A PUBLICATION OF THE MARION-POLK COUNTY MEDICAL SOCIETY SUMMER 2019

CHART NOTES

Part of the Puzzle

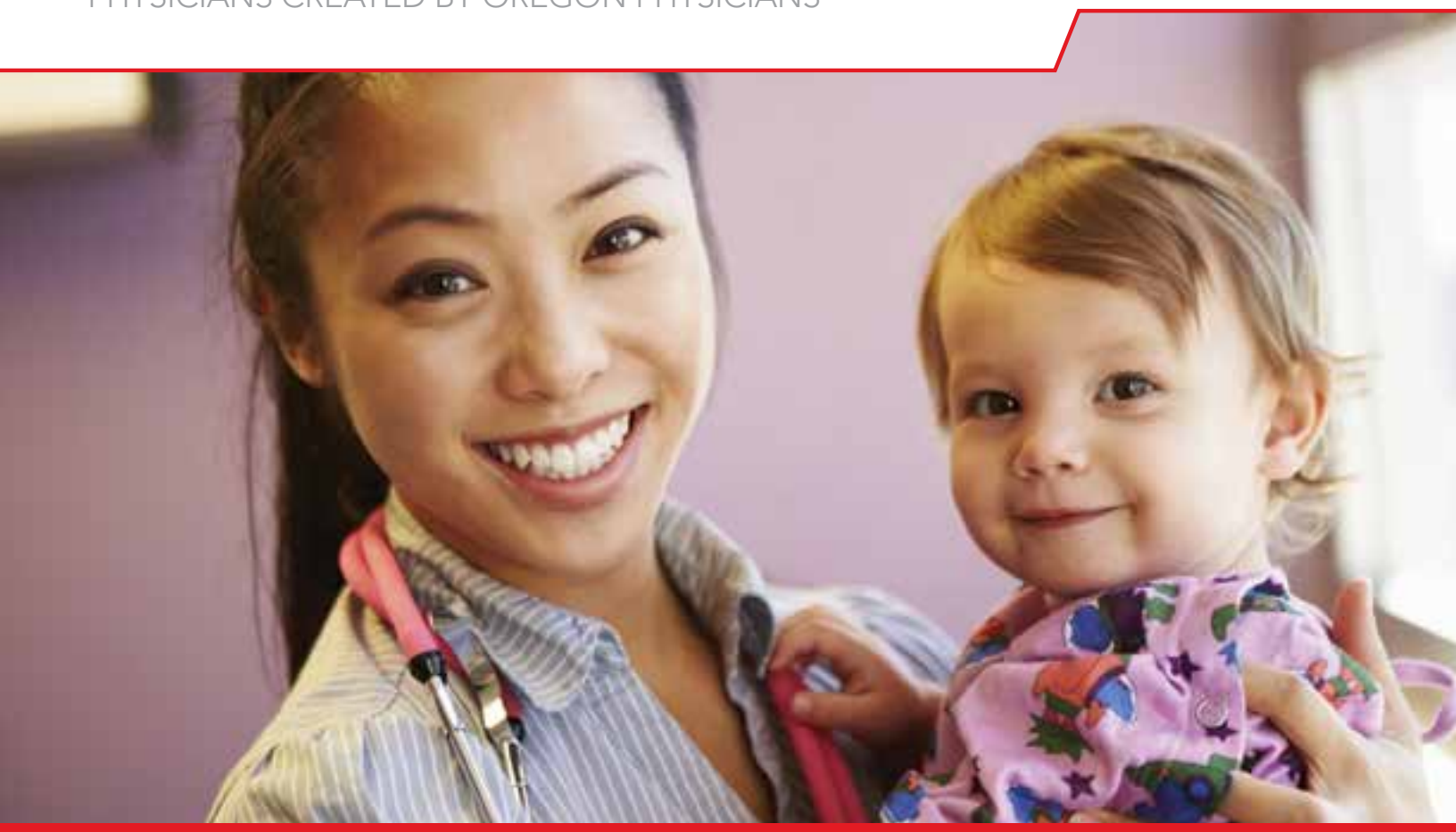
SOCIAL DETERMINANTS OF HEALTH

More than a catch phrase, social determinants of health are key to improving healthcare

pg 4

45 YEARS OF SERVING OREGON PHYSICIANS

CUSTOMIZED COVERAGE FOR OREGON PHYSICIANS CREATED BY OREGON PHYSICIANS



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CHARTNOTES

Marion-Polk County Medical Society
4985 Battle Creek Road SE
Suite 102
Salem OR 97302
P: (503) 362-9669
F: (503) 362-0109
E: info@mpmedsociety.org

mpmedsociety.org

President's Message

Erin Hurley, MD, FAAP

Social interaction a determinant of health

When you think of social determinants of health, what do you think of? I will admit, I wasn't completely sure I understood the topic before I ventured into writing this letter. According to the CDC, there are generally five areas recognized as determining the health of a population: biology and genetics (sex and age), individual behavior (alcohol, IV drug use, unprotected sex), social environment (discrimination, income, gender), physical environment (where a person lives, crowding conditions) and health services (access to quality health care, having insurance). The CDC further explains that the conditions in the places where people live, learn, work and play affect a wide range of health risks and outcomes. Think of the impact poverty has on many social factors. I have learned with my work at a child abuse assessment center that poverty has a positive correlation with child abuse. Child abuse can be a barrier to learning. Barriers to learning can increase chances to have lower levels of education, which in turn can have a negative impact on health, as well as income. See the vicious cycle?

The term social also makes me think of how we clinicians interact socially with each other, our patients, our families and our community. I often find my social interactions are the first thing to go when life gets hectic. And yet, having healthy social interactions can have a significant positive impact on our moods, sense of wellbeing and health. Studies have shown that having strong friendships as we age can help prevent mental decline, the touch from a romantic partner can decrease physical pain and social interactions can cause a release of neurotransmitters, giving us a natural high and lowering our cortisol levels, thereby lowering our stress. I often put work-related meetings and doctor's appointments on my calendar but leave out scheduling time for getting together with friends, having a date night with my husband or spending special time with my kids. And for me, if it isn't on the calendar, it isn't going to happen. It's time to make time for our friends if we aren't doing so already. I can say that focusing on strengthening friendships with my girlfriends over the past two years has been a great investment. I have a caring group of individuals I can reach out to for help, advice, encouragement or just a good time.

