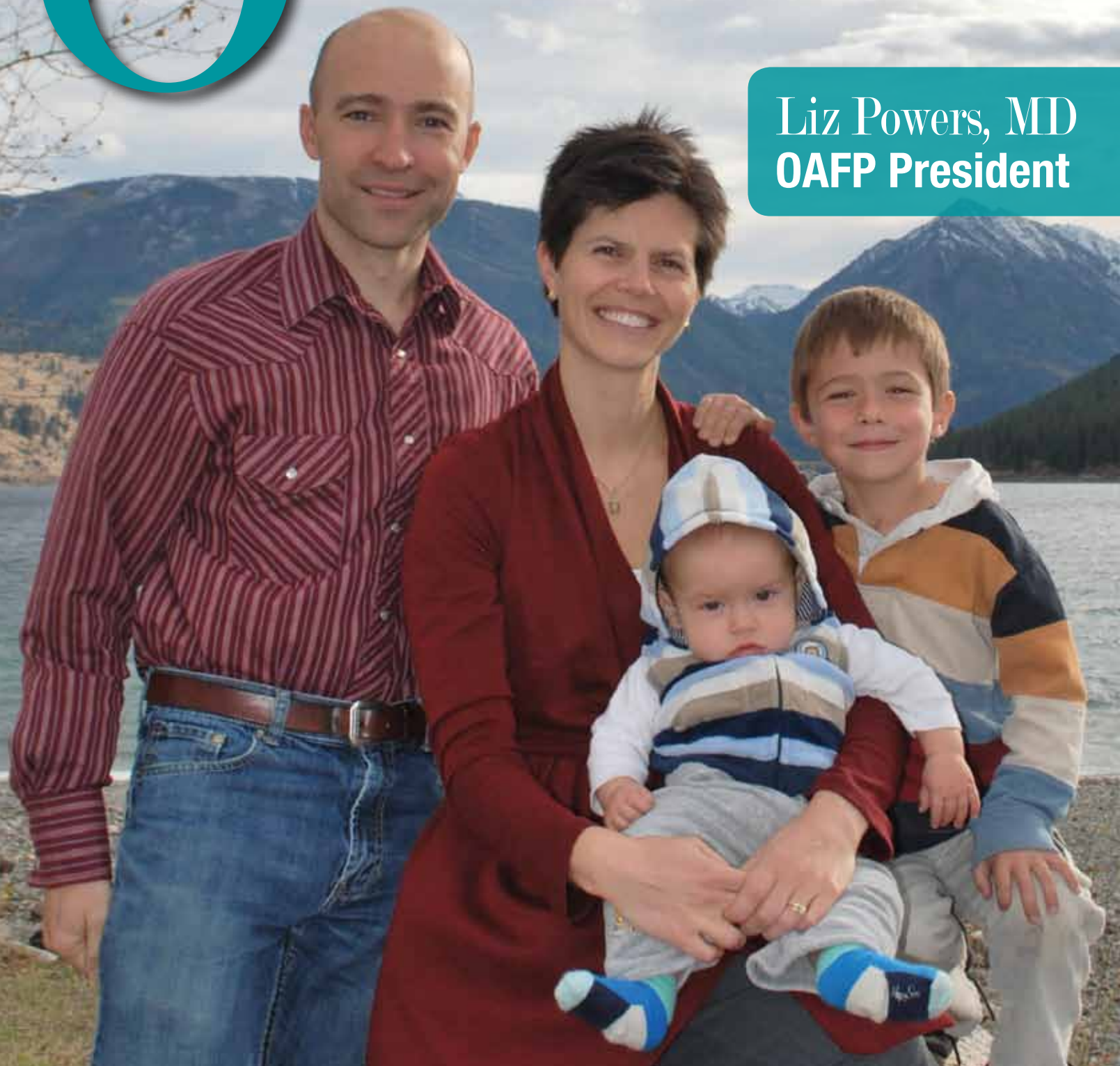




# Family Physicians of Oregon

VOL XIX • NO 2 • WINTER 2014

Liz Powers, MD  
OAFP President



Oregon Academy  
of Family Physicians



THE OFFICIAL MAGAZINE OF THE  
OREGON ACADEMY OF FAMILY PHYSICIANS





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About the Cover:  
Nic and Liz Powers, MD, along with five-year-old Malakai and eight-month-old Atticus, enjoying the beauty of the Willowa Mountains.

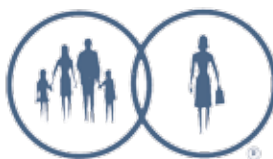


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EDITION 32



LIZ POWERS, MD

## Physicians as Transformative Leaders

This fall I did my first drive-through encounter. My patient (frail and in his 80s) wouldn't admit that he felt bad enough to come into the clinic, but his wife was really worried about him. So, out in the parking lot, standing in the drizzle, we checked his blood pressure and other vitals. We probed, prodded and finally poked him – he was due for flu and pneumonia vaccines – while we visited about his health. He didn't have pneumonia, just a cold, but he did have the beginnings of a skin infection that needed treatment. At the end of our outdoor visit, the gratitude expressed by this couple far outweighed any discomfort from being out in the weather.

Episodes like this have led me to realize that I am more content and more effective in my practice today than I was five years ago. A team approach to practice transformation and patient care has been the key to Winding Waters Clinic's success as a Patient-Centered Primary Care Home (PCPCH) and is the real reason I am happier in my job than I was when I started. Reimagining how we provide care has been one of the most professionally rewarding aspects of my work as a family physician. Sometimes I come up with creative improvements, but more frequently the push to do things a little bit differently comes from my co-workers. Thus I was not surprised when Roberta, a medical assistant, told me I would find my next patient out in his car in the parking lot.

I suspect we are all very conscious of the fact that physicians are looked to

as leaders, and have a paramount role to play in moving towards and providing team-based care. I've learned very practically over the last eight years, that change really can't happen without physician buy-in and support; doctors certainly have the ability to stop change in its tracks. Recent literature indicates that my physician colleagues and I, rather than being catalysts for change, may more often be obstacles inhibiting needed change. Cultural change has to happen first in those that have the power to make it happen, but a 2012 article in *Health Affairs*<sup>1</sup> highlighted four barriers to small practice transformation and all four barriers could easily be attributed to physicians:

1. Physician centrality
2. Lack of common vision/communication and shared experience
3. Authoritative leadership behavior, leading to a lack of psychological safety
4. Varied, but unimaginative, roles for non-physician clinicians

As a co-owner of a frontier clinic, I have as much control and autonomy over my practice as I could want. I am of the ilk who embrace change. I push for change any time I feel we can improve patient care. Yet sometimes when I see how and why things should change, I've struggled to share and implement that vision. Partners, colleagues, and staff become overwhelmed when the push for change is continual, and the pace of change too rapid. I didn't formally learn about leader-

ship or leadership styles<sup>2</sup> in college, medical school or residency. In my leadership self-study, analyzing the different leadership styles, I think I have always been an innovative leader – dreaming up seemingly impossible challenges and then trying to realize those dreams. Yet this approach isn't usually the most effective in our current culture of team-based practice. My current professional goal is to be like Ben and Jerry (yes the ice cream guys). I want to be a transformational leader!

