

MEDICINE in Oregon

A publication of the Oregon Medical Association

Policy · Community · Practice

The View

from the Board

**Physician Perspectives on
Oregon's Health Care Reform Efforts**

What You Need to Know about *Clarke v. OHSU*
Let's Join Forces to Fix Health Care

Volume 1, Number 2 • Summer 2008



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Health Care Reform

In this election year, reform is a front-burner issue. *Medicine in Oregon* offers a look at the issues.

10 FEATURE

The View from the Board
Edited by Betsy Boyd-Flynn

PLUS What is the Health Fund Board?

PLUS What is the Process?

- 11 Benefits Committee
- 12 Delivery Systems Committee
- 13 Eligibility & Enrollment Committee
- 14 Federal Laws Committee
- 15 Finance Committee
- 16 Health Equities Committee

PAGE 10 **The View** from the Board



OMA members get a peek inside the deliberations of the Oregon Health Fund Board, which was created in 2007 with the task for devising a plan for universal coverage, and comprehensive health care reform in Oregon.

Also Inside

4 FROM THE PRESIDENT

Tort Reform: Eyes on the Horizon

5 FROM THE DESK OF JO BRYSON

OMA's Take on Health Care Reform

MEMBERSHIP MATTERS

6 *Upcoming Events*

7 *Becoming a Delegate*
By Carla McKelvey, MD

7 *Joining the Circle*

9 *A Look Inside the Process*
By Stanley G. Sturges, MD

PLUS *Hallmarks of Parliamentary Procedure*

8 OMA ALLIANCE

A Focus on Veterans
By Eva Germaine-Shimotakahara

18 IN-HOUSE COUNSEL

Clarke v. OHSU
By Michael D. Crew and Thomas E. Cooney

20 SPOTLIGHT ON...

Let's Join Forces to Fix Health Care
By Senator Ron Wyden

22 SPOTLIGHT ON...

Together Rx Access

PLUS *How Physicians Can Help Uninsured Patients*

23 IN THE OFFICE

*Clear Comparisons: athenahealth
PayerView Rankings Released*

24 ADVOCACY IN FOCUS

Medicine's National Voice Grows Louder on Uninsured

26 MEDICAL HISTORY

Gus and Jim's Excellent Adventure
By Jim Kronenberg

BACK PAGE

Creative Outlets



**"Summer Roses,
Portland International
Rose Test Garden"**
by Carol Sandor, MD

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

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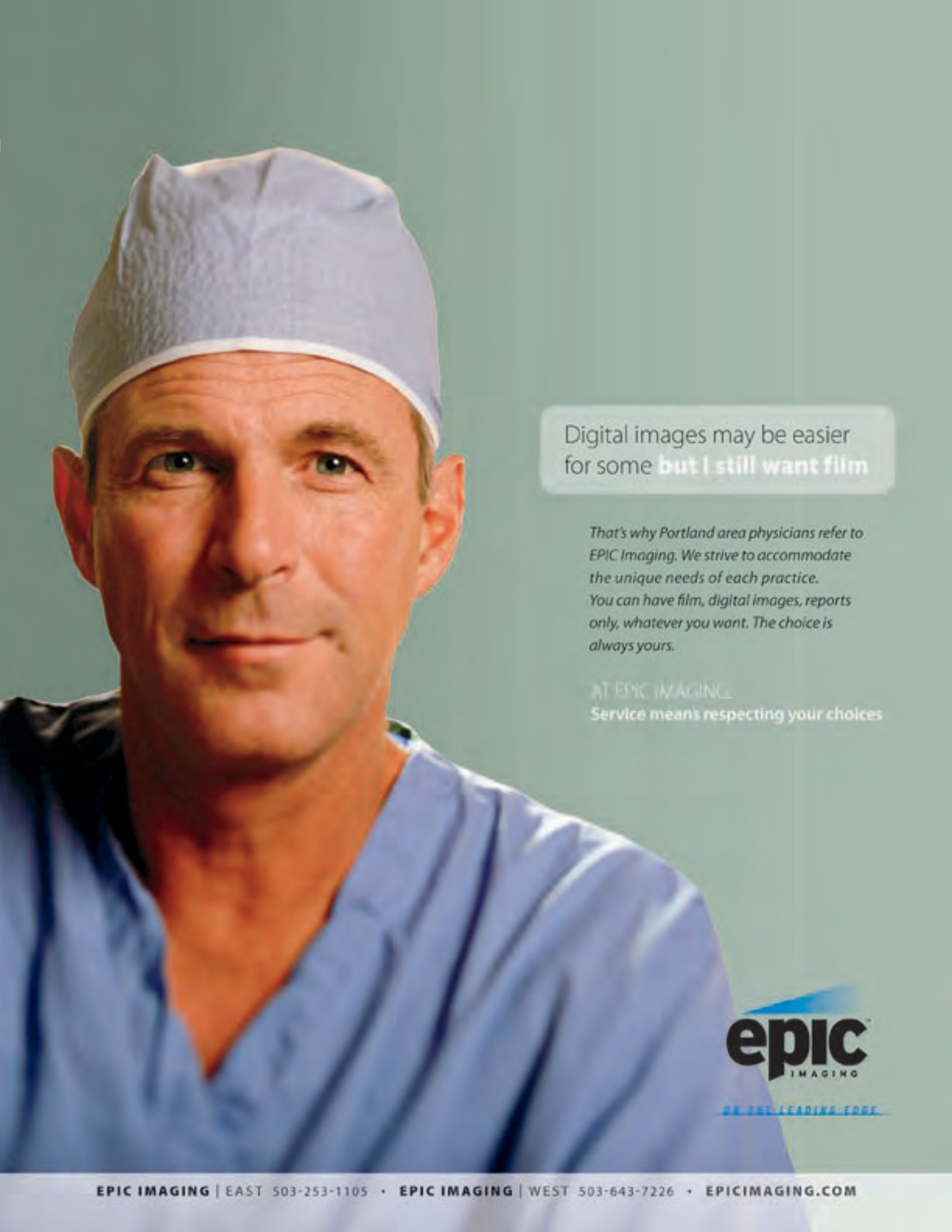
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On the Cover

At 10,497 feet tall, Mt. Jefferson is the second-highest peak in Oregon. Currently considered extinct, it last erupted around 950 A.D.