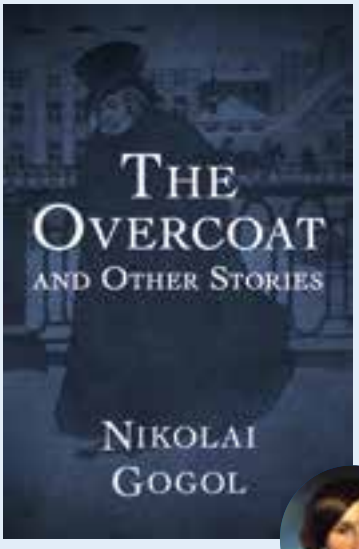
The Medical Society provides several opportunities each year for us to connect face to face. I am hoping we will find additional activities in the next few months that will encourage us to gather more often, not out of a sense of duty, but in an intentional manner to get to know each other better and at the same time become healthier and happier. Anyone up for a group yoga class or one of those painting parties? How about volunteering together for a nonprofit organization or helping out a family struck by cancer or other devastating disease? I know that I have found myself energized and have gained amazing lifetime friends when I have volunteered or participated in fundraising events.

BY HEATHER RAYHORN

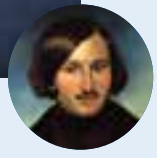
MORE THAN THE LATEST CATCHPHRASE

Government agencies and health organizations are taking social influences to health seriously

A picture of how social determinants of health affect people is clearly depicted in "The Overcoat," a 19th Century short story by Russian writer Nikolai Gogol.



The story is about a low-ranking, introverted official who is poor but loves his job. The man, named Akaky, realizes one day his coat is in disrepair. A new coat will cost him twice his salary. He saves for months, going hungry, until he has enough for a new coat. His new coat not only is warm but brings him new social attention at work that he's not too comfortable with and seems a bit lacking in sincerity.



After his newly kind coworkers throw him a party, he has to walk home in the dark to his less-than-safe neighborhood. Akaky is mugged and his coat stolen. He no longer even has his old raggedy coat, and he lacks the clout to get the police to help him. Within days, he gets a throat infection and dies.

The tale takes a supernatural turn with Akaky's ghost coming back, but the point of social determinants of health has been made: Our hero has died from an infection, but it ultimately resulted from poverty, a bad neighborhood and his lack of warmth and social support, including that of the local police. One might even add to the list food scarcity (he ate less to save up for his coat) and the stress of fake, cruel coworkers. None of these are things a doctor necessarily would traditionally address, but they all worked together to negatively affect Akaky's health to the point of an early death.

Thankfully today, social services such as Helping Hands in Salem provide free clothing while food pantries, programs like Meals on Wheels and government assistance prevent many people from going hungry. But people are still suffering from chronic disease and early mortality due to many of the same social determinants Akaky faced.

What are SDOH?

It's hard to escape the phrase social determinants of health, which has especially gained traction with the advent of the Coordinated Care Organizations (CCOs), despite being around in concept for much longer. It is front and center whether looking at the recently released Marion-Polk County Health Assessment, Oregon's new CCO recommendations or reports from national or international organizations such as the Centers of Disease Control or the World Health Organization.

Social determinants of health tell us there is more to our health than genetics, medicine or even one's choices. The World Health Organization defines social determinants of health as the "conditions in which people are born, grow, live, work and age." So, in terms of health, where we live matters, whether we have housing or access to healthy food matters, our education and employment matters, and how much money we have matters.

"We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health," the CDC reports[1]. "We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods or substandard education."

The World Health Organization published its first edition of "Social Determinants of Health: The Solid Facts" in 1998 to inform and support health policy making. A second edition was released in 2003. It claims that "even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich."[2]

SDOH: A Local Picture

Social determinants of health affect people all over the world, and while many social determinants are reflected in various communities, each area's picture is often different.

The Marion and Polk County health departments recently released a look at our areas in the Marion-Polk Community Health Assessment 2019.[3] Social determinants get their own section and show up in other sections of the report, as well.

"It's part of our recipe now," said Marion County Health

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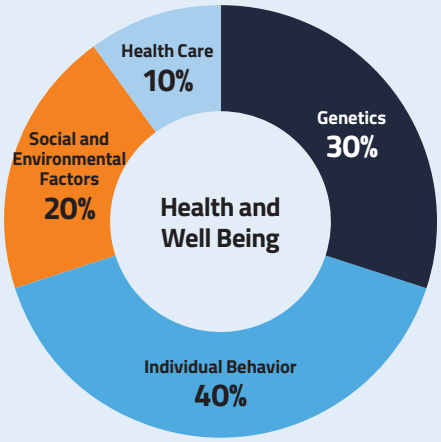
Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Better — Improving the Health of the American People. NEJM. 375:1221-8.

KFF

Social Determinants of Health [6]

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to Healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational Training		Discrimination	Quality of care
Medical Bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

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& Human Services Prevention Program Supervisor Kerryann Bouska about social determinants of health. "We need to make sure we are looking at inequalities and meeting people where they are at and addressing things comprehensively, not just looking out one lens."

The assessment, which comes out every five years, says our community (Marion and Polk counties) "particularly suffers from lower educational achievement, higher rates of people living in poverty, food insecurity and unaffordable housing." It also points out our community has several things going for it that affects our health including natural resources, local produce and recreational areas that help to support healthy living.

"Additionally, the population is growing," the report says, "and the economy is improving, providing opportunities for advancement and economic expansion. However, not everyone in the community is able to partake in these opportunities or equally share in the resources that are available."

The strategic issues that came out of this year's assessment are housing, behavioral health support and substance use, showing a shift to "focus on priority areas that are more upstream, or at the root of what causes health conditions, as opposed to the conditions themselves."

The focuses are being used in the departments' current work creating the Community Health Improvement Plan (CHIP), which should be done by the end of 2019. That plan, which will include resources and strategies, will then be picked up and used by area health partners, including hospitals and CCOs.

"Then it's up to the community to say this part of our system needs to be strengthened," Bouska said, adding it's about being smarter with current services using the data versus asking groups to start from scratch.

Bouska compares it to someone who wants to paint their house but after an assessment — real data — realizes what they really need is to fix the crack in their foundation. So instead of painting, the homeowner gets to the root of the problem, the crack. A program that delivers meals, for example, can focus on asking themselves if they are efficiently getting to the people who need them the most in our area, such as people in poverty without mobility, transportation and social support.

"Are you targeting the right audience with the services you are providing?" Bouska asked. "Are you making sure you're doing the best work in the right places to improve health and close health gaps?"

Changes in CCOs

The Oregon Health Authority also is looking more to social determinants of health as it plans for round two of the CCOs, called CCO 2.0, coming in January of 2020 as the first contracts come to an end. In the CCO 2.0 Recommendations[4], social determinants of health are listed as one of Gov. Kate Brown's four focuses for the future of the Oregon Health Plan (Medicaid). According to the OHA, The Oregon Health Plan serves a quarter of Oregonians, the majority of which are part of one of Oregon's 15 CCOs.

