip learners and teams with skills for conducting community health needs assessments and for identifying critical social determinants of health for our patient populations. Teaching residents and faculty clinicians to generate reports about their practice panel remains an important skill, but we are shifting emphasis to learning how to respond to these reports, recognizing that report-writing may be a skill best held by a member of the practice team rather than a skill that every provider needs.

Advocacy work and involvement in community organizations remain important components of resident and faculty time. We identified a need to shift our approach from viewing this as extra to recognizing it as essential. While our faculty sit on community boards, lead community advisory groups, work as public health officers, and engage as advocates

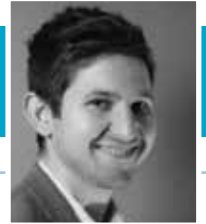
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around issues addressing health, we need to incorporate and recognize this work as part of our role as family physicians and train residents in this same model.

We were heartened to learn that we are not alone in our struggle to define the terms and strategies for population health in our practice, curriculum, and community. Having these discussions and finding the areas where we struggle has given us a roadmap for improvement. As in all improvement processes, we must celebrate our baby steps (such as more patients being screened for colorectal cancer), and not be discouraged by how far we have to go. Working to address the tension between taking care of the individual patient and the magnitude of improving the health of a whole community will always be central to our discipline. The increased spotlight on this topic from payers, health systems, researchers and others suggests that we have the potential to build better teams so we are not trying to address these issues alone. And that really may be the key to better health, better care, lower costs and more satisfied health professionals!

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SAM BARBER, OAFP LOBBYIST

## Primary Care in Oregon Sees Increase in Investment (Kind of) Plus End-of-Session Recap

For the third year, the Oregon Health Authority (OHA) published its Primary Care Spend Report in February. The report is the result of legislation authored and advocated for by the OAFP. The goal was to begin to track what percentage of health care dollars is going into primary care. In 2017, the OAFP passed subsequent legislation mandating insurers, coordinated care organizations and public employee plans to increase their spend on primary care by 1% annually until they reach 12% of their overall dollars spent.

The most recent report, which measures 2016 claims data, puts the vast majority of Oregon's major payers above the 12% threshold—a massive increase in spending from last year's report. The way the OHA calculates this report is fairly simple. They first measure how much a payer spends in total on medical care. That number is then divided by the amount that payer spends on primary care. A simple methodology, but the devil is in the details.

The catch to this year's sizeable increase

in primary care spending is that we are not comparing apples to apples. That is, this year's report does not measure the same thing last year's did. Included in the most recent report were four major changes in how primary care spend and overall medical spend were calculated, resulting in significantly inflated numbers. Some payers such as Kaiser and many of the CCOs have routinely been above the 12%; most, however, have not been close.

So, what changed, and why? The answer is that payers had complained at various times that the OHA was not accurately capturing their spending. And so they asked the OHA to alter the methodology.

Some of the changes sought by insurers are logical, at least on the surface. For example, the OHA added codes for inpatient pharmaceuticals such as flu and shingles vaccines. Vaccines are certainly examples of preventative medicine and ought to qualify. This increases (rightfully) an insurers' calculated spend on primary care.

But this methodology is not applied uniformly in the report. Inpatient pharmaceuticals utilized by hospitals, known as J-code pharmaceuticals, were *excluded* from the reports' calculations, greatly lowering a payer's "Overall Medical Spend." If pharmaceuticals used in a primary care setting are included in the calculation of primary care spend, should not pharmaceuticals used in a hospital be included in the overall medical spend?

The OAFP will be seeking to address questions like these in the coming year so



we can get an accurate assessment of how much money is really being invested in primary care. Consistent logic is important, the ability to compare Oregon’s investment in primary care to other states or national models measuring primary care spending is important and fairness is important (for payers and physicians). Hopefully by addressing some of the methodological issues with the report, and coming to agreement about what should and should not be included in the calculations, we can set ourselves up to better address the broader goals of the quadruple aim -- better health, better care, lower costs and reducing provider burnout.

**2018 End-of-Session Wrap Up: Decisions Affecting You and Your Patients**

**2018 SESSION SCORECARD**

Key: ↑ = Good for OAFP; ↔ = Mixed result for OAFP; ↓ = Poor for OAFP

Result	Issue	Bill #	Details
↑	RX PRICE TRANSPARENCY	HB 4005	Requires drug manufacturers to report on increasing cost of high-priced drugs. Requires insurers to report on the most expensive drugs prescribed and their impact on rates.
↑	OPAL-A	SB 1539	The bill did not pass but legislators appropriated \$900,000 in the final budget bill to expand the psychiatric hotline for consultations with physicians about patients’ mental health issues.
↑	CONCUSSION PROTOCOLS	SB 1547	Athletic trainers are not able to authorize concussion releases.
↔	HEALTH CARE AS A RIGHT	HJR 203	This proposed Constitutional referral did not make it through the Senate, so it will not be on the ballot in November.
↑	CCO 2.0	HB 4018	CCOs must make “significant” decisions in public meetings; spend some of their reserves on social determinants of health; and give notice if not renewing contract.

**Key Issues**

**HB 4133 – Maternal Mortality Review**

**PASSED**

Ways and Means appropriated \$46,000 for the Oregon Health Authority to staff an 11 to 15 member Maternal Mortality Review Committee. **Sen. Steiner Hayward** said, “We expect every profession who works with pregnant women will be involved.”

According to testimony from the Oregon Medical Association, “The United States is

the only highly industrialized country in which the maternal death rate is rising and has the highest maternal death rate of any developed country. From 2000 to 2014 it increased by about 25% and is now 21.4/100,000 live births.” The rate for African Americans, Native Americans and Alaska Natives is three to four times higher than it is for Caucasians, Hispanics and Asian Americans.

