

Family Physicians of Oregon

VOL XX • NO 2 • WINTER 2015



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- 69th Annual Spring Family Medicine Weekend & ORPRN Convocation Comes to Portland
- Members on a Mission
- OHPB Visits Eastern Oregon

If you are looking to
LEARN, CONNECT
and **REJUVENATE**
THE OAFP HAS YOU COVERED!



OREGON ACADEMY OF
FAMILY PHYSICIANS

MAKING HEALTH PRIMARY

THE OFFICIAL MAGAZINE OF THE
OREGON ACADEMY OF FAMILY PHYSICIANS



VOL XX • NO 2 • WINTER 2015

Family Physicians of Oregon

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About the cover:

The OAFP and the OAFP/Foundation have you covered – join us in Portland March 10-12, 2016 to learn, connect, rejuvenate and invest in the future of family medicine. Also, you can be part of the “Umbrella Brigade” that takes place during the conference. More details on pages 22-23.



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EDITION 36



LIZ POWERS, MD

Keeping our Fingers on the Pulse – Community Vital Signs

Those of us on the front lines see need daily; the health disparities and gaps in care fester like a sore tooth that can't be ignored.

I want to start with a mixed story; a story of success and failure, collaboration and frustration and a story that highlights why communities need ways to measure how well they coordinate care. This story is about a dental emergency, but for those of you who don't have dental care in-house, there is always another example of a need that can't be met within a given primary care home.

A relatively healthy man in his 30s came to our office last week with an acute fractured tooth. Our care team called around and found that only one dentist in Wallowa County accepts Medicaid and his local office was only open two days a week. We made an appointment; our patient waited five days and then arrived at the dental office to find that, in the meantime, his Medicaid coverage had expired. He was told he needed to pay \$250 up front to have his tooth pulled. Unable to pay, he returned to our office, and in cooperation with the local hospital, our application assister was able to get him Hospital Presumptive Medicaid Coverage. He went back to the dentist's office with an active Medicaid number, but was told they wouldn't see him because he was "Open Card" and could not be treated until he had the cash or until he was officially assigned to our local CCO.

The patient returned once again to our office and was given antibiotics, pain pills and the reassurance that we would continue to work on a treatment plan and get back to him with options. We reached out to the state for guidance, but despite everyone's best efforts, we made little progress and one week after his initial visit, the patient took four of the prescribed pain pills and used a pair of pliers to pull his own tooth.

I don't yet know the outcome of this story. I don't know if there's a retained tooth fragment or if this was a "clean" extraction. I do know that this patient is on antibiotics to try to prevent infection. It's hard to comprehend the bravery and desperation required to pull one's own tooth. Most bad teeth remain untreated, continuing to rot and hurt, keeping patients in long-term misery. What I do know is that this points to an issue that goes beyond coordination of care.

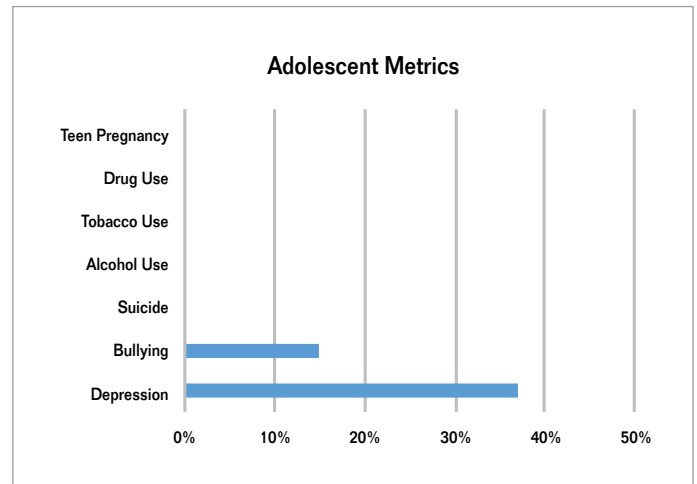
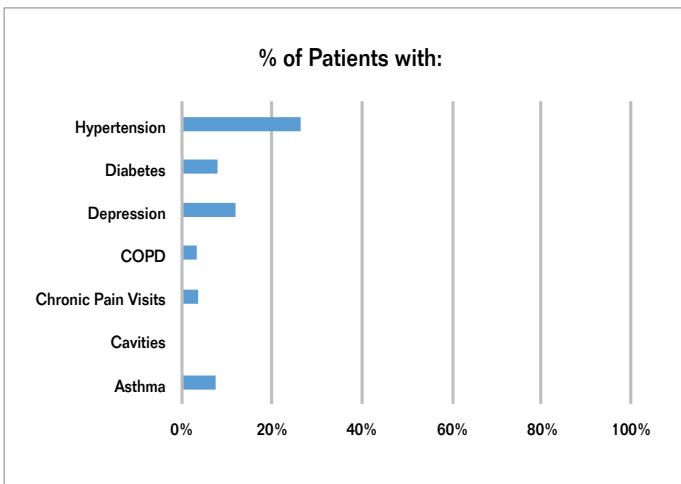
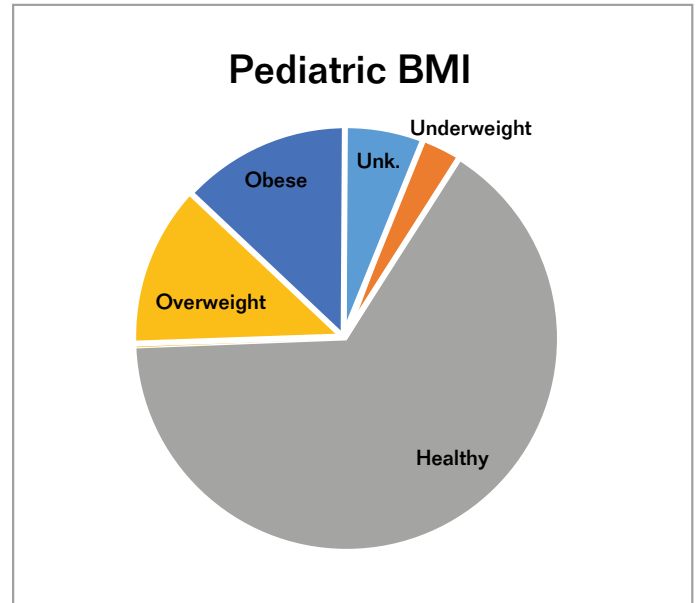
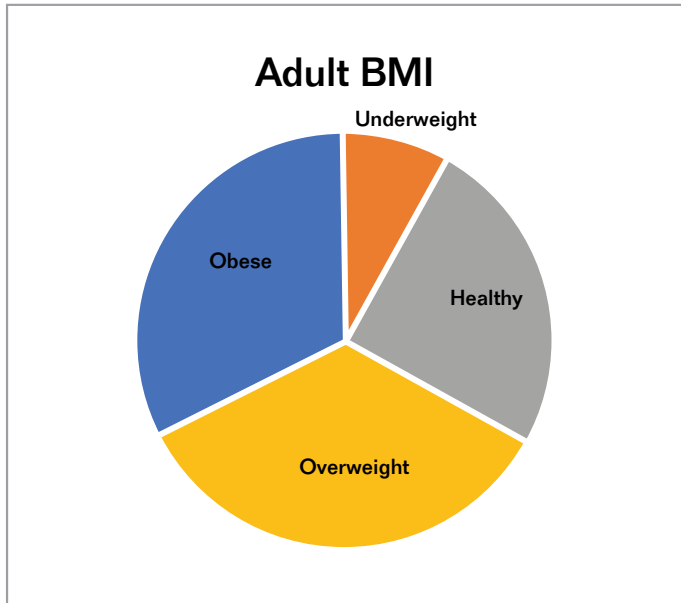
We check every patient's vital signs at each visit; these are measures of a body's basic function that help assess the general physical health of a person, give clues to possible diseases and show progress toward recovery. Recently, Wallowa County has weathered animated discussions about health and the role of health care in our community. Those of us on the front lines see need daily; the health disparities and gaps in care fester like a sore tooth that can't be ignored.