"From the beginning, Oregon's coordinated care model recognized that many things affect our health outside of the doctor's office," the CCO 2.0 Recommendations say, noting how CCOs were built to have flexibility within their budgets to provide services outside traditional medical services. But it adds, "Over the next five years, CCOs will increase their investments in strategies to address social determinants of health and health equity."

The report says this includes building stronger relationships with members, nonprofit organizations, hospitals, schools and local public health departments, as well as increasing strategic spending by CCOs on social determinants of health and developing strategies to increase understanding of spending in this area and track outcomes.

Amanda Peden, a transformation analyst with OHA's Transformation Center, said over the last five years, the CCOs have done some innovative work within the area of social determinants of health that they hope to build on with CCO 2.0 and make more consistent with better tracking. While at times that will include funding, Peden reiterates it also means making strong partnerships with those in the community who are already focusing on these areas.

"They are the experts already doing the work," she said. "We want to avoid the health system re-creating the wheel, stepping outside the work they are structured to do."

The InterCommunity Health Network CCO, which covers Lincoln, Benton and Linn counties, for example, is funding an organization called CHANCE to provide peer support to those getting mental health services and in addiction recovery through such things as housing and transportation.

"One of the things we heard loud and clear is that housing is really a problem around the state," Peden said. "One of the things that is changing for the next round is having all plans working toward housing." This includes prioritizing housing supports and services for social determinants of health spending and initiatives, in addition to other community priorities.

Some of that work has already happened in Marion and Polk counties. For example, Marion County Willamette Valley Health Organization has a CCO-funded employee who is working with assisting the homeless in Marion County.

"We hope that CCO 2.0 results in more integration between the medical and social systems so doctors have more tools at their disposal and community connections to address the social needs of their patients," Peden said. She said CCOs will be required to have detailed plans for using and paying traditional health workers, such as community health workers and peer support specialists who are critical in connecting patients with social resources.

Adding to the push to address social determinants of health, House Bill 4018, passed during the 2018 session, requires CCOs to spend a portion of their net income or reserves on social determinants of health and health equity.

As you'll see in this issue of Chart Notes, many private organizations and providers also are talking about social determinants of health on a local level, figuring out how they too can better serve their community in this area. The overall goal is through policy to reduce the negative social determinants of health so that people like Akaky are simply classic tales and not daily reality.

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A look at local SDOH numbers

The Marion-Polk Community Health Assessment[3] offers a good look at Marion and Polk counties. Here are some of the findings that describe how SDOH affect our communities compared to the rest of Oregon:

Poverty levels:

Despite decreasing poverty rates in Marion and Polk counties as well as in Oregon, community members in Marion had lower household median incomes and a higher percentage living in poverty, especially children, than Polk and the state. Roughly 25 percent of children were living in poverty in Marion, compared to 17 percent in Polk and 20 percent in Oregon. Unemployment comes in at 4 percent for both counties compared to 3.8 percent for Oregon.

Food needs:

Just over 10 percent of the population were considered to be food insecure, which was slightly lower than the state, but about one in five children were food insecure. While most adults were eligible for some form of nutrition assistance in Marion County, more were reliant in Polk County on charitable sources such as food banks. Only 74 percent of food-insecure children in Marion and 68 percent in Polk were eligible for some form of assistance. In Marion, 41 percent of community members, mostly in urban areas, were living in a food desert compared to 18 percent in Polk. Food deserts are areas that are both low-income and have low access to supermarkets or large grocery stores. This especially becomes a problem when paired with lack of transportation, leaving people to walk to fast-food restaurants or convenience stores for food.

Low-income communities have fewer supermarkets that sell affordable, nutritious food than wealthier ones.[6]

Rural numbers:

One third of Marion County community members lived outside of the five largest cities in Marion County. Polk County came in about half of that (16 percent). Those who live in more rural areas are more likely to have issues with accessing health care services, healthy food and transportation.

Education:

More community members have a high school diploma/GED than in recent years. However, educational achievement in Marion was lower than Polk and the state, especially with regard to college graduates. In Marion, 22 percent of people had a Bachelor's degree or higher, compared to 30 percent in Polk and 31 percent in Oregon.

Diversity:

In Marion County, one in four households speak a language other than English at home, compared with 14 percent in Polk and 15 percent in Oregon.

Housing:

Low rental vacancy rates and a high cost to rent relative to income is making housing unaffordable for many, and homelessness is growing.

Safety:

The violent crime rate, which has been growing, was higher in Marion than it was in Polk and the state, which comes in 14th in the country for violent crime.

Neighborhoods:

Life expectancy for our communities came in basically the same as Oregon's average with men expected to live to 77 and women to 81 in Marion County, with Polk County adding on a year for both men and women. What's interesting is when you look at neighborhoods within the counties or even within the city of Salem. For example, according to USALEEP[5], those who live north of downtown Salem in the Highland neighborhood have an average life expectancy of 75, but if you live just a mile away across the Marion Street Bridge in West Salem, that number grows to 82, showing how much neighborhoods, or perhaps the poverty they represent, matter. The highest life expectancy at birth in Oregon is 89.1 years, in a section of northwest Portland that hugs the southern border of Forest Park. The lowest life expectancy in the state — 66.2 years — is in a part of central Medford running along the west side of Interstate 5.

1. Centers for Disease Control and Prevention. Social Determinants of Health: Know What Affects Health. Jan. 29, 2018. cdc.gov/socialdeterminants/index.htm.
2. World Health Organization. Social Determinants of Health: The Solid Facts. 2nd Edition. Copenhagen, Denmark. 2003.
3. Marion-Polk Community Health Assessment. 2019. co.marion.or.us/HLT/communityassessments
4. Oregon Health Authority Health Policy & Analytics Division. CCO 2.0 Recommendations of the Oregon Health Policy Board. Portland, OR. 2018 October.
5. USALEEP. Oregon Life Expectancy at Birth by Census Tract. 2010-2015. https://arcg.is/10DPu4.
6. Oregon Health Authority. Place Matters Oregon. 2019. placemattersoregon.com.

