A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY WINTER 2020

CHART NOTES

Facing difficult challenges with Resilience

The mid-Willamette Valley faced the challenge with the best kind of innovation and original thinking.

pg 8

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A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY

CHART NOTES

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President's Message

Doug Eliason, DO

Healthcare after COVID

COVID has dominated our lives for the last nine months. Now vaccines are being submitted to the FDA and we are seeing the first glimpse of hope of what Winston Churchill famously said--it was not the beginning of the end, but maybe the end of the beginning.

What lies at the end of COVID? Will everything return to "normal"? Will the Government and insurance companies reward healthcare handsomely for our hard work during the pandemic?

For those of you who listen to the oracles of healthcare the answer is unfortunately, "No." Blossoming Federal and State deficits and intense competition among insurance companies may spell many lean years for medicine for years to come. So what is a healthcare system to do?

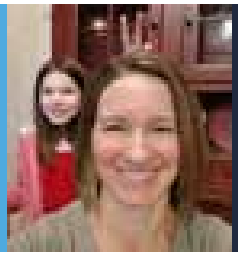
Population Health may be the antidote we search for. So what is this often talked about and unfortunately poorly understood concept of population health? First, it is not public health. Public health will make a healthier population but rarely ties a dollar tag to it. If public health says let's help people stop smoking, population health says programs to stop smoking cost x and the benefit in lower health costs of nonsmokers is Y, and Y is larger than X so it has a return on investment.

In medicine, we worry that providers should not look at costs and only do the best for their patients. For this to work there must be unlimited dollars for health care (and I can assure you there are not). So the insurance company steps in, rations those dollars, and tells providers what we can do. Population health works by providers being partners in health care saving by following evidence-based care and eliminating low-value care and emphasizing high-value care. And it works best when we share in those shavings.

So it is not time to call COVID done but it is time to reflect and prepare for what comes after. For me, it will be a new career in population health, as I explore what is possible in our health care system.

From the Executive Director

Krista S. Wood, MBA



Practicing Resilience at MPCMS

The COVID pandemic wreaked havoc on our plans for the Medical Society's sesquicentennial. We had to change our meetings to virtual and cancel our events. It was strange at first. No one really knew the technology, but now it's second nature. On the plus side, our board attendance is up. Members join from home and we've gotten to know each other on a different level. Sometimes our kids or pets photobomb a meeting. It gives us a glimpse into each other's personal lives, which is something the board has wanted for a long time, to have more personal relationships with one another.

The virtual experience has also been good because everybody gives each other a bit of grace. We're all dealing with the same thing and there's no playbook. If you have technical difficulties, everybody's very understanding about it. Networking with other groups has given us some fun ideas for 2021. The annual meeting will take place virtually with a speaker, President's award, and our elections. We hope to have break out rooms for socializing and have some ideas to make it special in spite of the distance.

This is not the year of celebration we had intended, but we thank all the membership for hanging in, taking care, and doing what you do so well.

Hope to see you at the annual meeting.

Letter from the Editor

by Nancy Boutin, MD, MBA

At some point in the future, when we review the most over-used expressions from the COVID era, my vote will go to "these unprecedented times." Don't get me wrong, the last year has been the most disruptive time I've experienced and I've had it really easy compared to a lot of people. But unprecedented means something that has never happened before. I've had family friends, relatives, and patients who lived during the last pandemic. Salem Hospital opened its doors two years before the first recorded case of Spanish Influenza. We have experienced social and racial strife, wildfires, and economic catastrophes many times in the past. Healthcare and healthcare workers have survived them all.

We have seen shining examples of resilience over the past year in Marion and Polk counties. Organizations and individuals have risen to challenges they hadn't faced before. They have responded to opportunities for experimentation, innovation, and to flex, building on foundations of preparedness and courage.

A number of business writers offer similar advice for how to ride the wave in 2020: take care of your employees, be useful, inspire others, adapt to new work habits, blow up your silos, and "communicate, communicate, communicate."

In this issue of Chart Notes we'll hear about Rick Pittman's view of the future; Howard Baumann's view of the past; and from the OMA's president-elect, Mark Fischl, about the past and future of medical leadership in our two counties and the state. Prassana K Pati, elder statesman of Marion Polk County Medical Society, offers us his suggestions for self-care in the face of COVID.

We'll see how local healthcare organizations and providers have responded to a variety of tests and trials. We'll look at temporary emergency measures and the adoption of technologies and practices we knew about, but only adopted slowly--until we had to. At some point in the future, when we review where we were and where we've come, we may identify the COVID era as a time of evolution via punctuated equilibrium, creating a healthcare delivery system more adapted to the existing environment.

As always, if you have questions, thoughts, or suggestions about this issue or ideas for future issues, we'd love to hear from you.

IN MY OPINION BY RICK PITTMAN, MD

A CHANGE IS GONNA COME—OH YES IT WILL

"I was born by the river in a little tent Oh and just like the river I've been running ev'r since"

Sam Cooke's lyric came rushing into my head this morning as I had the luxury to remain in bed and ponder over this quarter's column. While I was neither born by a river nor in a tent, I was born by the ocean in 1951 at Harbor County (Dad in the military), and I have been running ever since. We lived in San Pedro at the time of my birth and ended up in Vallejo, California by the time I was in 3rd grade-having passed through San Diego, El Sobrante, Batesville (Arkansas), and Richmond, CA. In Richmond, we lived in an apartment complex and were frequently chased home by the Black kids, my stepmom meeting us halfway from school with a baseball bat to fend off attackers. A good Pinot and a quiet evening and I will tell you the rest of the story.

To escape Richmond we moved to a new housing development in Vallejo. The brand new 1,400 sq. ft. house cost $14,995.00 and was quite a step up for the eight of us. We were one of three white families in a predominantly Black and Filipino neighborhood. In 1967 race riots broke out. Vallejo High School was 65% black, 10% Filipino, and 25 % white. Because I was from a predominantly black neighborhood, I was surrounded by my "brothers" to protect me from harm. Some of the white kids from across the tracks were not so lucky. In December 1968, the Zodiac Killer murdered a friend of mine and his girlfriend in the parking lot of Blue Rock Springs park—It could have happened to any of us who frequented that park at night for amorous reasons. Fifty years ago these were tumultuous times. Besides the scale, do they sound any different than now?