Yet, for those who don't have these daily reminders, the need is less apparent and is often outweighed by the fear of intruding into people's private lives. For this reason, a group of community partners are developing a set of vital signs that will give the residents of Wallowa County insight into the health of our community. This view into health in Wallowa County will motivate discussions of how to get the best care to more people in need.

While the data presented below are incomplete and currently only available from Winding Waters Clinic, our vision is that these data will come from providers across the spectrum, including dental and mental health care arenas. Some of the data will be available practice by practice in our EHRs, some from the insurance companies and CCOs and some data is collected and made available by the state. Freely sharing aggregated data will allow us to produce a community "scorecard." At a community rather than a clinic level, this will be powerful information in directing energy and resources to our biggest health disparities. Monitoring these vital signs over time could show in our community progress toward a system that supports health and wellness for all of Wallowa County. Our first attempt at capturing important community vital signs looks like this:

continued on page 6

Conditions Influencing Health Status



**SAVE
THESE
DATES**

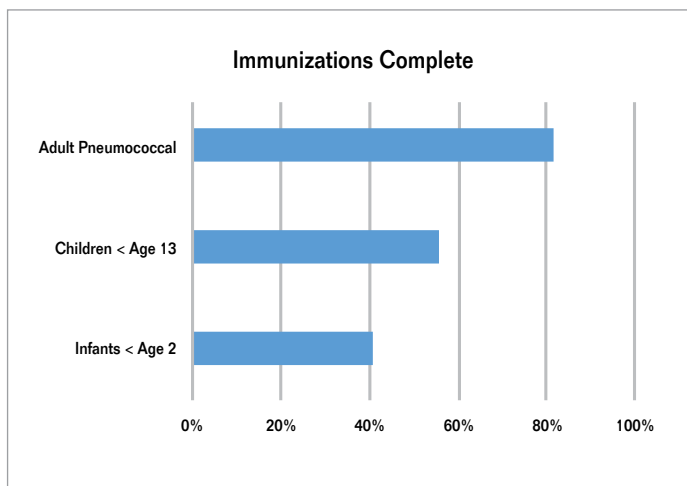
For more information, contact Kerry Gonzales
at the Oregon Academy of Family Physicians
www.oafp.org
(503) 528-0961 • Fax (503) 528-0996

69TH ANNUAL FAMILY MEDICINE WEEKEND
Scientific Assembly & Congress, March 10 – 12, 2016
OAFP/Foundation Auction, March 11
Embassy Suites Hotel, Portland

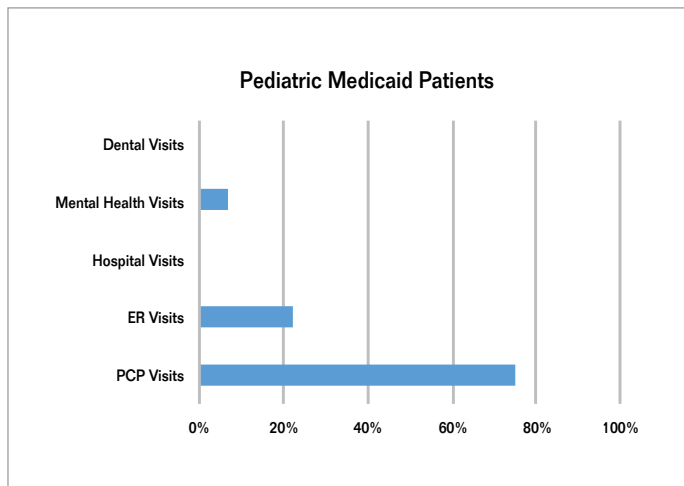
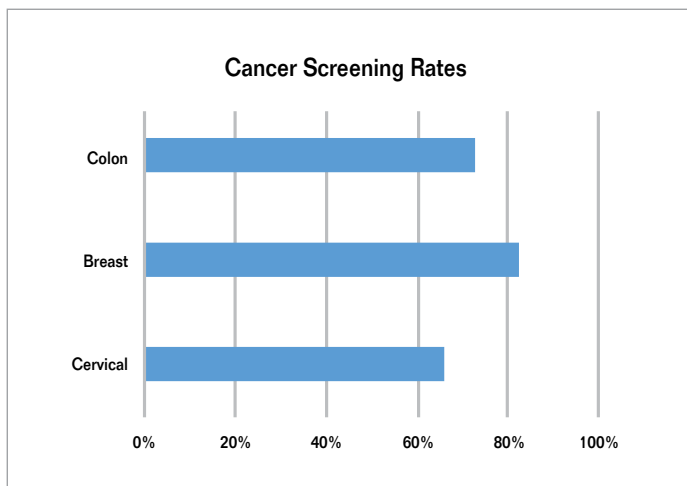
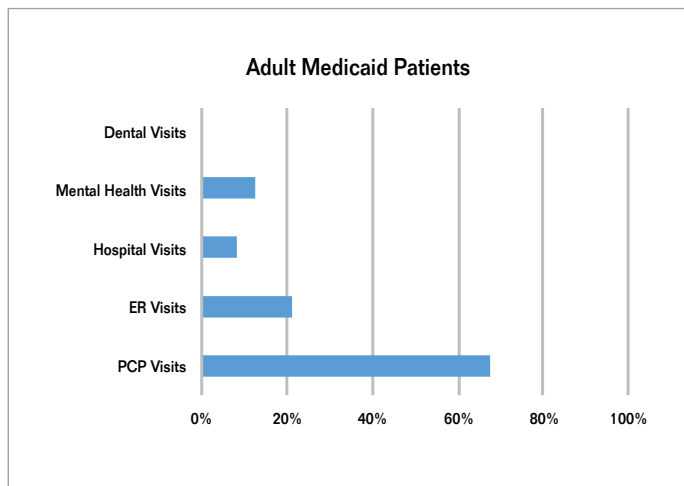
**WOMEN'S HEALTH CONFERENCE AND
ALSO REFRESHER COURSE**
April 29 - 30, 2016, Portland

Conditions Influencing Health Status

Preventative Health



Access/Utilization



**EVERYBODY
KNOWS
YOUR NAME**



WHERE HEALTH IS PRIMARY.

**Health is
Primary**

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Let's make health primary
in America. Learn more at
healthisprimary.org.

 **HealthIsPrimary**
#MakeHealthPrimary



HOLLY MILNE HOFKAMP, MD, ASSISTANT RESIDENCY DIRECTOR, OHSU FAMILY MEDICINE

Achieving the Triple Aim: OHSU Family Medicine Curriculum Innovations

In 2012, OHSU Family Medicine Residency matched our first four-year residency class as part of the Family Medicine Length of Training Pilot Project. As described in previous “From the Hill” issues, our goals with the four-year curriculum are to provide increased flexibility of training while maintaining a comprehensive scope of practice and to address new competencies required to lead health care transformation in Oregon. This July, our first class of fourth year residents began their final year of training. In this issue of “From the Hill,” I’ll highlight some of the new competencies that our residents will demonstrate upon graduation and the learning models used to achieve these competencies.