The bill passed handily in both chambers, but there was some debate over whether the information found by the committee should be discoverable.

Arthur Towers, Oregon Trial Lawyers Association, said, “In many maternal deaths, the death is not due to negligence. But in the few that are due to negligence, the ability for a family to have their day in court is a cornerstone of our democracy.”

Stakeholders agreed on an amendment that clarified that any conclusions drawn by the Committee will not be discoverable, but the source data they look at will remain so.

**OHSU Intergovernmental Transfer Funds Higher than Expected**

The Legislature approved an Other Funds expenditure limitation of \$10 million to allow additional revenues received in

the Health Care Provider Incentive Fund to be spent on workforce training programs and/or provider incentive programs such as loan repayment and scholarship programs.

It is anticipated that the intergovernmental transfer mechanism with OHSU will generate roughly \$8-10 million this biennium—a \$4-6 million increase over what the State expected.

**HB 4005 – Rx Transparency Passes**

**PASSED**

In 2017, Rep. Rob Nosse (D-Portland) led a workgroup that attempted to address increasing pharmaceutical drug prices and the effect on consumers. Based on findings from that workgroup, lawmakers sought to pass comprehensive legislation on pharmaceuticals in the 2017 session but were unsuccessful.

Rep. Nosse was back this session with a scaled-back version. The bill requires pharmaceutical companies to report to the Department of Consumer and Business Services on any drug that costs \$100 or more for a one-month supply and increases in price of 10% or more. The bill also requires insurers to report the top 25 most frequently prescribed drugs; 25 costliest; 25 with greatest increases and the impact on premiums.

Rep Mike Nearman (R-Independence) said, “The problem with the base bill is that it puts the burden of transparency on manufacturers, and ignores PBMs and insurance carriers.”

In response, bill supporters added another prescription drug work group to recommend cost effective solutions across the pharmaceutical drug supply chain. Sen. Dennis Linthicum (R-Klamath Falls), who proposed the amendment with Sen. Elizabeth Steiner Hayward (D-Beaverton), says the task force will look at whether there is “unjustifiable price gouging” anywhere across the Rx supply chain.

Rep. Knute Buehler (R-Bend) responded by calling the bill, “Thin soup.” He said, “Cost transparency is good but is that going to solve the problem? I don’t think so.”

# Taking it on the Road: Seven Years Later

*(Or, What our Infamous 'Bike Boys' Are Doing Now)*

We all came away with a sense that rural family physicians were an impressive breed of people doing great things for their patients and towns.



*Matt, Wes and Nathan as fresh-faced medical students in 2010.*

Our plan started to take shape during our first year of medical school in the Jones Hall Auditorium at OHSU. It was 2010 and Matt (**Matthew Sperry, MD**), Wes (**Weston Baker, MD**) and I (**Nathan Defrees, MD**) were bantering between breaks in our anatomy lecture about a summertime adventure. We had just started med school, but the idea of a final summer break hurrah was too exciting to ignore.

Our commonality was that we all loved bicycles and all three of us commuted to campus by bike. We were also Oregonians and shared a deep love of adventure for our great state. Between lectures we began talking about our ideal summer: spending it on the open road with a loose itinerary and spontaneity as a road map. We envisioned a circumnavigation of Oregon by bicycle -- down iconic Highway 101, across the Coast Range into the Willamette Valley, the climb over the Cascades into the open expanses of the High Desert, and exploration of the Strawberry, Blue and Wallowa Mountain ranges of Northeastern Oregon.

We also suffered from typical medical student motivation. We needed a purpose for the trip, an overarching thematic element. **Peggy O'Neill**, OHSU Department of Family Medicine, Medical Student Education, helped corral our loose idea for a summer plan and pitch it as an advocacy program for the Oregon Academy of Family Physicians (OAFP). We were introduced to **Kerry Gonzales**, OAFP Executive Director, who took us under the wing of the OAFP to make a trip possible. What she referred to as a “happy coincidence” was that she had recently received a grant from the Northwest Health Foundation to help engage the state’s business community in a conversation about rural health care. Kerry helped us reach out to physicians and

communities along our proposed route and before we knew it we had 15 presentations scheduled. We would be talking about rural health care needs, recruiting strategies and the economic impact of recruiting primary care physicians to communities. We would talk to Rotary and Lions Clubs, Chambers of Commerce, Toastmasters, and various other groups. We would partner with local physicians to help lead these discussions. Matt soon convinced his girlfriend Daphne to join in; she had a keen sense of adventure and was a first-year veterinary student at Oregon State University. She would add a unique perspective to the group with the added benefit of getting to check out future practice locations of her own.

With the financial and organizational backing of Kerry and the OAFP, we embarked on a 1,000-mile trip. We left in July of 2011, shortly after wrapping up our first year of medical school. For the next five weeks Matt, Daphne, Wes and I bicycled nearly every day. We stopped in Pacific City, Reedsport, Eugene, Paulina, John Day, Baker City, La Grande, Union, Enterprise and countless other Oregon communities. We camped in state parks, stayed with physicians in their homes and made a lot of friends along the way. We saw how physicians lived (we joked that they all lived



*Nathan, Wes, Matt and Daphne at the Defrees Ranch on their 2011 bike trip.*



*Speaking to the Wallowa County Rotary Club.*

on the top of the highest hill in town, making riding our bikes there very difficult) and saw the impact they could have in rural communities. We all came away with a sense that rural family physicians were an impressive breed of people doing great things for their patients and towns.

At the time none of us would have said that it was a career-altering adventure, but in hindsight it is hard to argue. All three of us chose family medicine as a specialty and are practicing in towns that we passed through. Matt and Daphne are now married and have settled in Hood River, I am in Baker City, and Wes will be moving to Enterprise this coming fall.

