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Policy | Community | Practice

A publication of the Oregon Medical Association
Fall 2016

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# MEDICINE in Oregon

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Fall 2016

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**OMA Editorial Staff**
Aaron Ragan-Fore, Editor
Carla McKelvey, MD
Shannon Anderson, MPAS, PA-C
Joy Conklin
Mark Bonanno, JD, MPH

**Submissions**
We welcome and encourage our members to contribute to Medicine in Oregon.

For more information, contact Aaron Ragan-Fore
(503) 619-8125
*editorial@theOMA.org*

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fax (503) 619-0609
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*OMA@theOMA.org*

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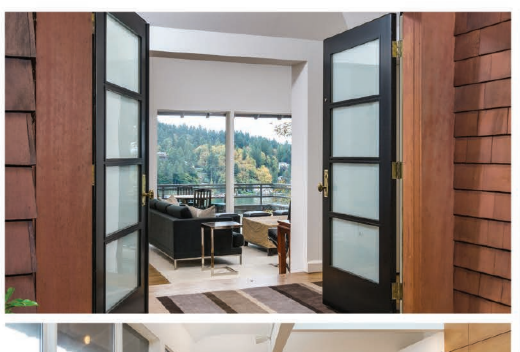

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President
Oregon Medical Association
robert.orfaly@theOMA.org

Providers and policymakers have talked for years about a dichotomy in focus and resource allocation between the physical and mental components of wellness.

# The Dichotomy Between Mental and Physical Health

**THIS ISSUE OF MEDICINE** in Oregon offers insights into the challenges and innovations in mental health care in Oregon from several respected experts in the field.

As an orthopaedic surgeon, I do not consider myself such an expert. However, I readily appreciate how the manifestations of mental health have major implications in the care that I provide.

I am sure I am not alone. From the intersection of mental health with gun violence and drug addiction, to the barriers to communication and treatment compliance experienced in this patient population, no provider can escape the impact of mental health issues on their patients.

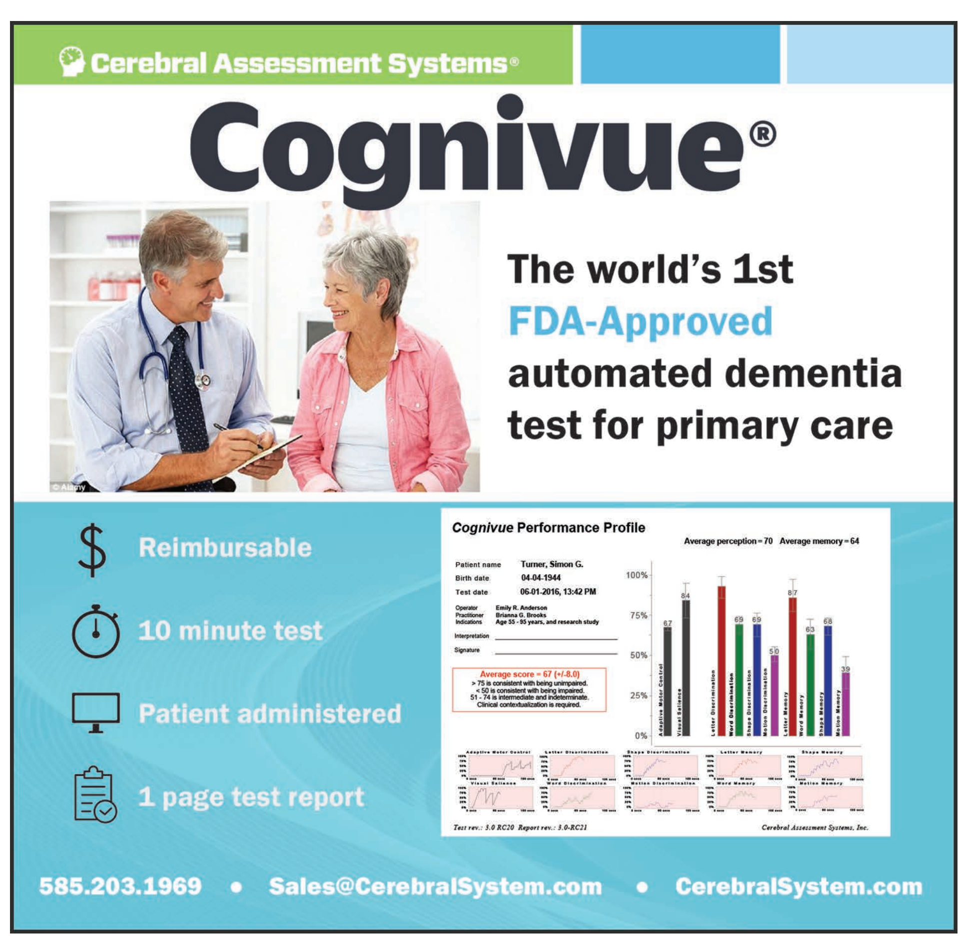
Nonetheless, providers and policymakers have talked for years about a dichotomy in focus and resource allocation between the physical and mental components of wellness.

One reason for this disparity may be the fact that so few of us in the medical community truly feel we have the necessary expertise to treat mental illness. There is no question that mental health specialists are invaluable in their ability to direct care in this realm.

However, I hope that the following articles not only provide a glimpse into the treatments that these providers render but also offer avenues that the rest of us can take to provide support and direction to our patients suffering from mental illness.

Another reason for this disparity may be the sense that lasting improvements are so hard to come by. Certainly from an orthopaedic perspective, broken bones that are appropriately set and limbs that are adequately rehabilitated seem like a more tangible success than can be achieved in many psychiatric conditions. Once again, I am inspired by our authors and their work to produce improved treatment plans and enhanced outcomes for these challenging problems.