Family medicine is poised to address population health and health care transformation at multiple levels; in the clinic, in the community and at a policy level. In addition to traditional clinical competencies required to deliver comprehensive medical care in the office, new competencies in the areas of leadership, the Patient Centered Medical Home (PCMH), quality improvement, information mastery, population health, public health and behavioral health are essential to achieving the Triple Aim of better care, improved outcomes and lower costs. We set out to design a longitudinal four-year curriculum to train residents in these competencies and prepare residents to be champions of the Triple Aim.

During the first year of residency, residents gain exposure to fundamental concepts of leadership and the Patient Centered Primary Care Medical Home (PCPCMH). With these foundational building blocks, residents begin to understand their role as a physician leader in the clinic and have the tools necessary to recognize high-functioning Patient Centered Primary Care Medical Homes. More importantly, they start to gain skills in leadership and practice transformation that will enable them to convert an existing practice into a high-functioning PCPCMH upon graduation. During the second year, the longitudinal curriculum continues as residents develop skills in information mastery and quality improvement that help them to deliver evidence-based medicine at the point of care and see opportunities for improvement in their clinic. In the third year, residents continue to build leadership and change management skills by leading clinic-based teams in quality improvement efforts. This year also features a longitudinal behavioral health curriculum that focuses on incorporating family systems theory into clinical practice to enhance patient-centered care.

In the fourth and final year of residency, we take a broader view of health through the year-long Population Health and Leadership curriculum. This year builds on concepts learned in previous years and expands to cover a variety of content areas including: Social Determinants of Health, Health Equity, Community Engagement, Population Health Data Analysis, Public Health, Health Policy, Advocacy and Practice Management. This curriculum is delivered weekly throughout the entire fourth year of residency.

There are three main components of the curriculum:

1. Boot Camp

This is a series of half-day didactic sessions held in the beginning of the year to introduce foundational material in the content areas described above. Partnerships with the Portland Metro Area Public Health Departments, Portland State University College of Urban and Public Affairs and with state legislators have been created to make this learning experience rich and interactive.

2. Triple Aim Tuesdays

These are half-day sessions held throughout the year to reinforce learning centered on the above content areas by reflecting on experiences that residents have rotated through as well as delivering new didactic material.

3. Experiences

Residents rotate through experiences with various public health departments and Kaiser Permanente’s Population-Based Care Department. They also have a legislative advocacy experience with **Senator Elizabeth Steiner, MD**, a prac-

tice management experience in their home clinics and an experience looking at one important social determinant of health – access to food – through a partnership with the Oregon Food Bank.

As you can see, we've joined with a number of community partners to teach residents about the importance of breaking down silos when trying to make change and improve the health of populations. We have made connections with multiple area public health departments in response to the Institute of Medicine's 2012 call for integration of primary care and public health to promote population health. Residents participate in weekly health officer meetings, environmental health ride-alongs and both Multnomah County and Columbia County clinical experiences to gain a better understanding of public health and to identify the role

of a family physician in the integration of public health and primary care. We've also partnered with Kaiser Permanente to provide robust clinical experiences as well as experiences with their Population-Based Care and Quality Management departments to expose residents to cutting edge, integrated approaches to population management at a health system level. Another very exciting partnership that we've developed is with the Metropolitan Alliance for Common Good, an organization that is helping to teach our residents valuable community engagement skills through a formal didactic curriculum and through participation in ongoing local campaigns around issues that affect our patients and their health everyday.

As doctors, we are increasingly recognizing that we cannot create community health alone. Just last month, a Family Medicine for America's Health theme is-

sue of "Family Medicine" featured multiple articles that call for enhanced patient and community engagement in the overhaul of the health care delivery and financing systems. If we are truly to achieve the Triple Aim, we must shift our view of care from service in the office, where there's a caregiver and client relationship, to one where patients and communities are empowered to work with physicians. We've heard these messages before. We all want to act, but we need training to develop the knowledge and skills required to do so. Our four-year curriculum trains residents to think in this broader context of health and places them in a unique position to help us all think about population health in new and creative ways. I can say with certainty that our residents are energized by our new curriculum and are excited to join you upon graduation in making Oregon a healthier state.



● PUBLIC POLICY AND LEGISLATIVE AFFAIRS



SAM BARBER, OAFP LOBBYIST

DOUG BARBER, OAFP LOBBYIST

Oregon Considers a Basic Health Plan

Should Oregon create a new health plan for those who earn too much to qualify for Medicaid but still struggle to afford the cost of premiums, copays and deductibles, even with federal subsidies? That is the question a stakeholder group has wrestled with for the past three months. Their proposal, which the 2016 legislative session will consider, asks for \$45,000 to create the blueprint for a Basic Health Plan (BHP) in Oregon.

Basic Health is a section of the Affordable Care Act that gives states the option to provide an alternative form of health care coverage for low-income residents (up to 200% of federal poverty) who do not qualify for Medicaid coverage or coverage through their employer. Advocates have been pushing a Basic Health Plan (BHP) in the Oregon legislature for the past three years.

Some legal immigrants would also qualify for a BHP. Under federal law, legal immigrants must wait five years before they can qualify for Medicaid. These legal immigrants would be covered by a BHP, as would Pacific Islanders from nations that are part of a Compact of Free Association (COFA) with the United States who are also not eligible for Medicaid.

The primary target for Basic Health, however, is the working poor — those with incomes between 138% and 200% (\$15,654 - \$23,540) of the federal pov-

erty level (FPL). Currently, that population is eligible for subsidized commercial insurance through Oregon's Insurance Marketplace. Here are some examples:

- A 40-year-old non-smoker in Portland making \$16,000 can buy a silver-level health insurance plan worth \$3,132 for \$318 or \$26.50 per month, with a \$100 deductible, \$10 primary care copay, \$5 generic Rx copay and a \$750 out-of-pocket maximum. BHP advocates say that is too much. Their plan would reduce the premium to no more than \$10 per month.

- An individual making \$18,000 would pay \$720 or \$60 per month for the \$3,132 plan, once tax credits are subtracted, with an \$850 deductible, \$15 primary care copay and \$10 generic Rx copay. The BHP plan would drop the premium to \$20 per month.

Federal law says if a state offers a BHP, everyone in the 138% – 200% FPL income range must take the BHP. They are no longer eligible for subsidized commercial insurance. In Oregon, that means 46,000 would have to give up their commercial plans. For the 25,000

Federal law says if a state offers a BHP, everyone in the 138% – 200% FPL income range must take the BHP. They are no longer eligible for subsidized commercial insurance. In Oregon, that means 46,000 would have to give up their commercial plans. For the 25,000 uninsured with incomes between 138% – 200% FPL, the BHP would be their only option.

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As it stands now, in order to receive federal funding for the BHP, a state is required to have at least two options for coverage and a competitive contracting process. The BHP proposal would allow CCOs and commercial insurers to compete by offering BHP plans through the Insurance Marketplace.

To fund the plan, the Federal Government gives a state 95% of what would have been spent on tax credits in the Marketplace for this population.

With this in mind, the stakeholder group decided that the most viable option would be a hybrid marketplace. That means CCOs and commercial insurers would compete for BHP enrollees. Plans would be offered through the Insurance Marketplace.