Matt had an impressive resume coming into medical school -- he had helped start the Adventist Emergency Medicine Scribe program and strongly considering pursuing emergency medicine as his specialty. After our bike trip he returned to one of our favorite stops along the bike trip, Reedsport, for a rural Family Medicine rotation with **Robbie Law, MD**. This, along with our experiences on our bike trip, helped turn Matt around and by his fourth year of school he decided to pursue a family medicine residency. He was accepted into the first class at the Providence Hood River Rural Residency program and helped trail blaze the development of an excellent training program. He and Daphne loved the location and the practice environment, enough that Daphne and Matt stayed to practice veterinary and human medicine. Matt joined Columbia Gorge Family Medicine and is providing full-spectrum care in Hood River. Daphne and Matt can be found after work and on most weekends riding their mountain bikes in the trails of the Columbia River Gorge.

I was set on returning to my hometown of Baker City at the outset of medical school. After the bike trip I became very involved with the OHSU family medicine interest group and then spent three glorious months as a rural scholar on rotation in Burns, Oregon with Kevin Johnston, MD.

These experiences cemented family medicine as my choice in specialty and after graduation I went to the Family Medicine Residency of Idaho in Boise. After exploring much of Idaho by bicycle, I am happy to report that I have returned home to Baker City and joined the St. Luke's Eastern Oregon Medical Associates practicing full-spectrum care. My wife Jess and I have an active toddler named Sloan who is just starting to love riding bikes of her own.

While Wes was born in Oregon and had strong family ties here, his upbringing had taken

him all over the country and the world. He had spent several years in Japan and then boarding school and college in New England. He was an Oregonian at heart however and returned here for medical school. After our bike trip he spent time as a rural scholar in Union, Oregon; a stop on our bike trip where a fortuitous roadside meeting with **Kim Monte, MD**, turned into burgers and a clinic tour. Wes then decided to stay at OHSU for residency and is finishing up his fourth year with all of our favorite OHSU family medicine faculty. Wes is now married to the woman he met just prior to the bike trip, Bre, and they have a beautiful two-year-old daughter, Adelaide Wallowa Austin. They will all be moving to Enterprise this fall where Wes will join the Winding Waters Practice and provide full-spectrum care.

Whether it was as a spark, inspiration or affirmation, our bike trip across Oregon played a part in steering us all towards caring for rural communities as family physicians. As Wes, Matt, Daphne and I are settling into our new lives the big question is when is our next bike trip? Maybe a Southern Oregon route this time?



# Time for Goodbye's

KERRY GONZALES, OAFP EXECUTIVE DIRECTOR



I guess it is time to write this article. It's very hard to retire from a job you love. I've enjoyed 19 years as the OAFP's Executive Director, and before that, eight years working for the Academy part-time. I have worked with some amazing staff over the years.

**Peggy O'Neill** continues to be a family medicine champion and our liaison to the OHSU Department of Family Medicine, and you will continue to have the privilege of working with **Lynn Estueta** as she leads the OAFP/Foundation. I will forever be grateful to **Mary Lundy** for hiring me and training me so well.

Working with family doctors is a special kind of privilege. I was always proud to represent the "white hats" in the medical establishment. Your clear dedication to your patients makes it easy to advocate for you and tell your stories. The OAFP's guiding principle of asking "Will this improve the lives of our patients?" has guided us at every turn, whether evaluating legislation, pursuing new policies or contemplating new initiatives.

I have seen many changes to our organization over the last 20 years. Most notably, we have increased our focus on legislative advocacy and included practice transformation in our education and communications efforts. We have included the whole medical team in our definition of primary care and will continue to pursue partners and allies among our medical team colleagues.

It is an exciting time for primary care these days. It seems we are on the brink of substantial changes to the way primary care is paid for and delivered. Family doctors continue to be the ones with creative solutions and the energy and dedication to implement them.

We have been successful in passing legislation in Oregon to increase the overall spend in primary care. In fact, that work is being duplicated in several states this year. However, we are discovering that

passing the legislation might be considered the "easy part." Implementation, follow up and verification are where the real work begins and we are entering that phase now.

I have always been aware that there are only 53 jobs like mine in all of the United States (one Executive Director for each state, plus Washington DC, the Armed Services and Puerto Rico). This is a great job, working with great people. In addition to the doctors we work with, there is a welcoming, sharing community of Executive Directors across the U.S. They are quick to accept you and generous in sharing their successes and occasional failures. They have been an invaluable resource to me and will be to my successor.

I am so pleased to introduce **Betsy Boyd-Flynn** to all of you. Prepare to be amazed! She will bring new energy, expertise and experience to the OAFP.

The next few years are critically important for family medicine. We need to build on the momentum we have going now and get the resources and relief our members need. You will be well served by the OAFP's dedicated Board of Directors and Betsy Boyd-Flynn.

While I'm looking forward to retirement, I am also looking forward to staying in touch with you all and doing what I can to nudge Oregon's primary care system in the direction we all desire.

All the best,  
Kerry



In the fall issue of *Family Physicians of Oregon*, discussion surrounded the transformative health benefits the Region of Klamath Falls was experiencing due to their involvement in the Blue Zones Project. As you recall, Klamath Falls was selected as the first Blue Zones demonstration community in Oregon, and in April, 2017, Grants Pass, The Dalles and the Umpqua Region were also designated Blue Zones demonstration communities. In this issue we will delve into what the Umpqua Region has accomplished since the Oregon Healthiest State announcement.

Located in the Umpqua River Valley in southern Oregon, this Blue Zones Project Community initiative focuses on the City of Roseburg and the surrounding area and serves a population of approximately 42,000.

