



Family Physicians of Oregon

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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:

Roses are in full display throughout Oregon during the summer months. This Georgiana Pittock Centennial Rose shown on the cover was named to commemorate Portland's historic Pittock Mansion's 100th year anniversary held in 2014.



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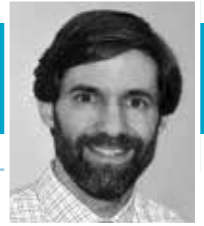


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EDITION 38

● PRESIDENT'S MESSAGE



DAN PAULSON, MD

How Participating in the Comprehensive Primary Care Initiative Transformed the Way we Deliver Primary Care to Our Patients

For the past three-and-a-half years, Oregon has been one of seven sites across the country participating in the Comprehensive Primary Care Initiative (CPCi). This program, supported through the Center for Medicare and Medicaid Innovation, paid clinics on a per member per month basis in addition to the usual fee-for-service for providing care for our patients. Medicare and several private insurers participated in this private-public program. Sixty-five clinics in Oregon participated in this pilot program, which is scheduled to end in December of this year.

Overall the program has been very successful. It has shown the ability to reduce hospital admissions and ER visits coupled with improvements in the quality of care the clinics were able to provide for their patients. In some regions of the country, participating in CPCi also showed a reduction in overall health care costs; in Oregon the results were basically cost neutral. However, while the upfront investments in Oregon have not resulted in significantly lower overall health care costs, the quality of care, patients' satisfaction with their care, and overall provider satisfaction with the work they were doing, all significantly improved.

Let me share some of the things that we have done in my clinic (Springfield Family Physicians) as a result of our participation in CPCi. This work is labor intensive so naturally our investment has been in new personnel; mostly in care coordination. We hired an RN to lead this effort. She has started an in house diabetic education program. We knew that our

referrals out of clinic for diabetic education had less than fifty percent follow through with the first appointment. Now we have eighty percent of our patients showing up for their first visit and seventy percent of the patients in the program have lowered their A1C's.

We also have an LPN and an experienced MA who call every patient that has been discharged from the hospital or has been in a local ER. They make sure that the recently discharged patients have been able to fill new prescriptions, have the home care they need and have a timely follow-up appointment in clinic. For the patients in the ER, we also offer follow-up care in clinic and encourage those with "ambulatory-sensitive" conditions to call the clinic first to be seen. Every patient seen in the ER is mailed a brochure explaining our extended hours, eagerness to see them in the office for non-emergent conditions, and an explanation about appropriate use of the emergency department.

Overall, we feel that CPCi has done more to help us transform the way we deliver primary care to our patients than any other program has, to the extent that it is hard to remember what things were like in the clinic four years ago.

Other changes made as a result of CPCi include better identification of our highest risk patients, better internal measurement of quality measures and more consistency with recommended preventive care. We have been able to integrate behavioral health into the clinic and have added a second medical assistant for most of our providers. Our staff feels an increased sense of enthusiasm and ownership of their jobs as we develop more of a team approach in caring for our patients.

In fact, Jane Conley, our Practice Administrator, can't say enough about the benefits of CPCi. "In my opinion, participation in CPCi has done more to help us transform the way we deliver primary care to our patients than any other program we've been involved in. And it's much more than just the extra funding, which was essential and allowed us to hire key

continued on page 6

continued from page 4

support staff we would otherwise been unable to afford. Looking back, I can honestly say that following the program requirements changed me and other leaders in our organization and helped us to see what true “transformation” looks like. Our participation in CPCi has helped us realize that it takes a much larger team of people and resources to truly make a positive impact in the lives of our patients, their wellbeing and the overall cost of healthcare in our communities.”

There have, of course, been some struggles along the way including changing formats for data reporting, inconsistencies in data reporting and payment structures between the various payers and uncertainty about how many patients were included in the payments. However, the biggest problem has been that we are required to provide the additional services for all of our patients (which is what we want

to do) but the program included payments for only twenty to twenty-five percent of our patients. This has strained resources in the clinic at times as we do not want to segregate our care by insurance. We are hopeful that the new Comprehensive Primary Care Plus (CPC+) program (read more about this program on page 14) will help alleviate this issue.

Based on the nationwide success of CPCi, CMS is expanding the program beginning in 2017. The most important part of the new program is that a greater number of patients and payers will be included. This will make it easier for clinics to hire the personnel necessary to provide additional services to our patients. In my clinic, our diabetic educator is booked over a month out for new patients. Our care coordinators are at the maximum capacity with handling the volume of calls to patients who need their services. The additional payments from CPC+ could allow us to hire the additional personnel to meet the increased need for our patient population.

The state of Oregon submitted an application for participation in CPC+ in June and we are waiting to see if we are chosen for participation. This enhanced collaborative requires commitment from primary care providers, commercial insurance plans and the Oregon Health Authority in order to be considered for participation by CMS. The OAFP has been working tirelessly on your behalf to help make this application as strong as possible and have the highest level of participation – from meetings with federal legislators in Washington, DC to phone calls, emails, and a letter writing campaign culminating in a signed letter of CPC+ support to Governor Brown and members of Oregon’s health care community by our federal delegates. We are optimistic that we will again be chosen to participate. If the state is chosen, the OAFP will actively encourage clinics across the state to participate. I encourage you to watch for further information about CPC+ and strongly consider participating if Oregon is chosen.

2016 Annual Family Medicine Graduation/Mentor Dinner

Celebrating the Next Generation of Family Physicians

For twenty-six years, the Department of Family Medicine and the Oregon Academy of Family Physicians have hosted the Annual Graduation/Mentor Dinner. It is a special evening, allowing students another opportunity to honor the family medicine physicians who have mentored and supported them throughout their medical school years. And, according to **Scott Fields, MD**, one of this year's student mentors, "serves as a reminder of the important social bond that exists between the generations of physicians and medical students. This event also demonstrates the strong bond and mutual respect that occurs between motivated learners and inspiring teachers."