Our writers for this issue demonstrate what can be done now and what we as a medical community hope to achieve in the future to improve care for all Oregonians.



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Bryan Boehringer
CEO and Executive Vice President
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Appropriate care for behavioral and mental health still reigns as one of the industry's most challenging issues.

# Mental Health: A Top Priority

**QUICK, WHAT'S THE WEATHER** like two states over? What's the score of the game? And what were those dinner ingredients I needed to pick up on the way home?

Living in today's world of instant access to information has a lot of benefits.

But our ready access to news can also be dispiriting. Not a week goes by without a news alert about acts of violence across the globe. And far too often, we later learn that addressing mental health concerns proactively could have prevented heartbreak.

Whatever the specific causes, it's hard to ignore that in this state and country, there are still far too many people who can't access necessary mental health services.

Through the OMA's town halls, focus groups and surveys, our members have communicated to us that improving coordination of, and access to, mental and behavioral care is a top priority for this association. Many have found themselves in the tough situation of having a patient who needs mental health services but having no resources to provide.

The final report for CCO metrics in Oregon for 2015 is out, and the results continue to show that investments in better coordination of care have resulted in increased access to prevention services for Oregonians, with a simultaneous decrease in the use of emergency rooms and other high-cost care. While better coordination has improved outcomes on the physical health side, we continue to seek integration of behavioral health.

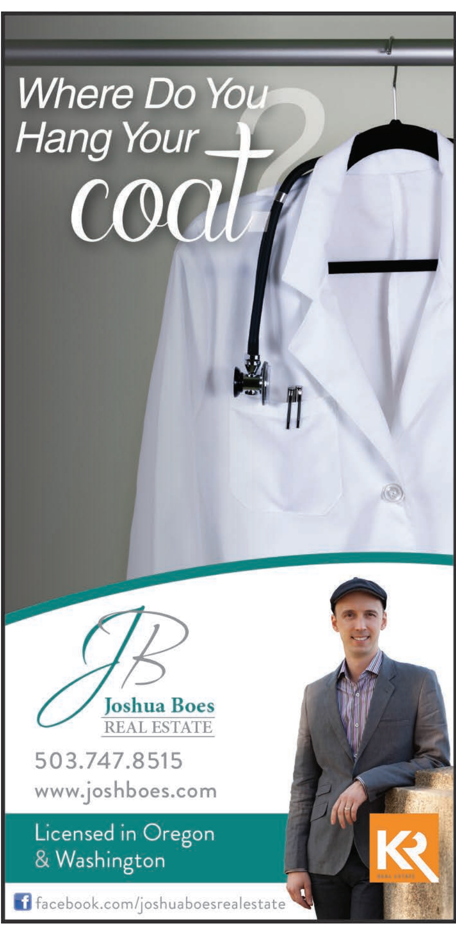
Given some of health care's most vexing problems, like funding and care for behavioral health issues, the OMA is trying to focus on solutions rather than highlighting past problems. Appropriate care for behavioral and mental health still reigns as one of the industry's most challenging issues.

It hasn't been for a lack of effort. The legislature has made additional investments in behavioral health, the Oregon Health Authority has created a Behavioral Health Collaborative to improve cross-agency collaboration and health outcomes, and local law enforcement works to improve their recognition of individuals with mental illness and ensuring that they respond appropriately.

Again, there are choices we make every day that can help shine a light on the need for better care, even something as simple as understanding the damage we do when we call a person "crazy" or "nuts" or "mentally ill," rather than respectfully (and empathetically) noting they may have a mental illness.

No one is untouched by the impact of mental illness.

Again, thank you for your membership.

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**Mar. 4, 11:30 AM–2:15 PM**
OMEF Event Center, Portland

**May 12, 8:00–10:45 AM**
Hilton Eugene, Eugene

**June 9, 8:00–10:45 AM**
Riverhouse on the Deschutes, Bend

### Advanced Training in Risk Management

**Jan. 25, 8:30–10:45 AM**
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**Mar. 4, 8:30–10:45 AM**
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**Apr. 12, 6:00–8:15 PM**
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**May 10, 6:00–8:15 PM**
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Thank you for your continued membership in your Oregon Medical Association.

Your support of the OMA is an affirmation that the practice of medicine in Oregon matters, and that providers deserve a voice in the policymaking process.

In the past several months, your membership has allowed us to:

- **Halt the tripling of the wrongful death cap, keeping provider costs down and ensuring access across the state**
- **Actively fight the opioid epidemic in Oregon, a state with one of the nation's highest rates of abuse**
- **Offer providers education on a host of subjects, including newly-legal recreational marijuana at our Political Fall Forum and opioid abuse at our Annual Meeting**

We have an important legislative session ahead, and need the voices of all physicians and physician assistants to help us shape Oregon's healthcare policy landscape.

As always, I want to hear from you. Feel free to contact me at **bryan@theOMA.org**.

We look forward to your continued membership.