The Blue Zones Project application was organized by The Leadership Council of the Community Healing and Response Team (CHART), the community coalition that formed in the wake of the school shooting two years ago. More than 45 people from across the community attended the October 11, 2016 site visit that moved the Umpqua project forward as a finalist and then ultimately, the selection as a Blue Zones demonstration community the following spring.

In the past year these community leaders have hosted 15 focus groups and 36 individual interviews with over 180 community members in all. To help fine tune their strategic plan for this multi-year initiative, a steering committee consisting of 22 community leaders created and approved the plan that was adopted in January of this year.

Now the community is ready to put all of that preparation into practice. Last December, over 800 residents from the community gathered at the Umpqua Community College auditorium to learn more about how the Blue Zones Project – Umpqua will lead the way to a happier, healthier region.

The event featured a wellness fair, a 20-minute yoga demonstration, a performance by the Nebo Thunder Drum Circle and a rousing procession by the Roseburg High School Marching Band Ensemble. At the heart of the kickoff was a keynote presentation by Nick Buettner, one of the original Blue Zones researchers and current Blue Zones community and corporate program director. After discussing the lifestyles of people living in the original Blue Zones around the globe, Buettner asked the crowd to make a personal commitment to their own and their community's, well-being.

The region has completed its' community assessment with a Gallup Poll Well-Being Index Survey. In order to reach their goal of community transformation, eight committees, staffed by over 80 community volunteers, have been formed and each has drafted implementation plans in the areas of: Food Policy, Tobacco Policy, Built Environment, Worksite, Restaurants/Grocery Stores, Faith-Based Organizations, Schools, and Individual Engagement.

In just a few short months, here's what Blue Zones – Umpqua has achieved:

- 320 community individuals have signed up to volunteer with the Blue Zones Project; to date, 186 have actively volunteered;
- 91 residents participated in Purpose Workshops; 29 joined Purpose Moais\*;
- 56 residents participated in a Cooking Class to learn how to cook with a plant slant; 30 joined Potluck Moais\*;
- One grocery store has registered to start making it easier for Umpqua residents to shop healthy in their neighborhood;
- Two restaurants have registered to begin making healthy choices easier for their customers; eight restaurants attended the Restaurant and Food Service Summit last month;
- Four schools signed up to take part in a nutrition initiative;
- Nine worksites registered to begin helping their employees be healthy at work: three of these work sites were among the top 20 targeted work sites; and
- Seven faith-based organizations participated in a Blue Zones Project Summit. All seven were among the Top 20 targeted.

*\*Moai is a term used frequently in the Blue Zones Project realm. It refers to groups of five to eight people that meet weekly to encourage strong social connections either through walking groups, potluck groups or purpose groups.*

Many future events and activities have been scheduled, including purpose workshops, community walking groups, office open houses, cooking demonstrations and cooking classes.

John Dimof, organization lead for Blue Zones Project Umpqua, hosted the first cooking class – small groups that will meet once a week for 10 weeks and enjoy plant-based dishes while forming new friendship's around healthy behavior. He told participants, "Our county consistently places low in comparison to other counties in Oregon for our health rankings. Contrast that with Blue Zones around the world where people are living to age 100, about 10 years more than we are here, and with hardly any chronic illness. We are happy to be able to provide community members opportunities to make healthy choices at our worksites, at restaurants and grocery stores, at our faith-based organizations, at schools, and of course, right at home in our kitchens."

**Heidi Beery, MD**, a Roseburg family physician, has also been doing her share to instill healthy habits within her community by facilitating a 12-week education/nutrition class. She teaches information about diabetes prevention, heart disease and cancer, the underlying causes of many chronic diseases, and how to live a healthy lifestyle. She also explains the benefits of eating more plant-based foods, mindfulness, personal health empowerment and weight loss. According to Beery, "The Total Health Improvement Program has thrived with the additional support of the Blue Zones Project and it is amazing to see hundreds of people restoring their health in our community."

*If you want to know more about the Blue Zones Project Umpqua, visit [oregon.bluezonesproject.com](http://oregon.bluezonesproject.com).*

# Interdisciplinary Care Effective for Opioid Use Disorder

## *Rural Clinic Blends Medical, Behavioral Services in Tiered Model*



*Rebecca Cantone, M.D., assistant professor at OHSU (Oregon Health & Science University) Family Medicine at Scappoose, speaks with a patient about the patient's opioid use disorder.*

In a recent issue of the *Annals of Family Medicine*<sup>1</sup>, the success of two OHSU family medicine clinics – Family Medicine at Scappoose, a rural health clinic, and Family Medicine at Richmond, a federally qualified health center in Portland – was touted in regards to their use of an interdisciplinary model to care for patients with opioid use disorder (OUD).

Many primary care clinics have developed treatment models for OUD, but few have done what this group has (accomplished) in integrating comprehensive behavioral health strategies to improve outcomes, according to the *Annals* article.

“Although medication-assisted treatment (MAT) models that emphasize medications may be effective, failure to offer robust psychosocial services can yield suboptimal outcomes, especially in complex patients,” the authors said. “We implemented a behavioral health-focused model for MAT to expand access, better engage patients in treatment and improve health outcomes. This was built on concepts of harm reduction and improvement in functioning, emphasizing behavioral health counseling in addition to medications.”

Corresponding author **Rebecca Cantone, MD**, assistant professor at OHSU Family Medicine at Scappoose, told AAFP News that although some patients do well with medication or counseling alone, her team thought treatment would be more successful if they combined multiple elements: managing the physical addiction, cravings and withdrawal; working through the addiction itself; and managing the issues and/or psychosocial factors that led to the addiction and/or substance use in the first place. MAT, as the name implies, is assisting the treatment, she noted. “It is not the actual treatment, nor was it designed to be.”