To save money, the plan would pay Medicare rates (77% of commercial rates) to providers. The benefit package would mirror the Oregon Health Plan without adult dental. MODA said dental services are an important part of the benefit package and they would oppose a plan that leaves out adult dental coverage. Martin Taylor, Care Oregon, said, "I think we can make the rest of this budget neutral, or at least there is a chance of it. But (\$26 million for) dental is a budget buster."

Participants in the BHP would have no copays or deductibles. Premiums would start at zero for those at 138% FPL with graduated premiums for those with incomes going up to 200% FPL.

Like CCOs, Oregon Educators Benefit Board (OEBB) and the Public Employers Benefit Board (PEBB), the Basic Health Plans' premiums would be held to a 3.4% growth rate.

There are still a number of questions that may be answered by a new blueprint study:

- How much would a BHP cost the state for administration and to help cover benefits?
- Are CCOs and commercial plans willing to offer a BHP?
- Will providers accept another 75,000+ patients who pay Medicare rates?
- Given the state's track record, is it in the position to offer and administer a new insurance plan?
- If Oregon increases its minimum wage to \$13 or \$15 an hour, how many would still be eligible for a BHP?

According to the workgroup, the earliest conceivable date for implementation would be 2018. The workgroup proposes that the legislature provide \$45,000 in 2016 to develop a "blueprint" that would come back to the 2017 session for approval.



2015 AAFP Congress of Delegates

In September, a contingent of OAFP Board members travelled to Denver for the annual Congress of Delegates (COD), the AAFP's legislative and electoral body. The COD met for three days prior to the AAFP Annual Family Medicine Experience (FMX). The Oregon delegation consisted of me, co-delegate **Glenn Rodriguez, MD**, alternate delegates **Evan Saulino, MD, PhD** and **Gary Plant, MD** as well as OAFP President-elect **Dan Paulson, MD** and Executive Director **Kerry Gonzales**. In addition, **Stewart Decker, MD**, Resident Director from the Cascades East Family Medicine Residency in Klamath Falls, who served as an alternate delegate to the Resident Physician constituency, also caucused with us.

The OAFP had two resolutions before the Congress. The first asked the AAFP to produce a report documenting the most

common attributes of the patient-centered medical home and the costs involved for practices to maintain these innovations. Given the multiple variables involved, the resolution was referred to the AAFP Board of Directors. Our second resolution dealt with the high cost of generic drugs and the effect on our patients. Two other chapters brought forth a similar resolution and the COD asked the AAFP request the U.S. Congress and appropriate federal agencies "to investigate current policies that result in unreasonable pharmaceutical price increases that create barriers to accessing low-cost, generic medications." Our delegation was pleased with the disposition of our resolutions.

Other actions taken by the COD on controversial issues included the adoption of a resolution calling for the AAFP

to support legislation and chapter efforts toward ending non-medical exemptions for immunizations and one to oppose legislation that would put restrictions or diminish funding for health centers receiving Title X and Medicaid funding, apropos of the recent Planned Parenthood defunding efforts. One of the more interesting discussions to me was around the public health implications of discriminatory policing and excessive force on minority populations. Serving on the reference committee hearing this testimony, I found it chilling to hear AAFP members describe their own experiences being racially profiled.

Other neuralgic issues for delegates included the hassles around PAs, EHRs, meaningful use and maintenance of certification. Regarding the latter, testimony before the reference committee was uniform in



Left to right: Mike Grady, MD, Dan Paulson, MD, Kerry Gonzales, Evan Saulino, MD, PhD, Glenn Rodriguez, MD and Gary Plant, MD attend the 2015 AAFP Congress of Delegates.

support of efforts to streamline and simplify the MOC process. The resolution was referred to the Board. The complete list of actions taken by the congress can be viewed at the AAFP 2015 Congress of Delegates website -- <http://www.aafp.org/about/governance/congress-delegates/2015.html>.

In electoral business, the COD installed Wanda Filer, MD, of Pennsylvania, as AAFP President and elected John Meigs, Jr., MD, of Alabama, as President-elect. New board members elected were John Bender, MD, from Colorado; Carl Olden, MD, from Washington and Gary LeRoy, MD, from Ohio. Javette Orgain, MD, from Illinois, moved up from Vice-Speaker to Speaker and Alan Schwartzstein, MD, from Wisconsin, was elected Vice-Speaker.

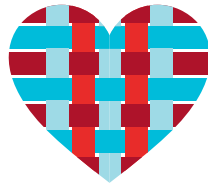
The COD is a stimulating, if at times, hectic three days, but it is always a pleasure interacting with family physicians from around the country. OAFP members who plan to attend the FMX might consider



Wendy Warren, MD, Roberta Garvey, PA-C and Holly Montjoy, MD attend the OAFP Reception in Denver.

coming a few days early and observing the COD "in action." All AAFP members may attend and offer testimony before reference committees. Also those of us who arrived early to the meeting were able to attend the first-ever OAFP reception hosted for mem-

bers attending the FMX. Close to 40 members joined us for refreshments and hors d'oeuvres. It was a great way to get to know fellow Oregonians prior to the conference and many people expressed an interest in doing this event again. See you in Orlando!



HEALTHY HEARTS NORTHWEST

Improving practice together

Are you ready for

- Better heart health for your patients?
- Hands-on support and resources to help your practice with quality improvement?
 - New payment models based on quality measures, not volume?

What is Healthy Hearts Northwest (H2N)?

Healthy Hearts Northwest is a three-year project funded by the Agency for Healthcare Research and Quality (AHRQ) that helps primary care practices improve their patients' cardiovascular health while also building their capacity for quality improvement (QI). The Oregon Rural Practice-based Research Network (ORPRN) at the Oregon Health & Science University will select 130 small-and medium-sized practices throughout Oregon to participate in H2N. ORPRN seeks to help these practices build their QI capabilities and infrastructure and to transform practices into learning organizations that engage in sustained, continuous, systematic QI. The practices will learn practical strategies that can strengthen their organizations and restore the joy to primary care. The initial focus of H2N will be implementing Patient-Centered Outcomes Research (PCOR) to improve heart health, as described within

the Million Hearts campaign related to **ABCS**: **A**spirin, **B**lood Pressure, **C**holesterol and **S**moking cessation.

Four reasons why your practice will benefit from participation in H2N:

1. Better outcomes for your patients.

H2N is an opportunity to improve the cardiovascular health of your patients and your community. Heart disease is the leading cause of death in men and women in the United States. Risk factors for cardiovascular disease such as hypertension, hypercholesterolemia and smoking remain poorly controlled.

- One-third of U.S. adults have hypertension, yet only half of those individuals have their blood pressure controlled.
- One-third of adults have hypercholesterolemia, among which two-thirds are inadequately treated.
- Twenty percent of adults in America continue to smoke.

2. Better outcomes for your practice.

Improved knowledge, along with streamlined internal processes, better data access and seamless electronic health record (EHR) coordination can have a positive outcome on staff satisfaction and morale. Team-based QI leads to measurable improvement allowing your practice to concentrate on what's always been most important: providing the highest quality of care to every patient.

3. Better outcomes for you.

H2N is designed to break the cycle of limited bandwidth for change, increasing your capacity for practice improvement. During the study, ORPRN's Practice Enhancement Research Coordinator (PERC) will provide an at-the-elbow presence to apply the latest evidence, use data for improvement, encourage greater patient adherence and benefit from timely staff training.