During their final year of medical school, students are asked to choose a family medicine physician who had a strong influence on why they chose family medicine as a specialty. A total of twenty-two graduating family medicine students chose one or two of the following physicians as their mentors: **Mark Bajorek, MD; Mary Lou Belozzer, MD; Fran Biagioli, MD; Cliff Coleman, MD; Chummi Deverajan, MD; Scott Fields, MD; Jessie Flynn, MD; Brian Frank, MD; Glenn Gailis, MD; Bill Irvine, MD; Tim Joslin, MD; Sharon King, MD; Grace Lee, MD; Lyndsay McCartney, MD; Christina Milano, MD; Kim Montee, MD; Carin Pludeman, MD; Janey Purvis, MD; Amanda Risser, MD; Deborah Satter-**

field, MD; Ben Schneider, MD; David Simmons, MD; Dwight Smith, MD; Craig Stephens, MD; and Amy Wiser, MD.

At the end of the evening, Dr. Fields summed up the evening with these thoughts: "The stories told tonight regarding the meaning of the special relationships that were formed and the impact on the lives of both students and mentors, leaves you with a sense of optimism about the future of family medicine and the health of our communities." Congratulations to the Class of 2016 and a heartfelt thank you to all of the physician mentors who continue to support and encourage our future family physicians on a daily basis.



Christina Milano, MD enjoying the Graduation/Mentor Dinner.



James Rohlfing with Bill Irvine, MD.



Jessica Goman and her mentor, David Simmons, MD.



Ben Houser and family with physician Scott Fields, MD.



Charlie Procknow with his mentors Glenn Gailis, MD and Jessie Flynn, MD.



Min Lee with his mentors, Lyndsay McCartney, MD and Mary Lou Belozar, MD.



2016 Family Medicine Congressional Congress Update



Dan Paulson, MD, Evan Saulino, MD, PhD, Michael Grady, MD, Ilana Hull, MD, Elizabeth Steiner, MD, Kerry Gonzales and Michael Goodwin, MD meet with Sen. Jeff Merkley while at the FMCC Conference.

A presidential election year is an interesting time to be on Capitol Hill. Despite the usual hustle and bustle, things seem to be almost at a standstill as everyone apprehensively waits to see how the outcome of the election will impact the congressional agenda going forward. That said, this did not stop family physicians from around the nation from descending on Washington, D.C. this past April to advocate for better health for our nation at the Family Medicine Congressional Congress (FMCC).

This year, Oregon's delegation was the largest it has ever been at an FMCC meeting. I was fortunate to receive funding through an AAFP scholarship and was honored to join with eight other OAFP members from around the state. The group consisted of **Kerry Gonzalez**, Portland; **Michael Good-**

win, MD, Woodburn; **Kevin Johnston, MD**, Burns; **Michael Grady, MD**, Silverton; **Dan Paulson, MD**, Springfield; **Carrie Pierce, MD**, Klamath Falls; **Evan Saulino, MD, PhD**, Portland; and Senator **Elizabeth Steiner Hayward, MD**, NW Portland/Beaverton. Together we represented every congressional district in the state. While many other tables

in the large conference hall combined delegations from numerous states to fill the seats, we proudly filled up our own table, reflecting the OAFP's continued commitment to advocacy.

The first day's agenda was geared toward educating attendees about key policy topics and building skills for effectively engaging



Kevin Johnston, MD and Carrie Pierce, MD meet with Rep. Greg Walden.

with legislators on these issues. The meeting was opened by the insightful and passionate AAFP president, Wanda Filer, MD, who many met when she participated in the OAFP Annual Family Medicine Weekend held in Portland in March. A lively presentation by a political analyst about predictions for the 2016 election followed and the day continued with panel discussions and workshops about payment reform, chronic disease management, lobbying tips and tricks, mental health reform, and the Health is Primary communications campaign recently launched by Family Medicine for America's Health (healthisprimary.org). There were also a number of specific legislative priorities the AAFP requested each delegation discuss at legislative meetings the following day. These "asks" were:

- Curbing Prescription Drug Abuse: Authorize and support opioid prescription drug monitoring programs and ensure information becomes available to physicians across state lines, provide greater access to naloxone, and raise the patient cap for physicians treating patients with medication assisted treatment of addiction.
- Teaching Health Center GME Permanency: Provide stable funding to community-based primary care residency programs which help address the shortage and geographic maldistribution of primary care physicians and train physicians more likely to care for underserved populations.
- House Primary Care Caucus: Request House members join this bipartisan caucus created to bring greater attention to primary care (chaired by David Rouzer (R-NC) and Joe Courtney (D-CT)).
- Appropriations Request 2017: Provide at least \$59 million for Title VII Section 747 Primary Care Training and Enhancement grants; \$364 million for the Agency for Healthcare Research and Quality; and \$70 million for National Health Service

Corps.

After refueling with a dinner of delicious tapas and tales from all corners of our state, we were ready for a busy day of meetings with Oregon's legislators. We faced security lines, the capitol subway, the labyrinth of tunnels beneath the Capitol buildings, countless stairs and the distraction of taking "shoefies" on the PDX carpet displayed in each of our legislators' offices – but somehow, we successfully made it to meetings in all seven of our state's Senators and Representatives. We met directly with Sen. Jeff Merkley, Sen. Ron Wyden, Rep. Kurt Schrader, Rep. Suzanne Bonamici, Rep. Greg Walden and Rep. Peter DeFazio and met with key staff in Rep. Earl Blumenauer's office. Overall, our legislators were very knowledgeable about the issues most important to the AAFP and supportive of our requests. The issues surrounding opioid drug abuse certainly hit home for many of our legislators and they listened closely as we told stories of patients who had fallen victim to the epidemic. All of our House members agreed to join the Primary Care Caucus and Sen. Merkley agreed to consider starting a similar group in the Senate.