### **Care Model Staff**

Created by Cantone’s colleagues Nicholas Gideonse, MD, and Joan Fleishman, PsyD, the treatment model was

adapted from a tier model used by the University of Massachusetts. As founding medical director of the Scappoose clinic, Cantone helped adapt the model for use in the rural clinic. **Brian Garvey, MD, MPH**, is the current medical director of the Scappoose MAT program.

Cantone said the biggest obstacles the team faced when implementing the new model were hiring enough staff to support it and getting everyone trained. Both facilities are staffed by family physicians, nurse practitioners, registered nurses, physician assistants and a medical director, and residents and medical students regularly rotate through each site. It’s important, Cantone noted, to have a dedicated behavioral health professional on site because most medical staff aren’t as skilled as this type of professional in providing addiction counseling and relapse prevention strategies. In Oregon, physicians, nurse practitioners and physician assistants can train to provide buprenorphine-containing medications. The number of these trained medical professionals at both OHSU family medicine facilities continues to grow, she said.

“Collaborating with local substance use treatment centers, detox centers and mental health is also incredibly important to have the backup and next steps for patients who are not doing well,” Cantone said.

During the initial phase of treatment, the behavioral health professional addresses substance use history, family dynamics, social situation and readiness for engagement in treatment. “The behavioral health clinicians have specific interest and experience working with patients with substance use and are trained in trauma-

informed care, motivational interviewing, cognitive behavioral therapy and relapse prevention,” Cantone said. The behavioral health personnel use American Society of Addiction Medicine criteria to recommend levels of care and ensure that outpatient MAT is a safe and appropriate level of treatment, she added. They have frequent contact with patients using a dual-diagnosis approach that addresses mental health and psychosocial issues, as well as the substance use disorder.

### Patient Experience

Cantone said the two facilities try to select patients for the program who can engage in regular visits but who do not require the rigid structure of daily methadone dosing. Patients who have already tried or who have contraindications to methadone are appropriate candidates. “The patient must be interested in acknowledging that opioid use disorder exists, and not solely that they have pain and just got cut off,” she said. “People who acknowledge, or are open to discussing the issue of addiction in their life, are the best candidates.”

First, patients have a combined appointment with a behavioral health professional and the registered nurse to review medications and medical risks and to assess their level of motivation. They complete an initial behavioral health screening and then receive a combined recommendation to either start or not start treatment; this recommendation may include other treatment options. “If recommended, patients get a medical provider treatment appointment to review medical risks and benefits, update any necessary labs, and decide on medication timing and dosing,” Cantone said.

All accepted patients start out at Tier 1 with very intensive visits that occur about twice a week. If they have any relapses and/or are struggling, they continue in this maximum support tier.

As the MAT dose stabilizes with no

opioid use, patients progress to Tier 2 and Tier 3, progressively having fewer visits with the medical team.

Patients who have been stable on a reasonable medication dose (which varies depending on the provider, but ideally is 8-12 mg per day), who also have engaged in addiction counseling with the behavioral health staff and/or an outside agency, and who have ongoing stabilization with a support system/job/life can progress to Tier 4, said Cantone.

“Many patients will stay in this tier for quite some time, depending on ongoing life circumstances and relapse risk, as determined by the patient, medical provider and behavioral health provider,” she said. Patients and any provider can choose to escalate care or taper it off, if desired.

“Having a tier system that dictates the minimum number of visits while allowing providers to escalate that at any time is (key) to our success,” Cantone said.

### Using the Model

For family physicians who may wish to use this model to treat OUD, Cantone emphasized that allowing behavioral health professionals to handle the psychology and treatment of addiction makes things easier for physicians. “It only works if the behavioral health and medical providers have an ongoing relationship with open communication to maintain a safe and effective treatment plan,” she said.

Cantone said her team is available to help interested family physicians by sharing materials and answering questions. “You’ll need to start by finding a skilled and motivated behavioral health provider who is excited and competent in addiction medicine treatment, as well as a program medical director to help with the ongoing coordination of care for both patients and staff,” she said.

OHSU Family Medicine at Scappoose

started developing its model with a large executive team that envisioned a plan at the clinic level, before prescribing clinicians or practicing behavioral health clinicians were involved, to ensure all supports were in place before hiring staff or redesigning the program.

“Most of all, I recommend medical providers strongly consider providing medication-assisted treatment in some context to help with the continuing problem of opioid use disorder in the United States,” Cantone said. “We are training medical students and family medicine residents, as well, to help build a future workforce more comfortable with managing addiction.”

<sup>1</sup> *Annals of Family Medicine, Jan/Feb 2018; Vol 16 No 1:83. Author Chris Crawford.*




## FAMILY MEDICINE PHYSICIAN

**Mid-Columbia Medical Center**, in collaboration with Oregon Health and Science University (OHSU), is hiring two **F/T BC/BE Family Medicine physicians** to join the Family Medicine Team. Located in the beautiful Columbia River Gorge, one of America’s top recreation destinations, this opportunity is accompanied by a clinical faculty appointment at the OHSU School of Medicine in Portland, Oregon.