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ON THE LEADING EDGE



Monica Wehby, MD

Tort Reform Eyes on the Horizon

This issue focuses on health care reform efforts currently underway in Oregon that could significantly affect the practice of medicine.

Every day, we find ourselves increasingly buried in paperwork and bureaucratic compliance, leaving us less time to actually care for our patients.

Monica Wehby, MD, is president of the Oregon Medical Association. She is a pediatric neurosurgeon in private practice in Portland, and has been a member of OMA since 1997.

THE OREGON HEALTH FUND

Board, created as a result of Senate Bill 329, is tasked with developing legislation to provide quality, affordable health care for all Oregonians. Unfortunately, medical liability reform is not on their agenda. To those of us in the trenches, it is obvious that tort reform is an integral and vital component of comprehensive health care reform.

Tort reform remains a priority of the OMA because it is critical in achieving our goals of a secure profession, access to health care for all patients, and shared responsibility between physicians and patients for the course of care. In 2004, we at the OMA worked passionately on the Measure 35 campaign to reinstate the cap on non-economic damages, losing by less than 1% of the vote. Today, we continue to work to keep this issue at the forefront of our legislative efforts.

OMA is a founding member of the Oregon Liability Reform Coalition, a coalition of interested parties working for tort reform. ORLRC was established to promote educational awareness and public policy to reduce the adverse impact of litigation on businesses, taxpayers and society; to limit the expansion of tort liability; to reduce the cost of defending lawsuits; to speed resolution of civil actions; and to improve the fairness and certainty in our civil justice system. The coalition was modeled after the Washington LRC, one of the most successful tort reform coalitions in the nation, with a broad membership base of businesses, government entities and nonprofit organizations.

As you'll read in our column from our legal counsel, Mike Crew, the picture changed somewhat in late 2007 with the *Clarke vs. OHSU* decision. Though the current state administration and legislature has proven resistant to discussing real reform, the long-forecasted crisis could be upon us.

The OMA supports, as a matter of policy the following reforms:

- ♦ Structured attorney fees
- ♦ Mandatory periodic payments
- ♦ Elimination of windfall payments of future medical or other future maintenance costs if the patient dies
- ♦ Expert witness disclosure
- ♦ Mandatory pre-screening panels where the determination of the panel is disclosed at trial
- ♦ Disclosure, at trial, of collateral sources
- ♦ State Tort Claims coverage for physicians and others who treat Oregon Health Plan patients
- ♦ Expansion of the state subsidy program statewide from non-physician resources. The OMA would also support a "Catastrophic Fund," where the funding would have to be from statewide resources and with state backing of any awards in excess of a specific maximum limit.

Each of these actions could assist in addressing the professional liability issues in Oregon. While a few of these actions are controversial, each is worthy of legislative debate and public input as we look towards a comprehensive approach to health care reform.

At the time of this writing, the Governor has pledged to convene a task force to examine issues of liability with respect to disaster response. We anticipate this will allow physicians to pledge their help during public health emergencies, and we are monitoring this process to ensure that physicians are adequately protected when they are so critically needed.

The OMA continues to work diligently for medical liability reform. We will keep fighting until we win. ●



Joanne K. Bryson, CAE

OMA's Take on Health Care Reform

OMA has tasked volunteers and staff to take an active role in shaping reform efforts at the state and national level.

H EALTH CARE REFORM IS a top priority for the OMA. We know our members are working in a health care delivery system that is dysfunctional and costly. For example, in Oregon we have a below-average physician-to-population ratio—with just 19 practicing physicians per 1,000 Medicare beneficiaries. Health care premiums continue to rise and physician reimbursement rates continue to be cut.

But what do we mean when we use that phrase, 'health care reform?' Generally, reform efforts attempt to broaden the population covered by private or public health insurance, expand the array of health care providers consumers may choose among, improve the access to specialists, improve the quality of care and decrease overall costs. As you'll learn in this issue, OMA has tasked volunteers and staff to take an active role in shaping reform efforts at the state and national level. Our involvement has been steered by ten adopted OMA principles, some of which are:

- ♦ Every Oregonian should have access to a basic health care benefit package that is affordable and includes preventative, acute care services and chronic disease management.
- ♦ Access to and financing for health care services should be a shared public/private cooperative effort that must have catastrophic coverage to protect individuals and families from financial ruin, and allow the purchase of additional services or insurance. The cost of universal coverage is to be shared equitably and proportionately by individuals, employers and government. Financing must be economically feasible, explicit, and sustainable.
- ♦ Physicians, other health care providers and informed patients must be the primary decision-makers for each patient's individual

health. Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.

- ♦ Physicians and other health care providers should be reimbursed at a rate that covers the true cost of providing medical services.
- ♦ The medical tort liability system should provide fair compensation for individuals harmed by the delivery system, through an efficient process which promotes continuous quality improvement and patient safety. Physician liability insurance premiums should primarily cover payouts to injured patients. The system should have low overhead costs.
- ♦ The health care system should include the level of resources necessary to sustain and develop a sufficient physician workforce that can provide access to health care services for all Oregonians.

In this issue, beginning on page 10, you can read about the progress of the reform mandated here in Oregon by SB 329 from physicians on each of the six subcommittees, and an overview from Charles E. Hofmann, MD, OMA Past-President and one of seven members of the Oregon Health Fund Board. The board has been working toward developing a comprehensive plan to ensure access to health care for Oregonians, contain health care costs, and address issues of quality in health care.