Transformational leadership enhances the motivation, morale and job performance of others by connecting one's sense of identity and self to the project and the collective identity of the organization. Examples of transformational leadership include being a role model for others that inspires them and makes them interested; challenging others to take greater ownership of their work, and understanding the strengths and weaknesses of others, so the leader can align them with tasks that enhance their performance. ***Boil it down and transformational leaders expect the team to transform even when it's uncomfortable. They count on everyone giving their best and they are themselves in the thick of it, serving as a role model for all involved.***

For me the rewards of empowering others have been great. Just last week I had a patient who was sick, yet had overwhelming barriers to getting well; he had no insurance, no car, no money for medication, no help with wound care, no

*continued on page 6*



hope. I left the exam room feeling helpless myself. The medical part of caring for this patient was easy – antibiotics and packing for a skin abscess. However, the logistics were daunting, and two years ago this would have consumed much of my afternoon. Instead, I called a huddle and explained the situation to our care team. Moving on to my next patient, I was confident that we would be able to get our patient the care he needed. Sure enough, within an hour our patient had his needed medications, had transportation for follow up, and even had a half-smile on his face. By the next day, our patient had submitted his application for health insurance.

***“If you want to go fast,  
go alone. If you want  
to go far, go together.”  
– African proverb***

Our practice administrator tells me that the most valuable way I lead transformative change is by changing myself, by always being willing to “put in the work, on the front lines with staff, to make change successful.” I’m certain the changes will keep coming, and I’m sure glad to be on a team that has learned to adapt and excel. I encourage you to keep at the hard work of transformation. One day, maybe your team will tell you that yes, you really do need to go do your first drive-through encounter out in the parking lot.

<sup>1</sup>Nutting PA, Crabtree BF, McDaniel RR. Small Primary Care Practices Face Four Hurdles – Including a Physician-Centric Mind-Set – In Becoming Medical Homes. Health Affairs Vol 31 No 11 Nov 2012

<sup>2</sup>Leadership styles. 1.Charismatic 2.Innovative 3.Command and Control 4.Laissez-Faire 5.Pace Setter 6.Servant 7.Situational 8.Transformational (examples – Ben Cohen and Jerry Greenfield – of Ben and Jerry’s) – ASAE The Center for Association Leadership <http://www.asaecenter.org/Resources/ANowDetail.cfm?itemNumber=241962>





FRANCES BIAGIOLI, MD, PROFESSOR, OHSU FAMILY MEDICINE

## OHSU Curriculum Update

OHSU's new curriculum is under way for first-year medical students. Students and faculty are settling into the routine in a typical fashion: students are worried about *what's on the test*, while faculty stress the *big picture*. The preclinical curriculum starts with a fundamentals block followed by six organ system blocks. To get through the same material in 18 months as was previously done in 24, students are scheduled with activities for all but four hours per week. Students still have weekly clinical precepting. Initially, students were required to switch preceptors every three months, working with five different specialties. The Family Medicine department successfully lobbied to allow students the option to select a primary care continuity precepting experience for three consecutive blocks (nine months). This allows family doctors in the community and on the hill to provide longitudinal mentoring that has been a long Family Medicine tradition.

The new curriculum includes one half-day per week for Learning Communities or "College" activities to promote comradery and mentoring relationships. Students select a College based on their career vision and are grouped with faculty and students with similar interests. College activities include discussions, panels, workshops, and social events with curricula centered on wellness, financial resources, debt management and service learning. We see the

Colleges as a good way to have early, continuous, meaningful interactions with students. **Tanya Page, MD** co-leads the metropolitan primary care college; **Tim Herrick, MD** and **Ben Schneider, MD** lead the rural college; and **Sean Robinson, MD** (sports medicine) co-leads the urban medical specialties college. Each College is comprised of several coaches, each with five students. Coaches have regular individual and coach cohort activities dealing with the week to week stresses (and fun) of medical school. **Drs. Carol Blenning, Sonia Sosa, Amy Wiser, Eric Wiser,** and I serve as coaches.

The Family Medicine Interest Group (FMIG) is another area of opportunity to interact with students and is led by Ben Schneider, MD, Ryan Palmer, EdD and Peggy O'Neill. FMIG has been very active and events target students based on their current interest level: early events for those curious about Family Medicine, middle events for those who self-identify with Family Medicine, and late events focus on students applying to Family Medicine residency. FMIG student leaders work with OHSU and community Family Medicine physicians to facilitate these extremely popular student events; one of the procedure workshops filled within minutes and we had to offer a second date to meet the demand. Family Medicine electives are also creating a lot of interest. For example, due to overwhelming student

response, the Labor and Delivery elective led by **Jessie Flynn, MD** and **Joe Skariah, MD**, had to move to a large lecture auditorium.

In addition to clinical and small group teaching, Family Medicine faculty are actively involved in several leadership roles. Ben Schneider, MD is the Director of Student Development in the Dean's Office and was nationally recognized for his work with the 2014 Careers in Medicine Excellence in Medical Student Career Advising Individual Award by the Association of American Medical Colleges (AAMC). **Cezary Wojcik, MD** served as the course director for the first block of the curriculum, the fundamentals of medicine. **Cliff Coleman, MD, MPH** works with two other faculty to "thread" clinical and art of medicine subjects into the basic science blocks. **Robyn Liu, MD** and Ryan Palmer now co-lead the Rural Scholars program, Carol Blenning, MD is the director of the Rural and Community Medicine Clerkship, and I recently took over as the director of the Family Medicine Clerkship.

The clinical portion of the new curriculum is still in the design process. The School of Medicine appointed a Core Clinical Experiences curriculum group; however, the primary care voice of this group is a sole pediatrician. The taskforce has been directed to develop a template for the clinical education following curriculum committee guidelines.

*continued on page 8*

Those guidelines require students to complete seven core clinical experiences: Family Medicine, Internal Medicine, Neurology, Obstetrics and Gynecology, Pediatrics, Psychiatry and Surgery. Each department will determine which competencies students need to attain to fulfill their specialty's core experience. All core experiences must be completed before the creation of the Medical Student Performance Evaluation (formerly referred to as the Dean's Letter). This timing is important, because this means that all students are required to do their Family Medicine experience before submitting applications for residency.