**Bryan Boehringer**
CEO and Executive Vice President

# It's time to join or renew!

Please visit our self-service web portals at

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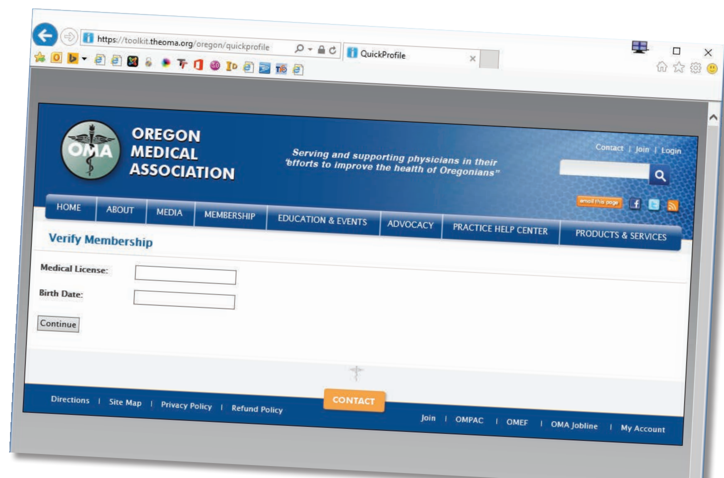
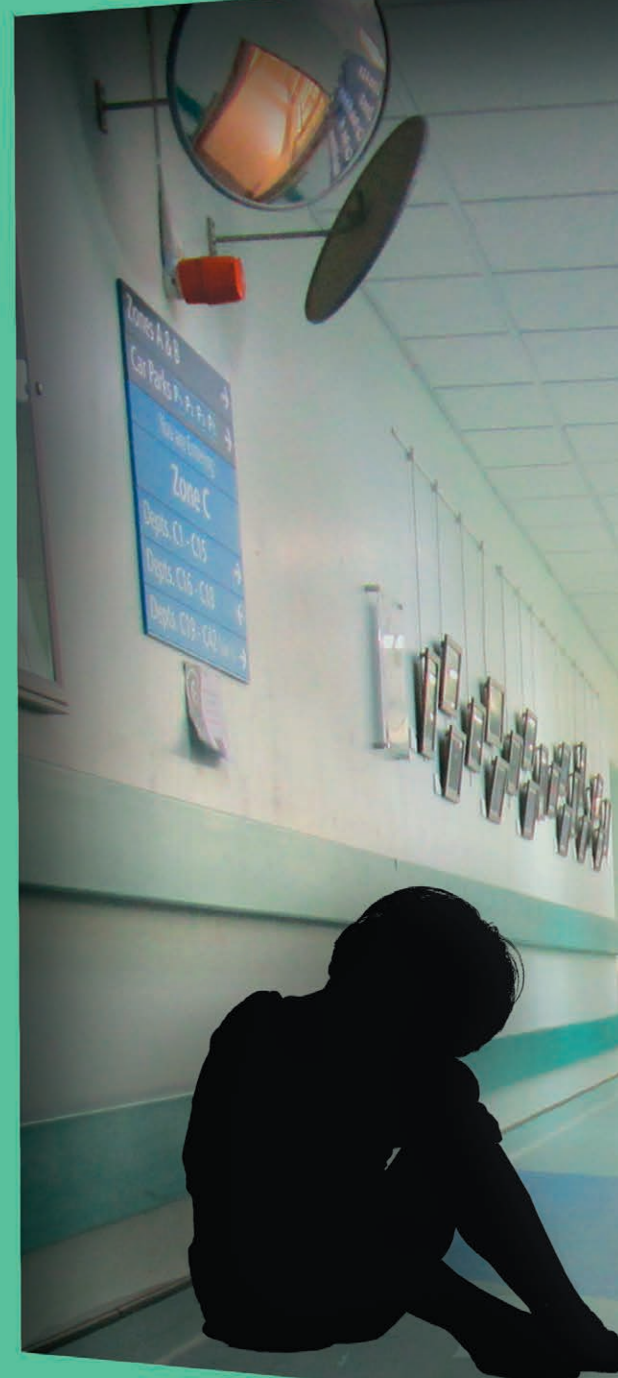




# THE CUBBYHOLE EFFECT

Tucked away in emergency departments, "psychiatric boarders" wait for change.

By Sharon Meieran, MD, Kaiser Permanente NW

**I recently worked a shift in the emergency department. Nothing strange there; that's my job. But on this particular shift I assumed care of a 14-year old-child who had been in the ED for over 400 hours.**

I did the math. That's over two weeks in a typical ED room, alone, with no windows, no regular exercise, no real therapy except for medications. My patient was being held because he had presented in psychiatric crisis, it was unsafe for him to be discharged home, and there was nowhere for him to go.

I returned for another shift three days later, and care was once again transferred to me. Transfers of care regularly occur two or three times a day for doctors and nurses, so this child essentially lived in the ED for over three weeks with more than 100 transfers of care before he was discharged to a residential facility.

## Room and Board?

My young patient was a victim of what is known as "psychiatric boarding," the practice of keeping patients in emergency departments simply because they are not safe to be discharged, and there are neither inpatient beds nor alternate treatment available to provide the care they need.

Psychiatric boarding in EDs has become a crisis nationwide, with even higher lengths of stay for children and the elderly. Oregon is no exception. The demand for psychiatric inpatient beds far exceeds current supply, and the need is ever-growing. Psychiatric complaints have become one of the leading causes of people seeking emergency care, and underlying psychiatric conditions factor into many more visits related to other complaints.

There are many reasons we have arrived here: increasing diagnosis of mental illness, co-existing substance abuse disorders at epidemic levels, poorly resourced community mental health services, poor coordination of care with the community justice system, failure of governmental agencies to even try to measure the extent of the problem, and many other factors.

continues ▶

Regardless of underlying reasons, the fact remains that we have traveled beyond the tipping point. We are at the breaking point.

## Oregon's Response to Boarding

In Oregon, however, we are beginning to see scattered bright spots, giving us cause for optimism.

The Unity Behavioral Health Center in Multnomah County (described in detail on page 16 in this issue) has the potential to create a paradigm shift in care for people experiencing mental health crises. We see increased recognition of the benefit of peer support from people with lived experience of mental illness to help people in current crisis. We are starting to recognize the need to adequately resource community mental health programs so people do not get to a crisis point in the first place.