Many of the legislators also shared their own health policy priorities and we discussed ways we could partner and support their ideas in the future. Sen. Wyden discussed successes of the Independence at Home pilot of the ACA, which brings home-based primary care to frail elders, improving quality and decreasing cost of care. He also discussed the importance of curbing the cost of pharmaceuticals and potential opportunities for states to pursue the public option which he has promoted for years. Rep. Blumenauer's staff described his interest in improving the quality of end-of-life care and expanding hospice benefits. Our group also took the opportunity to tell our legislators about the Comprehensive Primary Care Plus (CPC+) model of care announced by CMS just days before the meeting and to talk about the way Oregon is uniquely positioned to benefit from this program after our successes with the CPC initiative (see page 14 for further discussion of CPC+). A number of us have been working in



PDX carpet in every Oregon legislator's office making us feel right at home!

CPC clinics and were able to share personal stories about the ways in which additional services provided under CPC enhance quality and patient experience and make it more fulfilling to do the difficult work we do.

Our discussions reinforced how fortunate we are in Oregon to be represented by forward-thinking legislators who support primary care and see the value our specialty provides to their constituents. I was truly honored to represent Oregon and stand united with so many incredible members of the American Academy at the FMCC. There is a lot of work to be done and it is easy to feel overwhelmed and paralyzed by the vast and numerous problems that plague our individual clinics and our health system as a whole. However, it is apparent that family medicine has earned its place at the table and it is our responsibility to play an active role in shaping the future of health care in our country. No matter where the election takes our nation, it will be important that we continue to play a key role in these discussions both at home and at the national level. I urge every member of the OAFP with an interest in the political process to consider attending the FMCC in the future. We all have personal and patient stories to tell and it is those sto-

MEMBERS ON A MISSION

de Los Oregon Siete Descends Upon the Guatemalan Hillsides



BY MATTHEW SPERRY, OAFP RESIDENT DIRECTOR
PROVIDENCE HOOD RIVER RURAL TRAINING PROGRAM



The air is thick with sounds, smoke, exhaust and humidity. It's 3:00 p.m. and school just let out. Hordes of students in starched white shirts and dark blue slacks roam the sidewalks. Others go flying by on mopeds; usually at least two on each scooter. Minibuses, mega buses and ancient buses thread through the crowd. On the periphery, the stray dogs make their way; their business their own. The streets of Huehuetenango (Huehue) are unlike anywhere I've seen in the United States.

We've just finished a long journey to get to our destination, leaving Hood River in the wee hours. Our group exits the airport in Guatemala City and walks into the crowds of hawkers, taxi drivers and luggage assistants all vying for our attention. An assault on the senses of a new place and a new culture hit us as we reach Huehue after a six hour, somewhat arduous bus ride into the hills.

We came as a team from the U.S., organized by the esteemed Suzy Happ. Stateside, she's a Home Visiting RN with Providence Beginnings working with expectant mothers in Portland, but here in Guatemala she is known more properly as "Santa Susana." She has been working for 15 years to improve the lives of pregnant women and mothers here in Huehue and collaborating with the Providence Family Medicine Residency program for the past three years to bring residents down to help with her work. Our group was diverse — besides Suzy, we consisted of three attending physicians, **Bob Gobbo, MD** and Orlando Acosta, MD, Program Director and Faculty respectively from the Providence Hood River Rural Training Program; **Mike Waddick, MD**, Faculty from the Providence Oregon Family Medicine Program; two residents, **Maliheh Nakhai**, from Providence Oregon and me; and Elena Mejia, family nurse practitioner and lactation consultant with Providence.

The capital city of Huehuetenango is a bustling metropolis, but the rural parts of the district are some of the most remote and impoverished in Guatemala. Heading north out of the capital means heading up into the highlands; a mountainous country divided by high passes and poor roads. Many villages here are connected only by trails. To be an expectant mother in this district is a very different experience than for those living in the U.S. or even for those living just north of Huehue, in neighboring Mexico. Guatemala has the highest rate of maternal mortality in Central America; nearly three times that of Mexico. Approximately 90% of births in this part of the country are attended by village midwives, or comadronas. These women provide a crucial role in the rural districts, attending births in places where the government health system could never reach, often with little training and for little compensation. However, if there is a birth emergency, help may be seven hours away -- by foot, on a trail, at night.

Casa Materna (Mother's House) is working to address these needs. It provides safe housing with medical support for women with high risk pregnancies next door to the government hospital. There, women can receive the care they need to prevent complications. Further, Casa Materna and its mother organization, Project Concern International (PCI), are actively working to provide training and equipment to comadronas working in rural parts of the district. Which is why after a brief stop-over in the city of Huehuetenango, we continued to travel further north, up into the highlands, snaking along one lane roads with gut wrenching drop-offs and blind corners.

In addition to seeing patients in clinics, doing trainings/collaborative education with local doctors and health workers and providing resources such as OB ultrasounds, we also participated in the outreach and training that PCI provides for comadronas throughout the Huehuetenango district.

We arrived in the small villages of Santa Eulalia and Soloma bringing with us a small arsenal of mannequins and other props to simulate obstetrical emergencies. Each training session was attended by 40 - 60 comadronas, many of whom had trekked in seven hours by foot that morning to attend. The sessions were educational chaos at its best. We focused on small groups

and hands-on simulation, working through interpreters from our own Spanish to the local dialects. The topics were high yield: recognition and transport of high risk pregnancies before they developed into emergencies, building kits of clean instruments to minimize the risk of infection during birth and managing postpartum hemorrhage and other peripartum emergencies. The style attempted to mimic the "sociodrama" style we see used by community health workers -- using skits and collaborative learning sessions to reinforce the most pertinent issues. Quite often the collaboration is the most useful part of the experience; the best teaching frequently done by the more experienced midwives in the crowd.