Regarding rural education, the future curriculum still requires all students to do a rural clinical experience, but this potentially could be met by any number of experiences. The current rural and community health clerkship will most likely be one way that the rural require-

ment could be met and may very well be the dominant one as the infrastructure is well-established. Currently the majority of third year students spend ten weeks with family physicians (five weeks rural and five urban). We feel it is important that students be exposed to both urban and rural family medicine and will continue to advocate for this.

Before deciding on a specialty, we want students to work with family doctors in different settings. This allows students to see different scopes of practice, varied patient populations, and the difference between academic, rural, large and small group, and private practice family physicians. In order to avoid replacing the ten weeks with five and maximize the time students spend with a variety of family physicians, our faculty are developing a set of Family Medicine competencies that are uniquely associated with each setting. Our aim in defin-

ing these competencies is for students to experience the practice and career flexibility Family Medicine has to offer.

Oregon family physicians are critical to the creation of future family doctors. The clinical portion of the new curriculum starts in mid-February, 2016; the class ahead will be at the end of their third year. This means that from February to July 2016 there will be double the number of students needing clinical placement. Especially during that time, we hope Oregon family physicians will continue to provide positive examples for students in clinic, by teaching and through mentoring relationships, demonstrating the mental challenges of Family Medicine, sharing how continuity fosters relationships, and showing the ways family physicians effect change in the community.







DOUG BARBER, OAFP LOBBYIST

## Payment Reform Legislation

**M**ore than 500 clinics in Oregon are now recognized as patient-centered primary care homes (PCPCHs). These PCPCHs have hired care coordinators, medical assistants, nurses, social workers and behavioral health specialists in order to provide better preventive and chronic care management services. Many offer extended clinic hours and phone consultations. Although they have stepped up to offer higher quality care, better access, and enhanced services, PCPCHs have found they cannot continue to provide this different kind of care when they are paid the same way they have always been paid. Payment reform is needed.

So the OAFP is working with OAFP past-president and State Senator **Elizabeth Steiner Hayward** (D-Portland) on PCPCH legislation for the 2015 legislative session. The proposal would provide "Innovation Payments" of \$6 PMPM (Per Member, Per Month) for Tier 1 PCPCHs, \$8 PMPM for Tier 2, and \$12 PMPM for Tier 3. This would apply to all state (Medicaid, OEBB & PEBB) and commercial health insurers in Oregon.

These PMPM payments would provide funding to value PCPCH work, and could help fund the medical assistants and care managers who often provide valuable care coordination, as well as behavioral health providers and other clinic staff who work providing team-based care but whose services are not reimbursed by traditional fee-for-service payments.

PCPCHs have found they cannot continue to provide this different kind of care when they are paid the same way they have always been paid.

### PCPCHs Work

Early data from the Coordinated Care Organizations (CCOs) that rely on PCPCHs as a cornerstone of their coordinated-care model show these medical homes can help provide better care, better health and lower costs. Data from the Oregon Health Authority<sup>1</sup> showed that care delivered by a system of Patient-Centered Primary Care Homes resulted in:

- 9% fewer ED visits
- 18% reduction in ED spending
- 12% fewer inpatient readmissions
- 7% increase in primary care spending
- 18% increase in outpatient primary care visits

### Multipayer Agreement

In November 2013, most of the major health insurers in Oregon agreed with providers (including OAFP, OMA and ONA) that payment reform was needed to support primary care innovation. But more than a year later, little progress has been made.

A couple of the CCOs (Eastern Oregon & Josephine County) provide payments to support their PCPCHs. But most of the major health insurers are still thinking about how to accomplish this goal.

OAFP's proposed legislation is designed to kick-start that payment reform

process and define what sustainability looks like.

OAFP past-president **Evan Saulino, MD, PhD**, visits PCPCHs all over the state in his part-time contract work with the Oregon Health Authority. "Clinics are excited about the improvements they've made to make patient care better," he says. "But they tell me, 'we don't think we can afford to continue doing what we're doing, since so much of what this clinic does is uncompensated.'"

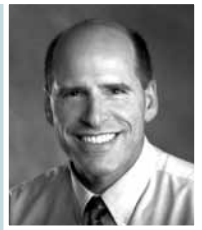
Saulino says, "We need to put some teeth in the multipayer agreement. If all the payers contribute, we can ensure straightforward support to strengthen the primary care system, and provide fuel for the innovation that hundreds of clinics across Oregon have started. This will ensure clinics can work to improve the health of their entire population, and won't be too expensive for any one payer."

In the weeks and months ahead, look for more information on the OAFP website regarding this vital payment reform legislation.

<sup>1</sup>Oregon Health Authority. (2013). Oregon's Health System Transformation: Quarterly Progress Report. Retrieved from <http://www.oregon.gov/oha/Metrics/Documents/report-november-2013.pdf>.

# 2014 AAFP Congress of Delegates

BY MIKE GRADY, MD, AAFP DELEGATE



The 2014 AAFP Congress of Delegates (COD) met in Washington, D.C., October 20-22. The Oregon delegation consisted of me, fellow Delegate **Glenn Rodriguez, MD**, Alternate Delegate **Elizabeth Steiner, MD** and OAFP President **Liz Powers, MD**. Also present were immediate Past President, **Evan Saulino, MD, PhD** and the Chair of External Affairs, **Robyn Liu, MD**. Chapter Executive **Kerry Gonzales** rounded out the Oregon caucus.

The COD is a rather frantic two and a half days filled with caucusing, reference committees, floor votes, campaign speeches, and other politicking. Delegates have the opportunity to share their views and help shape new policies. The Congress considered several Board reports and dozens of resolutions dealing with issues ranging from e-cigarettes to e-prescriptions. It would be hard to summarize all of the proceedings, but I'll share my personal perspective on one issue.

The AAFP's Consumer Alliance Program in general, and specifically the association with The Coca-Cola Company (TCCC), continues to be neuralgic. The Board feels these alliances are necessary if the AAFP is to remain financially strong enough to fund current programs without raising dues to unacceptable levels. Many AAFP members, including many OAFP members (and now unfortunately some former members) are disturbed at the association with a purveyor of many of the beverages that contribute to the obesity problem in the U.S. A resolution that asked the AAFP to end the relationship with TCCC, supported by the Oregon delegation, was defeated.