In addition, collaborative efforts are underway to enact legislation to address discharge planning and transition of care for people with mental illness in hospitals and EDs. The proposed legislation was spearheaded by parents of two children who suffered mental health crises, were discharged from hospitals without effective plans for care, and attempted or completed suicide before they were able to receive the care they needed.

The story of one of those children is available on page 18.

These parents sought assistance from State Representative Alissa Keny-Guyer, who immediately took meaningful action. Rep. Keny-Guyer has convened a task force to ensure proper hospital and ED discharge planning, communication and coordination of care for behavioral health patients and those who care for them.

The group includes State Representatives Mitch Greenlick and Lew Frederick; individuals with lived experience of mental illness; large insurance providers and hospital system representatives; community mental health advocates and care providers; and others.

## Advocates for Meaningful Access

I've seen increasing recognition of the need to include public safety systems in the equation, as our systems of public health and safety are inextricably linked. In Multnomah County, innovative efforts are being made to increase opportunities for jail diversion for individuals that need mental health or addictions treatment.

Coordination of care statewide through the Emergency Department Information Exchange (EDIE) and PreManage* have enabled meaningful, real-time interventions to occur with individuals who are frequent ED users, and often have a combination of underlying mental health conditions, suffer from homelessness, have substance abuse problems, and may be known to the criminal justice system.

Finally, the state is trying to objectively quantify the extent of the problem. For too long, health care providers working on the front lines have known that ED boarding has reached crisis levels, and that care has not been readily available either before hospitalization or after discharge.

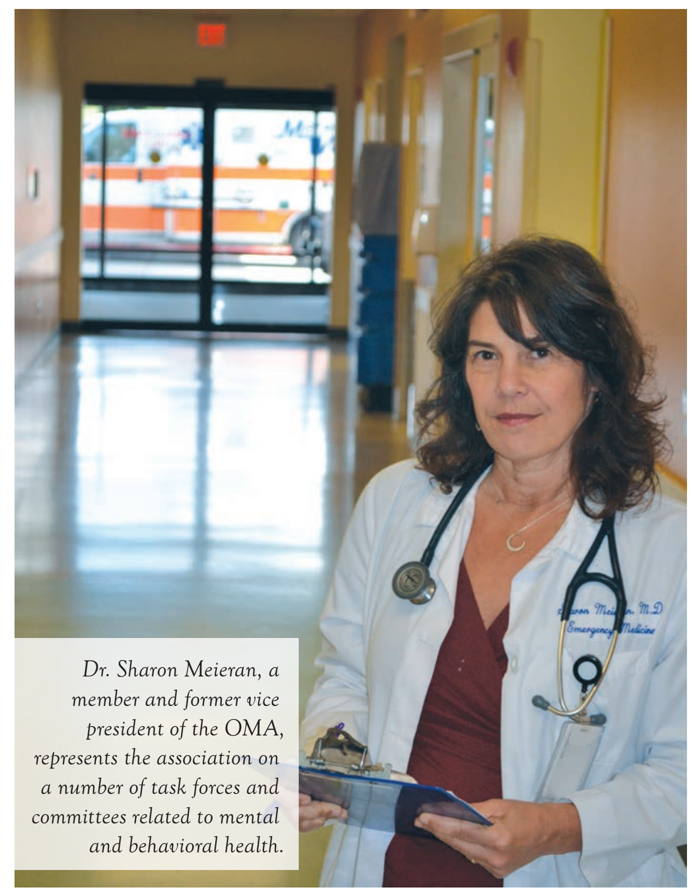
We providers have tried our best to advocate for our patients, slap what Band-Aids we could on the immediate presenting problem, and sound the alarm to those who would listen.

Unfortunately, until recently, the attitude of administrators and government officials has been: "If we don't measure it, we won't have to actually do anything about the problem."

For the first time, we're seeing recognition at the local, state and federal levels that this is a public health crisis and should be treated as such.

The situation is dire. Our patients continue to experience crises, and we often continue to treat them in the least effective and most expensive ways at our disposal.

However, it does feel like finally there are glimmers of hope. In Oregon, at least, we are engaging in a paradigm shift so that hopefully the young patient I saw—repeatedly—will never again have to experience ED boarding, and those experiencing crises will have meaningful access to humane and effective treatment.



*Dr. Sharon Meieran, a member and former vice president of the OMA, represents the association on a number of task forces and committees related to mental and behavioral health.*

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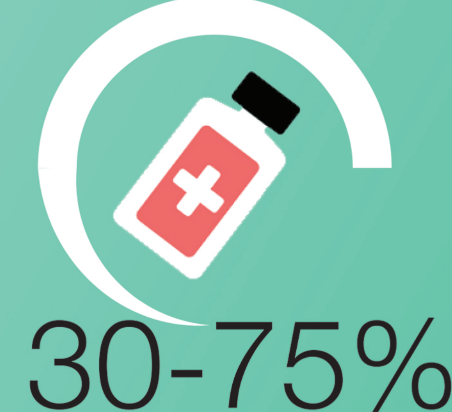

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Chris Farentinos, MD, MPH
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# Standing united

## New Portland center will lead the way in integrating behavioral health care

**WE'VE ALL HEARD IT COUNTLESS TIMES:** psychological well-being is essential to overall health. In order to provide effective care we must treat the whole person.

Nationally and regionally, health care systems currently lack the resources to fully accomplish this important task. We see evidence every day in emergency departments across the state. Behavioral health patients must often wait for days in emergency rooms before they are afforded a bed in a more appropriate care setting.

It's time for a response.

Legacy Health has taken a leadership role in the formation of an integrated system of care for behavioral health patients, an initiative called the Unity Center for Behavioral Health.