As with most international experiences, it's usually an open question of who benefits most. I certainly hope the training we provided has some lasting benefits throughout the community; a small part of making childbirth a safer experience. Given the duration of the project, it has seen some significant successes: Todos Santos, one of the first communities where the comadronas organized and made training a priority, has seen its maternal mortality rate plummet to zero in the past couple of years. Hopefully we will see the same in other communities as the projects spread.

Suzy Happ had the following words about the positive effects of bringing resi-

dent physicians to Huehue: "It's enriched the experience in many ways and allowed us to do so much more for the clients we serve in an impoverished corner of Huehuetenango. I am particularly impressed with the ability of the residents to adapt the teaching on handling obstetric emergencies to diverse groups, from local doctors to less highly-trained auxiliary health workers to village midwives who usually speak a dialect, don't read or write and have limited formal training. This is the work that builds relationships and capacity and makes lasting impact."

But we too reaped benefits from this experience; gaining valuable teaching time, new perspectives and a chance to put our skills into practice in a challenging environment. We witnessed a medical climate that operates so differently from our own, and saw how simple interventions can be profoundly life-changing. The nature of residency is to be constantly learning, typically in some of the most advanced medical institutions in the world, surrounded by mind-boggling technology. And yet, sometimes we forget something as trivial as a sheet of clean plastic to protect the mother and infant from the dirt floor can be life-saving.

For further information on the work being done by PCI in Guatemala go to <https://www.pciglobal.org/guatemala/>.



From left to right: Matt Sperry, MD honing his acting skills to portray a specific medical issue; Maliheh Nakhai, MD distributing planned birth kits to over 100 midwives; and Elena Mejia working with a group of comadronas.

Comprehensive Primary Care Plus (CPC+)

CMS's Largest Investment in Primary Care to Date

What's in it for you?

Many of you have heard of, and some are currently participating in, the Comprehensive Primary Care Initiative (CPCi) that was launched in October 2012 and runs through December 2016. Oregon was one of seven regions chosen to take part in this four-year multi-payer pilot to foster collaboration between public and private health care payers to strengthen primary care. CPCi is currently being implemented in 65 practices, with over 500 providers providing care to 500,000+ patients throughout the state. The additional payments received through this initiative have provided CPCi practices with the necessary financial resources to create new ways of working, hire care management team members and develop new relationships necessary to coordinate care.

In fact, according to **Dan Paulson, MD**, "As a family physician practicing in Springfield, I can tell you firsthand the value of participating in CPCi. Our clinic has been able to improve the health of our patient population and control costs. Through the financial support of this program, we have been able to provide integrated behavioral health within our clinic; hire a hospital discharge planner who helps our patients get the follow-up care they need; and a nurse who does diabetic education. And we are better able to meet each and every unique challenge that our patients may bring to the exam room."

Evan Saulino, MD, PhD, practices at Southeast Family Medicine clinic in

Portland, and concurs with the value brought by CPCi investment. He says, "CPCi brought a couple hundred thousand dollars extra into our clinic each year that we would not have had if we didn't participate. We've primarily spent the dollars on integrating a full-time behavioral psychologist, a clinical pharmacist and an RN to focus on patient education and to help make transitions of care safer for patients. These have been critical improvements in our model of care. CPCi investment has allowed us to finance these important services that are not usually reimbursed in the traditional fee-for-service payment models of the past. We and our patients need this work to continue. We cannot and will not go backwards."

Joyce Hollander-Rodriguez, MD, a family physician working in Klamath Falls, is also onboard the CPCi bandwagon. "CPCi has been very valuable for us. The financial aspect was very helpful and we had over a million dollars so far from this project; about \$250-\$300,000 per year. We used that money to expand our team and add refill coordinators that check on chronic disease indicators and coordinate the refill process and referral coordinators that make sure we get records back and close the loop with our specialists. We also were able to block out time for our RNs to work on case management. During this time we also expanded our clinic teams to add advanced practice providers, began the Patient Family

Advisory Council, implemented shared decision-making tools, started the transitions of care calls after discharges, set up a risk stratification course of action for our patient population and other aspects of the milestones. It was very important for us that this revenue be used for innovations and new work in the clinic to be truly transformative. Risk stratifying our patients has also been very important. We have always thought we had a high risk patient group, but this allowed us to see that as true when we could compare our data to benchmarks and data across our region. It turns out our patients are in the highest quartile of risk and are even high risk compared to others in that quartile."

Because the early evaluations of CPCi data showed such promising outcomes, the Centers for Medicare and Medicaid Services (CMS) announced a 10-fold expansion of this strategy -- Comprehensive Primary Care Plus (CPC+). CPC+ builds on the foundation of CPCi and integrates lessons learned from this four-year pilot program including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, health information technologies, and claims data sharing with practices. CPC+ brings together CMS, commercial insurance plans and state Medicaid agencies to provide aligned financial support necessary for practices to make fundamental changes in their care delivery.

In addition, CPC+ qualifies as an Alternate Payment Methodology under the recently enacted Medicare Access and CHIP Reauthorization Act (MACRA), meaning that CPC+ clinics automatically qualify for this payment track and do not have to figure out the new merit-based incentive payment system known as MIPS.