On the national front, we face an urgent—and recurring—need. At the time of this writing, organized medicine was once again fighting down to the wire to avert scheduled physician reimbursement cuts. Medicare reimbursement rates in Oregon in the bottom five percent in the nation. For the last eight years, we have been ➔

going round in circles with Congress each year, asking for a payment update in line with increases in the costs of caring for patients and fix the flawed Medicare payment formula. Each year the best we get is an averted crisis, but we continue to work for sustainable reform.

In recognition of the need for larger national reform, OMA has been working in support of Senator Ron Wyden's Healthy Americans Act. For this issue, Senator Wyden has contributed a piece about his bipartisan bill (p. 20)—and there will be more coverage of that in our upcoming issue on workforce challenges.

The work we are doing serves every Oregonian, not just physicians and physician assistants. For the many baby boomers entering the Medicare system, we need to ensure they can find a physician who is able to keep his or her practice open to Medicare patients despite facing yet another payment cut. For a pregnant women living in rural Oregon, we need to ensure they can find a physician to deliver their children, since so many have stopped providing obstetrical services, or moved out of state to avoid crushingly high malpractice premiums and low reimbursement rates.

For physicians, our hope is that you will read this issue from cover to cover, because we want you to know how important this issue is. The OMA is vigorously advocating on your behalf every day through the reform process. There is no better time for health care reform and one thing is certain—now is the time for real change.



UPCOMING events

Coding Book Order Forms

Available on Aug. 1

Email christi@theoma.org for more details

Risk Management Seminars

Visit www.theoma.org/lossprevention for locations.

Risk Management for
Medical Office Personnel

Sept. 5, 12; Oct. 3, 15

Advanced Training in Risk Management

Sept. 6, 13; Oct. 4, 15, 25

Basic Training in Risk Management

Sept. 13; Oct. 25

OMA Executive Committee Meeting

Sept. 11; Oct. 9, 4–7pm

OMA Headquarters

11740 SW 68th Pkwy, Ste 100, Portland

Employment Law Boot Camp

Tuesday, Sept. 16, 8:30 am–12:30 pm

OMA Headquarters

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OMA Alliance Fall Session

Sept. 18–19, Coos Bay

Medical Couples Workshop

Visit www.theoma.org/workshops for more details

Saturday, Sept. 20

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OMA Board of Trustees NEW TIME!

Friday, Oct. 3, 6–9pm

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OMA House of Delegates

Interim Meeting

Oct. 4–5

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OMA 2009 Dues Statement

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Tuesday, Oct. 14

Practice Management

Workshop Series

Visit www.theoma.org/workshops for more details

Oct. 14–15, Eugene

Oregon Medical Board Meeting

Oct. 16–17

Crown Plaza: 971-673-2700

1500 SW 1st Ave, Ste 620, Portland

Discrimination Law

Audio Conference

Visit www.theoma.org/workshops to

register for audio conference

Friday, Oct. 17, 1–3 pm

Coding Workshop Series

Visit www.theoma.org/workshops for more details

Oct. 21–23

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11740 SW 68th Pkwy, Ste 100, Portland

20th Anniversary OMA Alliance

Teen Health Workshop

Wednesday, Oct. 22, Eugene

2008 OMA Executive Committee

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Vice Speaker | Mary McCarthy, MD

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OMA Alliance

President | Eva Germaine-Shimotakahara

Becoming a Delegate

By Carla McKelvey, MD

OMA Speaker of the House

DELEGATES ARE CHOSEN FROM their local medical societies or specialty societies. In many cases, expressing an interest in being delegate to your local medical society is enough to get “hired.” The only requirement is that you must be a member of the Oregon Medical Association.

As a delegate it is your responsibility to attend the House of Delegate meetings—the annual is typically held in April and the interim meeting will be held October 4–5 this year. Delegates are responsible for expressing the views of their medical community. We have a diverse group of physicians across the states with a multitude of concerns and interests. Only by having physicians attending from all areas of Oregon can the OMA and House of Delegates adequately reflect all of those issues.

The House of Delegates starts on Saturday morning where committee reports are presented and resolutions are presented and discussed. The debate can be heated. But Sunday is the day when the House makes its final decisions about the resolutions. Some delegates believe their responsibility is over after the fun ends on Saturday, but it is important to come back on Sunday to vote and make your final comments.

If you have additional questions about serving as a Delegate to the OMA House, contact Corrie Pierce at corrie@theOMA.org or 503-619-8000. See page 9 for more information.

Medicine in Oregon Submission Guidelines

We welcome submissions from our members, including opinion pieces, essays about your practice, or visual art. We do not offer payment for published work, but can provide additional copies of the magazine in which your work appears.

If you are interested in writing but do not have a clear idea or a specific topic in mind, you may wish to contact a member of the editorial advisory board or the staff editor. They may be able to assign you a topic or make suggestions for content we are seeking for a particular issue.

Get a sense of what is planned by viewing the editorial calendar for the year, which is kept up-to-date on the OMA website at www.theOMA.org/MiO.

Submission deadlines for each issue are as follows:

Sept. 30: Fall issue, Workforce Challenges

Dec. 15: Winter 2009 issue, Technology at Work

March 15: Spring 2009 issue, Theme TBD

Send your submissions electronically to betsy@theOMA.org.

Written submissions should be sent in rich text format or MS Word 2003. Any accompanying photos or illustrations can be sent either on CD or via e-mail. Please note these must be high-resolution files, 300 dpi or higher. **We also have a 6MB size limitation on e-mail we can receive.** Include a brief (25 words or fewer) biographical note, including your specialty, where you practice and (optionally) how long you have been a member of OMA.

Submissions of visual art can be submitted either via mailed CD or e-mail, or contact Betsy Boyd-Flynn at 503-619-8000 to arrange an in-person meeting.

Joining the Circle

OMA thanks those members who have paid their 2008 dues, and welcomes the following new members and those who have reinstated their membership with the OMA since April 30.