**Benefits include:**

- OHSU faculty appointment
- Employer sponsored & funded retirement package
- Up to \$3,000 annual stipend for CMA and ten days of education time per year
- Generous personal time-off & sick time allotment
- High quality, low-cost healthcare benefits for employees & family
- Paid membership for professional societies & journals
- Paid professional fees, including DEA, licensure, etc.
- National Health Service Corps Loan Repayment eligibility
- Oregon State Rural Health Tax Credit Eligibility (up to \$5,000/yr)
- Paid relocation
- H1B & J1 sponsorship available

Please send CV to:  
[kimberlyjo@mcmc.net](mailto:kimberlyjo@mcmc.net)  
EOE



**MCMC**  
MID-COLUMBIA MEDICAL CENTER  
A Planetree Patient-Centered Hospital

# It's a Match!



*Sylvia Peterson-Perry, Brianna Muller and Annie Buckmaster are all smiles showing off their Match Day locales!*

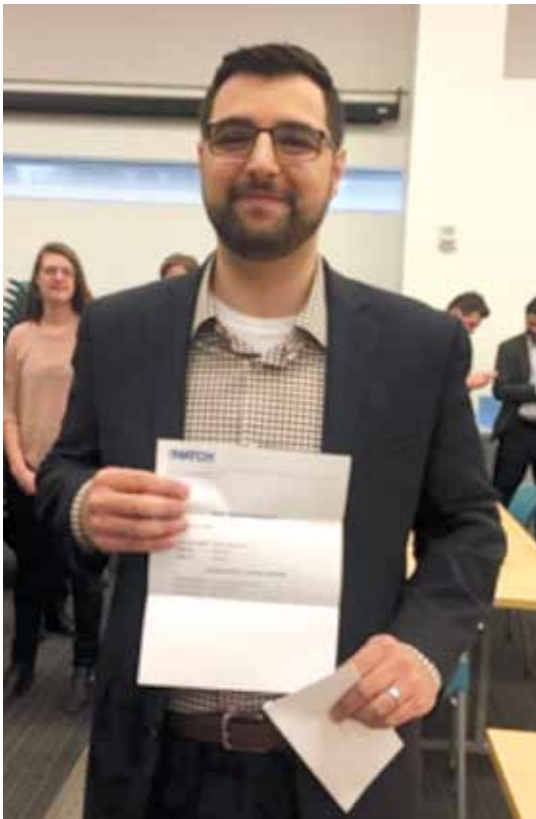
On Friday, March 16 at 8:59 a.m. in teaching hospitals across the country it would be safe to say that you could have heard a pin drop. That's because Match Day, coordinated by the National Resident Matching Program, was taking place.

At OHSU, that annual rite of passage took place at the Collaborative Life Sciences Building where medical students gathered to find out where they would continue their training as physicians over the next three to four years. Surrounded by family, friends, faculty members and classmates, shouts of joy and tears of relief happened simultaneously upon opening the sacred white envelope holding the keys to their destiny.

Seventeen 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 eight family medicine graduates will be training in Oregon.



*Five of our family medicine students will be staying at OHSU to continue their residency training. From left to right: Justin Lee, Nathan Andrews, Annie Buckmaster, Ishak Elkhail, and Laurence Moore.*



*Skender Najibi, celebrated with his wife, brother and parents who traveled from California for this momentous occasion.*



*Hugging it out, from left to right: Ishak Elkhail, Alex Polston, Michael Turner and Margo Roemeling.*



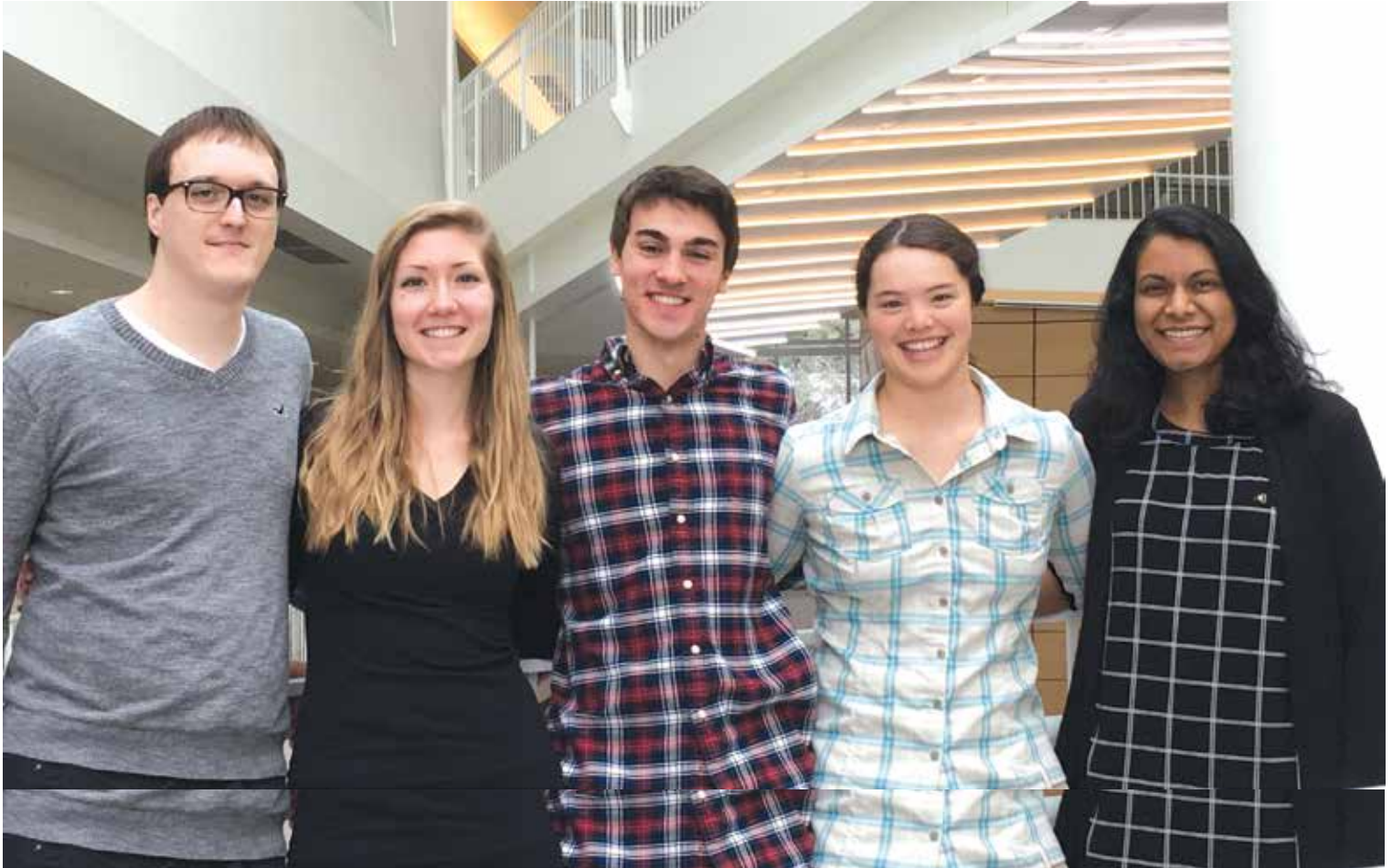
## Congratulations to the OHSU medical students who matched in Family Medicine:

- |  |  |
|--|--|
| 1) <b>Nathan Andrews</b><br>Oregon Health & Science University (OHSU)      Portland, OR    | 12) <b>Justin Lee</b><br>Oregon Health & Sciences University      Portland, OR             |
| 2) <b>Lynne Booth</b><br>Lancaster General Hospital      Lancaster, PA                     | 13) <b>Brianna Muller</b><br>University of New Mexico School of Medicine Albuquerque, NM   |
| 3) <b>Madeline Boyd</b><br>OHSU Cascade's East Family Medicine      Klamath Falls, OR      | 14) <b>Skender Najibi</b><br>Contra Costa Regional Medical Center      Martinez, CA        |
| 4) <b>Annie Buckmaster</b><br>Oregon Health & Sciences University      Portland, OR        | 15) <b>Elisa Nasol</b><br>Harbor-UCLA Medical Center      Torrance, CA                     |
| 5) <b>Lily Cranor</b><br>OHSU Cascade's East Family Medicine      Klamath Falls, OR        | 16) <b>Alex Nielson</b><br>PeaceHealth Southwest Medical Center      Vancouver, WA         |
| 6) <b>Cameron Davis</b><br>University of Nevada Las Vegas School of Medicine Las Vegas, NV | 17) <b>Sylvia Peterson-Perry</b><br>Swedish Medical Center      Seattle, WA                |
| 7) <b>David Davis-Boozer</b><br>Kadlec Regional Medical Center      Richland, WA           | 18) <b>Alex Polston</b><br>Providence Hospital      Anchorage, AK                          |
| 8) <b>Ishak Elkhail</b><br>Oregon Health & Sciences University      Portland, OR           | 19) <b>Margo Roemeling</b><br>OHSU Cascade's East Family Medicine      Klamath Falls, OR   |
| 9) <b>Peter Engdall</b><br>Family Medicine Residency of Idaho      Boise, ID               | 20) <b>Julia Ruby</b><br>Swedish Medical Center      Seattle, WA                           |
| 10) <b>Emily Harvey</b><br>Providence Hospital      Anchorage, AK                          | 21) <b>Nick Wolfgang</b><br>Providence Oregon Family Medicine Residency      Milwaukie, OR |
| 11) <b>Megan Hatch</b><br>Tacoma Family Medicine      Tacoma, WA                           | 22) <b>John Yates</b><br>Providence Oregon Family Medicine Residency      Milwaukie, OR    |

# STUDENTS SPEAK OUT!

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

BY AMITY CALVIN, JORDAN GEMELAS, SARA HAYS, HANNAH JACOB, AND DEREK WISEMAN, CO-CHAIRS, OHSU FMIG



*2021 FMIG co-leads pictured left to right: Derek Wiseman, Sara Hays, Jordan Gemelas, Amity Calvin and Hannah Jacob.*

New energy and inspiration has fueled the start of the year for the OHSU Family Medicine Interest Group (FMIG). FMIG brings together students who have always been passionate about family medicine, those wishing to explore the field and students interested in other specialties who want to learn more about primary care. Our five new co-leads from the class of 2021 would like to take this opportunity to introduce themselves and highlight some ideas for this upcoming year:

**Amity Calvin** grew up in Sisters, Oregon, where her mother, May Fan, is one of the local family docs. She graduated from Middlebury College after four years of crew, EMT shifts, and raising baby octopuses. She started at OHSU with an open mind but her

love for family medicine has only become stronger. FMIG has had a large role in this process for her, primarily through hearing from dedicated, passionate family medicine physicians during lunchtime talks and events. In her role as Lunchtime Talk Coordinator, she hopes to continue bringing in wonderful people to help showcase family medicine to our classmates in Med 21.

**Derek Wiseman** is a native Oregonian, from Klamath Falls. He graduated from the Oregon Institute of Technology with a degree in Biology/Health Sciences, and then spent the following year as faculty teaching Anatomy & Physiology labs. He was initially attracted to family medicine because of its broad and meaningful nature. He enjoys many aspects of the field including continuity of care, broad

scope practice and preventative care. Since his arrival at OHSU, he has learned that family medicine is a very diverse field, allowing physicians to tailor their work to align with their personal interests. His interests are in rural health care and full-scope family practice. He is excited to help involve students in impactful community projects. Through his role as one of the Community Outreach Coordinators, he hopes to educate and interest more students in the field of family medicine. In his spare time, Derek enjoys reading, painting, cycling, attending concerts and movies.