Practices enrolled in CPC+ will receive monthly care management fees, performance-based incentive payments, and an improved reimbursement structure from all participating payers (CMS, Medicaid, and commercial) within two primary care practice tracks. Practices apply for the track they feel most comfortable in, while in both tracks clinics will make changes in the way they deliver care, based on the following five Comprehensive Primary Care functions that were created as part of the original CPCi program. These five functions are well-aligned with Oregon's Patient-Centered Primary Care Home program requirements:

- Access and Continuity;
- Risk-stratified Care Management;
- Comprehensiveness and Coordination of Care;
- Patient and Caregiver Engagement; and
- Planned Care for Chronic Conditions and Preventive Care

Set to begin in January 2017, this national five-year multi-payer medical home care delivery and payment model expands CPCi to include 20 regions with 5,000 practices, which would cover more than 20,000 physicians and the 25 million patients they serve. In Oregon, this means that more clinics across the state will be able to participate, including ones that were ineligible under the original program. It is designed to help practices move away from a fee-for-service financing model to a new system that will give doctors the ability to deliver the care that best meets the needs of their patients, focusing on health outcomes rather than the number of patients seen each day.

The overall goal of CPC+ is to improve the quality of care patients receive, improve patients' health and spend health care dollars more judiciously. Also, a key goal is to increase physician and team satisfaction with the work we do. Participating in CPC+ is a perfect way to build on our successes and continue to improve primary care in Oregon in a way that is financially sustainable.

Practice applications for CPC+ can be submitted after July 15, and must be completed by September 1, so the timeline is very tight! Please look to the OAFP website for continuing information and details as we will be working with others in Oregon to develop materials that can support clinics through the application process.

SAVE THESE DATES

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

SAM STUDY HALL – COMING IN DECEMBER
Portland locale

70TH ANNUAL FAMILY MEDICINE WEEKEND
Scientific Assembly & Congress, April 20 – 22, 2017
OAFP/Foundation Auction, April 21
Sunriver Resort



Rural Health Professional Training and the OHSU Campus for Rural Health

Eighteen years ago, I did a community project while on my rural rotation in Reedsport, Oregon, looking at whether there were unmet health needs of the elderly caregivers in that area. Many aspects of those six weeks helped me envision a future where I practiced in a rural area. I did not get the opportunity to thank the community of Reedsport for being a part of my education, nor do I have a sense that I really was able to give back to the 20 lovely elderly couples that I interviewed through home health and hospice. I hope that I remember to say thank you to my preceptors - **Robbie Law, MD, Janet Patin, MD** and their group - when I see them at meetings and I hope that our Cascades East graduates who have gone on to practice in Reedsport have been a form of giving back to that community.

This past June marks the last time the Rural and Community Health clerkship was a required core clerkship for OHSU medical students. With a new competency and team-based curriculum, the core clerkships last four weeks and students choose at least one rural experience which can occur with a variety of disciplines. While concerns have been expressed around the changes to rural training within the new curriculum format in past OAFP forums, the medical student education team in the OHSU Family

Medicine department has worked to preserve some of the strong rural learning experiences across the state and maintain opportunities for students desiring longer continuity rotations, as well. The OHSU School of Medicine team has new rotations and electives for rural student rotations and the rural community rotation remains an option. The OHSU Family Medicine Department offers eight and twelve week rural rotations with **Sean Robinson, MD** as the director. The Rural Scholars program out of the Oregon AHEC office remains vibrant with **Robyn**

Liu, MD as director and Ryan Palmer, EdD as education director. Cascades East developed the Oregon FIRST program, now in its third year, where fourth year medical students have a longitudinal year in Klamath Falls with a continuity panel of patients throughout that time.

I write this as a family physician educator in the school of medicine, a physician in a rural community, and as a regional associate dean. Bringing those roles together and being the bridge between rural communities and the OHSU curriculum is my goal. One could interpret my job as needing to be OHSU's ambassador to our communities, but I strongly believe this communication must be bidirectional and that is why I use the metaphor of a bridge.

Klamath Falls and Coos Bay are the sites for OHSU's new Campus for Rural Health. We have just finished our first pilot year with an average of five to seven medical, dental, physician assistant, advanced practice nursing and pharmacy students attending month long rotations in our community. There are options for some students to stay longer, with our pharmacy students spending six months in Klamath. However, it remains an experience exposing students to rural health care settings, not the deeper dive into rural health of the longitudinal programs in Family Medicine, Rural Scholars or Oregon FIRST.

There are two aspects of the Rural



Campus that take learning in newer directions: the community project and the interprofessional education. While community projects have been a part of the rural and community health clerkship since well before I went through that rotation 18 years ago, the version in the rural campus has a slightly different spin. In the Campus for Rural Health, each community works to identify a need or gap that can be addressed through a longitudinal project that may take six to twelve months, or longer, to complete. Students

This experience solidified my commitment to serving rural underserved populations...it has reinforced my passion for rural healthcare and my desire to become a rural provider.

-Jean McCalmont, OHSU FNP student

engage with community partners as they plug into a broader project, providing tangible results as they give back to the community that hosts them. We work to teach our learners about community-engaged research during these projects where we try not to come in as academics with our own research goals and impose them on communities. And as we build new rural learning experiences, it will be stronger if we demonstrate community-engaged curricula, as well.

Interprofessional learning is defined by the World Health Organization as "students from two or more professions

learning about, from, and with each other to enable effective communication and improve health outcomes."¹ The students in the OHSU Campus for Rural Health have interprofessional experiences by living together in shared housing, working together on the community project, and sharing reflections about being in a rural area. We have two major clinical sites where they work side-by-side in patient care, and hope to expand the clinical opportunities as more practices develop collaborative practice models. The students also participate in a team-based home care program with undergraduate school of nursing students.

My breakthrough moment about interprofessional education occurred a few years ago when one of our residents entering practice in a frontier site asked how to navigate the issues of supervising a PA who had been in practice for 30 years when she was a brand new graduate. Knowing how to honor a person's clinical experience and wisdom, while still feeling confident that you bring a unique knowledge and skill set to the interaction can be daunting if it is unfamiliar. That was when I realized we needed training to occur in collaborative teams so that grads were prepared for future practices.

In our community and many others, the demand for well-prepared primary care physicians and rural health professionals remains high. We hope that in our efforts to educate and train the entire health professional team, we will better meet the needs of our communities.