New Members

Thomas J. Altstadt, MD
Brett D. Burbridge, PA
Jeanne H. Button, MD
Viju P. Deenadayalu, MD
Robert E. Dexter, MD
Sara M. Duesterhoeft, MD
Laura A. Evans, PA
Holly I. Faber, MD
Jeffrey S. Feinblatt, MD
Elizabeth M. Foster, MD
Neelam Garg, MD
Paula A. Gerber-Gore, MD
Bryan A. Gunnoe, MD
Melissa A. Hemphill,
Tannia L. Hines, PA-C
Kimberly L. James, MD
Paul E. Johnson, MD
Annick-Marie V. Kaufman, MD
Andrew Y. Kee, MD
Eric B. Kirker, MD
Daniel W. Kirkham, MD
Amee J. Koch, PA-C
Luci M. Kovacevic, MD
Rebecca A. Kyle, DO
Don H. La Grone, MD
Stephen A. Leonardo, PA
Dafna L. Lohr, MD
Andrew R. Maslona, MD
James L. McAnally, MD
Kevin B. Meyer, MD
Trinh Meyer, MD
Jonathan B. Miller, PA-C
Sandra E. Miller, MD
Tessa J. Molter, PA
Brenda F. Murphy, MD
Jeffrey D. Myers, PA-C
David P. O'Brien, MD
Mark Allan Ng Ramirez, MD
James S. Rickards, MD
Theodore J. Robnett, MD
Dana K. Rubin, PA-C
Sarah L. Scholl, PA
Peter Simmons, MD
Timothy M. Simrell, PA
Susan J. Smith, MD
Robert Soans, PA
Sean L. Sweeney, DO
Julia C. Timberlake, MD
Doru A. Totoian, MD
Debra S. Walhof, MD
Sarah A. Walter, MD
Alice Wang-Chesebro, MD
Charles M. Wood, MD
Lindsay E. Wyant, PA

Reinstated Members

Kenneth R. Ampel, MD
Lance E. Anderson, MD
Tamara X. Arthur, DO

Maziar Azadpour, MD
Roman J. Babij, MD
Kelly M. Bartholomew, PA
Roger P. Blair, MD
Bruce L. Bobek, DO
William John Brown, MD
Richard O. Buck, II, MD
Virginia Buck, MD
Tammy A. Bull, MD
Chelsea C. Burchette, PA
Jacob W. Cambier, MD
Michael E. Coley, DO
Laurence Colman, MD
Keith D. Conant, MD
James Paul Cuyler, MD
Benton J. Davidson, MD
Jeffrey D. Disney, MD
Melanie N. Doak, MD
Tom R. Dunham, MD
Lisa A. Egan, PA-C
Angela D. Enos, PA
John O. Evered, MD
Alden B. Glidden, MD
Harry E. Groth, MD
Avon I. Hansen, PA
Susan M. Hansen, MD
Gary F. Henkel, MD
Kim M. Heydon, MD
Jonathan D. Jahnke, MD
H. Desmond Johnson, MD
Amy R. Lawrence, MD
Colin Dwight Lee, MD
Robert A. Lowe, MD
Michael J. Malos, MD
Bridget A. Metcalf, PA
Diane L. Miller, MD
F. William Miller, MD
Stanley A. Myers, MD
Raymond P. Nolan, MD
Linda C. Novak, MD
Julio A. Ordonez, MD
Michael M. Owens, MD
Alyssa R. Pace, PA
Philip Y. Paden, MD
Jennifer A. Penfield, PA-C
Marcia A. Picou, MD
Thomas E. Pitchford, III, MD
Donald F. Plumb, MD
Alicia M. Ross, MD
James L. Rushing, MD
Samuel J. Russo, DO
Kari L. Smart, MD
Derrick J. Sorweide, DO
Sylvia Y. Southworth, PA
Linda M. Tesman, PA-C
Geoffrey Tyson, MD
Erik J. Van Kleek, MD
Adam N. Williams, MD
Craig A. Winkler, MD

Membership information is available through Beth Cherry at 503-619-8000 or beth@theOMA.org.



Eva Germaine-Shimotakahara

A Focus on Veterans

“...one of the biggest challenges they face is the lack of mental health professionals to help them deal with their unique problems.”

Eva Germaine-Shimotakahara, BSc.N, BA, is the 81st president of the OMA Alliance. She was born in Nova Scotia, Canada, and completed her nursing education at St. Francis Xavier University. She has been married to Dr. Steven Shimotakahara for 25 years, and has three grown children.

FIRST BECAME INVOLVED in the OMAA in 1999 after reading an article in OMAA’s newsletter, *The Grapevine*. The article was about violence in the media and the work that was being done by the AMA and OMA Alliances through the Stop America’s Violence Everywhere campaign. My 12-year-old daughter had just taken a stand against young children being exposed to violent video games in public places, and I was looking for an organization that would stand behind her efforts. The OMAA/AMAA was ideal. They had an abundance of educational materials both for children and parents related to violent media and bullying.

Since then, I have worked with the most incredible group of volunteers at the OMAA to help promote good health in our communities. Much of our work is with Oregon’s youth. Presently, we are active in schools with the Faux Paw program, which teaches children how to be safe from predators while online.

My youngest child joined the military in December of 2007, and so this year, the OMA Alliance has chosen to address the plight of our returning military from combat situations. We will host educational forums on post traumatic stress disorder and traumatic brain injury utilizing mental health professionals, physicians and combat veterans. One in five returning combat personnel suffer from these disorders, and one of the biggest challenges they face is the lack of mental health professionals to help them deal with their unique problems.

Divorce, addiction, violent behavior and suicide are other issues they face when they return home from serving our country. In the past year, there has been a 13 percent increase in suicides among returning war veterans—the highest rate since 1980. Often times, returning veterans are afraid to talk about their problems and difficulties as they feel they may lose benefits or be seen in an unfavorable light.

It’s time to change these perceptions and give veterans the care and honor they deserve. We need to protect this precious generation of military volunteers who are the protectors of our beloved country. For the OMAA fall meeting in Coos Bay on Sept. 18 and 19, we have collaborated with Bay Area Hospital to host three speakers who will address PTSD and traumatic brain injury. For the OMAA winter meeting in Salem, February 2009, we will meet with legislators to advocate for improvements in access to health care for veterans.