Legacy is undertaking the project in collaboration with Oregon Health & Science University (OHSU), Adventist Health and Kaiser Permanente NW in an unprecedented partnership aimed at treating psychiatric emergencies in a more efficient, patient-centered manner.

### No One Left Untreated

Unity will be housed in the existing Legacy Research Institute building (formally known as Holladay Park Hospital), near the Moda Center near downtown Portland. Our vision is to utilize a medical-psycho-social model of care in which no one will be left untreated. Unity Center will offer trauma-informed care, and aims to create a sanctuary of care for individuals suffering from a mental illness or addiction.

Unity Center will be licensed under Legacy Emanuel Medical Center. Patients will have timely access to the services and support they need to succeed, well past their period of care. This will include the development of a new Psychiatric Emergency Service (PES) co-located within a centralized inpatient facility.

In addition to the PES, Unity will feature 102 inpatient beds (80 adult beds and 22 adolescent beds)—a consolidation of current psychiatric beds from Legacy, OHSU and Adventist—as well as enhanced partnerships with community organizations providing behavioral health and substance use disorder services.

Unity Center Psychiatric Emergency Service will provide rapid assessment by a social worker, nurse and psychiatrist and then offer effective interventions. The PES will provide a living room-like milieu with observation recliners that will allow adult patients to rest in comfort during monitoring and treatment for up to 23 hours.

In this model nurses, social workers, peer support specialists and mental health therapists are integrated in the therapeutic environment, interacting with and monitoring patients continuously. It is this level of staff interaction that provides for safe and effective treatment.

Peer support staff stationed at the PES will, through their lived experience of a mental health challenge and their recovery success, help increase patient engagement, hope and resilience. A common goal of PES programs is stabilization of acute symptoms and avoidance of unnecessary psychiatric hospitalizations. Unity is designing its behavioral health PES service after successful models in Northern California and Arizona. Research on the PES model has shown that approximately 70-75 percent of patients can be safely discharged back to the community.

### An Intentional Model

Promoting coordinated and friendlier transitions of care is a personal issue to me. My career in Portland since 1994 has been primarily working in community-based programs. The breakdown often occurs at the transition point between hospital and outpatient treatment. In planning for Unity, we were offered a unique opportunity to bring together a large number of

community-based services and to establish a more intentional model for transitions of care with co-location of navigators and in-reach workers.

Leveraging technologies such as electronic notification systems will allow Unity staff to notify primary care, payers and outpatient agencies such as Cascadia, Central City Concern, LifeWorks and others when patients arrive, and will trigger a more effective hand-off.

Another unique aspect of this project has been the collaboration with the Portland Police Bureau, EMS, county staff, the City of Portland and other hospitals. We learned, for example, that in Alameda County, California, the police got "out of the business"' of transporting patient in crisis, affording them the right to be transported by ambulance like in any other medical emergency. We have adopted (or perhaps shamelessly copied!) the model, changing state rules to provide our community with the same treatment.

Our vision is to create a portal for recovery, a no-wrong-door approach and a place where individuals in crisis can find hope and connections. Unity will ultimately serve as a central hub for county and community-based mental health navigators, housing resources, addictions providers and peer support service agencies in the Portland Tri-county Area. ○

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# The Hesitant Healer

## Exploring (and Exploding) the Disclosure Myths that Cause Uncertainty for Oregon Providers

By Aaron Ragan-Fore

**THERE IS NO SHORTAGE** of tragedies we may speak of in examining the life and death of Susanna Blake Gabay, a college student from Mosier who took her own life in 2010 by overdosing on prescription pain pills.

Jerry Gabay, Susanna's father, says that one of these tragedies is that his child's death might have been prevented, if providers had simply informed him or other family members that Susanna was engaging in suicidal ideation.

And there are nearly as many myths surrounding the resulting legislation.

### Susanna's Story

Dating back to her junior year in high school, a series of warning signs–episodes of deep depression, panic attacks, emergency room visits, self-harm and other erratic behavior–prompted Susanna to go on antidepressants and to meet with therapists. Her parents encouraged the choice.

Susanna had been valedictorian of her high school class. She was a creative, warm young woman, compelled by social justice and the study of world cultures.

So it was no surprise that, following a breakup, Susanna took some time away from her studies for a six-month sojourn in Mexico. She chose to go off her medication, and returned to complete her junior year of college classes seemingly refreshed and level-headed.

More surprising was the fact that Susanna grew more symptomatic, not less, in the following months, culminating in her suicide in May of 2010.

Jerry, an attorney, channeled his grieving process into action. Working with Oregon House Representative Alissa Keny-Guyer (D-Portland), among others, he helped draft legislation that would eventually become House Bill 2948. Representative Keny-Guyer was the chief sponsor.

Governor Kate Brown signed the bill into law as Oregon Revised Statute 192.567 in June of 2015. Known as The Susanna Blake Gabay Act, the law clarifies when and to whom providers may disclose protected patient information. But, for valid or not-so-valid reasons, a number of misconceptions persist among providers.

### Myths and Misconceptions

Chris Apgar, CISSP, of Apgar and Associates, LLC, a firm specializing in HIPAA privacy and security compliance, helped us explore some of the myths that continue to dog the realm of patient confidentiality and HIPAA compliance here in Oregon, even after the passage of the Gabay Act.

Chris Apgar, CISSP

Myth #1: "My adult patient must always have absolute privacy."

"The most persistent myth surrounding disclosure of patient information is the belief that because the patient is an adult, the provider can't tell the family," says Apgar.

"In the event of an emergency or threat of harm to self or others, if the patient cannot make decisions due to mental incapacity, it is okay to release info," Apgar states.

Myth #2: "Sharing patient information violates HIPAA."