The project and the presence of the PERC, our version of your personal health extension agent, will provide the practice resources and enable you to focus on what matters most—making people well. Physicians who participate in H2N and are Board Certified in Family Medicine and Internal Medicine will receive Maintenance of Certification (MOC) credit.

4. Better outcomes for primary care.

The smaller primary care practice is at the center of our nation's health care system; it is where most people go to get care. With Evidence-NOW and Healthy Hearts Northwest, more primary care providers will be equipped with the latest medical evidence and knowledge to best apply it.

What are primary care leaders in Oregon saying about Healthy Hearts Northwest?

"We appreciate being considered for the H2N project and we are honored to accept this invitation! We know that this is an important step in helping us take better care of our patients and we look forward to the opportunity."

Jane Conley, Practice Administrator
Springfield Family Physicians

"This is an excellent opportunity to improve health outcomes for our county."

Elizabeth Powers, MD
Winding Waters Clinic, P.C.

To join or request more information, go to the H2N website: www.healthy-heartsnw.org. Contact Caitlin Dickinson, ORPRN H2N Project Manager, or Lyle J. (L.J.) Fagnan.

OPAL-K: HELP IS JUST A PHONE CALL AWAY



The Oregon Psychiatric Access Line about Kids (OPAL-K) is a telephone consult service that allows anyone who provides primary care for children and teens to call and consult with a child psychiatrist.

Since opening the phone lines in June 2014, OPAL-K has taken 630 calls with a 99% satisfaction rate. OPAL-K is a collaborative effort between OHSU's Division of Child and Adolescent Psychiatry, the Oregon Pediatric Society (OPS) and the Oregon Counsel of Child and Adolescent Psychiatry (OCCAP). The program is funded by the Oregon Health Authority.

The free, same-day consultation service is available from 9 am – 5 pm, Monday through Friday. No question is too big or too small. Written Care Guides for common mental health concerns are also available on the OPAL-K website.

In order to eliminate delays when you call for advice and get immediate access to consulting psychiatrists, you can register for this service by calling 503-346-1000 or email OPAL-K.

FOUNDATION NEWS



LYNN ESTUESTA,
OAFP FOUNDATION EXECUTIVE DIRECTOR

The Foundation board has been strategizing about how best to meet the needs of our members. To that end, we have created a new logo, developed a mission statement and surveyed our Foundation donors to find out who gives, why they give and the types of programs and opportunities they are interested in seeing sponsored in the future.

NEW LOGO

Many members consider the Foundation and the Academy to be one in the same; in fact, they are not. The Foundation is the charitable branch of the Academy, supporting the educational initiatives of family medicine and the goals of the OAFP in order to improve the health of all Oregonians.

While developing a new logo for the OAFP Foundation, we worked together with the OAFP and the AAFP to create a distinctive, yet complementary, logo. Whenever you see the Foundation logo as shown on the left, you can be sure that we are promoting programs and opportunities to advance the future of family medicine.



*Investing in future family physicians
to serve our Oregon communities.*



OREGON ACADEMY OF
FAMILY PHYSICIANS

MAKING HEALTH PRIMARY

MISSION STATEMENT

Over the past twenty years, the OAFP Foundation has actively supported medical students exploring rural family practice, medical students matching in Family Medicine Residency Programs and many family medicine student interest group activities. We've provided anti-tobacco education in elementary schools and local and regional ethics lectures.

Now, the OAFP/Foundation has developed a mission statement of its' own: *Investing in future family physicians to serve our Oregon communities*. Proceeds will go directly to mentorship, networking, education and scholarship programs and activities. Our goal is to raise funds from a variety of sources including generous contributions from our members, outside corporations and grants,

and expand upon new opportunities for the next generation of family physicians – both medical students and Family Medicine Residents.

DONOR SURVEY RESULTS

In order to determine how our current donors perceive the Foundation, gain insight on donor demographics and find out why donors give, we surveyed 100+ donors in August. The response rate was 23%.

Here's what our donors had to say:

- 44% of those answering the survey were extremely/very familiar with the programs the OAFP/F currently funds;
- 44% believe the organization does an extremely/very good job of explaining how the donations are spent;
- 44% believe their donation makes a great deal/a lot of impact;
- 81% are extremely likely to contribute again; and
- 96% have donated through the annual auction.

When querying the demographics of our donors, 42% practice in an urban setting; 31% practice in an employer-owned setting; and 42% have been in practice for over 10 years.

When asked why they give, the majority of respondents answered that they wanted to support student education and rural work experiences. In addition to programs already backed by the Foundation, donors also suggested including scholarships for Family Medicine Residents to the funding mix.

We wish to thank all of you for your continued support of the future of Oregon family medicine. Your donations do make a difference. To contribute to the OAFP/Foundation, you can send a check to 1717 42nd Ave. Ste. 2103, Portland, OR 97213 or donate online at <http://oafp.org/oafp-foundation/>.

See page 26 for details on the Foundation's biggest fundraiser of the year – the auction – taking place March 11, 2016!

2015 – 2016 OAFP Foundation Board Members

Correction from the Fall 2015 issue of the Family Physicians of Oregon:

Kathryn Kolonic, DO

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



This holiday season, and throughout the year, many of us take time to shop for friends, co-workers and family members, and many of us do so by shopping online with Amazon.



AmazonSmile is a simple and automatic way for you to support the OAFP/Foundation every time you shop, at no cost to you. When you shop at smile.amazon.com, you'll find the same prices, products and services as Amazon.com, with the added bonus that Amazon will donate 0.5% of the purchase price to us!

If you already have an Amazon account, you'll just need to go to smile.amazon.com and type in "Oregon Academy of Family Physicians Foundation" as your chosen charitable organization. After that, always log in on smile.amazon.com and Amazon will donate 0.5% of your eligible AmazonSmile purchases.

Tell your family and friends about this too – the more the merrier!

EARN CME WHILE YOU SUPPORT THE OAFP

Now you can improve patient care and bridge your knowledge gaps with AAFP Self-Study CME at a time and place that's convenient for you and help the OAFP earn additional income through the AAFP Self-Study CME Revenue Share Program.

Use AAFP self-study packages to enhance your expertise and expand your knowledge on 10 common family medicine topics including Emergency and Urgent Care, Chronic Conditions, Internal Medicine and Infant, Child and Adolescent Medicine, among others. Each self-study package features recorded audio and video presentations from current live clinical courses. Each interactive self-study package takes from 20 – 45 hours to complete (dependent on the length of time learners may want to review lectures and to complete post-tests) and include:



- 18 – 43 lectures, 30 – 60 minutes in length
- Opportunities to report CME and evaluate after each lecture
- Interactive interface with QuestionPause™ to briefly stop the presentations
- 200+ page full-color syllabus
- Online post-tests

When you purchase an AAFP clinical self-study package in one of two formats – USB flash drive or online access – a portion of the price of each package will go directly to the OAFP. At checkout, simply add **4MYCHAPTER** in the source code box. For complete package details and pricing go to http://www.aafp.org/cme/offer/clinical-learning-packages.html?cmpid=ss15_ed_cme_self_ch_ss.

STUDENTS SPEAK OUT!

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

All Family Medicine Interest Group events commenced in September with our annual “Meet the Docs” dinner. We were so appreciative to have the presence of several of our university and community Family Medicine physicians. Each of our participating physicians shared their unique and individual pathways into medicine, the qualities that drew them to choose Family Medicine as well as their current interests and scopes of practice. We enjoy having this event every fall to inspire the new and incoming FMIG students and showcase the variety and exciting areas that make up the field of Family Medicine. We want to give a special thanks to the following physicians for sharing: **Jessica Burness**, **Jessie Flynn**, **Tanya Page**, **Sean Robinson**, **Jonathan Vinson** and Joe Skariah.