BY RICK D. PITTMAN, MD, MBA

SWEDEN'S HEALTHCARE AN EXAMPLE TO FOLLOW

"Live free or die" is the mantra of the American people. This emphasis on our individuality and freedom from government controls is perhaps one of the largest obstacles for health care reform in our country. In this issue of Chart Notes, we look at the social determinants of health and how we are dealing with these issues locally. What we really need is comprehensive Health Care Reform, and we can take some lessons from Sweden, one of the richest countries in the world. (The Commonwealth Fund, 2017)

In the United States, we spend 17.2 percent of our gross domestic product on healthcare (and that number is increasing) while Sweden only spends 9.5 percent of its gross domestic product on healthcare. In Sweden, everyone has equal access to healthcare services. Inpatient, outpatient, prescription drugs, primary health care, dental care for children and young people, public health, preventative services, disability, rehab services, home care, nursing home care and patient transport support services are all covered by the publicly financed healthcare system. There are cost ceilings on individual's contribution to healthcare. Once a Swedish citizen reaches their co-pay of approximately $137 (actual amount depends on where they live), the rest of their healthcare is free within a 12-month period of their very first provider visit. Their maximum out-of-pocket expense for outpatient medications is around $225 a year. Children are exempt from cost-sharing for all health services. The percentage of healthcare cost paid for by the government (Sweden vs. USA) is 81.4 percent vs. 45.1 percent. And while they do have some private insurances, this only accounts for approximately 2.5 percent of the population.

Sweden's system is unique because most of it is decentralized. There is a mandate from the central government that the local governments provide each and every resident with quality healthcare that is easy to access, in addition to providing a social foundation for their elderly, disabled and other socially challenged people, such as the mentally ill. They also provide dental care to those patients 20 or younger. They have an extraordinary social service program providing homecare and transportation to and from healthcare providers when needed. There is a complex coordination of care for patients who are recently discharged from the hospital. These policies, in part, are responsible for Sweden's better overall population health when compared to the United States. (WHO, 2018)

Spending more money on health care does not translate into better population health. A single-payer system, like Sweden, is able to control the quality and costs of healthcare. Healthcare reform in the U.S. must factor in the social determinants of health. We must decrease the out-of-pocket expenses for our population, for in most every other country in the world, you would not go bankrupt from medical bills.

Unfortunately, the "give me liberty or give me death" attitude will make it very difficult to increase taxation and government control, which is needed in my opinion in order to provide universal access and affordable healthcare.

The Commonwealth Fund. (2017). Mirror, Mirror on the wall; an international update on the comparative performance of American Healthcare. Retrieved from https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and
Healthcare Reform: Lessons to be learned from Sweden. Rick Pittman, MD, MBA 4.29.2019
WHO. (2018). OECD Health Data 2018-Frequently Requested Data. Retrieved from http://www.oecd.org/health/health-data.htm

BY HOWARD BAUMANN, MD

McKINLEY ELEMENTARY SCHOOL

Stepped Into the Gap

The years 1919-1920 were not a good time for Salem. Although WWI had just ended, the Spanish Influenza had not. It would infect more than 50,000 Oregonians statewide and kill a total of 3,675. To make matters worse, the Salem Hospital had just been evicted from its hospital on Center Street. Both the city of Salem and the Salem Hospital appeared totally unprepared for this pending pandemic.

No matter how you categorize the determinants of health, social or otherwise, nothing will succeed unless your public health system is intact. It's one thing to not have quite enough hospital beds, but it's another to essentially have none at all. This was the case in Salem exactly 100 years ago.

So, how did Salem Hospital get into this mess? The story goes back to 1899, when the Salem Hospital moved from its location in the prior Blind School building on 12th Street to the larger Glen Oaks Orphanage building on Center Street. However, within 10 years, the physicians again realized that they needed a larger facility and to modernize. Architectural plans were drawn up and a capital campaign initiated when two major setbacks occurred: First was the forced acquisition of the Glen Oaks building and most of its surrounding grounds in 1914 by the Oregon State Hospital, who needed extra space to handle its overcrowding. This was accomplished by eminent domain actions by the Governor and the State Legislature.

However, Salem Hospital was given the promise that they could stay in the building as long as they were actively building their new hospital. The second bomb shell was our country's entry into WWI, which suddenly brought a halt to hospital construction and also stopped funding sources due to the many war-related charities that were seeking funding as well.

Then things got even worse. With no building supplies and no funding, construction was dead in the water, essentially halted at the level of the dugout foundation of the hospital. Construction remained idle over the next four years, a fact not unnoticed by the state who by now had run out of patience and finally demanded what they felt was rightfully theirs.

Salem Hospital agreed to vacate by July 1, 1918. After continuing excuses and stalling tactics, a 30-day eviction notice was finally posted on Dec. 14, 1918. Obviously, this was ill-timed given that influenza had just started to hit Salem, with at least 1,000 households soon to be affected. Despite intense negotiations between the state and hospital administration, Governor Withycombe proceeded to order the State's Attorney General to officially close down the hospital effective Jan. 13, 1919. This is when the hospital dug in its heels and refused to budge, arguing that this was a very poor time to close a hospital and that they had no place to go.

McKinley Elementary School, about 1915.
(Photo courtesy of the Salem Public Library Historical Collection)

Pop quiz:

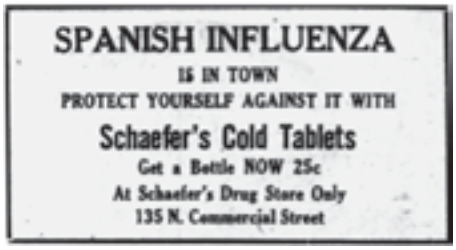
What important function did McKinley Elementary School perform in 1919-1920?

- **A** Housing barracks for WWI soldiers.
- **B** Tuberculosis Hospital while the State Tuberculosis Hospital was under construction.
- **C** Temporary location for the Salem Hospital.
- **D** I really don't know, but one of my kids once attended the school.

Several available possibilities had been under consideration, all compromised in one way or the other:

- The Argo Hotel downtown was rejected by the owners.
- Willamette's previous Medical School building on the NW corner of campus was too small.
- Refitting McKinley School into a hospital had cost concerns and a hesitant school board.
- Reconfiguring the Glen Oaks building into a larger unit and using an adjacent cottage for the noninfected patients was also considered, but the court eviction was still in effect.

A day later, like a miracle, the Salem Board of Education stepped forward with permission to use McKinley Elementary School. Located on the corner of McGilchrist and High streets SE, McKinley School had recently been vacated due to declining student enrollment. Thankfully, the conversion could move along rapidly to a fully functional, 50-bed hospital with the operating rooms and kitchen in the basement. On Feb. 20, 1919, patients were moved by car to McKinley School.



Pharmacy advertisement.
(Statesman Journal October 22, 1918)

In November 1920, Salem Hospital returned to their prior Center Street location and into a small cottage that had been adjacent to their former hospital. The hospital had been enlarged somewhat but was still cramped, but it would do as they awaited the completion of the new Salem General Hospital. McKinley soon reopened as a junior high school until Leslie Junior High opened in 1927, thus freeing up McKinley to return to its former role as an elementary school.