The OAFP brought three resolutions to the Congress. The first resolution asked the AAFP to develop evidence-based ma-



*Physicians Liz Powers, Glenn Rodriguez, Mike Grady and Elizabeth Steiner attend the 2014 AAFP Congress of Delegates*

terials to distribute to patients regarding the medical effects of consuming marijuana. Given the trend toward legalization of both medical and recreational use (as I write this, Oregon has just passed the ballot measure legalizing recreational use), having a summary of what is known about the medical effects of cannabis consumption would be valuable. The resolution was referred to the Board. Our second resolution that directed the AAFP to develop a recognition program for practices that have chosen to be Pharma-free was not adopted; similarly our resolution, co-sponsored by the New Hampshire chapter, asking the AAFP to support state and national efforts toward a single payer system did not win favor with the Congress.

An exciting part of every COD is the election of the AAFP officers. Annually the Congress chooses a President-elect and three (this year, four) Directors to serve on the Board. This year's winners were Wanda Filer, MD, President-elect, (Pennsylvania); and new Directors Mott Blair, MD (North Carolina); John Cullen, MD (Alaska); Lynne Lillie, MD (Minnesota); and our neighbor to the north, Carl Olden, MD (Washington).

Overall, the tone of this year's COD was congenial; absent some of the sharp divisions on social issues that have marked recent Congresses. The message from AAFP leadership is that these are hopeful times for our specialty with breakthroughs forecast on payment reform, GME funding and enthusiasm over the roll out of the Family Medicine for America's Health campaign. Among the delegates however, there remains considerable angst over the growing administrative burdens of practice including EHRs, ICD-10, and prior authorizations. Attending the Congress is a good opportunity to feel the pulse of family medicine nationally.

Finally, our senior Delegate to the AAFP, **Meg Hayes, MD**, was unable to attend what would have been her final Congress of Delegates. On behalf of the delegation and the OAFP, I would like to thank Meg for her many years of service on the OAFP Board, including a term as President and for the last eight years as Alternate Delegate and Delegate. She has always been an articulate and passionate proponent of our issues before the AAFP Congress.

## Is Rural Medicine Calling You?

**F**or the past ten years the OAFP Foundation has given OHSU medical students the opportunity to gain a better understanding of rural family medicine by providing them with a scholarship (known as the Laurel G. Case Award for Rural Experience) to live and work with a rural family physician for a week or two during the summer between their first and second year of medical school.

From year to year the makeup of the students participating in the summer rural medicine experience is fairly similar. There are students who grew up in a small community and once committed to the life of medicine, have always planned on practicing in a rural setting; there are students who haven't quite made up their minds about their medical specialty, but are curious about practicing in a smaller locale; and there are students who sign up for this experience to improve their physical exam skills and stay sharp over the summer, though quite certain that rural medicine isn't their calling.



*Front row: Board members Patricia Ahlen, MD and Chris Traver, medical students Jessica Petrovich, Leigh Hess, Lisa Pearson, Neela Ramanujam, Rita Aulie, and board member Ron Stock, MD. Back row: Board member Peggy O'Neill, Benjamin Carpenter, board member Bill Origer, MD, Casey Luce, and board member Dale Bookwalter. Recipients not in photo: Annette Whitney, Emma Cantor, Justin Lee, Mary Clare Bohnett, Robin Brown, Scott Hoffmann, and Sylvia Peterson-Perry. Board member not in photo: Paul Neumann, MD.*

Though their intentions are varied, the unmistakable common thread tying these students' experiences together is their newfound respect for their rural colleagues, a fresh perspective on the specialty of family medicine, and a renewed confidence in their clinic skills.

This year the 14 medical students who participated in the summer rural experience worked with the following Oregon family physicians:

**Betsy Anderson, Mary Lou Belozar, James Brauer, Jerri Britsch, Spencer Clarke, Glenn Gailis, Renee Grandi, Andrea Janssen, Andrew Janssen, Kevin Johnston, Doug Lieuallen, Rachel Locker, Russ Nichols, Eric North, Senna North, Sarah Peters, Tim Peters, and Carin Pludeman.** We wish to thank this group of doctors for opening their doors and sharing their lives with these students. As you read on you'll see that this experience was life changing.

### Here's what the Laurel G. Case recipients had to say about their summer rural family medicine experience:

*"Throughout the week, I was able to see many different patients with a plethora of different concerns. From minor procedures to home visits, and everything in between, this was an incredibly comprehensive experience. With such a broad scope of practice, especially complete continuity, I feel that my personality, interests and skills could fit well into this type of rural practice. Overall, my time spent in Burns was an incredibly memorable experience, most certainly one that I will highly recommend to other students."*

*"The breadth and depth of my preceptors' medical knowledge was definitely distinct from what might be required for non-rural family medicine physicians. He used his acumen and experience to*

*diagnose, counsel, and treat his patients – his physical exams skills were excellent. In a metropolitan world of specialists and consults, less seems to be asked of family physicians. My time in Heppner showed me that rural docs are more than capable of handling an enormous array of patient needs far from large, urban areas."*

*"I had a wonderful summer rural experience. The part of rural family medicine that I am most drawn to is being a part of a community and seeing the same patients at different times in their lives. My time in Enterprise certainly reinforced this. I'm thankful to have been able to spend two weeks as a member of this special community."*









## RECOLLECTIONS OF A MID-20<sup>TH</sup> CENTURY FAMILY DOC

**O**n Christmas Day of 1952 I received a beautiful leather house-call bag and supplies from my mentor, Frank Bartlett, and his physician son Jay, who worked in the same office. The doctor's bag was accompanied by an invitation to join their practice in Ogden, Utah following the completion of medical school and internship.

The house-call bag was wonderful, and looked, like its owner, very new and inexperienced. It was the size of a small valise with compartments in the lid for bandages, thermometers kept in alcohol, small bottles containing sedatives, analgesics, and meperidine, syringes, and sampling tubes for blood counts and lab tests. A roll of cotton, a small container of suturing instruments and sutures, scissors, a sphygmomanometer, anoscope, and vaginal speculae occupied the bag's lower compartment.

On July 19, 1954 I placed the bag in the trunk of the family Chevrolet and set off on this new adventure. I bought a hat to wear my first day of work, trying anything to look older than my 26 years.

My first day of practice began in the hospital's x-ray department. Frank and Jay always looked at the films they had ordered and discussed any issues with a radiologist. They did the same routine with the laboratory, acknowledging that the radiologists and pathologists were consultants who liked hearing about our patients and being involved in clinical medicine. (Later, when I was a teacher, those good habits paid off for both patients and students).

The Bartlett's took the time to read the nurses' notes and discuss each patient with the nurses. I adopted this same habit

in my practice and have always respected the nurses that I worked with and the contributions they made to my patients and to my education as a doctor. However, I recall years later being scolded by a nurse at Harbor-UCLA for writing in her chart. All I had written was "Noted: thank you," along with my signature. It was a reminder that I was in a different world.