Family Medicine Interest Group workshops have been in full swing. We kicked off September with the beginning of our suturing series with Joe Skariah, MD. We



Fall suturing series workshop with Dr. Skariah

have now had two beginner sessions and are excited for our upcoming advanced suturing with hand-tie workshop in late November. We were also fortunate to host a circumcision workshop for interested FMIG students, led by one of our own

dedicated faculty leaders, **Ben Schneider, MD**. Finally, **Jim Chesnutt, MD** headed a concussion workshop for students to expand upon their fall neurology courses.

Earlier this October, a group of FMIG students visited the family farm of Lyn Jacobs, MD, a family physician at the Virginia Garcia Memorial Health Center in Cornelius. Dr. Jacobs came to speak with students about health care for migrant farm workers several weeks earlier and graciously invited us to her home so we could learn even more from her. During our visit, we helped Dr. Jacobs and her husband harvest squash, tomatillos, zucchini, peppers and herbs for the weekly CSA. We also had the opportunity to chat with Dr. Jacobs about her experience as a family physician and farmer and got to pick her brain on meaningful care, food as medicine and work-life balance. Harvesting and relaxing outdoors was a great way to recuperate from a busy academic week and get



Fall FMIG “Meet the Docs Dinner”



Fall circumcision workshop led by Dr. Schneider

to know Dr. Jacobs and each other better outside of the classroom. Playing with puppies was an added bonus!

This fall, FMIG also dove into the issue of the financial aspect of primary care. This November we put on our annual panel discussion called “Can I Afford to Go into Primary Care?” The panel was comprised of two physicians, **Sonia Sosa, MD** and

Jinnell Lewis, MD representing rural and urban underserved practices and two professional recruiters. The overwhelming answer is that between loan repayment programs and the increased market demand for family physicians driving up salaries, it is indeed affordable to go into primary care. It was exciting for first and second year students to get a real world, market-based perspective as they contemplate their future specialty.

Also in November, FMIG sponsored two additional informative events for students. The first was an inspirational lunch-time lecture centered on “Family Medicine for America’s Health” delivered by department chair **John Saultz, MD**. The second was an evening session on “Residency Interviewing” moderated by **Ben Schneider, MD** and included faculty members, residents and **Roger Garvin, MD**, director of OHSU’s Family Medicine Residency Program, as panelists.

Though it seems like it was just yesterday that our current cohort of FMIG student leaders was transitioned by our awesome predecessors, it is already time to

begin the process of selecting new leaders to continue the FMIG tradition at OHSU. We are thankful to everyone, including student members, faculty, our advisers and the OAFP Foundation for making everything we were able to do possible! We may be heading out to begin our clinical rotations soon, but we look forward to continuing to stay involved in FMIG throughout our years in medical school.

2015-2016 FMIG Leaders:

Callia Elkhal
Claire Groth
Mallori Jirikovic
Alex Polston
Julia Ruby

2015-2016 FMIG Advisors:

Peggy O’Neill
Ryan Palmer, EdD
Benjamin Schneider, MD

2015-2016 FMIG Support:

Genevieve Hammond



FMIG students with Dr. Jacobs at her farm



MEMBERS ON A MISSION



“Family medicine is the only specialty that allows a physician to work in the developing world in conjunction with medical research, direct medical care in very austere environments and understand the needs to assess and develop health care strategies for communities.”

Paul Neumann, MD has practiced family medicine for over twelve years at Santiam Medical Associates in Stayton. For the past five years of his professional life, Dr. Neumann has balanced his community practice with his international work on relief teams, providing medical care and expertise in countries dealing with humanitarian and natural disasters.

His worn passport carries the memories of those who have touched him throughout the world:

- **Nepal** (5-2015) “First-in” team assessed needs for capacity building and direct medical support following quake;
- **Cambodia** (2-2015) Provided direct care for acute and chronic disease;
- **Uganda** (6-2014) Instructed local clinicians on WHO IMCI program and assessed implementation;
- **Uganda** (1-2/2014) Delivered direct care to South Sudanese refugees and provided education for local staff;
- **Lebanon** (5-6/2013) Surveyed Syrian refugee tented settlements (>3,000 persons), coordinated medical resources, provided direct patient care for refugees and coordinated with international aid organizations;
- **Niger** (2/2013) Offered acute medical care for villagers near Mali border;

- **Uganda** (7-8/2012) Coordinated and provided acute and chronic care for Congolese refugees located in Uganda tented settlement (>20,000 persons);
- **Somalia and Dadaab, Kenya** (2-3/2012) Responsible for acute and chronic care to displaced population and host communities;
- **Haiti** (12/2010) Supervised cholera treatment center during cholera epidemic and provided emergency medical services for refugee settlement (>2,000 people);
- **Haiti** (10/2010) Delivered acute and chronic disease management;
- **Haiti** (2/2010) Offered acute care for victims of earthquake disaster;
- **Mexico** Provided acute and chronic patient care;
- **Costa Rica** Provided emergency department services;
- **Guatemala** Co-directed community improvement project; and
- **England** Provided mental health social skills rehabilitation.

From the sheer number of missions that Dr. Neumann has participated in, you may wonder why he began this work and what draws him back again and again. Neumann told us that, “Working as a doctor overseas has always been a calling. I’m lucky I

didn’t have to discover or decide to do what I do, I’ve stepped this pathway with intention my entire life. I chose family medicine because of the versatility of this specialty for international service. I can develop a vaccine program, sew up a wound, stabilize a critically ill infant and manage chronic diseases. This is all because of my family medicine training. Family medicine is the only specialty that allows a physician to work in the developing world in conjunction with medical research, direct medical care in very austere environments and understand the needs to assess and develop health care strategies for communities.” He believes his motivation to do medical relief work is the same as most doctors -- service and caring. “Treating and caring for individuals, communities and families that have nowhere else to turn is extremely satisfying work. I’m blessed to do it.”

As you can imagine, there are no “typical” days in the field when you are responding to natural and manmade disasters in foreign lands, but here are a few entries from Dr. Neumann’s blog posts while in the Beqaa Valley in Lebanon in May through June of 2013 and in Kisoro, Uganda in July and August of 2012.

continued on page 28

Attend the Most Important Meeting for Family Physicians in 2016!

2016 ANNUAL FAMILY MEDICINE WEEKEND & ORPRN CONVOCATION TO BE HELD IN PORTLAND

Your Place to LEARN, CONNECT & REJUVENATE



OAFP's 69th Annual Spring CME Weekend, the largest conference of the year, will be held March 10-12, 2016 at the Embassy Suites Hotel in downtown Portland. The OAFP and the Oregon Rural Practice-based Research Network (ORPRN) will team up once again to provide evidence-based con-

tinuing medical education, health reform updates and practice enhancement strategies coupled with all-important oppor-

tunities for fellowship and fun with colleagues and family members.

On Thursday, March 10, ORPRN will open the meeting with lectures focused on health disparities. Information on efforts to improve community health will be explored. On Friday and Saturday, March 11-12, participants can choose from a variety of seminars, break out sessions and hands-on workshops featuring a wide-range of topics, including timely lectures on social determinants of health, ACES, trauma-informed care, POLST, motivational interviewing and adolescent well visits.

What else can you look forward to at next year's meeting?