Twelve years ago, I became a citizen of the U.S. I’m very grateful for how America has embraced me. I care deeply about this country. I believe wholeheartedly in its values, and I am proud to be a volunteer with the OMA Alliance.

If you are not already a member or involved in the OMAA/AMAA, please join us. We need your membership and help to accomplish our programs and goals. Please pay your dues so we can continue this volunteer work that is so important to the health of all Oregonians. ●

To learn more about the OMA Alliance:
visit www.theOMA.org or email Pat Webster: pat@theOMA.org.

A Look Inside the Process

The Nuts and Bolts of the House of Delegates

By Stanley G. Sturges, MD, Certified Parliamentarian

THE OREGON MEDICAL ASSOCIATION'S House of Delegates is an opportunity for physicians to try out their skills in a democratic process of debate. The necessary aspects of formality allow the right to participate on an equal basis and as a result each delegate has a vote to affect the best interests of organized medicine and patient care.

The meeting of the House of Delegates follows the parliamentary rules according to the *Standard Code of Parliamentary Procedure, fourth edition*. There is an organized agenda which often includes a guest speaker. At the Annual Meeting, nominees for leadership are installed by vote.

Day One: Reference Committee Hearing

In the morning session, the Reference Committee hears discussion and debate on action items and proposals and then meets later to review the day's reports and testimony. Their report is available for deliberation by the House of Delegates the following morning. The House then votes on the recommendations of the Reference Committee.

When providing testimony before the Reference Committee a member must identify themselves by name and status, (e.g., "Ash Patil, delegate from MSMP") and waits for the Chair's recognition.

Day Two: Deliberation

The second morning includes deliberation by the assembly, controlled by the Speaker and Vice-Speaker. Reports and action items that have been discussed the day before and

processed by the Reference Committee are now presented, in parts, by the Chair of the committee. The House votes on each part as presented.

If a delegate disagrees with the recommendation of the Reference Committee, he/she may move to amend the action proposed, and this requires another delegate to second the motion. If an amendment is to be proposed, it must be submitted in written form so it can be projected on a screen. A second is not required if the amendment is proposed by a caucus of members.

The Speaker of the House may then allow the delegate who made the motion a chance to debate the issue. Delegates may then speak either in favor of or against the amendment or may even propose a change in the amendment (called a secondary amendment), which requires a second. The Speaker will control and focus the discussion and voting, first on the secondary amendment, and then the main primary amendment, and then the main motion, according to this pathway.

Formal Procedures are Key

No matter how passionate a delegate feels about the action at hand, the rule is that the delegate must go to the microphone, identify himself/herself by name and delegation, and be recognized by the Speaker. There can be no personal attacks against other delegates. There can be no arguments voiced while sitting in the audience.

How to Participate

All members of the Oregon Medical Association are encouraged to submit

Hallmarks of Parliamentary Procedure

Parliamentary Procedure is logical, and is intended to make meetings run well and efficiently. Principles of parliamentary law:

- 1) foster equality of rights for each member,
- 2) ensure the majority vote decides the issue,
- 3) ensure minority rights must be protected,
- 4) allow for full and free discussion of every action proposed,
- 5) require that every member know the meaning of the question before the assembly, and
- 6) require that all meetings must be characterized by fairness and good faith.

a resolution to be considered at a regular meeting. The rules of the Association require that the resolution be submitted in a format that presents the arguments in favor of the action, each paragraph starting with "Whereas," followed by the proposal which may be in parts, all preceded by "Resolved that..." Staff members at the OMA are available to assist in crafting the resolution, as well as meeting the required timeline. ●

Questions about parliamentary procedure at the OMA can be directed to Stanley Sturges at sgsturges@comcast.net. If you have a question about the House of Delegates, contact Corrie Pierce at corrie@theOMA.org.

Further references: *The Standard Code of Parliamentary Procedure, 4th Ed.* Robert's Rules of Order, Newly Revised, 10th Ed. *The Complete Idiot's Guide to Robert's Rules* by Nancy Sylvester.

The View

from the Board

Medicine in Oregon spoke to Chuck Hofmann, MD, a Baker City internist, OMA Past-President and one of seven members of the Oregon Health Fund Board. We gave Dr. Hofmann the chance to review reports from the physicians on the committees (*beginning on page 11*) and share his take on the process.

“I’M REMAINING OPTIMISTIC,” said Hofmann, who is aware that as the committees’ reports come in, truly difficult work for the Board begins as they try to create a good plan that has a chance of succeeding politically. “I would not have devoted my time and energy to this process if I didn’t feel like we could make the system better for everyone—coming from a system where everyone doesn’t even get needed vaccines. Almost regardless of outcome, we’re going to make things better than they are now.”

Hofmann recognizes that the financing of the reform plan is going to be the hardest part. “Even with payroll taxes and maximized Federal matching, we’re still half a billion dollars short of paying for near-universal coverage,” and so, says Hofmann, the Board is going to have to suggest hard compromises.

“Oregonians have lofty goals and lofty aspirations, and we’ll need to determine what’s affordable.” The areas where the push is going to come is in determination

of the benefits package, the extent of delivery system reform, and the extent of the subsidy for Oregonians with incomes between 100% and 400% of the Federal Poverty Level.

In response to physicians who might be pessimistic that the plan will not adequately account for physician interests when it comes to implementation (as some of the participants in the subcommittee process have been), Hofmann is reassuring: “I don’t see how anyone can be hurt by increasing health care insurance coverage and improving reimbursement.”

To the public that might be concerned that the plan won’t be meaningful, Hofmann offers a similarly bracing message: “We have an obligation to help you, and we’re going to help you. If you have no access now, we are going to give you the best we [as a society] can afford. It’s all about shared responsibility, but ultimately this should be no different than police and fire protection.” ●

What Health is the Fund Board?