These were frightening times; hospital beds were at a premium in Salem. In addition to the Salem Hospital, the Salem Deaconess Hospital had just increased from 12 to 20 beds in their recently acquired Capitol Hotel facility on Winter Street.

No matter what the situation, time or location, healthcare cannot be left so vulnerable, such as what happened here in Salem a century ago. A lesson for us all.

As for the pop quiz, the answer, obviously, is "C", Temporary location for the Salem Hospital.

1. John McMillan, A Century of Service 1896-1996 [Kearney, Ne.: Morris Publishing,1996], 18.
2. McMillan, 10-19.
3. McMillan, 17.
4. Statesman Journal December 14, 1918.
5. Statesman Journal January 10, 1918.
6. Statesman Journal January 15, 1919.
7. Statesman Journal February 21, 1919.
8. Statesman Journal February 18, 1920.

The practice of medicine is a highly stressful occupation,

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PHYSICIANS DIE BY SUICIDE EACH YEAR IN THE U.S.

The suicide rate among male physicians is

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TIMES HIGHER

than the general male population.

The suicide rate among female physicians is

2.27

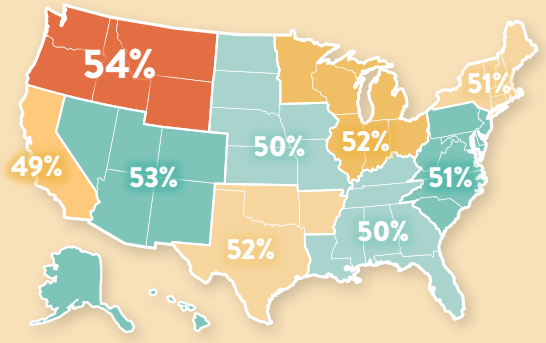
TIMES HIGHER

than the general female population.

SEVEN OUT OF 10

PHYSICIANS UNWILLING TO RECOMMEND HEALTHCARE AS A PROFESSION

Burnout by Region



CLINICAL APPROACHES TO SDOH

BY HEATHER RAYHORN

Local clinics are quick to talk about social determinants of health. They see the need and are trying to get ahead of the problem. Each has its own take on how they are doing this. Here are three examples.

WVP

On a Thursday morning, a group of medical and lay staff at WVP's Boulder Creek Clinic met for an hour discussing their toughest cases: a schizophrenic, a heroin user who struggles with housing, a chronic alcoholic who frequents the ER, a Spanish-speaking woman who doesn't read English, a Marine who is having memory issues and keeps falling but his doctor can't figure out why. They listen, look at patient records and give medical suggestions but also advice on how to break down barriers such as resistance and social determinants of health.

For example, one patient who fell getting out of his car could benefit, they reasoned, from a walker or wheelchair from NW Senior Services as well as a case manager talking to his apartment manager about installing shower handles. They came up with a plan to reach out to him to see if he's open to support and see how well his wife, who gives him his prescriptions, is doing.

It's all part of a change WVP clinics made at the end of 2017 when they moved from individual providers trying to navigate what patients need to a group-assessment approach for higher-risk or challenging patients. The WVP clinics also started adding a variety of medical professionals and social workers.

At Salem's Boulder Creek Clinic, a primary care medical home, its in-house case management team is made up of doctors, a drug and alcohol counselor, a mental health nurse practitioner, a pharmacist who weighs in on a patient's medicine and case managers/social workers who focus on patients' practical needs, many of which are considered social determinants of health, including transportation, prescription delivery, help making appointments and connecting patients to community resources such as food banks and housing.

Douglas Eliason, a D.O. at the Boulder Creek Clinic, calls the case managers the "eyes and ears because they give us insight into how people are living, from family to nutrition."

When the program started in the fall of 2017, the Boulder Creek team's Psychiatric Mental Health Nurse Practitioner Russell Huffman was seeing a woman in her 60s who was in a foster home with violent people. Her anxiety was off the charts. She had depression and was suicidal.

"No amount of medication I provide is going to make her feel safe, nor should it," he said.

What she most needed, he said, was someone to help her move somewhere safe.

Huffman said the case management team is huge in the area of social determinants of health: "It will go pick them up, take them to NW Senior Services, make appointments, help patients who don't speak English as a first language understand doctors. They do things we know that help people feel better."

The idea is to integrate social work into the medical field instead of working separately.

"Before, we rarely sat together and talked," Eliason said, calling that the Lone Ranger approach. "You went to

a doctor when you had a cold and a psychiatrist when you were distressed. It was two worlds, but it's not. The concept is to not fragment care. That was the thing we didn't have our finger on."

WVP uses a questionnaire to find out which patients would most benefit from this approach. The form, which all patients fill out, screens for social needs or issues such as housing, food, medical care, transportation, abuse, reading and heating.

Their funding for new hires came from a 2018 grant from Providence and other insurers. The grant benefits all WVP practices throughout Marion and Polk counties. Medicaid, Medicare and some insurances also help pay for the services. In the end, the theory is that it makes more sense — and is most cost effective — if doctors can prevent say a diabetic from having a heart attack and spending five days in the hospital. It's putting the money up front, Eliason said, to prevent big costs down the road.

Though they don't have numbers on their success, Eliason said the changes he's seen are notable because of this team approach. Patients are more likely to come to appointments, are getting advice from counselors and are looking at their eating, and providers are happier and feel supported.

"The neat thing about it is our awareness of the services go up so we are learning to use those tools outside medicine better," Eliason said. "As providers, we don't tend to be very savvy, but we are getting better. It takes a team because I don't think anybody can absorb this on their own."

NW Human Services

Last July, NW Human Services with other community partners started their own farmers market just outside of the NWHS parking lot in the low-income West Salem Edgewater neighborhood. Managed by the Salem Community Market, which worked closely with the clinic, the goal of the Thursday market is to provide shoppers in all economic levels access to fresh food, not just those who can afford it. Most all of its food-related booths accept WIC, SNAP and EBT. And shoppers who have an Oregon Trail Card who purchase $10 in items such as fruit, vegetables, nuts and meat get an extra $5 to use on those items through a market match program.

Kristin Kuenz-Barber, NW Human Services' strategic partnership manager, said the market was a huge success last summer, attracting an average of 22 vendors. The market returned in May and will run through September.

NW Human Services, a medical home model clinic, has a large portion of low-income clients: According to clinic research, 66 percent of its clients live at or below the 200 percent poverty level, and 44 percent live in a food desert (an area that combines poverty and a lack of healthy food choices). Along with accepting all insurances and providing a sliding-fee scale, the clinic has utilized community health workers since 2017, working in lots of areas that address social determinants of health. The clinic also has two full-time van drivers who provide transportation for the homeless at area shelters to the clinic for medical appointments three times a week. Last year, they transported 1,189 individuals to services, according to NW Human Services stats.