American essayist Wendell Berry said, "I believe that the community - in the fullest sense . . . is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms."² This quote resonates with me as we train others to care for every individual in the context of family and every family in the context of community. It feels

more and more essential as we aim for our health systems to define population health as all members of our community, not just the enrolled members in a health plan. And this is not just the realm of family physicians but every member of our health care team who works toward our shared goal. It is a concept that is equally important across the rural-urban continuum; for some students these concepts come into focus in unique ways in a rural setting and that is where they realize their own self-efficacy in promoting health. That moment

I really do hope the future of medicine will lean this way in the education of other students coming behind us. It really teaches you how to work well as a cohesive group, ask for help when needed (and not be afraid to do so), and get other people's opinions, because this is how we keep patients safe!

-Shelby Ross, OHSU PA student

happened for me in Reedsport, Oregon and I hope we can train health professionals for many rural communities as a way of saying thank you.

Endnotes

¹ Framework for Action on Interprofessional Education and Collaborative Practice, Health Professions Networks, Human Resources for Health, 2010.

² Wendell Berry, *The Art of the Commonplace: The Agrarian Essays of Wendell Berry*, (Counterpoint Press, 2003), 146.



Four Things I Wish My Doctor Told Me about Postpartum Depression

Our culture celebrates the joys of motherhood. We shower expectant mothers with gifts and tell new moms to “enjoy every minute” because babies grow up so fast. But what if pregnancy or motherhood is nothing like what you expected?

Many women have heard about postpartum depression, perhaps when a friend or celebrity shared her experience. But we don’t talk enough about how common, complex and devastating postpartum depression can be. One in every seven mothers in the United States has postpartum depression; much of it goes untreated. Suicide has become the second leading cause of death for women in the first year after giving birth.

I love children and have always wanted to be a mom. Although mental illness and mood disorders like depression and anxiety run in my family, I never expected to have postpartum depression.

Like me, you may have an image of a depressed new mom in your head, who recently gave birth,

and is so weepy and sad she can’t take care of her baby or form an emotional connection to them. But I want all mothers-to-be and their healthcare providers to know postpartum depression may look nothing like this at all and most importantly, to know that this is an illness that can be treated.

1. Depression is Common in Pregnancy and in the First Year after Giving Birth

I thought postpartum depression was a continuation of baby blues – the normal hormonal shifts many women experience in the first few weeks after giving birth – and it is for some women. But you can develop mood disorders in pregnancy or, like me, when your baby is older. Mine hit when my baby was four months old and we began planning a stressful move.

My doctors and midwife asked me how I was doing in the weeks after the birth. Besides being sleep-deprived, I was fine. No medical providers asked me in the following months if I was okay,

or mentioned that postpartum depression can develop later. I wish my doctor had given me a postpartum depression checklist and that my pediatrician asked me how I was doing during my daughter’s well baby visits.

2. It Might Not Seem Like Depression

I seemed fine to others, and didn’t believe I was experiencing depression and anxiety. I seemed together, but on the inside, I was falling apart. I was completely overwhelmed by everyday activities like grocery shopping, driving and preparing meals. I was scared and ashamed of the way I was feeling. I felt like I was going crazy. And I was angry.

I knew something was very wrong and I didn’t feel like myself. As a first-time mother, though, it’s so hard to know what is “normal.” You might be

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Corey, with her daughter Clara, enjoying the California coast.

thinking to yourself, “this is so much harder than I expected. Other moms seem to be doing fine. Why can’t I handle this? What’s wrong with me?” No one wants to feel like this.

3. How to Recognize Symptoms and Find Support

Things improved quickly after I was diagnosed with postpartum depression, anxiety and panic disorder. I finally knew what was wrong and found great local and online resources. I learned about postpartum mood disorders and connected with other moms who were going through them. We all had different stories and symptoms, but we all loved our babies and wanted to feel like ourselves again.

4. This Treatable Illness Passes

It is not my fault I had postpartum depres-

sion. Like physical illness, it was out of my control. I needed treatment to get better. Joining a support group for first-time moms with postpartum depression and anxiety, combined with counseling and medication worked for me.

It was hard to believe the illness would pass when I was in the depths of it. But it did. My daughter, the love of my life, just turned a year old. She is doing great, and I feel like myself again. I can laugh and make jokes, appreciate the natural beauty around me, see the good in people, and discover the world through my daughter’s eyes. None of this would have been possible without knowing I had postpartum depression and getting treatment and support.

We owe it to mothers to talk openly about postpartum depression. One million women in the United States experience postpartum mood disorders; only one in five gets treatment. Let

struggling mothers know they are strong, good mothers. What they are experiencing isn’t their fault, they are not alone, and they will get better. To do that, they need your help.

Corey Barber was a lobbyist for OAFP from 2010 to 2011. She now works for a cardiac medtech company and lives in Berlin. Corey spent the last year in Los Angeles and loved exploring Southern California with her husband and daughter. She participated in *Climb Out of the Darkness* with other survivors to raise awareness about postpartum mood disorders.

For further updates regarding symptoms and treatments for postpartum depression, a postpartum checklist, and more information about a *Climb out of Darkness* event in your area, go to <http://postpartumprogress.org/>.



Postpartum Depression: The Important Role of the Family Physician

BY JONATHAN VINSON, MD

As a physician who practices full-scope family medicine, I have the privilege of seeing the complete picture of an expectant mother’s pregnancy, birth and parenting. I can reassess problems throughout the pregnancy, during the birth/post-partum period and beyond, and I can continue to evaluate the parental well-being at well child visits.

The following is a brief overview of how I approach postpartum depression (PPD) with my expectant families:

Since women with a history of depression prior to pregnancy are at a higher risk to experience PPD, the ideal time to assess risk is at a preconception visit. Many times though, I first assess for risk of PPD at the initial OB visit. My assessment continues through pregnancy to identify risk factors – signs that a mom is under-resourced in any way or is in an abusive relationship (there is evidence that pregnancy is a high-risk time for intimate partner violence).