Vallejo, Calif., May 21, 1967—Negroes stoned cars, snipers battled police after a drag race was broken up. https://www.usnews.com/news/national-news/articles/2017-07-12/race-troubles-109-us-cities-faced-violence-in-1967

You would think that growing up in this environment, I would not have any racial bias and be a great dancer. If you remember from the last issue of chart notes, we posted a link to testing for implicit bias from Harvard and I failed. I was immersed in minority culture for most of my formative years— I was the minority, and I did learn to dance. I went running away to college and beyond, and if you asked me, I would have said I did not have a racist bone in my body, but the test says otherwise. "I am the least racist person in this room," and while this statement may, at times, be true it does not mean I have no prejudice.

While some people are able to own up to their shortcomings, face them and conquer them even if it means reaching inside, perhaps learning new social skills, it seems that most of our country is divided—more than divided, fractionated.

What is the answer? Bob Dylan said it best "...the answer is blowing in the wind... the trouble is that no one picks up the answer when it falls to the ground." In fact, Dylan's song was an inspiration for Sam Cooke's "A Change is Gonna Come." Cooke's record was released two weeks after he was shot. Details are muddy.

By the time you read this, the election will be over and you can bet a Change Is Gonna Come—Oh yes it will.

CHART NOTES - WRITER BIOS

NANCY BOUTIN, MD

Managing Editor

Nancy is the Medical Director of Willamette Valley Palliative Care. She has contributed articles to Chart Notes off and on for twenty years. She is very happy to be back at the keyboard.

RICK D. PITTMAN, MD, MBA

In private vascular surgery practice for 28 years before obtaining a MBA from OHSU/PSU, Dr. Pittman works full-time as a vein and wound care specialist in the Silver Falls Dermatology Clinics and spends his spare time in the garden, behind a camera or in the workshop restoring cars.

HOWARD BAUMANN, MD

Howard Baumann retired in 2010 after 34 years practicing gastroenterology at Salem Clinic. He is a member of the American Association of the History of Medicine, the Society for the History of Navy Medicine, and is a Board Member of the Oregon State Hospital of Mental Health. He contributes regularly to Chart Notes and Historical Tidbits.

THANK YOU MEDICAL PROFESSIONALS

The Marion-Polk County Medical Society would like to thank all of the medical professionals in our local community for your unwavering dedication, service and sacrifice. From those working tirelessly with COVID-19 positive patients, to those working behind the scenes to secure PPE, operationalize tele-visits or simply respond to emails and phone calls - your role is invaluable and appreciated. As we plan future issues of Chart Notes, we would like to share your experiences during this pandemic. How has it affected you, your practice, your relationships with your patients? How are you moving forward? If you would like to share your story/experience please contact Nancy Boutin at nancyboutin@me.com or Krista Wood at krista@mpmedsociety.org.

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An Interview with Mark Fischl, MD

PRESIDENT-ELECT OF THE OREGON MEDICAL ASSOCIATION

WITH NANCY BOUTIN, MD, MBA

Mark Fischl, Salem Clinic internist, has been a involved with medical leadership through the county and state societies since his earliest days in Salem. He has been part of a changing landscape of physician employment models, payment models, and a full generational shift of providers. From 9/11 to the COVID pandemic, Fischl has helped shape, and been shaped by, the evolving practice of medicine in our community and the state. As President-elect of the Oregon Medical Association, he is the third MPCMS member to lead the OMA in the last decade. We met virtually to discuss his two decades of society service and the goals for his presidential year at the OMA.

NB: Tell me about your credentialing interview at Salem Hospital.

MF: I had moved to Salem that week and was camping out in the house. My old car didn't have a radio. I did an early workout, cleaned myself up, and went to the hospital to meet with Dr. Bennington-Davis, the medical staff president. One of her first interview questions was, "Did you hear about the terrorist attack in New York City?" She explained about airplanes flown into the Twin Towers and I sat there staring at her, thinking, "This is the weirdest interview ever. She's curious how I handle a stressful event." I thought it was more likely that a psychiatrist was messing with my brain than that New York City had been attacked by terrorists.

NB: Many people reacted to the news of 9/11 with disbelief, but this is the first time I've heard someone thought it might be a psychological litmus test.

MF: I majored in psychology as an undergrad and I've always been interested in how the mind works, how we make connections, and how we are influenced. Given Maggie's specialty, I put two and two together. Since the idea of a terrorist attack seemed so improbable, I settled on the next logical conclusion.

NB: When did you get involved with medical society leadership?

MF: Within a year of coming to Salem, Bud Pierce asked me to sit on the Marion Polk County Medical Society Board. He was a driving force, and I agreed. I've always felt the medical society is a neutral zone among the competing healthcare factions. Our goal has been to provide a safe place for all sorts of providers to advocate for patients and providers without any hidden agenda. That appealed to me.

NB: And then what?

MF: After working at the county level, I was asked to represent our two counties at the OMA. That led to an at-large executive board position. I served in that capacity for several terms and moved up, through the elective process, to my current position as president-elect.

NB: The gavel usually gets passed at the September OMA meeting. What happened?

MF: When the pandemic hit, there was as much disruption in the work of the OMA as anywhere else. We decided to put ourselves on hold for a year and continue in our current offices. I will be moving into the president's position next year.

NB: This isn't the first time you've been in the middle of medical society disruption.

MF: I was on the executive boards of both the county society and the state society when shuffles occurred with a change in Executive Director and a realignment of priorities. Sometimes I say it's my fault because I am the common denominator for the explosions. But I'm the kind of person who likes to tear the Band-Aid off. When things like that happen, I think it's best to face them head on and deal with them rather than letting them get worse. I like to think I was helpful by adding a calm voice.

NB: What other changes in OMA function have resulted in response to the pandemic?

MF: COVID caused us to contract our operations. We had to close our meeting center. We couldn't hold our in person events, although moving the statewide meeting to a virtual platform increased accessibility. We have had to find ways to make ourselves relevant for our members and the community at large.

NB: And where have you landed?

MF: We thought we were an obvious source for reliable reporting about the pandemic. There's so much information in the world that you can only trust so many people. You have to pick those people carefully. The website has been diligent about vetting information, checking links, and making sure the people we refer to are appropriate — and now when someone goes to the website, they see it is trustworthy. We have now become such a trusted site, even local health departments use us as a source.

The other thing we have done is to remain active in state politics. We keep track of bills that may impact healthcare and we try to help physicians get involved at different levels. Courtni Dresser, our lobbyist in Salem, is well-respected and has great access to the legislators. They take her calls, which is a good indication of our status.

So I would say [the OMA's] two biggest roles are to be a trusted source of information and to support physicians and patients. With COVID we've had to pull back to our core identity. That's not necessarily a bad thing

NB: What do you hope to tackle in your presidential year?