Surgical procedures were scheduled most mornings and I was first or second assistant if there were no urgent house calls to make. We visited our hospital patients twice a day; rounding together in the morning and splitting the after hour duties between two Ogden hospitals. Some patients were post-op, some were medical, some were newborns, and some were post-partum. The cross-coverage benefited our patients and gave all a chance to meet more patients and their families as well. Our practice was broad-based and we were never quick to refer as we had both the talent and the experience within the group to handle the majority of the cases presented to us. One of us was available 24/7; it was often exhausting and disruptive of family life.

Established patients were scheduled for screening examinations, which they liked. We caught up on travel history and family matters, and the head-to-toe physical exams often disclosed problems that the patients were unaware of or were denying. Suspicious lymph nodes, scalp lesions, breast lumps, hernias umbilical, inguinal and femoral, and correctible foot problems were often followed by appropriate surgical procedures. However, many surgeries were postponed; in the

days before insurance, patients were reluctant to accept treatment.

Post-op sutures were usually removed at home, as were plaster splints for fractures. The cast saw was pretty scary to most patients until I demonstrated that it did not cut when applied to a fleshy part of my hand. House calls were a burdensome part of the practice but cemented relationships with families, provided an opportunity to point out health hazards such as throw rugs, and occasionally brought in a new patient who had avoided visits to our office. While visiting an arthritic patient, I noticed a carcinoma the size of a quarter in the middle of her husband's forehead. Fortunately, he was treated by thorough excision and a skin graft.

We charged \$5 for house calls, and a standard office visit, except for annual history and physical exams, was only \$2. All lab work was included in these fees, as we used the results for monitoring or confirming a diagnosis. We had two good microscopes, a gas burner for boiling urine with tablets that gave various colors depending on sugar, Wintrobe tubes for sedimentation rates, a Sahli hemoglobinometer, and counting chambers for red and white blood cell counts. The immediate results we received by doing our own lab work were far better than sending patients to outside laboratories and hoping they would follow up.

Some families paid, some did not. Our receptionist was often successful arranging monthly payments, which was especially helpful for young families for whom the \$75 maternity care fee was particularly burdensome. I'm not sure when actual col-

*continued on page 16*

lections equaled the \$600 salary Frank paid me monthly, but it was worth it to him to avoid some of the night work as Jay and I took turns covering nights and weekends. Frank personally made the visits to old friends and long-time patients and through these practices we became extended family to many. These relationships were reflected in the cost of professional liability insurance. In 1966 when I left Frank's practice for an NIH fellowship in Salt Lake City, I called my insurance agent to inquire about a possible refund. I was pleased to get a refund check and paperwork showing my original premium of \$130 for two years of coverage.

Observing Frank's relationships with his patients was very instructive. He was keenly aware of the value patients placed on being touched during their appointments, so listening to the chest and checking for calf tenderness was part of every hospital visit.<sup>1</sup> While instructing patients awaiting discharge, Frank did not sit at the bedside and write notes in his chart.

Instead, he stood at the foot of the hospital bed, making full eye contact, fiddling with their toes through the bed sheets to keep their attention. I saw firsthand the value of touching when family members of some of my seriously ill hospital patients asked me if they could call the Mormon Church Elders to the bedside. I always welcomed it and observed church members anoint the patient with consecrated oil, place hands on the patient's forehead, and pray. On more than one occasion they prayed for the doctor, too. The reassurance appeared to stir some patients to rally and renew their fight to live; it helped and I was impressed.

I once saw Frank paint tincture of merthiolate, a red liquid, on a young woman's patch of alopecia areata of the scalp. Later, I reminded him that the condition was known to be self-limited and to heal itself, so what had been the reasoning behind applying the solution? He answered that if he had told her the diagnosis and natural course she would have seen the only

dermatologist in our small city and spent money needlessly.

So that's how we practiced in those days; the same way the founders of our specialty did it. It was hard work, but it was real medicine by docs who learned from experience and developed the confidence to treat conditions many of today's family doctors refer away to subspecialists before determining they could have treated these patients themselves. We also ran our own practices and didn't have a predetermined number of patients per office session dictated by hospitals' outpatient practices or insurance companies. Our work was busy and demanding as there were more patients than doctors to care for them. Sound familiar?

*Fred Matthies, MD, is an OAFP Life member who remains active in pursuing medical education and health reform issues at the state and national level.*

<sup>1</sup>Medical ethicist Howard Brody, MD, PhD, emphasized the same when he presented the keynote lecture at the 2011 OAFP Scientific Assembly.

## ALSO Refresher Course

### APRIL 18-19, 2015 • SKAMANIA LODGE

**THE ONLY  
REFRESHER  
COURSE  
BEING HELD  
IN 2015!**

Plan to attend the ALSO Refresher Course that will be held April 18 – 19, 2015 during the Annual Family Medicine Weekend at Skamania Lodge in Stevenson, Washington. ***This is the only ALSO Refresher Course being taught in the upcoming year so you won't want to miss the one being held in your own back yard!***

Targeting physicians, midwives, nurses and other health care providers, the ALSO Refresher Course will enhance the knowledge and skills needed to effectively manage potential emergencies during pregnancy, labor, and delivery. **And participants who successfully complete the refresher course before their ALSO certification expires automatically receive an additional five years of certification.**

This course gives you the chance to review the most updated obstetric protocols and practices complete with hands-on workshops that include assisted delivery, maternal resuscitation, malpresentations, maternity care, shoulder dystocia, and intrapartum fetal surveillance.

The ALSO Refresher Course has been accepted for up to 9.25 credits by the AAFP.

Go to the OAFP website ([www.oafp.org](http://www.oafp.org)) and register today!



## ● STUDENTS SPEAK OUT!

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

This fall, FMIG has worked hard to put together a series of events to help show new students the breadth of family medicine and to help existing students' further their interests in the field.

We kicked off these goals by hosting a "Meet the Docs" dinner where physicians from six different clinical settings shared stories about how and why they became family practitioners and what their practices and lives outside of the practice look like now. During this event, we were joined by **Drs. Jessie Flynn** (OHSU Family Medicine at South Waterfront and Southwest Community Health Center), **Christina Milano** (OHSU Family Medicine at Richmond), **Jonathan Vinson** (Providence and Air National Guard), Mara Colbert (Kaiser Permanente), Joe Skariah (OHSU Family Medicine at Scappoose), and **Wes Baker** (OHSU Residency Class of 2018). This

group of diverse physicians did a fabulous job of sharing how they made their career choices and why they would encourage students to explore family medicine further. The student feedback after the event was extremely positive.