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Kristin Kuenz-Barber works a booth at the Thursday farmers market at NW Human Services in West Salem. Courtesy of NW Human Services

...continued from page 7

But the clinic has especially been working in the area of bringing healthy food to their clients and community in the past year and a half.

In addition to the Thursday seasonal market, the clinic also has started a year-round program called Neighborhood Fresh Connect, which runs twice a month on the second and fourth Thursday. Memo Plazas, who just moved into the position of NW Human Services' first social determinants of health coordinator, said he fills up his car with a dozen crates of excess food from the Marion-Polk Food Share and brings it back for NW Human Services clients. Patients can choose from free fruits, vegetables and breads once they check in and receive their produce pass.

Tamiko Campbell is one of the people who have benefited from the program. The 39-year-old moved to Oregon from Orlando, Florida, in October. She and her boyfriend have been "couching" it with friends, relying on them for food. She is not on government assistance or the Oregon Health Plan. When she needed dental work, NW Human Services provided her free dental care through their hardship program, she said.

NW Human Services' Social Determinants Health Coordinator Memo Plazas and Community Health Worker Sylvia Cervantes get food from Marion-Polk Food Share for Neighborhood Fresh Connect.

Courtesy of NW Human Services

"That was amazing," she said. "That was really stressing me out."

Campbell lives within walking distance of the clinic and comes on Neighborhood Fresh Connect days. A vegetarian, she said she can stretch the food she gets one to two weeks. It gives her healthy food to prepare when before her only access to food was through what friends were providing.

"They've given me a piece of mind," she said about NW Human Services. "My big thing is they actually care. You can tell when someone actually cares. They show that every time. It's not just a job."

Plazas, as the social determinants of health coordinator, is taking over heading up the clinic's social service programs and outreach. He said a goal of NW Human Services, which combines medical, dental and behavioral health care, is to bring community partners together in one place for ease of access. That will soon include parenting, housing and money-management classes, he said. Adding access to healthy food is just one more way to supply a variety of needs in one place.

Kuenz-Barber said it's not just about access though: "People may be able to get to a grocery store like Safeway, but fresh food is expensive." Healthy food, she adds, is essential to combating chronic diseases. Given their low income, many, she said, only have a choice between unhealthy food or no food.

In June, again working with the Food Share, NW Human Services will begin handing out CSA (consumer supported agriculture)-style boxes of vegetables weekly at the clinic through September. Called Farm Share, the boxes will be available during the Thursday farmers market. Oregon State University Extension Service is also pitching in and will provide recipes and cooking demonstrations for the different veggies. Kuenz-Barber said those who qualify for the free program will remain anonymous but will have their weight, blood pressure and blood sugar tracked prior to the program start and at the end in order to assess for positive change.

Kaiser Permanente

Kaiser Permanente also recognizes that more than health care contributes to our health, and they respond by investing in local groups that are already working to address social determinants of health. The national nonprofit sets aside 3 percent of its income to help improve community health. Part of that goes to grants. Along with giving funds, Kaiser Permanente forms partnerships with their local organizations that get grants, offering tech help and training and staying involved with the initiatives on a personal level.

In Marion and Polk counties, Kaiser Permanente has multiple initiatives that fall under the realm of social determinants of health, including one that addresses school attendance and another that addresses helping the Micronesian community.

Addressing School Attendance

As part of a larger goal to help improve school attendance in the Northwest, Kaiser Permanente issued two three-year-long, $150,000 grants in 2018 to address chronic absenteeism in the Salem-Keizer School District as well as the Central School District in Polk County.

School attendance is a significant indicator of graduation, and research shows that graduation and education in general are indicators of better health.

"Education is a leading predictor of health," said Jennifer Jordan, senior consultant for Community Health and Government Relations

at Kaiser Permanente Northwest. "It affects economic opportunity."

Oregon and Washington, however, rank lowest among states for students attending school. A report released in September 2017 by Johns Hopkins University and Attendance Works shows that the two states experience among the highest chronic absence rates in the country. Chronic absenteeism is defined as missing at least 10 percent of the school year. In 2016, 22.4 percent of students in the Salem-Keizer School District were chronically absent, according to the Department of Education. Oregon graduation rates also are among the lowest in the United States at 73 percent in 2016, according to U.S. News and World Report.

Alvaro Rey-Rosa, a pediatrician at Kaiser's North Lancaster location, said for the past year and a half, his office has been asking parents about their child's school attendance as part of their "social determinants of health" screening.

"We see it a lot; it's quite significant. We didn't ask before, so we didn't know," said Rey-Rosa, a native of Guatemala who has spent his career serving poverty-stricken areas, including Guatemala, inner-city New York, Appalachia and North Salem.

If parents report their child missing school frequently, Dr. Rey-Rosa said he asks about it in a non-judgmental way. Sometimes it's for medical reasons that can be addressed, such as asthma. Sometimes it can be due to social issues such as working parents who cannot afford day care and need a babysitter for younger children in the home. It also can be due to mental-health-related issues including anxiety and depression. The last one is becoming more common, especially for pre-teens and teens, he said. His office starts screening for depression at age 11.

"I didn't realize how much missing school affects a child's future," Dr. Rey-Rosa said. "It has been a learning process and very eye-opening. The concept of social determinants of health is relatively new. We are learning much more about how a child's social situation can affect his or her health."

Questions about school attendance can get a conversation started. Rey-Rosa said he can help parents understand why it is important for their children to attend school regularly and how that can affect not only their children's future socioeconomic status but also their health.

Helping a Community

Kaiser Permanente also has given a two-year, $40,000 Capacity Building Leadership Grant to help the Salem-based Micronesian Islander Community group (MIC), which aims to unite and assist Oregon's Micronesian community.

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CLINICAL APPROACHES TO SDOH

...continued from page 17

Health is a big part of the nonprofit's outreach, and MIC employs three community health workers who oversee four Oregon counties including Salem-Keizer.

"Some of the work we do," said MIC Chairperson and Community Health Worker Jackie Leung, "is community health work focusing on chronic disease in the Micronesian community, helping people fill out documents, knowing how to use their insurance and workshops on topics the community has developed as a need."

This is the pilot group of community health workers the Micronesian Islander Community group trained. Courtesy of MIC

Doctors see the culture challenges in this community, including a high-carb and high-fat diet that gives them one of the highest rates of diabetes in the world, as well as language barriers. For example, Jordan mentioned that there's no word for reimbursement in the Micronesian languages, making it challenging to explain insurance.