MF: My goal is to make sure the organization is trusted, open, and transparent. Humans can be so easily influenced. Unfortunately, many very intelligent people think that they are above that, while the data is overwhelming. We've seen the divisions that occur and the damage that divisiveness causes.

I recently read an article that shows when people with similar viewpoints make a decision together, they feel good about it. Groups with disparate views feel uncomfortable, but they almost always come up with better solutions to the problem at hand. There is a disconnect between the quality of the product and the subjective experience of the decision-makers, which tends to discourage engagement. We just have to find a way to educate people that discomfort is actually a sign of success.

NB: Does that mean you hope to foster diversity of opinion?

MF: Yes. One focus of the current OMA president is equity in healthcare. The more voices we hear, the better. I want to build on his work, including more attention to the role of implicit bias.

NB: That's a hard needle to move.

MF: In *How to Be an Antiracist*, Ibram X. Kendi says that if you're trying to influence people to alter their behavior and they don't, it's your fault, not theirs.

So, if I want to foster change and what I'm doing doesn't work, I have to change my approach to help people move to an open, honest place. I was in a meeting once, talking about this subject, and someone said, "It's not enough to do the right thing. You have to do it for the right reason."

And I thought, "I'm okay with that."

ORGANIZATIONAL RESILIENCE IN THE MID-VALLEY

BY NANCY BOUTIN, MD, MBA




Remember the old proverb? The one that drew a straight line between the want of a nail and the loss of a kingdom? In the same way, lack of personal protective equipment (PPE) in clinics and hospitals during the early days of the COVID pandemic could have crashed healthcare in our community. Instead, the mid-Willamette Valley faced the challenge with the best kind of innovation and original thinking. Salem Health collected autoclave packaging and invited the community to sew masks for hospital use. Willamette Valley Hospice turned the hospital's out-of-the box thinking inside out. Long before cloth face coverings could be easily purchased on Amazon or Etsy, staff and volunteers started making them for patients and families to wear during home visits to protect WVH staff. Alternate care delivery systems needed to be invented on the fly. Federal waivers permitted payment for telemedicine, even in organizations that hadn't yet worked out the bugs. At Santiam Hospital, the service integration team suddenly found themselves responding to community members stuck at home. Just a few months later, they responded to community members whose homes had been destroyed in wildfires. Here are just a few of the many stories of organizations in our medical community innovating and building on their strengths during "unprecedented times."

Salem Health Respiratory Clinics

By the time Salem Health sent out its first *Common Ground* COVID communication on February 28th, one day before Washington State announced the nation's first case and first death, the SH leadership had been following news of the virus for months. They had developed standard work based on previous protocols for Ebola and measles. Within days of the news from Seattle, leadership set up an incident command center and published a COVID intranet resource page for updates, triage and screening pathways, as well as standard work documents. *Common Ground* showed up in staff emails every couple of days with information about the rapidly changing WHO and CDC recommendations.

On March 11, 2020, Salem Hospital identified Marion County's first COVID-19 positive patient. Like every other healthcare entity in the US, PPE supplies on hand would not meet the anticipated need and solutions needed to be found.

In her dual role as Associate Chief Medical Officer and Primary Care Medical Director of Salem Health Medical Group, Michelle Rasmussen, MD, led the effort to adapt outpatient care to the challenges of a

COVID testing at a Salem Health respiratory clinic.

pandemic. "We had to figure out how to see patients without enough PPE," she says. "We decided to consolidate it in certain clinics and send COVID patients to those 'respiratory clinics.' At the time, we didn't understand the full scope of possible presenting symptoms, or we might have chosen a different name.

"Low risk patients would be directed to regular clinics where they had less chance of exposure to the virus and staff did not require enhanced PPE. We decided to use telehealth triage to determine which patients to send to which clinic. The ED opted to avoid offering testing, except for patients who needed hospitalization, so we offered an alternative to going on campus."

With the help of SH's Incident Command, Rasmussen's team was able to move quickly. "The four providers who usually work at River Road were given the option and they all agreed to move from continuity care to COVID, literally overnight."

Three days after the first SH diagnosis, Rasmussen and her team spent the weekend moving tests, scrubs, gowns, and PPE to the River Road and Woodburn Clinics. Patients were called and appointments changed. The respiratory clinic schedule morphed to mirror an urgent care clinic--20 minute slots, same-day access, and a respiratory clinic EPIC inbox so all test results came there. Standard work had to be created and there needed to be a process for collecting data and reporting to the state. The River Road respiratory clinic opened on St. Patrick's Day and the Woodburn Clinic the day after.

In the meantime, patients displaced from their home clinic needed to be accommodated, although, Rasmussen says, "Most people didn't want to come in due to exposure concerns, and routine appointments were postponed."

Providers had the option of seeing their non-COVID patients at one of the "sterile" clinics, giving a warm hand-off to a colleague, or scheduling a virtual visit. During the initial days, under the public health emergency waiver, video visits were held over every platform from Doximity to Facetime, but most patients were moved to a more HIPAA-compliant EPIC platform as soon as they could be signed up for MyChart.

Patients with symptoms suspicious for COVID are evaluated in the respiratory clinics or via telehealth, as well as COVID-positive patients with any other medical problem. All patients with shortness of breath are seen for pulse oximetry. There is no barrier for in-person assessment. Unfortunately, EPIC's lack of conference calling makes video visits impractical if translation services is needed.

Going into the fall and winter surge, the clinics are busier than ever. Most of the SHMG providers rotate through the respiratory clinics and Rasmussen says there are "a few heroes who ask, 'You need me to go work there every Friday? You bet.'"

Rasmussen anticipates that some of the clinical changes made in response to the pandemic will become standard. The goal, she says, is eventually to have 25% of primary care visits done virtually, with a portion of appointments held for same-day scheduling. There is no defined threshold for disbanding the respiratory clinics, but the team has proven their ability to flex with the needs of the community in a matter of a few days. Disbanding would be a nice problem to have.

Notes from the Field—Willamette Valley Hospice

From the beginning of the pandemic, experts recognized that many infections occurred through "community spread." That means the healthy-looking person standing across the coffeeshop counter may be as likely to pass the virus along as someone who looks sick, and less likely to make you think about CDC guidelines. Hospitals and clinics have some ability to control their environment and the flow of people through their doors. But what do you do if you are an agency that provides care for 300+ patients in private homes and long-term care facilities?

Staff wear handmade gowns made by community volunteers at the Edward F. Tokarski Home.