We then hosted a wide array of hands-on skills workshops, lectures, and community service activities, which did an excellent job of demonstrating the many different faces of family medicine, from sports medicine to rural practice. Our skills workshops have included a joint injection workshop with **Ryan Petering, MD** (OHSU Gabriel Park Clinic) and two suturing workshops and **Brian Frank, MD** (OHSU Richmond Clinic) and Joe Skariah, MD. During the joint injection workshop, first and second year students utilized the newly renovated OHSU anatomy lab where they were given the opportunity to

perform injections on bodies from the Oregon Body Donation Program. During the suture workshops, first, second and third year medical students were instructed on how and when to perform different surgical techniques. They then practiced extensively on swine feet "patients." In the spirit of "see one, do one, teach one," a group of suture workshop participants, led by **Emma Cantor** and **Rita Aulie**, went to Woodburn High School to teach basic suturing skills to junior and senior high school students in the Area Health Education Center's (AHEC) Health Preparation Program. The high school students enjoyed having medical students in their classroom and we hope to continue working with AHEC's high school programs throughout the year.

Outside of the classroom, we joined forces with the OHSU Family Medicine residents led by team captain **Will Perez, MD** (OHSU



*Joe Skariah, MD instructs students at a suture workshop.*



*OHSU Family Medicine Team supports the Portland Aids Walk.*

Residency Class of 2017) to form the OHSU Family Medicine team for the Portland AIDS walk. This was a great opportunity for students and residents to get to know each other in a fun, informal way while also connecting to the Portland community and supporting a great cause. Our team raised over \$600 and the event as a whole raised over \$450,000 for the Cascade AIDS Project!

We also took advantage of the beautiful, sunny fall weather and spent a Saturday with Lyn Jacobs, MD (Virginia Garcia Memorial Health Center). Dr. Jacobs and her family run a Community Supported Agriculture (CSA) Farm, La Finquita del Buho, in Helvetia, Oregon. Students and their families spent the day at the farm learning what Dr. Jacobs does on her farm and in her clinic as well as help out with some of the fall harvest needs. After a short introduction about how the farm came to be, we began our work digging out weeds and harvesting beans, squash, tomatoes and

herbs. The farming was fun but, as many of our students told us, much harder than they had expected! After a couple of hours in the fields, we took a break and ate some of the delicious vegetables that we had harvested while listening to stories from Dr. Jacobs.

We were also fortunate enough to have state senator **Elizabeth Steiner, MD** join us for a lunchtime talk. She discussed political advocacy amongst physicians, organized medicine and how students could begin taking part in the efforts to change the health care landscape. This talk provided students with a great platform to begin thinking about the ways that they, as current students and future phy-



*Students showing off their harvested crops at Dr. Jacobs's farm.*

sicians, could start engaging in the community to help improve health outcomes.

Overall, we had a very busy fall, and we are looking forward to even more exciting events this winter. Thank you to our student steering committee, **Rita Aulie, Annie Buckmaster, Emma Cantor** and **Brianna Muller** and our faculty advisors, **Benjamin Schneider, MD**, Peggy O'Neill and Ryan Palmer, EdD for their huge efforts to make all of these events happen!





# Breaking the Barriers to Better Health

In 2008 I traveled to eastern Ghana after my first year of medical school. I went to study the barriers children faced accessing the health system in a rural district called Akatsi (a-ka-chee). This research showed that the biggest challenges to access were faced by children living in rural communities on the outskirts of the district. Poor roads, the rainy season, and poverty limited their ability to seek the medical care they needed to grow into healthy adults.

Out of this experience grew Rural Health Collaborative (RHC), an organization my wife and I started to improve the health of rural communities in the Akatsi District. Our first trip as a non-profit was in 2011. We trained 20 women from 20 different villages in the district to be Community Health Promoters; they are called Kekeli women. Kekeli means “brightness” in the local language. The Kekeli women were taught a myriad of public health skills: basic sanitation and hygiene, malaria prevention, and oral rehydration to name a few. Their job was then to return to their communities and teach these skills to others. In addition to education, they also treat basic wounds and refer ill children to the town center for further treatment.

Since that initial training our organization has returned four times, most recently in June 2014. We have now trained 35 women in the district and plan to train an additional 15 next year. Our recent efforts have focused on reducing maternal mortality in the district. About half the women deliver their babies in the home and only a small percentage of those do so under



the supervision of a skilled birth attendant. Rather than train the Kekeli women to deliver babies themselves we taught them a curriculum called “Home-Based Life Saving Skills” - essentially a basic life support course for obstetrics. The program teaches skills to stop hemorrhage after birth, recognize signs of newborn distress, and develop emergency transportation plans within each village. They are now teaching these skills in their communities.

RHC is a global organization with a local focus on the Akatsi District. Our goal is to do everything we can to improve the health of rural communities in Akatsi by focusing on community projects such as the Kekeli program. We also strive to collaborate with local groups, including the government, so that the work we do is relevant and sustainable. Additionally, we aim to empower the Kekeli women we

train to be leaders in their communities. Women in Akatsi lack opportunities to develop unique skills. By teaching them not only to be content experts but also how to lead their communities in decision making, they gain status and elevate the position of women in society.

We’ve only just begun our work in the Akatsi District and we hope to be at it for decades to come. The relationships we’ve developed inspire us to continue to give what we can, encouraging and empowering our partners every step of the way.

If you’d like to learn more about our mission and story, visit our website at [www.rhcollaborative.org](http://www.rhcollaborative.org). You can meet our Executive Team and look back on our history by reading our blog. If you have a question about our work or even just a comment or thought, please don’t hesitate to contact me.



# Nominations Sought for OAFP 2015 Family Doctor of the Year

It's that time of year again! Do you know a colleague, who is a member of the OAFP, who exemplifies the finer attributes of a family medical practitioner, one who is engaged in community affairs as well as provides compassionate, comprehensive and caring family medicine on a continuing basis? If so, it's time to fill out the nomination forms for the 2015 Family Doctor of the Year.

Nominations to the Academy must be accompanied by a letter outlining why the physician is deserving of

this award. The nomination form and complete details listing the relevant criteria can be found at [www.oafp.org](http://www.oafp.org). Supporting letters and other materials from the community lend weight to the nomination. The surprise announcement of the winner will be made at the Annual Spring CME Weekend held at the Skamania Lodge, Stevenson, Washington on April 16-18, 2015.

The deadline for the nomination is February 6, 2015. We look forward to receiving your submissions.