Dr. Jason Phillips, who works at the North Lancaster Kaiser Permanente, sees 20 to 30 Micronesian patients out of his 1,500. There is a tendency, he said, for those in the Micronesian community to not want help and not come in if it doesn't hurt. But diabetes doesn't always hurt, he said.

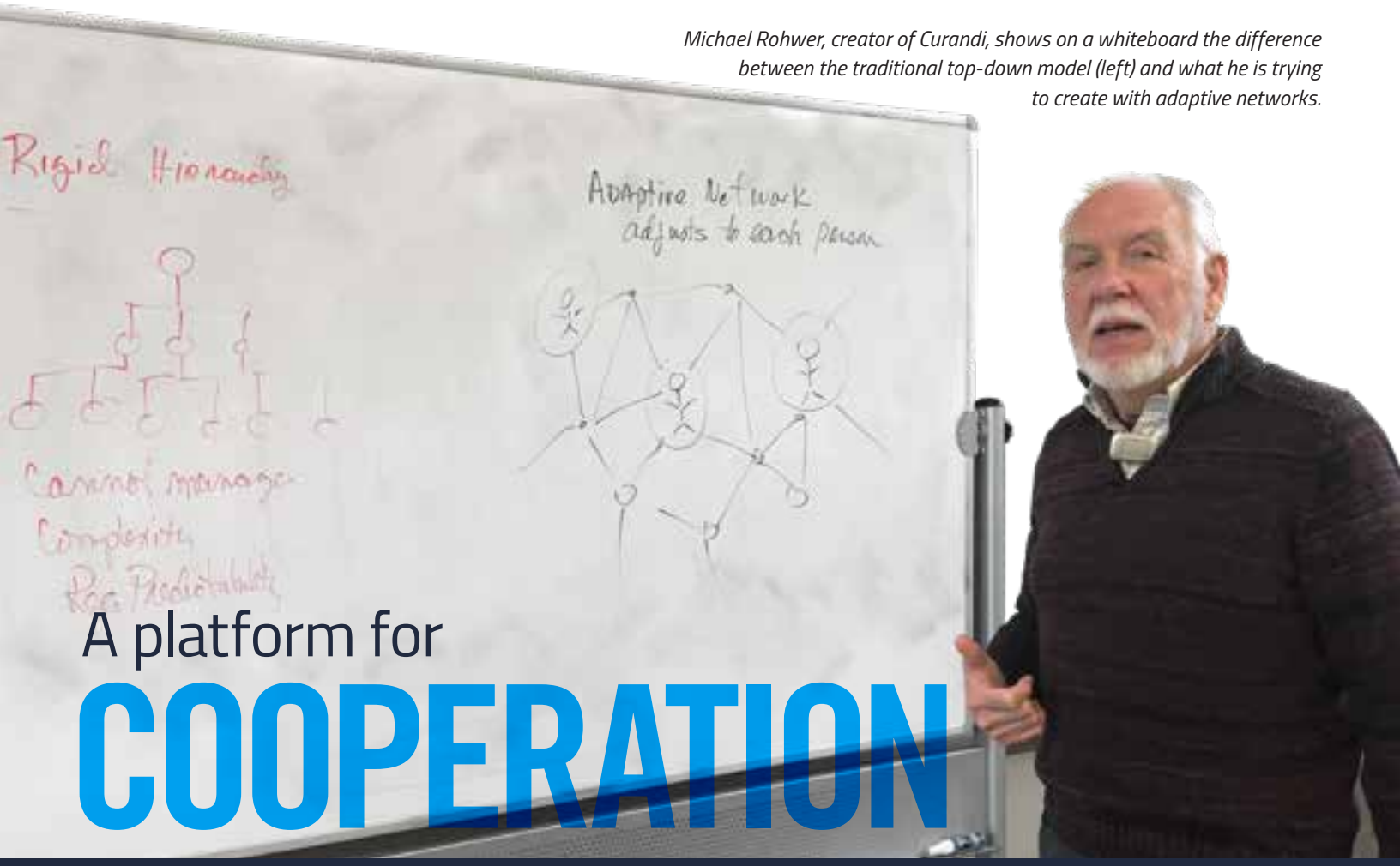
He said he appreciates what MIC has done with helping this community navigate the health care system and has noticed in the past year more patients following up. His no shows from this community, he said, have gone from 50 percent to something more like 20 percent.

The Capacity Building Leadership Grant, which actually is one of several grants the group has received from Kaiser Permanente, has helped the group focus on leadership and education workshops.

"Kaiser Permanente has been very generous for supporting many of our activities," Leung said. "They've helped us to serve our community more efficiently."

What These Three Clinics Have in Common

In Oregon, medical homes are technically called Patient-Centered Primary Care Homes (PCPCH). WVP, Kaiser Permanente and NW Human Services are among the more than 650 primary care clinics in Oregon designated as PCPCHs by the Oregon Health Authority. The philosophy behind this approach is patient-centered, comprehensive and team-based, aiming to reduce costs and help people by removing obstacles to achieving good health, including social determinants of health. There are nearly 50 Oregon PCPCHs that have been awarded the 5 STAR designation, including NW Human Services. A comprehensive evaluation of the PCPCH program by health policy researchers at Portland State University found that PCPCH program implementation resulted in an estimated $240 million in savings to Oregon's health system between 2012 and 2014. The PSU evaluation also revealed that for a clinic that has been a PCPCH for three years, the total cost of care per member, per month is lowered by $28 - double the overall average savings of $14 per member, per month for a PCPCH in the first year of recognition.



Michael Rohwer, creator of Curandi, shows on a whiteboard the difference between the traditional top-down model (left) and what he is trying to create with adaptive networks.

A platform for COOPERATION

Retired doctor is working on improving social determinants of health by bringing organizations together

BY HEATHER RAYHORN

"Social determinants of health are a problem for healthcare but not a healthcare problem." This seems to be a mantra for Michael Rohwer, who repeats it multiple times.

Social determinants are a community problem, he says. And the problem can be treated more efficiently with modern network science. It's why he created Curandi.

The retired internal medicine specialist thinks the general business model needs to change from the bureaucratic top-down model. He points to the Internet to show the possibilities. The Internet is a network of systems that has had much success. Facebook's network, for example, was so successful that it dramatically changed the behavior of people.

"What is it about technology that is so powerful that changes our behavior?" Rohwer asked. "Our brains are the same, but our behavior has changed because of connection. Human existence is based on networks, and Facebook is playing with the most primal thing. It's the crack cocaine for human networks."

Rohwer has taken this idea of creating a system where relationships and connections can thrive with social determinants of health in mind.