- Keynote Speaker, Surgeon General, Vivek Murthy, MD (invited);
- Guest Speaker, AAFP President, Wanda Filer, MD;
- The first 150 registrants will receive a free "Health is Primary" umbrella sponsored by FamilyCare. A necessity for our "umbrella brigade" during Friday's lunch hour where we will walk to the iconic "Umbrella Man" statue in Pioneer Courthouse Square;
- Friday lunch at one of Portland's legendary food carts;
- The Annual Department of Family Medicine Statewide Faculty Meeting;
- Bravo Youth Orchestra performance and kickoff reception;
- A legislative update that will provide the latest developments regarding Oregon's health reform efforts moderated by Senator Elizabeth Steiner

Hayward, MD and OAFP lobbyists, Doug Barber and Sam Barber;

- The Friday evening OAFP Foundation Auction & Happy Hour (*more information on page 26*);
- The Congress of Members gathering that will enable members to guide the focus and direction of the Academy;
- The Saturday Celebration Luncheon where the 2016 Oregon Family Doctor of the Year is announced; and
- The Self-Assessment Module (SAM) Study Hall. In just a few short hours, you can take and pass both the written and clinical portions of the SAM and receive 12 hours of prescribed CME.

As you can see, there is something for everyone at the 69th Annual CME Meeting. Stay tuned for complete details at www.oafp.org. Put this event on your calendar today!



Oregon Health Policy Board Visits Winding Waters Clinic in Enterprise



OHA Board Members and Winding Waters Clinic Staff

Twice a year the Oregon Health Policy Board (OHPB) travels outside the Portland-metro area to hold their monthly meetings. Prompted by Oregon Health Authority Director Lynne Saxton's recent prioritization of rural health issues (e.g. access, provider recruitment and behavioral health integration), and coupled with the fact that Winding Waters Clinic was the first in the state to achieve a PCPCH 3-STAR designation, the OHPB chose to make their first-ever visit to Eastern Oregon.

On Sunday, October 4, members of the OHPB met with **Liz Powers, MD** and other Winding Waters Clinic staff, patients

and community members to learn about some of the innovative programs and partnerships they have implemented to help improve health outcomes and health education in Wallowa County. Following the discussion, there was a tour of the clinic with the staff (including front desk, medical assistants, care team members, RN care managers and behavioral health coaches), each sharing their role in the team-based care model. According to Powers, "We ended the day with a brief presentation highlighting the process of PCPCH transformation, along with the data we have gathered regarding improved access and improved clinical quality measures as a

result of our transformation. I think the OHPB members were impressed!"

Through this visit, members of the OHPB and OHA leadership have a newfound understanding of how a PCPCH functions, how this particular frontier clinic provides the highest-level of team-based comprehensive care and what challenges rural care providers face (e.g. payment barriers, licensing and credentialing, and information sharing, to name a few). This visit has already helped to improve channels of communication between OHA, OHPB and rural Oregon with the goal of continued transformation of the health system and improved opportunities for partnership going forward.



INVESTING IN THE FUTURE: THE OAFP/FOUNDATION HAS YOU COVERED!

Annual Foundation Auction & Happy Hour – March 11, 2016

Join us on Friday, March 11 at the Portland Embassy Suites Downtown – auction items will be on display throughout the day – making it easy for you to bid, and to bid often. At the end of day, you're invited back into the ballroom for happy hour. It's your chance to chat with old colleagues and new, while investing in the future of family medicine. The OAFP/Foundation's directive is to invest in future family physicians who serve our Oregon communities with proceeds from the auction helping us expand and develop programs for the next generation of family physicians.

If you would like to contribute to the auction in cash, goods or services, contact the OAFP/Foundation. Or you can donate by mail or online through PayPal – <http://oafp.org/oafp-foundation/>. If you'd like to attend the auction, registration will be online soon at <http://oafp.org/events-cme/>.

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May 25, 2013

Arrival in Beqaa Valley in Lebanon

The plump pink rose startles me. It is settled in a nest of thorns piled on the crumbling stone wall of an abandoned garden. Sunshine heats the smooth petals and gives the air a perfume of candied angels. I am breathing deeply as I hike up the steep path leading to our apartment. Blue skies are overhead and the smooth contours of snow-streaked mountains surround me. Near the path, a stunted peach tree exposes her small and plentiful peaches, ripe and moist under windblown leaves.

I am thinking of the complex tangle of religion, lives, land and history that surround me and create the simmering and explosive conflicts in this region. Really more than I want to think about as my legs ache pleasantly and my tongue still tastes the bright and earthy seasonings of tonight's meal.

Fifteen miles from Beqaa Valley, where we are housed, lays Syria. Within the amount of time it takes one to watch a movie, we could travel to sprawling Roman ruins, downtown Beirut, orderly vineyards, orchards of olive trees and dozens of camps housing Syrian refugee families seeking their safety in Lebanon. It is the refugees we are here to serve.

The camps here are fragmented, without an orderly arrangement of tents or resources. It isn't really known how many camps there are or how many Syrian refugee families live in these camps. I reviewed maps and data prior to arrival, but after witnessing the helter-skelter arrangements of impromptu camps, I suspect the information appears to be estimates at best. Tents and shelters are encountered in empty lots, near farm fields and adjacent to vacant buildings. These camps may shelter a few families or hundreds. We will be providing mobile primary health services and assessing for other medical needs.

May 29, 2013

Faces of Syrian Children

This morning began with Labneh (thick strained yogurt) and dark bread with fig jam. The open window allowed in sounds of the town of Zahle. Church bells across the valley compete with the chop of several northbound helicopters overhead. A warm morning breeze pushed lazily across our plastic breakfast table. After dishes are washed, we pack into our van like so many sardines and bounce through busy traffic to our first camp. Most days, we serve two separate camps and try to follow up on prior patients in other camps if possible. Today was no different.

We have been seeing measles and chicken pox and some of the children are quite ill. I have not encountered any refugee child that has been vaccinated since leaving Syria. Communicable diseases such as measles can cause severe illness or death in healthy children and so vaccines are very important. The challenge with some vaccines such as measles is that unless 'herd immunity' (most people vaccinated) is acquired by an extensive and organized program, the vaccinations may not be as effective and efforts at vaccination

would be in vain. We are working with other organizations to begin coordinating efforts towards vaccinations which I hope will happen if adequate funding and administration can be arranged.

In Lebanon there is an extensive health care system available to the Lebanese and the Syrian refugees. The challenge for the Syrian refugees is payment for medical services. There are programs to help some of the refugees, but not all. We are providing primary care services but have to refer patients with advanced needs. This has been disheartening in some situations when a patient has an injury or illness but is not treating it because of cost. Our team has treated a toddler that had a leg fracture that was treated by the parents by taping the legs together. The bone has healed improperly and this child has never been able to walk. Correcting the fracture would be a simple orthopedic procedure, however due to finances, the child remains non-ambulatory.

June 1, 2013

Vulnerable Today



A Syrian refugee child with Down syndrome and heart disease is nearly out of his medicine.

This child understands the warmth and security of his mother's arms. He may not realize his body is not the same as other children. He was blessed with life but we know he carries an extra chromosome that has caused a weakened and thin heart that one day soon may fibrillate and cease beating. On that day, the child will cool in his mother's warm embrace.

Imagine for a moment the despair of a mother who cannot protect a child from his own body. Now add to that the panic of trying to protect that child from your own government.