The 2007 Legislature established the Oregon Health Fund Board through Senate Bill 329. The Board was given the mandate to develop a plan to provide health insurance to the 620,000 Oregonians who are currently without coverage and to present that plan back to the 2009 Legislature. It convened six committees (some of which convened additional subcommittees) to focus on specific portions of the plan.

Benefits Committee

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan.

Delivery System Committee

The Delivery System Committee is chartered to provide the Board with policy recommendations to create high-performing health systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

Eligibility and Enrollment Committee

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board.

Federal Laws Committee

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians.

Finance Committee

The Finance committee is chartered to identify strategies to finance a comprehensive plan to expand health care access to uninsured Oregonians; and necessary and appropriate changes to the regulation of Oregon's individual (non-group) health insurance market assuming a legal requirement that Oregonians must maintain health insurance coverage (i.e., an individual mandate). The recommendations will include a model for an Insurance Exchange.

Health Equities Committee

The Health Equities Committee is chartered with developing multicultural strategies for program eligibility and enrollment procedures as well as with making policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program.

Benefits Committee

By Lisa Dodson, MD, a Portland family physician and member of the Health Services Commission


THE BENEFITS COMMITTEE HAS worked to define an "Essential Health Benefit Package" that will achieve nine goals: 1) improve the health of Oregonians, 2) incentivize a rational redesign of the health care system, 3) reward personal responsibility, 4) reduce overall healthcare costs, 5) be innovative, 6) provide a social safety net, 7) be affordable for individuals and the state, 8) reflect the values of Oregonians, and 9) be evidence-based. Among the most difficult tasks for the committee was determining "essentiality" and determining the method by which this would be determined.

After extensive discussion, the Benefits Committee has approved a framework for an Essential Health Benefit Package that utilizes the Oregon Health Services Commission Prioritized List of Health Services. The Prioritized List, which has formed the basis for the Oregon Health Plan, emphasizes preventative services, is highly evidence based and was developed to reflect the values of Oregonians. In addition to more than a decade of use, the Prioritized List also has an administrative structure for

regular review and reassessment through the work of the Oregon Health Services Commission.

Areas of innovation will include the concept of an integrated health home for all Oregonians, incentivizing low or no-cost access to a set of value-based and preventative services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits, rewarding patients for active participation in their own health status, emphasis on innovative chronic disease management and incentivizing delivery of care in the most appropriate, cost effective setting.

An emphasis on personal financial responsibility will be scaled to individual income levels. Value-based services will be required to be included in all packages. Coverage for services on the Prioritized list will be tiered, with lowest cost and highest access to services that are cost effective, evidence based and preventative, and delivered in the most cost effective, appropriate setting.

The EBP incorporates deductibles, an out-of-pocket maximum, and cost sharing at levels based on income and on the ranking of the condition on the Prioritized List and includes physical, mental health, and preventative 

Delivery Systems Committee

Medicine in Oregon spoke to Doug Walta, MD, a Portland gastroenterologist, to get his perspective on the work of the committee.

THE DELIVERY SYSTEM SUBCOMMITTEE

worked to find ways to change the fundamental processes of delivering care in the state of Oregon to improve quality, and better control and allow for transparency in the costs and quality of care. Some of the toughest challenges the committee faced were in coming to consensus—the committee included representatives from health systems, patient advocacy groups to payer groups. “The diversity of voices and philosophical perspectives led to a fundamental challenge,” said Walta, a Portland gastroenterologist and Co-Vice Chair of the committee,

The committee submitted their draft report in mid-May. Due to many constraints, including the time allotted for work and the complexity of the task, the ideas generated through the report—nearly 70 pages long—were, according to Walta, pushed forward without enough consideration of cost containment or ramifications of the consequences of change.

Revamp primary care through integrated health homes.

Despite the difficulty of the work undertaken by the committee, their report contains several specific recommendations that will impact physicians if they are implemented: their proposal will establish integrated health homes for the participants in the Health Fund Board program, eventually expanding to the larger population. Integrated health homes are a way of coordinating care through a primary care provider. Some demonstration projects for this model of care are already in operation through CareOregon, through the Oregon Medical Home Project out of OHSU, and for all patients through a Regence BCBS project launched in 2007.

According to Walta, the use of such care models, which among other things

would compensate the coordinating provider for their care management efforts, may help shore up the primary care specialty: “The goal is to try to create a change in finances and reimbursement that would make the specialty become viable again.”

The committee also tried to recognize and address the need for chronic disease management, including mental health. “As a committee, we could find some common ground...We all acknowledged the total disruption of mental health treatment in Oregon, and tried to reinvigorate that through the integrated health home.” In recognition of this need, the draft plan calls for “Full integration of public health, primary care, specialty care, acute care, emergency care, oral, behavioral and mental health care, long-term care and end-of-life care.”

Coordinate quality efforts through a Quality Institute

The committee also advocated creating a Quality Institute, which according to the committee’s report, will “lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians.” The proposal would stipulate initial funding for 10 years.

As a physician, Dr. Walta was particularly attuned to the need to make sure that the data used in any quality measurements is risk-stratified, as was the cardiac surgery databank collected by U. Scott Page (2007 OMA Doctor-Citizen of the Year, now deceased). “Risk stratification sorts out the confounding factors and maintains credibility” while really getting to the definition of what quality is.

One challenge the committee could not adequately resolve: there was a strong desire to better disclose cost of care to patients; but to put that

disclosure into operation carries logistical difficulties familiar to doctors. Before a diagnosis is made, it’s virtually impossible to clearly predict what the course of care will cost.

Another important element of the recommendations for the Quality Institute to administer is “accountable care districts.” This is a way of managing accountability for cost and quality across all care that is provided for specific populations. The idea is that a board in that district will work on certificates of need, etc. Walta was emphatic that the measures of quality be aimed at helping physicians and other providers to give better care, not to punish them. Part of their recommendation is that all health care quality and utilization data will be aggregated to allow a meaningful comparison of utilization across the state, to inform health planning in the long run. The problem with Accountable districts is they have never been implemented before, anywhere. This means, the details are very nebulous and the benefits are not clear.