There’s a myth among many moms that if they don’t have identified risks -- a “reason” to be depressed (financial stress, abusive relationship, colicky baby, etc.) -- then they shouldn’t complain to their family members or physician. As PPD affects mothers of any age, at any socioeconomic or relationship status, it’s important for

me to debunk this myth. Moreover, there may be a jarring disconnect between the expectations and the reality of early motherhood; this can be exacerbated by social pressure to be the perfect, joyous new parent. I tell new parents that PPD is common and that my office is a safe place to talk about struggles and frustrations no matter what they have posted to social media.

During the third trimester, I talk to parents about the broad spectrum of PPD. From “baby blues” and unexplained weeping to postpartum psychosis, each mom’s experience is unique; our treatment approach is tailored to each individual’s specific situation. While I try to minimize medications for my patients during pregnancy and nursing, there are safe medication options available. I also encourage partners and family members to advocate for moms, especially when things aren’t going well. It’s important for moms to know that they aren’t alone and that there are community resources and PPD resource groups available as part of the treatment plan.

It’s essential for family physicians (and all care providers) to take the time to allow new moms to explain their state-of-mind throughout their pregnancy, birth and beyond, so that PPD can be recognized early and treated appropriately.

Jonathan Vinson, MD practices full-scope family medicine at Providence Medical Group The Plaza in Portland, Oregon. He entered the field of family medicine for the opportunity to build long-term relationships with families through all phases of life and being able to treat patients of all ages. He especially enjoys obstetrics because pregnancy, birth and child-rearing are transformative episodes in the lives of his patients.

STUDENTS SPEAK OUT!

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



Panelists Schneider, Robinson, Jacobs, Flynn and Reagan answer students' questions.

OHSU FMIG was excited to coordinate a diverse set of lunchtime lectures for students this spring.

In March, FMIG hosted a brownbag lunchtime lecture with **Eriko Onishi, MD**, a hospice and palliative medicine physician. Her experience has been enriched by attending medical school in Japan and completing a family medicine residency in Indiana. Dr. Onishi demystified the nuances between hospice and palliative medicine and taught students critical skills for supporting patients through challenging life stages.

During another informative lunchtime talk in April, students had the chance to participate in an informal question-and-answer session with **Sean Robinson, MD**, an OHSU family medicine and sports physician. It was interesting to hear how Dr. Robinson pursued his passion for sports and community engagement as a sports medicine physician for local sports teams. He also provided a fascinating perspective on fellowships and his career path decision-making process.

Also in April, the OHSU FMIG organized the annual Medical Specialty Experience Panel featuring Family Medicine and Family Medicine Subspecialties for the first year OHSU MD class. Students left the event

energized by the diverse perspectives of several OHSU and community physicians, including **Ben Schneider, MD, Jessie Flynn, MD, Josh Reagan, MD, Sean Robinson, MD** and Lyn Jacobs, MD. From the panel, it was evident that the Family Medicine specialty offers many different facets and opportunities within primary care. For example, some of the panel members had special focuses such as obstetrics and sports medicine.

In addition, OHSU FMIG conducted some exciting workshops for students this spring. **Amy and Eric Wiser, MDs**, taught students essential details about how to perform physical exams. This workshop was fun, interactive, and extremely hands on. As medical students learn in a compartmentalized way, it is difficult to put the entire physical exam together as a whole. The Wisers provided students with some common cases they will see in clinics and how to approach the physical exam for each case. Then students broke up into pairs and practiced and performed these techniques on one another. The workshop was very useful with our current preceptorship and with clerkships coming up around the corner.

Along with the physical exam workshop,

FMIG also held a suture workshop taught by Joe Skariah, MD. Students learned a series of stitches including running, simple interrupted, vertical and horizontal mattress performed on pig's feet.



Students learn by doing in the Physical Exam Workshop.

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Suture workshop – where learning is fun!



Future family physicians enjoying each other's' company with the newly formed FMIG Mentorship Program.

FMIG also took some non-academic time this quarter to unwind and enjoy fellow members. In early June, the FMIG hosted a social event at Kells Irish Pub. Fourteen FMIG members and a few significant others enjoyed a meal and libations while watching Colombia beat U.S. in soccer. Students were joined by **Rachel Sircar, MD**, a first year resident in the OHSU Family Medicine Program and mentor in the new FMIG Mentorship Program. This program pairs medical students interested in learning more about Family Medicine with fourth year medical students or residents in Family Medicine willing to take on a mentee. A good time was had by all.

2016 – 2017 FMIG CO-CHAIRS

Kelsi Chan

Nicholas West

Joseph Pryor

Talitha Wilson

Emily Thompson

MEMBERS IN THE NEWS

HONORS, AWARDS AND ACCOLADES

Several awards were presented during the OHSU School of Medicine's 2016 Honors and Awards ceremony held in late May and those in the family medicine specialty were lauded numerous times throughout the event. Congratulations to all of you!



DR. SAULTZ

John Saultz, MD, outgoing Family Medicine Chairman, received the Excellence in Education Award.



DR. IRVINE

William Irvine, MD, affiliate instructor, was presented with the Community Rural Preceptor Award. This award is made by the Dean and recognizes a physician that has demonstrated outstanding dedication to the education of medical students in a rural setting.



MUSTAFA MAHMOOD

Mustafa Mahmood received the Gold Humanism Honor, the Alma Sneed Pathology Award, and the Multicultural Recognition and Service Award.



ELIZABETH SUH

Elizabeth Suh was given the Gold Humanism Honor, the James B. Reuler Service Award and the Family Medicine Clerkship Award.



ALINA SATTERFIELD

Alina Satterfield was granted the Gold Humanism Honor and the Humanism Award.