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ORGANIZATIONAL RESILIENCE

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Cheryl MacDonald, MD, Medical Director of Willamette Valley Hospice, says their two most effective tools have been communication and education. "As soon as the threat from COVID-19 became apparent, we activated our Emergency Management Plan (EMP). With the limited information known about the virus, we needed a strategy for taking excellent care of our patients while keeping staff safe. We've met every day since our first Teams call.

"We also instituted a weekly all-staff virtual meeting for updates and questions. Because recommendations changed so often during the first few months, we wanted to provide the most up-to-date, reliable information available. We needed to be transparent and trusted, even when a new message sometimes contradicted what we said just a week or two earlier. Attendance continues to be great and we record the meetings for staff who can't tune in to the live feed. As an added bonus, each week we have a must-be-present-to-win gift card giveaway that makes the meeting a little more fun."

To further engage frontline staff, WVH instituted a team that met confidentially with HR to bring COVID questions and concerns to the daily EMP call. MacDonald says the respect and responsiveness shown to that team ultimately led to the group deciding to go on hiatus; staff felt comfortable raising items directly.

WVH continues to face the same PPE shortages that challenge other healthcare organizations, but they made a decision early on to institute universal precautions. Staff would wear procedure masks and gloves for all visits, reserving gowns and face shields for staff who required prolonged patient contact within the CDC-recommended six-foot social distancing radius, such as bath aides and massage therapists. Patients on therapies known to aerosolize virus, like duo-nebs, could not be seen in person within two hours of treatment. The IT department bought e-tablets for use by patients who lacked internet access at home and trained family members how to use them. Window and porch visits also took the place of more traditional hospice visits.

Volunteers, and staff with work hours affected by facility lockdowns, had the option of sewing cloth face coverings for patients and families who wanted them, offering further protection to field staff. "So far, our efforts have been extremely successful," MacDonald says. "Very few staff have tested positive for COVID—a lower rate than Marion County as a whole, despite the constant interaction with at-risk patients. We're keeping our fingers crossed for continued good results while we wait for a vaccine."

MacDonald credits some of WVH's success to its home-grown status. "The other hospices in town might have an advantage when it comes to accessing PPE and they may have deeper pockets.

Music Therapist Jessica provides therapy through a window at a local facility when not able to enter the building.

But as a local organization, we have our own infection control nurse and safety officer in-house. They are on top of what's happening in our area and are in constant contact with county and state authorities. The EMP team understands and responds to conditions right here at home and we don't need to balance our needs with those of a sister agency 2,000 miles away. Also, our Board is made up of community leaders who live and work in the counties we serve. They can see firsthand what's happening and have been incredibly supportive."

As the state heads into the third wave of the pandemic, MacDonald remains optimistic that the efforts made to keep the entire staff informed—about COVID-19, safety guidelines, and work going on behind the scenes—will pay off.

"We can't do what we do," she says, "without a healthy, confident team out in the field taking care of patients. It's all about taking care of the caregivers."

Wild fire spreading down the Santiam Canyon.

Santiam Wild Fire Relief Fund

In the annals of disaster preparedness, one story remains fresh—the crash landing of United flight 232 in Sioux City, Iowa, in 1989. Every statistical model predicted total loss of the 296 souls aboard in the scenario that played out. But thanks to extraordinary cooperation in the air, and tremendous medical coordination on the ground, 184 people survived. Here in Marion County, a similar combination of luck and foresight put the Santiam Service Integration Team (SIT), organized under Santiam Hospital, in a perfect position to respond when 13 wildfires raged through Santiam Canyon during the first half of September.

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SIT team members at Santiam Hosoital.

ORGANIZATIONAL RESILIENCE

...continued from page 11

In 2017, leadership at Santiam Hospital became involved with The Canyon Collaborative, a group of volunteers who gathered regularly to help neighbors experiencing hard times. Maggie Hudson, MBA, Chief Financial and Operating Officer at Santiam Hospital, says, "They did really good work for years without any administrative support, which limited how far they could go. We realized the hospital's mission included connecting people with needed resources, so we funded one FTE to facilitate the Collaborative's good work. That springboarded into offering more comprehensive services."

Building on the Service Integration Team (SIT) model they observed at Polk County, Santiam Hospital developed three teams within existing school district boundaries: Santiam Canyon, North Santiam (Stayton, Lyons, and Sublimity), and Cascade (Aumsville and Turner). Teams consisted of local non-profits, faith-based organizations, government entities, community members and businesses. They hired Melissa Baurer as the SIT coordinator and opened their doors in July 2017.

The family or individual with identified needs is taken through an escalating series of interventions from simple problem-solving to a coordinated, expedited approach during SIT's regularly scheduled meetings. Melissa presents vetted funding requests to the larger group. "You get everyone together," Hudson says, "and hands shoot up like popcorn. People say, 'I can take that,' or 'We'll get that one.' Someone might have the bedframe or the bike in the garage to donate. Or a church will adopt a family who needs school clothes. Or Community Action can cover 80% of emergency rent relief, but wants us to fund the other 20%. We generally leverage our funds 4:1, to be able to cover as many requests as possible. Before the wildfires we commonly saw requests for rent or utilities. We always try to make sure the person has a sustainability plan; we should be a last-resort, short-term safety net."

Melissa and the SIT team had become well-established when COVID hit and community needs changed fast. Instead of medium-range problems like a mom who needs childcare or an overdue utility bill, the team heard about the immediate need for basic necessities. People infected with the virus quarantined. Vulnerable people sheltered in place. Parents working remotely needed to tend to their kids. "They couldn't come to us for help, so we decided to go to them," Melissa says. "With our partnerships we had drivers available, and volunteers who could shop. We even had police department partners who delivered medications."

SIT Mobile went live on April 2nd. With a single phone call, families in need could get services and supplies, including food, diapers, even toilet paper. Stop-gap coverage of rent and other basic bills kept people in their homes until COVID relief or unemployment checks arrived. Despite ever-increasing requests, the mobile system filled a critical demand in the community. "There are tangible, measurable outcomes," Hudson says, "such as the number of people connected to resources and the amount of dollars leveraged. Annual reports let everyone see the impact of their participation."

Then, on Labor Day weekend, the proverbial perfect storm hit Santiam Service Integration's community. Strong, dry winds swept through the canyon pushing walls of fire ahead of it. Families evacuated with whatever they could carry. Fires and apocalyptic smoke moved down the west slope into the valley. Destruction was capricious, devouring one home and leaving the next with only smoke damage. Towns already stretched thin by years of economic struggle faced immediate, overwhelming challenges.