# SAVE THESE DATES

**2015 OAFP LEGISLATIVE DAY**  
March 9, 2015 • Salem, OR

**68TH ANNUAL FAMILY  
MEDICINE WEEKEND**

Scientific Assembly & Congress  
April 16 – 18, 2015

OAFP/Foundation Auction, April 17  
ALSO Refresher Course, April 18-19  
Skamania Lodge, Stevenson, WA

**For more information, contact**

**Kerry Gonzales at the**

**Oregon Academy of Family Physicians**

**[www.oafp.org](http://www.oafp.org)**

**(503) 528-0961 • Fax (503) 528-0996**



# Physicians and Politicians Meet to Discuss the Importance of Health Reform

Over the past few months, some of our members have taken the time to reach out to key Oregon legislators, providing a contribution from our Political Action Committee, explaining the triumphs and challenges of practicing in a patient-centered primary care home, and conveying how changes in health reform affect their community.

If you are interested in becoming an OAFP Key Contact and inform and educate our elected officials, please contact Kerry Gonzales at [kg@oafp.org](mailto:kg@oafp.org).



*Physicians Evan Saulino, L.J. Fagnan, Michael Booker, Melissa Hemphill, along with OAFP Executive Director, Kerry Gonzales meet with U.S. Sen. Jeff Merkley*



*Ben Schneider, MD with Sen. Elizabeth Steiner-Hayward*



*Mike Grady, MD with Rep. Vic Gilliam and Sen. Fred Girod*



*Dan Paulson, MD and Mark Meyers, MD with Rep. Nancy Nathanson*



*David Gilmour, MD with Sen. Alan Bates*



# PRIMARY CARE BEHAVIORAL HEALTH IS TRANSFORMING PRIMARY CARE IN OREGON

## What is primary care behavioral health and why do we need it?

Primary care doctors have always addressed the psychosocial issues that accompany patients who present for medical care. As cited in Robinson and Reiter (2007), as many as 70% of primary care visits stem from psychosocial issues. As such, psychosocial issues overwhelm the time and resources available in traditional doctor-patient encounters. Because of these dynamics, more and more primary care practices in Oregon are adding behavioral health providers to their care teams. In family practice settings, behavioral health providers (BHP's) are often psychologists and advanced licensed clinical social workers with broad clinical training who are able to expertly advise primary care providers and their team members in regards to their patients' behavioral health needs.

Behavioral health integration is a key component of health care transformation because personal behavior contributes so greatly to population health. But what does behavioral health integration mean? What is or what should be the practice of primary care behavioral health (PCBH)? Many people interested in health care transformation, from primary care leaders to payers to mental health professionals, are asking these questions. Unfortunately, the answer to these questions in Oregon has been as varied as the individuals asking the questions. This is a bit of a problem for this new field of clinical practice. Without a standard definition PCBH will not be able to demonstrate

Behavioral health integration is a key component of health care transformation because personal behavior contributes so greatly to population health.

its unique impact on improving patient experience of care, improving population health, and reducing per capita cost of health care.

The Agency for Healthcare Research and Quality (AHRQ) agreed with this analysis. As a result, in 2013 it pulled together a panel of experts to define primary care behavioral health. They released *the Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. Primary care practices around the country are beginning to adopt these definitions. As a result, the practice of primary care behavioral health is becoming standardized. AHRQ's definition of primary care behavioral health is:

*The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic*

*medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.*

Okay, but what does this care look like? Imagine a rural practice in Oregon with two primary care providers (PCPs) supported by a nurse, certified medical assistant, and a referral clerk. The closest behavioral health provider is 20 miles away. The practice supports 3,000 patients and is interested in improving the biopsychosocial health of all of their patients. They have heard about primary care behavioral health and decide to hire a 1.0 psychologist. They begin universally screening the mental, physical, and social health status of their patients. Patients who screen positive for concerns are placed same day or next day in the BHPs schedule for a 30 minute biopsychosocial assessment and care planning session. The BHP sits in the team room with the PCPs and consults on patients throughout the day. The PCPs begin to notice that they are thinking about their patients' home life and behaviors more

*continued on page 26*



and more. Everyone on the team is beginning to feel more empowered to help patients not just with medications and procedures but with the quality of their life.

### Is integrating physical and behavioral health services in primary care an Oregon priority?

The Oregon Health Authority's (OHA) health care transformation plan includes eight elements to guide coordinated care organizations' (CCOs) transformation efforts. The number one OHA health care transformation element may surprise you; it's not developing and spreading Patient-Centered Primary Care Homes (PCPCHs) across the state (that's element #2). Instead the number one element is the integration of physical and behavioral health services. Considering this stated priority, how are Oregon primary care practices doing in integrating behavioral health within their clinics?

### How are CCO incentives reinforcing behavioral health integration in primary care?

Oregon primary care practices are aligning with the OHA's integration priority; one way is by adding a behavioral health provider to their teams. Primary care behavioral health is often considered synonymous with building a PCPCH; that is, "team-based care" often means "integrated team-based care." This is not always true but many PCPCHs have been developed with this in mind. Many others are now adopting PCBH strategies and hiring behavioral health providers (BHP) due to CCO incentives. For example, PCPCHs now receive incentives if they provide universal screening, intervention, and referral for common behavioral health concerns like depression, substance misuse, and developmental delays. It is worth noting, work to receive behavioral health universal screening incentives increases awareness of behavioral health concerns by PCPs but does not enhance primary care by adding behav-

ioral health expertise to the team. Furthermore, it has not been easy for PCPCHs in Oregon to attain these incentives without integrating a behavioral health provider on the team. Nevertheless, incentives that increase universal behavioral health screening in Oregon are improving identification and treatment of these problems.

As mentioned above, clinics that have short-term consultation services by a behavioral health provider in clinic are better equipped to attain CCO incentives. Those practices that have BHPs providing population-health interventions (like brief assessment, intervention, consultation, and referral) are more equipped to obtain behavioral health screening incentives. For example, a PCPCH with a BHP (ideal staffing is a 1.0 BHP per every 2,500 patients served) that has a schedule of 50% same day access would meet the needs of all patients who screen positive on universal screening measures. Licensed clinical social workers and psychologists can bill for screening, brief intervention, and referral to treatment (SBIRT) for alcohol and drug problems. The downside is that if they do this service the same day as another PCP service only one service will be reimbursed. Paradoxically, while clinics are receiving incentives to identify and briefly treat behavioral health concerns (a step in the integration direction) they are being de-incentivized to add behavioral health experts to the team to help (a step back). Many practices see greater metric success with a BHP as adequate incentive to hire these individuals. As practices move to alternative payment models that pay for quality outcomes, hiring BHPs may also increase because adding a BHP to the primary care team enhances the quality of services delivered.