HIPAA broadly regulates when and how providers may disclose patient information, of course, but Apgar says HIPAA and its many exceptions are often misapplied.

"There is not this great big barrier called HIPAA," says Apgar. "HIPAA does not get in the way of providing great care."

Myth #3: "If I do share patient information, it must be to a family member only."

"ORS 192.567 states that a provider may share patient information with 'a family member, other relative, a close personal friend or other person identified by the individual,' and that doesn't conflict with HIPAA," notes Apgar. "In fact, HIPAA has allowed this since 2003 when the HIPAA Privacy Rule was effective."

Myth #4: "Sharing patient information will get me sued."

"The text of the law acknowledges 'the exercise of professional judgment,'" Apgar says, "and it also makes allowance for 'reasonable inferences' on the part of the provider."

"One of the primary purposes of the law is to provide legal protection for providers who use their best judgment to disclose information," Apgar adds.

Myth #5: "Sharing patient information makes me a bad provider."

Apgar says that, while important, maintaining patient privacy is far from the most important element in practicing medicine.

"The purpose of ORS 192.567 is to encourage physicians to use their professional judgment, and in an emergency situation, there's nothing stopping them," Apgar explains. "Again, this is consistent with HIPAA."

"It comes down to whether you're meeting standards of care, and your responsibility as a physician," concludes Apgar. "To me, a physician has a duty to provide the best care they can." ○

*See page 20 for info on a valuable OMA toolkit to put the Susanna Blake Gabay Act into practice.*

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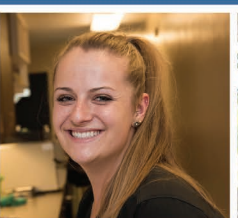
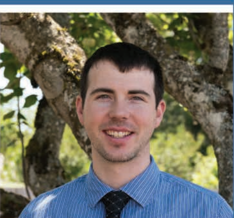

## Putting the Susanna Blake Gabay Act into Practice

Did you know that the OMA offers toolkits to our members to help them better understand the impact of specific compliance, regulatory and legislative issues? Each toolkit provides members with an understanding of the issue and its importance to their clinical practice, and where applicable, offers implementation guidance.

Our "Disclosing Patient Information Without Authorization" toolkit—available exclusively to OMA members online at *theOMA.org*—provides clear guidance about when, to whom and what protected health information (PHI) may be disclosed if a patient is unable to authorize the disclosure, with special emphasis on those experiencing a mental health crisis. The toolkit provides clear guidance on how the provider, using their professional judgment, may disclose PHI to an individual without authorization, if it is in the best interest of the patient and/or for the patient's safety.

theOMA.org/toolkits

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*Healthy Hearts Northwest is a part of the AHRQ's EvidenceNOW initiative aimed at helping practices improve the cardiovascular health of their patients.*

***Learn more at healthyheartsnw.org***

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This project is supported by grant number R18HS023908 from the Agency for Healthcare Research and Quality (AHRQ).
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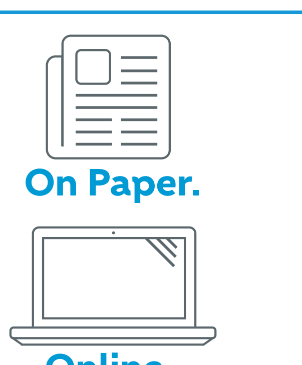

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- Actual Patient, Pam S. West Linn, OR – successfully treated for trigeminal neuralgia

# A Reachable Moment

## OHSU doc makes the most of hospitalization

By Jennifer Smith

**WHILE NOT A PREREQUISITE** for the job, optimism certainly comes in handy for a hospitalist who routinely faces the complexities and, often, inequities of the health care system. Throughout her career, Honora Englander, MD, assistant professor of medicine at the OHSU School of Medicine, has converted her experiences caring for hospitalized patients into solution-oriented programs for disadvantaged community members.

In 2009, Englander co-developed the Care Transitions Innovation, or C-TRAIN, a hospital-to-home transitional care program. Devan Kansagara, MD, associate professor of medicine at the OHSU School of Medicine, and many others helped launch C-TRAIN, which originally served uninsured and publicly-insured adults. To date, the initiative has helped over 1,000 patients regionally, been implemented in three area hospitals and expanded to include all insurance.

Seven years after its inception, C-TRAIN has highlighted health system gaps, including those in substance use treatment. Dr. Englander and colleagues saw an opportunity to leverage the influential time of hospitalization and begin to meet broader population needs. Dr. Englander calls it a “reachable moment”—an opportunity to initiate and coordinate addiction care and all the medical, behavioral and social support that accompanies a path to wellness.

Thus, IMPACT, the Improving Addiction Care Team, was born. IMPACT aims to improve quality and reduce health care costs for hospitalized adults with substance use disorders.

Honora Englander, MD, assistant professor of medicine at the OHSU School of Medicine

Many patients want to cut back or quit addictive substances and are interested in medications such as naltrexone for alcohol use and methadone or suboxone for opioid use disorders. To address these needs, IMPACT includes an inpatient addiction consult service comprised of a physician, a social worker and peer recovery mentors. Melissa Weimer, DO, assistant professor of medicine at the OHSU School of Medicine, currently serves in the physician role.

Patients have difficulty accessing care after hospitalization and wait times are often long. Thus, IMPACT includes “in-reach” from community addiction partners who will perform assessments during hospitalization and facilitate accelerated pathways to outpatient addiction care.

Finally, because many patients with addiction stay in the hospital for weeks because they are socially—not medically—vulnerable, Dr. Englander and colleagues are working with OHSU infectious diseases specialists, CODA (a specialty addiction agency) and Coram infusion pharmacy to develop an innovative model of combined medical and addiction care. In this new model, patients will be able to leave the hospital sooner and safer, and receive IV antibiotics in a residential addiction care setting.