**Hannah Jacob** is a first-generation immigrant to the U.S. who grew up in communities attempting to overcome socioeconomic issues such as lack of access to health care, cultural barriers and limitations brought about by lifestyle. She went to undergrad at Northwest University and earned her master's degree in Biochemistry and Molecular Biology at OHSU. As a physician, she hopes to pay forward the numerous free and low-cost health care services she's received by serving in communities in the U.S. and worldwide. The opportunity to gain knowledge in the treatment of a wide variety of illnesses and develop longitudinal relationships with patients has drawn her to family medicine. She is looking forward to supporting like-minded classmates in the journey to becoming competent advocates for our patients as a FMIG Community Outreach Coordinator. Hannah enjoys baking, playing piano and reading in her spare time.

**Jordan Gemelas** is an MD/MPH student from Madras, Oregon, and earned a degree in public health from the University of Washington. As a rural Oregonian, he recognizes the impact that family physicians have in their roles as clinicians, public health practitioners, and community leaders. He believes that primary care physicians are uniquely positioned to help continue leading the fight against health disparities across Oregon by working with underserved populations. As the FMIG co-lead responsible for ward walks and the mentorship program, he wants to help foster interest in family medicine and further his own understanding of the broad scope of practice that the field offers. In his spare time he enjoys playing the piano, exploring the Pacific Northwest and spending time outdoors.

**Sara Hays** grew up in Beaverton, Oregon and graduated from Tulane University with degrees in Biochemistry and Ecology. She returned to Oregon and worked as a medical

scribe in a local family medicine clinic prior to starting on her path at OHSU. Her interest in family medicine began with her close relationship with her family doctor, whom she's seen since she was five years old. As an aspiring primary care physician and now FMIG lead, she's excited to combine her passion for medicine with the programming and outreach opportunities available through the Department of Family Medicine at OHSU. As the FMIG Workshop Coordinator, she hopes to organize a number of clinical skills workshops in order to facilitate understanding about what it means to practice in this field. Outside of school, she enjoys healthy cooking, running and spending time with her dog Rusty.

Our Med 20 leads organized a number of successful events earlier in the academic year including: 'Can I Afford Primary Care?' with **Samuel Crane, MD** and Mike Martin, the OHSU Family Medicine Department CFO who provided salary information; and "Meet the Docs" detailing the broad scope of family practice by a panel of diverse family physicians including **Jonathan Vinson, Johanna Warren, Christina Milano, Clea Lopez,** Lyn Jacobs and Tom Phanthavady.

As a new group, we have hosted a number of film screenings such as "How to Die in Oregon" and "Being Mortal," a suture workshop with **Joe Skariah, DO**, and we are initiating a regular monthly ward walk to learn about hospital-based family medicine. In the coming

months, we have plans to host casting, ultrasound and advance directive workshops to help the first-year medical students develop these skills. We are also currently working to reestablish the Baby Beeper Program, which aims to introduce first-and second-year medical students to family-centered maternity care, labor and delivery. Our Community Outreach team is involved in planning the 2018 OHSU Health Care Equity Week, a weekend fair that provides free health screenings and services to hundreds of underserved Oregonians, while raising awareness of health disparities. Finally, many of us are looking forward to attendance at the OAFP conference in April as well as the AAFP national conference in Kansas City.

The co-leads would graciously welcome your assistance and expertise in engaging the next generation of Oregon family medicine physicians! Please email Rachel Faino at [holguira@ohsu.edu](mailto:holguira@ohsu.edu) if you have resources, ideas, or are willing to volunteer for lunchtime talks, workshops, or mentorship with medical students.

The co-leads would graciously welcome your assistance and expertise in engaging the next generation of Oregon family medicine physicians!

# MEMBERS IN THE NEWS

## HONORS, AWARDS & ACCOLADES



**Te-Yu Ruth Chang, MD, MPH, CPC, FAAFP** is the new Chief People Officer, Vice President for the Advancement of People and People Operations at Northwest Permanente, Physicians and Surgeons (NWP). She received her public health and medical degree at the University

of Michigan and completed her residency at Oregon Health & Science University. Dr. Chang has served in various leadership roles focused on care delivery operations, diversity and inclusion, and patient financial health.

In this new role, Dr. Chang will be leading wellness and resilience, diversity and inclusion, and talent acquisition and development strategies for a growing medical group with over 1,700 physicians, clinicians and professional staff. NWP is an independent, physician-led, multi-specialty medical group that contracts exclusively with Kaiser Permanente Hospitals and Health Plan Northwest. This medical group delivers high quality, affordable care to over 600,000 Kaiser Permanente members in Oregon and Southwest Washington.



**Christina Milano, MD**, Associate Professor of Family Medicine, OHSU School of Medicine and family physician at OHSU Richmond Clinic, won the Clinical Excellence Award at the annual OHSU Women in Academic Medicine Conference held last month in Portland.

Her nomination was submitted by the OHSU Family Medicine Chair, **Jennifer DeVoe, MD, DPhil**.

Here's a portion of what Dr. DeVoe had to say regarding Dr. Milano's nomination:

Dr. Milano's many contributions to improving patient health exemplify a leader whose efforts move far beyond the medical care of individual patients and advocacy work throughout the Portland metro area—she also serves as a mentor and resource for her colleagues and the broader LGBTQ community. She provides transformational feedback and advice to peers, helping support them and their work, and serves as a role model in



*Left to right: Jennifer DeVoe, MD, DPhil; Christina Milano, MD; Fran Biagioli, MD; and Megan McGhean celebrate Dr. Milano's award.*

numerous ways. As a leader in this field, she has been invited to lecture nationally on the subject of transgender health advocacy, discussing the impact of collaborative care organizations and partnerships on the experience of transgender individuals being able to access services and competent providers. In her national work, she has served as an excellent ambassador for our institution by teaching others how programs she's helped to implement at OHSU could be affected in other areas and care environments.

Congratulations Dr. Milano!

### 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