CCO's also ensure that primary care practices have procedures in place to refer patients to community behavioral health providers. This is a step in the integration direction but PCP teams can become frustrated during the referral process. Often, PCP teams lack positive relationships with community behavioral health providers and

the professional culture differences (primary care culture versus behavioral health culture) can result in "culture clash." The primary care BHP addresses these concerns by providing treatment for mild-moderate behavioral health concerns within the primary clinic and by facilitating patients who require specialty behavioral health services to these community providers. BHPs are competent in both primary care and behavioral health cultures, and, as a result, referrals go smoother and relationships between these provider communities improve. Despite the lack of monetary incentives for these services, PCPCHs continue to hire BHPs because of the discernable differences they bring to the practice setting – improved patient care and increased provider efficiency.

### The Integrated Behavioral Health Alliance of Oregon: addressing barriers to implementation of primary care behavioral health services in Oregon

This article defined PCBH within the landscape of a transforming health care system and gave some practical examples of the work of a primary care BHP. It also discussed some of the successes and challenges that PCPCHs experience when integrating behavioral health providers in their clinics. Because of the challenges described, a grassroots group of PCBH experts from across the state formed in 2014 to support standardized dissemination of PCBH throughout Oregon. This group is made up of PCBH clinical directors, behavioral health providers, primary care providers, CCO representatives, insurance representatives, health care transformation leaders, leaders of academic institutions and others invested in achieving high-performing primary care in Oregon. CCO Oregon supports this group now known as the *Integrated Behavioral Health Alliance of Oregon*. If you are interested in PCBH, would like to keep up on this group, or just want to learn more about PCBH; please visit the alliance's webpage at <http://www.ccooregon.org/workgroups/IBHAO>.







# MEMBERS IN THE NEWS

## HONORS, AWARDS, AND ACCOLADES



**Jennifer DeVoe, MD, DPhil.**, Family Medicine Associate Professor in the OHSU School of Medicine, family physician at Gabriel Park Clinic and Chief Research Director at OCHIN, has been selected to the Institute of Medicine (IOM). Election to the IOM is one of the highest honors in the fields of health and

medicine. Dr. DeVoe was elected in recognition of her outstanding professional achievement and commitment to services in health and medicine. DeVoe is the eighth member selected from Oregon, the fifth from OHSU, and the first woman from Oregon and OHSU. DeVoe stated, "This is definitely a momentous event for Oregon family medicine! I hope to represent our family medicine colleagues well."

In addition, Dr. DeVoe was recently elected vice president of the North American Primary Care Research Group (NAPCRG) Board of Directors. NAPCRG is a multidisciplinary organization for primary care researchers, including primary care generalist disciplines and related fields including epidemiology, behavioral sciences and health services research.



**John Saultz, MD**, chair of the OHSU Department of Family Medicine, is a recipient of the 2014 Alumni Award from The Ohio State University College of Medicine which recognized his lifetime achievement to advance the profession of medicine. Saultz, a 1979 graduate of the College of Medicine, was honored during the Medical Alumni Reunion Weekend held in October.



**Matthew Bliven, MD, FAAFP**, received the 2014 Physician Leadership Award by Capella Healthcare at their annual National Physician Leadership Group conference held in September.

He completed his residency at Providence St. Peter's Hospital in Olympia, Washington and earned his medical degree from OHSU. As a family physician, he has been serving the McMinnville community since 1996 at the Physicians Medical Center. He has also served in nu-

merous leadership roles at the Willamette Valley Medical Center, including Chair of the hospital's Physician Leadership Group, Chair of the Credentials Committee, and as a member of the Board of Trustees. In addition, Dr. Bliven is a board member of the Yamhill CCO and serves as chair of Capella's National Physician Leadership Group.

A native of Dallas, Oregon, Dr. Bliven has been in practice for 18 years and was awarded the degree of fellow by the American Academy of Family Physicians in 2013.



**Jason Kroening-Roche, MD, MPH**, and **Jessica Johnson, MD, MPH**, (shown with newly installed AAFP President **Robert Wergin, MD, FAAFP**) received the prestigious AAFP/Bristol-Myers Squibb Award for Excellence

in Graduate Medical Education at the 2014 AAFP Assembly held in Washington, DC in October.

Drs. Kroening-Roche and Johnson, third year Family Medicine residents at OHSU, were two of only twelve recipients of this annual award. Jason stated, "It was an honor to be recognized among such an incredible group of fellow residents. There is so much to be excited about as family medicine moves forward to care for communities and populations, and to do an even better job than we've ever done before."

## MOVERS AND SHAKERS

**Nic Buser, MD**, an OHSU medical school graduate, completed his residency training at the Providence Portland Family Medicine Residency Program in Milwaukie. It was his goal to live in the same community where he practiced, where he could see his patients in the grocery store and on the football field, and this dream became a reality when he joined Summit Family Medicine in Hood River. Dr. Buser is trained to treat patients of all ages, including obstetrics and mother-newborn care.



**Tessa Reff, MD**, who recently finished her residency at the North Memorial Medical Center Broadway Family Medicine Residency Program in Minneapolis, Minnesota, was searching for a clinic that would allow her to practice medicine the way she always envisioned – in

# MEMBERS IN THE NEWS

a small town, practicing obstetrics along with family medicine – and Samaritan Health Services Sweet Home Family Medicine fit the bill. Moving west with her husband and two small children, Dr. Reff looks forward to meeting her new patients and spending her down time camping, hiking, and gardening.

## INTERESTING BUSINESS WE SHOULD ALL KNOW



The OHSU Department of Family Medicine, along with funding from the Oregon Academy of Family Physicians, selected two OHSU second year medical students, **Glenn Kautz, MPH**, and **Brianna Muller**, to

participate in the 2014 OAFP Summer Family Medicine Research Internship Program. The students were able to assist with various research activities including data collection, entry and analysis.

Kautz assisted **Jen DeVoe, MD, DPhil.** with a joint study by OCHIN and the OHSU Department of Family Medicine regarding cutting-

edge health policy and primary care titled, “Mixed Methods of Evaluation of Payment Reform in Oregon’s Community Health Centers.” Through funding from the Robert Wood Johnson Foundation and the Patient-Centered Outcomes Research Institute, DeVoe’s team studied real-time changes in Oregon due to the Affordable Care Act. Kautz conducted literature reviews, wrote for the student blog, *Frontiers in Healthcare*, and visited community health centers to implement study surveys. He was very thankful for the funding provided by the OAFP which enabled him to learn a great deal about an area of clinical practice research that he looks forward to pursuing further in the coming years.

Muller worked on a research project funded by the National Institute of Mental Health named “Team Up -- Turning EHRs into Assets for Mental Health and Uniting Practice.” Led by Deborah Cohen, PhD, Associate Professor in the OHSU Department of Family Medicine, Muller was responsible for collecting data through patient surveys at community health centers across Oregon. This project aims to better integrate mental health into existing EHR systems in patient-centered primary care homes. She stated that the research was highly rewarding and hopes to integrate information gleaned from this community health research into her future career.

## 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:

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