We see Syrian refugee children every day that have started treatment in Syria and then abruptly lost their source of medical care after fleeing conflict at home. These little bodies and souls are especially vulnerable today. Local clinics and hospitals are already at capacity from the Lebanese population and the influx of Syrians and do not have the resources to care for the ballooning Syrian population.

July 19, 2013

Five kilometers as the crow flies

A day of service is over as I sit on the narrow concrete patio in front of my hotel room in Kisoro, Uganda.

Five kilometers away, over ten thousand souls are wandering behind a wooden fence. They are in a transit center after fleeing from their homes. A transit center is not a place to stay. It is limbo; not heaven and certainly closer to hell. You don't get to stay there. You are registered and moved somewhere else eventually. People mill about with swarms of children underfoot. An occasional goat or chicken protests and then moves loudly out of the way. The ground is rocky with sharp volcanic stone and few patches of trampled grass.

The air is perfumed with feces, wood smoke and urine.

During the day, we treat little bodies dry and depleted from days of diarrhea. Bodies with malnutrition, bullet holes and infections with viruses, bacteria and worms of unimaginable variety. Swollen bellies under thin arms and yellow eyes. Infants with limbs swollen with infection.

The transit center is a coarse mix of laughing children, broken bodies, broken souls and broken lives. Two meals of sorghum porridge a day and a crowded tent to share. A miserable place but better than where these Congolese are coming from. Daily, the families arrive. Over 16,000 refugees have been registered so far.

July 29, 2012 Stubborn Rocks



Here you open your eyes in any direction and you will see evidence of cataclysmic violence from below. Cinder cones eons ago exploded upward, now settled into characteristic triangle mountains pointing accusingly to the above. Within the earth, sharp volcanic rocks punctuate the poor and depleted

soil. These are the young stones of molten lava that cooled quickly as thrown from new mountains -- jagged, sharp and quick to tear flesh off fingers. To clear a small plot of land, angular rocks are argued away from the soil by hand and puzzled into squat and sturdy fences or heaped into smaller mounds the size of a funeral pyre. The earth here is dense and does not nurture her inhabitants easily.

My patient enters the exam room. He is new to the Nyakabande Transit Center and afraid of returning to his home in the Congo. He

does not strike me as a man who would fear anything. He is a big man, muscled firmly and strong of bone and spirit. Inside, I sense a break – his smile looks more like a crack giving entry into a place of tears than an opening for joy to escape from. His eyes seem alive but heavy, like a beast struggling with a fatal wound. He is dressed well with clean and fitted clothing, somewhat unusual in the patients I am seeing. I do not ask of his tailoring, but of his needs.

He complains of an ache in his back, present for three days. No clues are given to suspect the source is dangerous; no waking dampened with sweat, full cooperation of the leg muscles and nerves, no complaints when urine passes and no weight loss.

I question him on how he caused the injury to his back. He explains that his brother's daughter died three days ago and he volunteered to dig her grave. He explains he had to spend half a day pulling rock from the earth to make room for her little body. This is a brother's work and he completed his duty, placing heavy stones over the little body until her grave was filled. A terrible task leaves him with a deep persistent ache in his spine. I did not ask if his heart aches when he asks me to ease his pain.

Sometimes the body reflects injuries of the soul. These are the hurts that are dark and ethereal. These are the places human hands cannot touch to heal. This is the sad damage within a person that requires a greater power to bring back to wholeness and back to light. I am reminded of this daily when treating people damaged by the slow wounds of poverty and the sudden trauma of conflict and disaster. Here, grief and loss are settled into the very essence of being, like the dangerous rocks stubborn in soft soil.

Please continue your prayers for this man, his family, and all the others here.

Whether working in Lebanon, Syria, Somalia or Uganda, Dr. Neumann finds many of the challenges remain the same. Working with limited resources and making life and death decisions due to this lack are choices families in these crisis situations must make; something that is unimaginable to most American families. On the other hand, the rewards are immense. "I get to practice medicine as a doctor for patients that need the care and are appreciative. The intellectual, emotional, spiritual and physical challenges only deepen the feeling of satisfaction at the end of the day" says Neumann.

With the vast amount of experience Dr. Neumann has attained over the years working as a medical volunteer in complex humanitarian and natural disaster situations, he has some advice for those who

may be interested in participating in relief work. First, preparation and experience are critical when deciding to get involved in mission work. Neumann suggested taking a course on tropical medicine (he received his Diploma of Tropical Medicine and Hygiene from the London School of Hygiene and Tropical Medicine, East Africa) and honing up on diagnostic skills. Other helpful recommendations included gaining experience with travel to non-disaster settings; reflecting on why you want to get involved with this work (do you want to be a tourist or are you interested in being a part of longitudinal projects that make a difference?); reviewing different organizations in this line of work (do they have a long record in the country you are going to or are they providing acute care in different

settings without any plans for continuity?); understanding what other resources are in place for additional patient care within the country (you will encounter patients that need life-saving surgery or emergency care and you need to know what to do in these situations); knowing your own limits physically, emotionally and financially; and always staying as safe as you can and having a plan for getting home.

Thank you Dr. Neumann for sharing your medical expertise at home and abroad!

Many of our members do critical lifesaving work outside of their community clinics, both in this country and abroad. Please send us an email if you are interested in sharing your thoughts on a recent trip or mission you have participated in.

MEMBERS IN THE NEWS

HONORS, AWARDS AND ACCOLADES



DR. DEVOE

Jen DeVoe, MD, DPhil, was recently welcomed as the 2015-2016 president of the North American Primary Care Research Group (NAPCRG) Board of Directors during their 43rd annual meeting held last month. NAPCRG is the world's largest organization devoted to research in family medicine, primary care and related fields,

and is committed to presenting new knowledge to guide improvement, redesign and transformation of primary care.

INTERESTING BUSINESS WE SHOULD ALL KNOW



Joyce Hollander-Rodriguez, MD (far right)

Last month, during a presentation at Cascades East Family Medicine, the OHSU Rural Campus Academic Headquarters was officially launched. Klamath Falls is one of two rural campus pilot

sites in Oregon, along with Coos Bay, to promote a collaborative learning model which promotes a better understanding of rural health needs and provides further opportunities for recruiting physicians, pharmacists, dentists and other health care positions in rural Oregon.

"This is how we develop our future workforce," said **Joyce Hollander-Rodriguez, MD**, who was appointed as regional associate dean of the Klamath Falls rural campus in July. "The more we expose learners (students) in their professional learning to rural areas, the more likely they are to return to them." Hollander-Rodriguez will oversee students enrolled in the rural campus; six students began the rural health care program this fall and six to eight students will likely participate in the program each year.

Cascades East Family Medicine will serve as a place for the students in the Klamath Falls program to meet as a group, but they will conduct their clinical rotations at a variety of sites around the Klamath Basin. According to Hollander-Rodriguez, the learners will follow much of the same clinical curriculum followed at OHSU, with a new approach to bring these interprofessionals together and have them do a community project and discuss issues around rural health.



DR. SAULTZ

After 17 years as chair of the OHSU Department of Family Medicine, **John Saultz, MD**, will step down at the end of the academic year (June, 2016). Dr. Saultz will remain on the OHSU School of Medicine faculty as professor of family medicine and will continue to teach, provide patient care and conduct research.

According to Saultz, "Over the next few months, I will be sorting out my future plans. I do not intend to retire, but have decided to make this change because I am ready for something new at this point in my life. I have been planning this transition for two years, and the department is in a strong position across all our mission areas."

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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