"We went mobile for COVID," Hudson says, "which gave us the platform to address the wildfires. We were ironically well-prepared to deal with the situation,

Surveying the fire damage in Santiam Canyon.

so the community wanted us to start this wildfire relief program."

Cindy Chauran, who lost her home in Gates, reached out to her friend Deana Freres, active in the community, and told her she had an idea. The two contacted the SIT team and proposed the Santiam Wild Fire Relief Fund (SCWRF), to be run through the hospital. Within a week, the fund was accepting donations of money and goods, and distributing them along the SIT model. Local churches set up "stores" to make food, toiletries, clothes, and other necessities available free of charge.

By mid-November, the SCWRF had grown to over $2.2 million dollars. Hudson says that at some point, the efforts will move from relief to rebuilding, and other organizations will take the lead. But for now, the SIT team continues to connect people to resources and leverage money for the greatest impact. Over 900 families have been served, including 1825 adults and 770 children.

Story after story demonstrates community members rising from the literal and figurative ashes, finding resilience, and rebuilding. As odd as it sounds, the trials presented to Santiam and its service integration team by COVID prepared them for the wildfires in a way they never could have anticipated.

Given 2020's track record, perhaps we should expect a jet to crash land in our backyard. And if it does, Santiam Hospital will be ready.

In an article published in late November, consulting giant McKinsey & Company had this to say about COVID and healthcare, "While the COVID-19 pandemic has placed unparalleled demands on modern healthcare systems, the industry's response has vividly demonstrated its resilience and ability to bring innovations to market quickly. But the crisis is likely far from over and the sector's innovation capabilities must continue to rise to the challenges presented both by COVID-19 and the economic fallout from its spread. While many industries are facing unprecedented disruption, medicine and healthcare are uniquely affected given the nature of this crisis . . . Similarly, hospitals are caring for COVID-19 patients with evolving protocols while maintaining continuity of care for others, often against the backdrop of vulnerable staff, supply and equipment shortages, and, for some, accelerating financial headwinds."

McKinsey's analysis could have been written to describe conditions in the mid-Willamette Valley. That should give us all a sense of hope and pride in our resilient local institutions.

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BY HOWARD BAUMANN, MD

PLEASE JOIN US FOR A HISTORICAL TOUR OF WILLAMETTE UNIVERSITY'S COLLEGE OF MEDICINE

"Sorry, cancelled due to COVID-19."

Sound familiar? We had originally scheduled this tour for Saturday May 2, 2020, as part of our Medical Society's 150th Sesquicentennial Celebration. Krista Wood, Willamette University's VP Ross Stout, Visiting Professor Bill Willingham, and I, set up the tour. We were fortunate to have Dr. Willingham agree to join us as a guide, as he had just published his book on the history of Willamette's architecture.[1]

It's now six months later, and suddenly a thought hit me: ***"Let's take the tour anyway, COVID be damned!"*** The Editorial Board of Chart Notes approved my suggestion to present an almost identical tour of Willamette that I took in 2014. I originally "won" this tour at an auction fundraiser for Willamette Heritage Center at Mission Mill, which allowed me to ask three other retired physicians and their spouses, and they agreed to focus the tour to the medical aspects of campus.[2] Capi Lynn joined us to write an article for the Statesman Journal.[3]

I have always been interested in the relationship between our Medical Society and Willamette's College of Medicine, as both were founded by the same group of local physicians. Willamette opened its medical school in 1867, the first in the Northwest. Our Medical Society was founded in 1870, the first in Oregon.

Our tour started at the Art Building on the northwest corner of the campus, built in 1905 to serve as the College of Medicine's new building. Previously, the medical college had been located on the third floor of Waller Hall, which by 1905 had become overcrowded due to the increasing number of medical students, up to 52, and a need to expand to a four-year curriculum. The new building was state-of-the-art with laboratories and lecture rooms on the first two floors. An elevator connected the daylight basement to the top floor, while a large attic room housed a dissecting chamber which was lighted by fluted glass mounted in the ceiling. Today that room serves as the Art Department's photography and digital art studio.[4] (Unattached Footnote)[5]

Next[6] we toured Waller Hall, the only other original medical building on campus that still remains. Waller Hall was completed just in time for the new College of Medicine to take over the third floor with its classrooms, labs, and some dormitory space for the medical students.[7] The anatomy lab was a detached wooden shack on Mill Stream on the southeastern edge of campus. We do not have photos or drawings, but there are several medical student descriptions of the shack and discussions about its aromas. Our tour next took us to the top floor of Waller Hall to view the cupola, and to catch up on its history. We learned that Waller Hall and its cupola burned down in 1891 and 1919, but those were years the Medical School was located elsewhere.

We then toured Willamette's current anatomy lab in the Olin Science Center. We were greeted by Exercise Science Professor Peter Harmer, two of his lab assistants, and a covered cadaver on a stretcher. We were shown only the legs--each still had small green flags to mark identification questions for a test earlier that day. I think I heard a faint sigh of relief when we were told that we were running behind schedule and would have to forgo the quiz!

The tour ended in the Archives Department on the second floor of the Mark O. Hatfield Library, where Archivist Mary McRobinson and her staff, showed

Medical College postcard dated Oct.7, 1907. Written on both sides by a Willamette student to a friend in Nebraska whom she urges to apply to medical school here. (Author's collection)

us key historical documents and artifacts and answered our questions. Tour participants were intrigued by the fact that the College of Medicine had not always been located in Salem for all of its 46 years. In 1877, due to population and economic issues, the medical campus relocated to Portland for the next two decades. Here is the sequence of campus locations through the years:

1867 **SALEM** – College of Medicine founded on 3rd Floor of Waller Hall. A medical clinic is located downtown at Moores' Building on Commercial Street. Anatomy shack is located on Mill Stream.

1877 **PORTLAND** – Campus moved into rented space in Portland on 4th Street between Yamhill and Morrison Streets. The anatomy room was located on the second floor of a livery stable at Park and Jefferson Streets, the current location of the Portland Art Museum.

1887 **PORTLAND** – Willamette University constructed its own state-of-the-art medical school building on corner of NW 15th and Couch Streets, which included its own anatomy lab.

1895 **SALEM** – Back to Waller Hall's 3rd floor, but very crowded. The second floor of the Patton Building downtown on State Street rented for extra space. Anatomy shack is again located on Mill Stream.

1905 **SALEM** – New Medical School Building completed on the northwest corner of campus. Anatomy lab is located in attic room.

1913 **PORTLAND** – The College of Medicine merges with University of Oregon Medical School in Portland.