Dr. Walta expressed some regret at his sense that the group did not approach some very difficult questions— including making decisions about appropriate end-of-life care, the pharmaceutical industry and tort reform. Though the group did recommend a statewide Physician Orders for Life Sustaining Treatment, or POLST, registry, they did not approach making difficult choices about expenditures for treatment vs. return and likelihood of good outcome. “We didn’t address the hard issues of engaging the patient in the decision tree,” said Walta, which could be a real problem given that the care available to all patients under any universal plan will have to be limited in some ways.

The Delivery Systems Committee’s final recommendations are available online at: <http://healthfundboard.oregon.gov>. ●

Eligibility & Enrollment Committee

By Ann Turner, MD, internist and Co-Medical Director of the Virginia Garcia Memorial Health Center in Cornelius

THE COMMITTEE INCLUDED representatives of a broad cross-section of stakeholders including consumers, physicians and other health care providers, insurance brokers, community advocates, hospitals and health plans.

Affordability

The committee developed guiding principles to use for making decisions, which were shared responsibility, equity, sustainability and preventing “crowd out.” The term “crowd out” describes the possibility that people with lower incomes might abandon their current private employer-sponsored for public coverage. Thus the committee tried to ensure that employers offering health insurance were not penalized for doing so.

The committee’s recommendations in this area included:

- ♦ Individuals and couples with incomes less than 150% of the federal poverty level, and families with at least one child and incomes below 200% of the FPL will make no personal contribution
- ♦ Individuals and families with incomes between 200–400% of the FPL would receive either a subsidy based on a sliding fee scale or a tax credit for those with higher income levels of between 300–400% of the FPL.

This recommendation was based on research into how much “disposable” income individuals and families actually have. In addition, it conforms to the principle that no one should be expected to spend more than 5% of their income on health care. The committee discussed the exact levels at length, and was concerned about public perception and the longer-term sustainability of the program.

Enrollment

The committee reached consensus on the following higher-level goals; much of the discussion focused on the details.

- ♦ The committee advocated for a strong outreach program to ensure maximum

enrollment, that the outreach reaches culturally diverse communities using materials that are language- and literacy-appropriate.

- ♦ The application should be simple, streamlined, short, widely available and allow use of the prior year’s tax return
- ♦ There should be a grievance, mediation and appeal process that includes an independent ombudsman.

Eligibility

This part of the committee’s work took the most time and was most challenging in some ways. The committee developed ten recommendations regarding who should be eligible, and how to determine that status. Key provisions include:

- ♦ All persons should be eligible for a State contribution to their employer-based health insurance if their income is <300% of FPL. Employers who provide health insurance will receive a tax credit, but all employers will contribute to the Oregon Health Fund.
- ♦ All Oregonians are eligible, including those who are “non-qualified;” this will prevent the cost-shift that otherwise occurs for those without insurance.
- ♦ Eligibility will be for one year, and there will be no assets test; there will be presumptive eligibility for contributions.
- ♦ No one will be denied insurance for current or previous health conditions.

One of the most difficult issues was whether persons with health insurance through their employer would be eligible for the insurance offered through the Insurance exchange of the Health Fund. In the end, the committee felt that employers might choose to pay into the Health Fund, forego the tax credit, and have their employees opt for the insurance offered through the Health Fund program’s Exchange. This assures the greatest choice and equity for employers and individuals.

Importantly, the committee believes that as soon as someone becomes an

Oregon resident, that person should sign up for health insurance. Their attitude was essentially that new residents should hear: “Welcome to Oregon; here is what you need to do to get health insurance.”

As a physician who treats many patients with no health insurance, I have seen that patients cannot get the care they need to prevent serious complications for their health problems. What could have been treated at an early stage or prevented all together has now resulted in a condition that seriously affects the health status of the person.

The Eligibility and Enrollment Committee’s final recommendations are available online at: <http://healthfundboard.oregon.gov/>. ●

Benefits, cont.

dental services. Coverage will be provided for basic diagnostic services and comfort care measures. The EBP will define the “basement level” plan for Oregon residents. No lower level of benefits should be offered in the state, but private purchasers and governmental plans could offer plans with richer benefits, and/or less cost sharing. The low barriers to preventative services and value-based services must be maintained by all health plans. Prescription coverage will include a drug formulary based on use of generic and cost effectiveness data where available.

The Benefits Committee’s final recommendations are available online at http://healthfundboard.oregon.gov. ●

Federal Laws Committee

By Frank Baumeister, MD, a Portland gastroenterologist, OMA Past President and AMA Past President

THE FEDERAL LAWS COMMITTEE has studied the federal-state health care relationship in depth, with invaluable research and administrative assistance of its extremely competent staff. The Committee heard exhaustive testimony and received a thorough education in those federal policies having potential to conflict with the goals of the Healthy Oregon Act. The committee structured its recommendations and findings around specific categories of federal laws; two areas of inquiry mentioned in the committee charter, the Emergency Medical Treatment and Active Labor Act, and the Health Insurance Portability and Accountability Act, did not reveal any significant conflict and are not discussed here.

Medicaid-Related Barriers

Federal categorical, complicated, and increasingly stingy funding. Oregon's current waiver allows full coverage only for adults up to 100% of the Federal Poverty Level; increased state funding to maximize the federal match would allow approximately 214,000 of Oregon's 574,000 uninsured to be covered without additional waivers.

Proposed CMS cuts in funding would restrict further state enrollment, dismantle state programs, and shift more costs to the states. Inflexible CMS policies and an arduous and lengthy waiver process restrict states' ability to experiment. Since 2006, new federal citizenship documentation requirements have been an additional barrier for many legitimately eligible citizens. The Committee will address these and other issues with the Board and with Oregon's Congressional delegation.