Curandi's pilot program has partnered with Fostering Hope, a neighborhood-based service in Salem that uses Certified Community Health Workers to connect people with professional services and the voluntary support of family, friends and neighbors. The community health workers help people identify their needs such as healthcare, housing, employment, parenting skills, counseling and education for their children and themselves. Fostering Hope already had under its umbrella a group of community social services including Liberty House, CASA, Catholic Community Services, Family Building Blocks and NW Human Services.

Curandi is working to organize what was a loose coalition and create a more effective collaboration using ACT.MD, a health collaboration hub software. It went live for Catholic Community Services in February.

Nurse practitioner Chris Barber has been working with Rohwer to get the ACT platform up and running for Catholic Community Services, helping them transfer over assessments, reach out to clients with new assessments and train community health workers to use the platform. Barber had previously been the director of clinical and quality services at Medical Assistance Program with the state of Oregon, helping with the implementation of the Coordinated Care Organizations (CCOs), which from the beginning addressed social determinants of health. But even before that, as a nurse, she has always had a heart for how social determinants affect people.

Barber said while there are other platforms out there, most start on the medical side versus the social services side, which is the basis of social determinants of health. The goal of ACT, which has been used successfully in other portions of the country, is to bring together everyone who has a role in individuals' lives, from social services to schools, police and medical providers. It lets these groups connect with each other, get access to what individuals are saying about their housing, parenting, food and mental health, and see completed tasks and community resources. Barber emphasizes that it's neighborhood specific, building up neighborhoods as well as clients because the platform lets you start mapping what's available in neighborhoods and what's needed.

"The idea of a systems approach is not new," said Josh Graves of Fostering Hope. "What is new is Curandi's approach that the interconnections between people, organizations, providers, resources and networks is constantly shifting as a result of external influences. Adaptation is the constant if we are to be successful in ensuring high-quality, low-cost care that is effective and timely."

Having an efficient, flexible system of community services creates synergy that serves all aspects of a community including healthcare and education, both of which are affected by people who are unable to connect with social services that can help them.

"The answer to all problems is to restore connections," Rohwer said. "Basically, that's what I'm working on."

It's a big idea, and Rohwer seems to be the man for the job. It's clear when you meet him he is a dreamer with big ideas.

"Dr. Rowher is one of the most knowledgeable and innovative people that I have ever had the pleasure of working with," Graves said. "He is an outside-the-box thinker … way outside the box."

Rowher started Curandi, which is Latin for treatment or caring, in the summer of 2016, after founding and building Performance Health Technology (PH Tech), an administrative services provider. So starting a platform-based business was nothing new to him.

"I studied engineering before I went to medicine," he said. "I can't seem to not want to solve problems. I love science and how things work and how things don't work. And there's a lot of things that don't work now."

The idea for Curandi came in 2015 when he attended a talk that pointed out the problems in healthcare including the impact of complex systems, namely people, and their unpredictability. He left feeling a bit hopeless, but it also became a challenge for him on how to fix things.

"Curandi grew out of that," he said.

His goal is for his collection of social services that were formed in Fostering Hope to grow and to create a Community Coordination Network through ACT that connects people in both the medical field and social services arena, as well as other fields such as police and education, to make people healthier and to lower costs and raise quality. He says he wants to better help the 3 percent who are using 30 percent of the healthcare costs so that those costs are able to be reduced. The Community Coordination Network would fit in with the current referral system. He and his team are starting to talk with those in the medical community about using the network and hopes to have it up and running by 2020.

Another aspect Rohwer is excited about is the research. Fostering Hope has partnered with Pacific Research and Evaluation in Portland to track social metrics in order to get a picture of how our communities move and behave. When Rohwer was working in medicine, he said he used to make recommendations based on population-based evidence. But that gives a generalized picture.

"We really need to look at community tracking," he said. "Communities are dynamic and different."

He compares it to a weather satellite that gives an overall picture of weather patterns that are constantly in flux. Getting that overall picture of a changing community offers a new perspective and, like with weather pictures, helps communities more accurately prepare for their community's needs.

"What I'm trying to build for doctors is an accountable system so when they have someone with a social system problem like homelessness, they can refer it to this network but not have to solve the problem themselves," he said. "There are people who specialize in this. These people deal with people's needs all the time."

Curandi is a passion for Rohwer. It is not yet profitable. His goal, though, is to make a difference, to impact change.

"Even if this doesn't work, it will be a success if I plant the seeds for a better community and it works somewhere," he said. "And you run into all these people who need help. It's hard to say no."

CHART NOTES - WRITER BIOS

HEATHER RAYHORN, EDITOR

After covering the Salem area for 18 years as a journalist, Heather Rayhorn is now attending Corban University's graduate program in education to become a high school English teacher.

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.

CALENDAR - SAVE THE DATE

Friday, October 25, 2019 6-8:30pm
New Provider Celebration
Location: Dye House, Willamette Heritage Center
Free to All Providers in Marion & Polk Counties + a guest
Come Celebrate Your Newest Colleagues!

Sunday, December 1, 2019 6-8pm
19th Annual Family Holiday at the Carousel
Location: Salem Riverfront Carousel
Free to Members and their families
*Children Welcome!

Thank you to our sponsors of the May 2019 General Membership Meeting & Dinner:

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FINDING FRESH PRODUCE

BY HEATHER RAYHORN

Food scarcity is a social determinant of health. But a lack of access to healthy food is not always due to poor transportation or finances. Those who are overly busy, such as those in the medical field, can also find themselves eating unhealthy food on the go. Here are four ways to add healthy fruits and vegetables to your diet, whether it's hitting up a farmers market in your area or on your lunch break or having it delivered to your home.

Imperfect Produce sources organic and conventional produce directly from farms and delivers it right to customers' doors. The idea is they take perfectly fine produce that isn't pretty enough or large enough for grocery stores and save it from being tossed. Check them out at imperfectproduce.com.

The Salem Saturday Market runs April 6-Oct. 26 from 9 a.m. to 3 p.m. north of the capitol. It's Salem's biggest market and a nice Saturday outing.

If you live or work in West Salem, hit up the Thursday Farmers Market near NW Human Services from 9:30 a.m. to 1:30 p.m. on Thursdays May 2-Sept. 12.

If you work at or near the hospital, take a lunch break and hit up the Monday Hospital Market 9:30 a.m. to 1:30 p.m. It runs May 6-Sept. 30. Or during the same hours on Wednesdays, the Wednesday Farmers Market isn't far on the grounds of the Courthouse Square Plaza. It runs May 1-Sept. 11.

We want to hear from you. Do you have a story idea for ChartNotes? Maybe something about you or a fellow medical society member? Or something you want to know about? We want to hear about it. Email hrayhorn@msn.com

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