The other Salem buildings used for the training of medical students still standing (no Portland structures remain):

(1) The 1883 Kirkbride Building at Oregon State Hospital (which today also houses the OSH Museum of Mental Health).

(2) The 1910 Oregon State Tuberculosis Hospital (now the Administrative Building of Corban University).

Given that our Sesquicentennial Celebration doesn't officially end until October 2021, maybe we could still pull off a real live tour of Willamette's College of Medicine?

Kirkbride Building OSH

1 William Willingham, Collegiate Architecture and Landscape in the West. Willamette University, 1842-2012 (Canada: Friesens Corporation, 2019).
2 Drs. Bob Buza, Dan Sewell, and Don Masson.
3 Capi Lynn. Willamette's Secret Side. We tag along on a rare behind-the-scenes tour of the University. Statesman Journal, March 9, 2014. This was a great reminder for me of the tour events.
4 "A Fine Building," Statesman Journal, January2, 1906.
5 "Young Sawbones Housed," Capital Journal, January 23, 1906.
6 Ron Cowan. "Redo in Works at College," Statesman Journal, March 17, 2002.
7 Olaf Larsell, The Doctor in Oregon (Portland, Oregon: Bifords and Mort, 1947), 347.

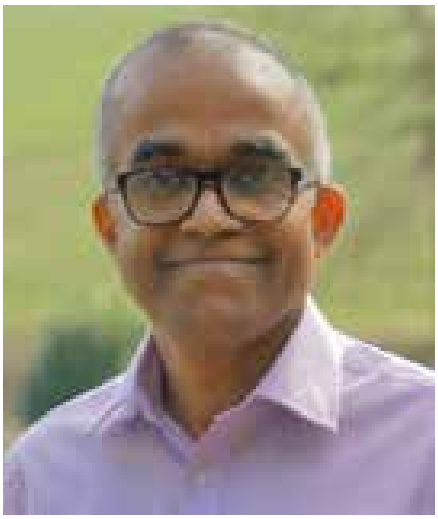
THE PANDEMIC

Practice Survey

BY NANCY BOUTIN, MD, MBA

This issue, our monkey surveyor asked if your practice had changed due to COVID and if you were willing to share your experience. All but one respondent had changed their practice in some way. Those willing to talk about it fell overwhelmingly into the primary care segment of our membership. Surprising at first, a quick review of the recent history of primary care and the finding starts to make sense. There have been warnings about the potential demise of primary care for several years, including a Chart Notes exposé a decade ago predicting the end of the "onesy-twosey" practices as more providers (and payers) moved to an employed model. And yet, an interesting countercurrent has developed in response. The new alphabet soup of PCP models, demonstration projects, and provider groups is probably worth its own issue of Chart Notes.

Satya Chandragiri, MD, the non-PCP survey responder, has two psychiatric practices—the private practice in town and the 160 patients in long-term care facilities outside Marion and Polk counties. For people who do well with tech solutions, the switch to virtual appointments has generally increased satisfaction. Dr. Chandragiri's independent clients who are tech—or



Satya Chandragiri, MD

hearing—challenged still come to the office. Unfortunately, that's not an option for his facility patients. Some of them can manage video appointments if a staff member brings them a laptop and explains what's happening. However, some patients with dementia, brain injury, or other cognitive deficits cannot function except face-to-face. Given the risk of exposure in group homes, Chandragiri says he feels like he should wear a leper bell to warn his family when he returns from a facility visit. And then there's his role as Chair of the Salem-Keizer School Board. . . .

Primary care responders divided themselves into several different groups. One group has already left their practice. One group changed their practice model before the pandemic and transitioned to a COVID-informed approach without any difficulty. At least one has actually expanded their practice, which is remarkable given the beating primary care has taken since last March.

In a survey published by the Primary Care Collaborative in late November, 25% of providers said their fee-for-service volume remained 30% lower than pre-pandemic levels. Two percent of practices had closed, while 5% had merged with a larger system. Almost half of the survey respondents said clinician salaries had been reduced or skipped. Thomas Bodenheimer, MD, MPH, and Founding Director of the Center for Excellence in Primary Care, wrote a blog piece for Health Affairs in May that paints a bleak picture of the state of primary care prior to COVID, saying that the average provider would require 21.7 hours per day to meet the needs of a 2.5 k patient panel. Burnout, decreased patient access, and underfunding had all taken their toll before the disasters of 2020.

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PRACTICE SURVEY

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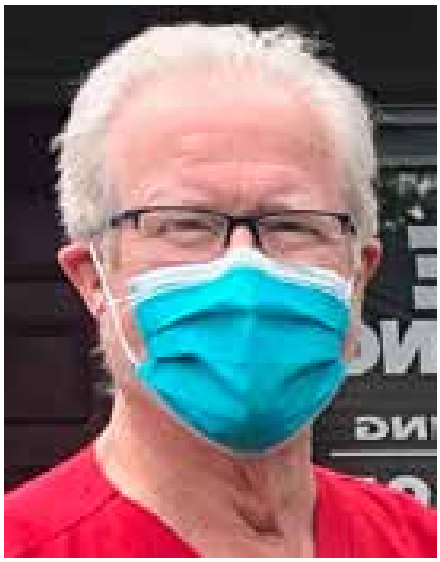


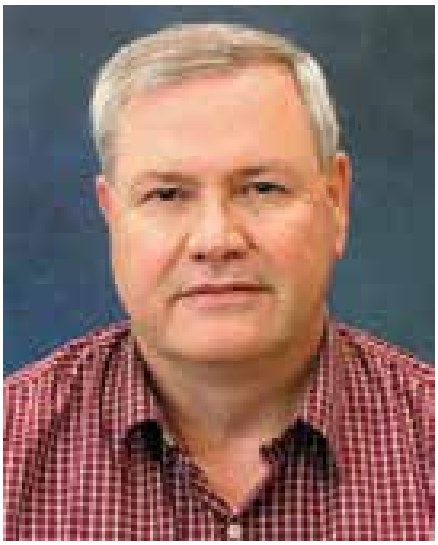
Richard Boughn, MD

Richard Boughn, MD, a stalwart of the mid-Valley medical community, rode the wave of healthcare change during his 40+ years of independent practice in Stayton. When he arrived in 1976, his office required patient payment at the time of service, but provided insurance forms and instructions to help patients get reimbursed for the bill they'd just paid. (What we call "reimbursement" is actually payment for services rendered, not a repayment for money we advanced elsewhere. Language matters, but that's a rant for a different day.) Between twenty and twenty-five patients a day, plus rounding at Santiam, Salem Memorial, and Salem General hospitals still left time for a little work/life balance. Medical staff meetings included dinner and a nice glass of wine. Paper charts were intended to help the doctor's memory, not serve as vehicles for billing or to meet quality metric requirements.