Launched a year ago, IMPACT had served 219 unique patients as of mid-June. It’s also proving to be an opportunity to promote provider understanding of addiction as a treatable chronic disease. IMPACT is shifting culture and practice through direct patient care, provider education and system improvement: an effort about which the entire medical community can be optimistic.

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Barbara Martin, PA
Central City Concern, Old Town Clinic

# A Sound Mind in a Sound Body

## At one urban clinic, treating mental afflictions goes hand-in-hand with treating physical ailments

**AS A PHYSICIAN ASSISTANT** working in primary care at Central City Concern's Old Town Clinic in downtown Portland, I've found that sometimes patient care includes more than meets the eye.

"Sally" is one of my patients; a 28-year-old woman who has struggled for many years with poorly controlled Type I Diabetes. Her best A1C test result in ten years was 9.0, and it has been much higher at times. She presents well in clinic, stating she understands her diabetes, and is able to recite back her insulin dosages. She's had multiple hospitalizations for ketoacidosis, however.

Over time, this patient and I have established a trusting relationship. She has opened up to me a bit, and has confided some of her mental health issues that directly impact both her physical and mental health. At times she is only able to eat "light colored foods" because she fears the devil might be hiding in darker colored foods. Sometimes she simply doesn't eat due to fears or beliefs. That's when she fails to take her insulin, as well.

She has since been diagnosed with schizoaffective disorder, and is taking an antipsychotic medication. It seems to be helping, and I hope it will help with her diabetes management in the long run.

### Adjusting our Approach

Old Town Clinic is a Federally Qualified Health Center (FQHC) in downtown Portland. We have many patients like "Sally," clients who have mental or behavioral health concerns. But these problems are prevalent in the general population as well. It is important that we as providers keep mental health concerns on our radars, and take some universal precautions.

continues ▶

At the clinic we do depression screening as well as screenings for alcohol and drugs, and we have recently started asking patients about suicidality as often as every two weeks when they come in for primary care visits. Primary Care Providers (PCPs) are supported in talking about this with questionnaires to help us ask important follow-up questions, as well as a safety plan accessible in the Electronic Health Record.

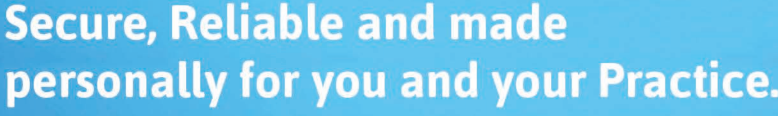
Our “Suicide Clinician of the Day” (S-COD) program allows any staff member to page the “S-COD” and a behavioral health support staffer will be there within five minutes. This helps PCPs feel more comfortable asking about suicide risk, and arms our entire staff, especially non-clinical staff, with a resource if they confront a call or visit from a patient who says they are feeling suicidal.

We have an outstanding behavioral health team at Old Town Clinic, including psychiatric nurse practitioners. We have licensed clinical social workers on-site for support, and we use health and behavior codes as we address behavioral aspects that have an impact on a physical health diagnosis. This allows us to bill for licensed clinical social worker (LCSW) services for our Medicaid clients.

We have also done good work in “upskilling” our PCPs so that we are better able to manage mental health conditions on our own. We have educated our staff on options for treatment-resistant depression, using augmenting medication therapy (such as lithium, atypical antipsychotics, or thyroid replacement when appropriate).

With the support of our behavioral health team, our entire staff is better able to care for our clients.

We cannot separate the body from the mind. Old Town Clinic embraces treating the whole person, and invests in the support structure and knowledge to do so. ○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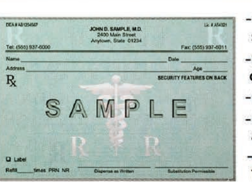


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# Provider Overload

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## Seven Strategies for Managing Stress

**HEALTHCARE REFORM INITIATIVES** have placed new demands on physicians and other medical providers, while simultaneously limiting their autonomy.

In many organizations, practitioners are expected to accomplish more with fewer resources, resulting in long hours, continuously heavy workloads, difficult decisions and chronic stress. These pressures can mount, exacerbating an already higher-than-average rate of burnout, substance abuse and suicide among practicing physicians.* With no indication that the pace of change will decrease in the near future, providers in every type of setting should consider the potential effects of unrelenting stress on themselves, as well as on patients, colleagues and others.

Fortunately, solutions exist for the problem of provider overload. Simple interventions—such as utilizing employee assistance programs, adopting flexible work arrangements and taking regular (and guilt-free) vacations—can help restore balance and combat emotional exhaustion and depersonalization.

The suggestions below are designed to help providers manage the stress factors of an active medical profession in a long-term, sustainable manner:

**1. Undergo an annual screening to measure stress levels and assess the potential effect on clinical performance and patient care.** Selected screening tools should focus on core symptoms and behaviors associated with stress, such as:

- Decreased concentration and noticeable forgetfulness
- Ongoing sadness and irritability
- Constant distraction and abbreviated attention span
- Overly hurried, anxious manner
- Frequent errors or persistently subpar job performance
- Avoidance of interaction with others
- Pattern of running late for appointments
- Chronic impatience with and/or excessive criticism of colleagues
- Recurrent health problems due to decreased immune system resistance
- Communication breakdowns with patients and others

One commonly used provider stress self-assessment tool is the Maslach Burnout Inventory. [*http://connectability.ca/Garage/wp-content/uploads/presentations/mindfulness/Burnout-self-test.pdf*] In addition, to help ameliorate excessive stress, see Finkelstein, C. "Improving Physician Resiliency," a continuing medical education module of the American Medical Association. [*https://www.stepsforward.org/Static/images/modules/12/downloadable/Improving_Physician_Resiliency.pdf*]

**2. Participate in stress-reduction educational programs.** Time-management and priority-setting classes can help increase efficiency and productivity on a daily basis, while lessening the feeling of being overwhelmed by job demands.