JAMES ROHLFING

James Rohlfing was presented with the Harry G. Kingston Anesthesiology and Peri-Operative Medicine Outstanding Senior Award.



Pictured left to right, George Mejicano, MD, Tracy Bumsted, Cornelia Hayes Steven, granddaughter of Edward S. Hayes; Charlie Procknow, Nicole Deiorio, MD and Ben Schneider, MD.

Charlie Procknow was presented with the Edward S. Hayes Gold-Headed Cane Award. Charlie was the 50th recipient of this prestigious award and the seventh family medicine recipient. This award is bestowed upon a member of the graduating medical school class in recognition of the compassionate devotion and effective services to the sick, with the conviction that its holder will forever epitomize and uphold the traditions of the true physician. In addition, Charlie also received the Gold Humanism Honor, the Alpha Omega Alpha National Medical Honor Society Award, and the Graduation with Great Honor Award.

Taryn Hansen received the Deans' Award for Exemplary Contributions to the MD Program and **Rebecca Guisti** was given the Gold Humanism Honor.



DR. NORRIS

Michael Norris, MD, OAFP life member from Oregon City, received the 2016 Clackamas County Community Impact Award this past spring. This award honors organizations and individuals that make a significant contribution to local communities by working to help

those struggling to meet their basic needs and improve their life circumstances. Having a heart for his community, Dr. Norris, along with others in the medical profession, began advocating in 2009 for a free clinic in Clackamas County. In 2012 the dream became a reality with the opening of the Clackamas Volunteers in Medicine clinic. Norris, the volunteer medical director for this clinic, and his staff, provide free medical services for county adult residents who lack health insurance, access to health care, resources to support the care needed for chronic conditions, and are below certain poverty measures. Congratulations on this well-deserved award Dr. Norris.

two years in Virginia. In addition to his full-time practice, he is currently a facilitator for the Stanford Clinical Teaching Seminars and an Assistant Professor of Family Medicine at the Western University Health Sciences/College of Osteopathic Medicine of the Pacific.



DR. HEMPHILL

Melissa Hemphill, MD is a family physician practicing at Providence Medical Group SE and a faculty member of the Providence Oregon Family Medicine Residency Program. She was recently elected by her colleagues at the AAFP National Conference of Constituency Leaders

(NCCL) Conference in Kansas City to be one of two new physician alternate delegates to the AAFP Congress of Delegates which meets this September in Orlando, Florida. She will be the official co-convenor for the NCCL Conference in 2017 and a full delegate to the 2017 AAFP Congress of Delegates.

INTERESTING BUSINESS WE SHOULD ALL KNOW



DR. HUGHES

Robert Hughes, DO, has been named the interim Program Director for the Samaritan Family Medicine Residency Program in Corvallis. Before joining Samaritan Family Medicine in 2003, Dr. Hughes was in private practice for

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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

MEMBERS IN THE NEWS

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NEW OAFP BOARD MEMBERS ANNOUNCED

In addition to the executive team and directors that were announced in the Spring 2016 issue of Family Physicians of Oregon, the Academy also has new resident and student directors to announce:



DR. RHEAULT

Nathan Rheault, DO, MPH, is a third-year resident in the Samaritan Family Medicine Residency Program. Dr. Rheault received his bachelor's degree in Biology from the University of Connecticut and his MPH and DO from Touro University College of Osteopathic Medicine in Vallejo, California. In his free time he enjoys hiking, camping, playing tennis and cooking.



DR. BRUNO

Justin Bruno, DO is a second-year resident in the Samaritan Family Medicine Residency Program. Dr. Bruno received his BS degree at the University of Texas at Austin and his medical degree at the Arizona College of Osteopathic Medicine in Glendale, Arizona. In his spare time he enjoys spending time with his wife and daughter.



DR. SIMMONS

David Simmons, MD is a third-year resident in the Providence Oregon Family Medicine Residency Program. Dr. Simmons earned his undergraduate degree at Oberlin University, a master's degree in music from Indiana University and his medical degree from OHSU. Dr. Simmons was an opera singer for 20 years before attending medical school, but now spends his free time with his son and daughter.



DR. MULLER

Brianna Muller, MS3, is beginning her MPH year at OHSU's MD/MPH program. She received a BA from the University of Notre Dame, where she studied anthropology. In her free time, she enjoys seeing live music, trying to pet all the dogs, and being outdoors, especially hiking, bicycle touring, and skiing.

MOVERS AND SHAKERS



Paul Neumann, MD has left clinic life in Stayton to assume his role as the Regional Medical Officer for the Foreign Service. Moving to West Africa in July, Dr. Neumann will be in charge of U.S. medical staff in Mauritania, Cape Verde, Senegal, The Gambia, Guinea and Guinea-Bissau.



DR. COWAN

Tavis Cowan, MD, grew up in eastern Oregon, attended medical school at OHSU and practiced at Samaritan Health Services and as an urgent care physician at Samaritan clinics in Toledo and Newport before moving to Vermont. He practiced at the University of Vermont Medical Center and also was an assistant professor at the Family Medicine Department at the University of Vermont College of Medicine. Dr. Cowan has returned to Oregon and is seeing patients at The Corvallis Clinic Immediate Care Center.



DR. YOUNG

Eric Young, MD, who received his medical degree at the Universidad Autonoma de Guadalajara, Mexico, and completed his family medicine residency at the University of Kansas Medical Center has joined the PeaceHealth Medical Group University District Clinic in Eugene.



DR. ORLINO

Sean Andrew Orlino, MD, recently joined the PeaceHealth Medical Group Barger Clinic in Eugene. Dr. Orlino earned his medical degree at the University of Santo Tomas Faculty of Medicine and Surgery in Espana, Manila, Philippines, and completed his residency at the St. Anthony Family Medicine Residency Program in Oklahoma City, Oklahoma.