Those days are long gone, but Boughn rolled with the times. He continued to care for patients he had known for years, occasionally up to five generations in one family. Some of his patients aged and transitioned to Medicare. Logging and mill families lost jobs and went on Medicaid. A few years ago, commercial insurers transitioned patients to medical homes and Boughn's practice didn't qualify. He was left with a panel made up of "self-pay" or government-sponsored insurance, and that didn't cover the overhead. When his lease with Santiam Hospital came up for renewal, and they needed space for a COVID clinic, he relocated to downtown Stayton. But with only 7-8 patients daily and office hours three and a half days per week, he decided the time had come to close the doors. Boughn took a job with the Social Security Administration, reviewing cases for disability determination.

He says a bad back keeps him from old hobbies and he would miss the mental stimulation of a medical practice. "There's only about seven people in the building these days," he says, "but I recognize names of retired doctors on some of the office doors. I guess they're working remotely."

Boughn says he looks forward to seeing old colleagues and socializing at work again—when distancing mandates relax.



Doug Eliason, DO

Doug Eliason, DO, who announced his new job in the President's Letter at the front of this issue, says he was thinking about an "encore career" even before COVID. He's always been interested in the administrative side of moving healthcare to a higher value proposition and decided to make the leap.

"I read a very interesting article that said when we come out of this, our national debt is going to be inflated, healthcare systems are going to be struggling, and the federal government will have very few options short of cutting healthcare funding. States will have to do it. Oregon will have a giant hole due to lost tax revenue. At the OMA Virtual Meeting in September, Governor Kitzhaber talked about the two things you can do: cut across the board with no thought about value, or shape cuts in such a way to cover high-yield healthcare. You stop paying for things we do to and for patients that have little or no value."

Eliason has taken the number two position, VP of Clinical Affairs, in a population health management company. The goal is to help providers make smart choices resulting in evidence-based,

...continued on next page

PRACTICE SURVEY

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high-value healthcare for patients on Medicare Advantage health plans—and reward providers with a share of the savings. He will be working with a physician CEO as the company expands into Oregon. Much of the organization's success, Eliason says, will depend on relationship-building on a local level and offering value for busy providers.

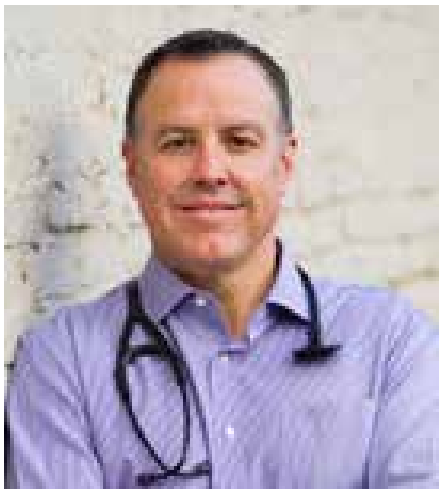
Sam Datta, MD

While most of our survey respondents have practiced in the mid-Valley for years, **Sam Datta, MD**, went to work with the Salem Health Medical Group days before the COVID pandemic arrived in the US. Additionally, he moved to an employed model after more than a decade in independent private practice; he came to Salem to join his wife, Deepshikha, a member of Pacific Pathology Associates.

At almost the same moment, the WVP clinics began consolidation into the Salem Health structure, Dr. Datta started his new job, the respiratory clinics opened, and non-COVID outpatient care contracted as many people canceled or postponed routine appointments—not likely what he had envisioned when he moved to Salem.

Ron Palm, DO, has practiced in Salem for the last 16 years. When he found himself trying to manage the 21.7 hour work day Dr. Bodenheimer warned about, he decided something had to give. He switched to a retainer-style, no-insurance care model called Direct Primary Care (DPC). In some ways it resembles the environment that greeted Dr. Boughn when he came to the mid-Valley more than 40 years ago. Palm's panel is about 900 patients, instead of the 2.5 k described in the Health Affairs blog post.

With appointments scheduled for 30-60 minutes, there is no backup in Palm's waiting room. He says he realized keeping potential COVID patients separate from "healthy" patients who wanted annual physicals or blood pressure checks didn't pose any real problems. Early in the pandemic, he scheduled routine patients in the morning and patients with COVID symptoms after 2:00. That gave staff plenty of time for additional cleaning and to ensure segregation between the two groups. As time has gone on, he's been able to push the starting time for his own



Ron Palm, DO

version of Salem Health's respiratory clinic later into the afternoon. He says if he still ran the ultra-busy schedule of his old practice, trying to manage the two groups would have been logistically more difficult.

Palm thinks that the trusting relationship inherent in the DPC model has helped him educate his patients about the realities of COVID and the importance of masks and other precautions. He has sent out bulk emails to address important information. He also tells patients, "Hey, I'm your doctor and I care about you. You trust me to tell you the truth. I think this is important and I want you to keep yourself healthy."

He believes the vast majority of his patients follow his advice on a regular basis. The Primary Care Collaborative, on the other hand, said that "61% (of providers) report spending significant time combatting misinformation about the pandemic among their patients."

The DPC model also appealed to **Manya Helman, MD**, who has maintained an independent practice for almost 30 years, alongside her board certification in addiction medicine. Like Palm, she avoided many of the challenges faced by providers and systems with more overhead and reliance on intermediary payers. As federal waivers paved the way for enhanced telehealth, Helman

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PRACTICE SURVEY

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Manya Helman, MD

realized she could partner with providers in underserved areas to offer addiction treatment and support.

"Because of the virus," she says, "the DEA okayed virtual intake appointments for medication-assisted treatment, rather than requiring in-person admissions. It opened up access for patients in more remote areas. One of our two certified alcohol and drug counselors (CADC) is very tech savvy and even has group sessions by video for people who like that."

Helman says the process seems tricky, but is really easily reproducible. Admission is done through a video call. All paperwork is sent through the mail or fax. She has an e-prescription program that she can use to send controlled substances electronically. The patient must have a family provider locally who can do random urine drug tests. Counseling occurs via telemedicine, although patients are expected to do a 12-step program in their community for added likelihood of success. There is a company that started on the East Coast, but now operates in Oregon, that will courier buprenorphine to patients and can even perform an observed urine collection, "which is to addiction medicine", she says, "what a CBC would be for a hematologist. "

Helman says that rather than seeing the effects of the pandemic as completely negative, she sees an opportunity for healthcare to use creativity to address problems, some of them long-standing.