**3. Join a provider support group.** Peer groups serve as a safe and effective forum to discuss professional concerns, such as errors in clinical judgment and noncompliant patients, as well as personal stressors, including family pressures, illness or office discord. Sessions should be led by an experienced facilitator who understands providers' concerns and the need for sensitivity and confidentiality. To learn more about creating a culture of provider wellness, see Eckleberry-Hunt, J. et al, "Changing the Conversation from Burnout to Wellness: Physician Well-being in Residency Training Programs." *Journal of Graduate Medical Education*, December 2009, volume 1:2, pages 225–230. [*http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2931235/*]

**4. Attend wellness conferences that offer continuing medical education credit.** These events can be very useful in terms of learning about self-care, forging contacts with similarly situated professionals and reestablishing a modicum of control over one's professional life. Perhaps most importantly, wellness conferences involve making or renewing a personal pledge to live each day consciously and make choices that mitigate the effects of mental, physical and emotional stressors.

**5. Develop greater mindfulness.** Yoga, meditation, tai chi and massage are proven stress reducers. Consider participating in these and similar activities on a regular basis, as well as spending a few minutes in a quiet space every day for relaxation purposes.

**6. Strengthen personal communication skills.** Well-honed interpersonal skills enrich relationships with patients as well as fellow professionals, decreasing the potential for misunderstanding, friction and unnecessary stress. Providers may benefit from a refresher course from such industry leaders as the Institute for Healthcare Communications [*http://healthcarecomm.org/*] or the American Association for Physician Leadership [*http://www.physicianleaders.org/shop/courses/physician-in-management-communication*].

* Ironically, an estimated 60 percent of practitioners—twice the rate of the population as a whole—lack a personal physician, leaving them with little support as job-related stresses increase. See Alexander, J. "Recognize and Manage Physician Stress and Burnout." Guest column posted at *KevinMD.com*, November 6, 2012. [*http://www.kevinmd.com/blog/2012/11/recognize-manage-physician-stress-burnout.html*]

For information on improving clinical communication awareness and abilities, see Ha, J.F. and Longnecker, N. "Doctor-Patient Communication: A Review." *The Ochsner Journal*, Spring 2010, volume 10:1, pages 38–43. [*http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/*]

**7. Recognize work well done.** Physicians set the tone for a medical practice. Routinely acknowledging and rewarding constructive effort, conscientiousness and consideration of others can help maintain a positive, productive and humane working environment even in a rapidly changing field. ○

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## ADDITIONAL READING


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# Seasonal Financial Quick Tips – Fall into Winter

## Build Your A-Frame Cabin of Protection for Your Financial Future

**WHEN I THINK ABOUT** winter it takes me back to my childhood. My family spent the winters in the Blue Mountains snowmobiling outside of my hometown of Pendleton, Oregon. I especially remember nighttime when we would all huddle up in our A frame cabins with our friends and family playing board games. While harsh winter storms blew outside, we would have a nice, warm fire blazing inside, creating a feeling of gratitude for safety, shelter and protection.

This is a critical example of what we should feel in our financial lives as well. From a financial planning perspective, a simple way to approach creating the feeling of safety is to view the process as building an A-frame of protection, savings, and growth for your financial future. Let's focus on the protection component in your financial life. Everyone knows they need to protect their home and their automobile with insurance. It is second nature to protect those assets, but what about your hands?

As a physician or physician assistant, your greatest asset is your income and it becomes paramount to protect your future income for yourself and your family. Are you adequately covered in the event of a disability?

### Let's look at a disability income example:

Imagine you are a young 40-year-old physician who specializes in orthopedic medicine and making $250,000 annually. You still have medical student debt after spending $300,000 to get your medical degree.

25 years from now, you'll be 65 years old:

- $250,000 x 26 years of income = $6,500,000
- Modest inflation of 2.5% increases this to $8,500,000
- Factor in deferrals to your 401k, a clinic match, and a modest growth in the market over those 26 years —this adds another $1,500,000
- Total future income value yet to be earned is close to $10,000,000

In summary, a 40 year old orthopedic physician making $250,000 a year has a $10 million asset they've yet to earn.

If you are willing to protect your $50,000 car, why wouldn't you want to protect a $10,000,000 asset? Now if you're an orthopedic surgeon, you can double those numbers and then some. As you can imagine, the physical demands are great for an orthopedic surgeon from the long hours of surgery, and the stress on the fingers and shoulders. The odds of a disability given these factors are relatively high.

When it comes to disability insurance, common mistakes are assuming your employer or your clinic has a group long term disability program that covers a pretty big percentage. Group coverage often has a monthly cap, and benefits are typically taxable. Furthermore, the definitions of disability are not typically adequate, i.e. the program covers salary only with no bonus, or it will cover W-2 income only and then exclude K 1 income. Lastly, it is not portable (transferable). A supplemental program should be assessed along with any clinic programs for anyone earning over $150,000 a year. Call an expert to help you build the A-frame you need for your financial future. As a 20 year partner of the OMA, you can rest assured we've built a cabin or two. ○

*Shawn O. Higley is the managing partner of The Partners Group Private Client Services. He can be contacted at* shawn@tpgrp.com *or (503) 726-5686. For more information, visit* www.OMA-tpg.com.

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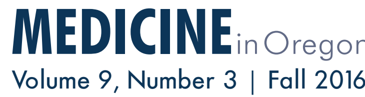
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