As we move into the expected winter surge of COVID cases, with resources stretched thin and workers expressing fatigue, we'll all need to use lots of creativity. Multiple vaccines have been approved, which should bend a disease curve that currently points toward exponential growth, but we still need to find, develop, and/or exercise the resilience needed to rise from this global disaster. Our providers have done it before and we'll do it again.

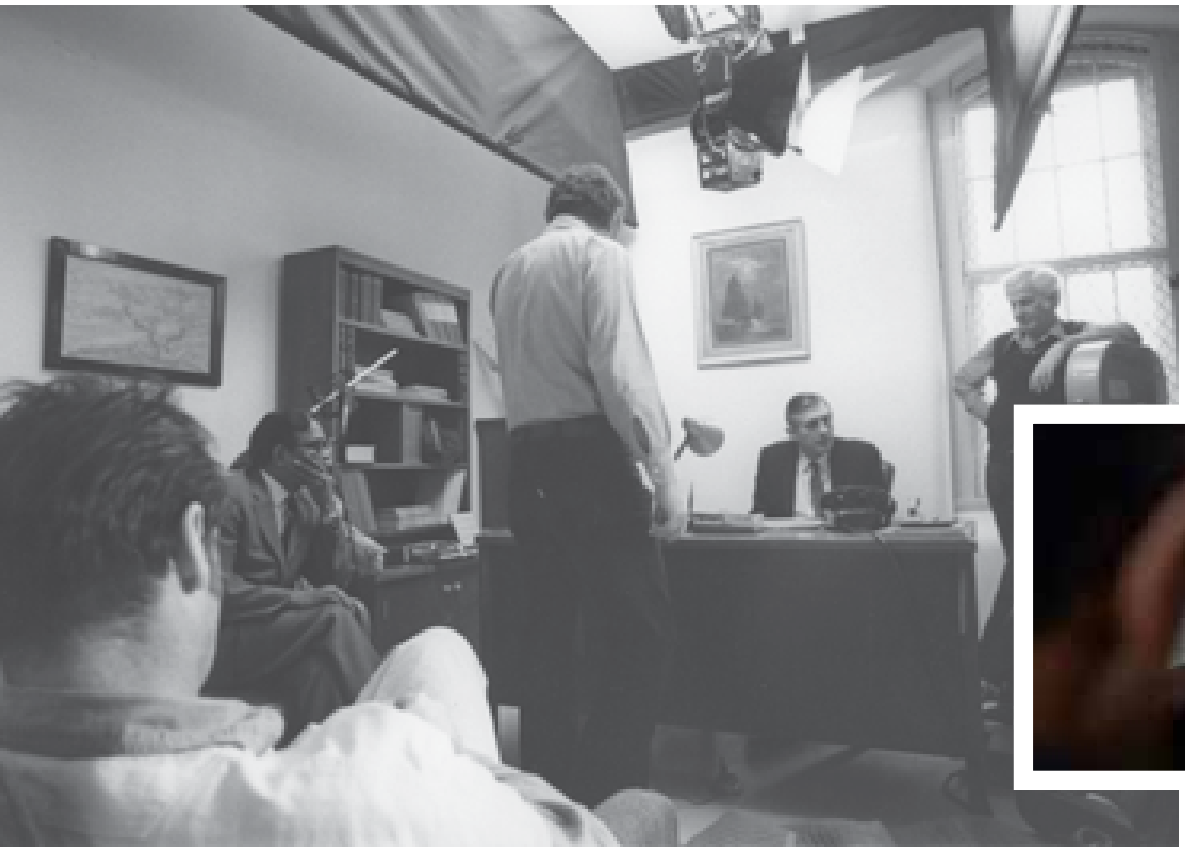
BY NANCY BOUTIN, MD, MBA

Last Word
ADVICE FROM DR. PATI

At 95-years-old, Prassana K. Pati, MD, is one of Marion Polk County Medical Society's most senior members. He has accumulated awards and singular experiences in his nine and a half decades on this Earth. He spent much of his career, 1958 to 1985, working at the Oregon State Hospital. He was named a Distinguished Life Fellow of the American Psychiatric Association. Without conducting a formal survey, it is safe to assume Dr. Pati is the only medical society member to have had a named, speaking, part in a movie that collected Oscar's top five statuettes—1975's "One Flew Over the Cuckoo's Nest," starring Jack Nicholson.

However, the moment that changed Pati's life, that prepared him for the Coronavirus pandemic, occurred in 1985 in the hallways of what is now Salem Hospital's B building. Pati, a hard-working, cigarette-smoking, 60-year-old psychiatrist, lay in the CCU recovering from a myocardial infarction. His personal physician, Joe Thaler, came to visit. Thaler suggested a little walk, which seemed like a risky plan to the patient. "He held my hand and walked the halls with me," Pati says. "He told me that when I recovered, he wanted me to walk—half a mile twice a day to start and then quickly progress to four miles a day. For 30 years I walked four miles around my SE Salem neighborhood every single day. If I hadn't, I wouldn't be here talking to you now."

Pati realized, no matter how busy or stressed a person might be, they needed to do something for their physical and mental health each and every day—patients, providers, and families. "No one is 100% mentally ill," Pati says. "And no one is 100% mentally well. We're all somewhere in between. We all need to be responsible for our own health—and doctors need to



Dr. Pati on the set of Cuckoo's Nest with Jack Nicholson.

Photo courtesy of OSH Museum of Mental Health

partner with their patients, not just the complaint they bring to the office, but the underlying cause. Doctors must help their patients find a way to take control of their health, no matter the barrier."

There are many realities Pati can't change. The deinstitution movement of the 1960s and 70s moved mentally ill patients out of psychiatric hospitals with the promise of community care that has never met the need. A viral pandemic has increased isolation for most, with a special impact on people living alone or in facilities. He can no longer take his beloved walks, and macular degeneration makes reading impossible. Still, he believes a daily routine of exercise and mindfulness can improve everyone's well-being. He begins each morning with a regimen of stretches and takes a few minutes for meditation.

Children in school, Pati says, should start the day with fifteen minutes of physical activity, teachers included. At home, he suggests that parents engage and exercise with their kids daily—a walk, some simple yoga, a meditation.

"If you're stuck in your house and you don't know what else to do," Pati says, "turn on some music and dance."

That sounds like a wonderful antidote to everything 2020 has thrown at us: just turn on the music and dance.

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