Medicare-Related Barriers

Medicare payments to Oregon physicians are so low that many physicians are no longer caring for Medicare beneficiaries. National Medicare rate reform is needed to correct gross inequities between high and low reimbursement states, encourage prevention and disease management, and promote evidence based care.

Oregon's medical workforce, especially in primary care, promises to be woefully inadequate to the task of universal coverage proposed in the Healthy Oregon Act.

Although popular and successful in Oregon, Medicare Advantage plans have tarnished reputations elsewhere, especially private fee-for-service plans whose marketing and management practices have drawn congressional scrutiny and censure. Further investigation into other states' experience is on-going.

Oregon's medical workforce, especially in primary care, promises to be woefully inadequate to the task of universal coverage proposed in the Healthy Oregon Act. Federal funding for graduate medical education is threatened; a

2007 CMS ruling and the Bush Administration's 2008 budget would have prohibited states from continuing to use Medicaid funds for GME, but Congress fortunately passed a prohibition on that ruling. Additionally, the 1996 cap on Medicare reimbursement for resident positions has not been revised to match growing needs.

Federal Tax Code-Related Barriers

The current federal tax code favors employment-based insurance and is unfair to the self-employed and individuals purchasing their own health insurance. It is recommended that all individuals be allowed to deduct health insurance

What is the Process?

June and July

The Board reviewed the reports and divided into two

board workgroups to turn the recommendations into a draft action plan by the end of summer (around the time MiO readers will get this issue).

premiums and other medical and dental expenses from their taxable income. Low income persons should receive refundable tax credits for their premiums. Our congressional delegation will carry this message forward and has already demonstrated strong support for such revisions.

Employment Retirement Income Security Act (ERISA) Barriers

This act superposes federal jurisdiction over various benefit plans of companies operating in multiple states, thereby preventing individual states from incorporating such plans in their own health reform programs. Public collection of data on such self-insured plans has thus far not been allowed. ERISA language is vague, however, and case-by-case litigation has ensued upon several states' reform initiatives. ERISA has never been amended, waivers have never been granted, and the issue remains murky. Hopefully the goals of the Healthy Oregon Act can be achieved without an ERISA challenge.

Other Federal Policy Barriers: Health Disparities Among the Native American Population

Our Native American population is under-funded, underserved, and suffering from significant disparities which must be corrected. The Federal Laws Committee has examined the Indian Health Service Tribal and Urban Programs, has heard advocacy testimony, and has a number of recommendations for the Oregon Health Fund Board, the Oregon State Legislature, and our national Congressional Delegation to improve the health care of our Native American population.

The Federal Laws Committee's final recommendations are available online at <http://healthfundboard.oregon.gov/>. ●

The Finance Committee

By Peter Bernardo, MD, a Salem general surgeon and OMA President-Elect

THE COST OF universal health insurance is dependent upon the number of eligible consumers, their economic and employment status, and the extent of the health insurance benefit provided by the plan. Hence, the work of the Finance Committee was very much dependent on the deliberations of the other committees.

Key Plan Concepts

♦ **Individual Mandate.** All individuals in the system must have health insurance, or may be subject to penalty. In the open insurance market (the Exchange) there should be guaranteed issue and renewability.

September and October

There will be a public input process with forums and around the state.

November and December

The Board will fine-tune the plan, and present it to the legislature in February 2009. The result may be an omnibus bill, or separate elements of the plan could be introduced as separate bills.

- ♦ **Employer Mandate.** Our current health care system is employer-based, but not all employers provide health insurance for their workers. This creates economic disparity between businesses. Employers who provide insurance often pay eight to 15 percent of their payroll towards premiums. All employers should share in the cost of providing health insurance for their employees.
- ♦ **New money must be raised.** To provide coverage for the unemployed and uninsured, financing should be sustainable and transparent in how it is raised and used, and should maximize federal matching funds.
- ♦ **The cost shift.** Uninsured Oregonians currently receive care through hospitals and clinics around the state. The cost of this uncompensated care (approximately \$450 million in 2004) is born by providers and insured patients through higher premiums. Providing health insurance for everyone will result in timelier, cost effective medical care and lead to lower health care costs.

The Need

There are approximately 620,000 uninsured Oregonians. Of these, about 240,000 people live in families with incomes of less than 150 percent of the federal poverty level. The majority of these would be covered by an expansion of the Oregon Health Plan. A system with a payroll tax to support health insurance would stimulate employers to provide coverage for an additional 20-40,000 people. The remaining 360,000 uninsured Oregonians could purchase commercial insurance through an Exchange. About two-thirds of these have incomes between 150 and 400 percent of the federal poverty level, and would be eligible for some premium support or state tax credit.

The ultimate cost of providing health insurance will depend on the benefit package and credit given to these 360,000

people. The estimate ranges from \$2.1 to \$2.7 billion, including new state tax revenue, federal matching funds, and new individual and business premiums. State government would need to raise \$450-750 million in new revenue annually to finance the plan.

Multiple Funding Sources

There is consensus among the Finance Committee members that the majority (60-100 percent) of new revenues should come from a two-part payroll tax: a "pay or play tax" and a basic minimum tax. Employers who do not pay at least five to eight percent of their payroll towards employee health care would pay that amount to the state. However, all business owners should see stabilization or a drop in premiums as a result of universal coverage. With that in mind, all businesses would pay a minimum payroll tax of 0.25 to one percent.

The Finance Committee is evenly split on the need for an additional revenue source. Most members agree that new taxes and fees should be few in number and politically viable. Any new tax should bring in significant funds and not require new government bureaucracy to administer. As a result, there is little support for multiple increased taxes on liquor, beer, wine and cigarettes, and no support for a new sales tax to finance this project.

Some members of the committee feel that the health care industry would see increased revenue from the decline in uncompensated care, and so should be taxed in support of the plan. This could include a one to two percent gross receipts tax similar to Minnesota. Such a tax might capture some of the gains from reduced cost shifting. Dissenting members feel that such a tax would merely add to the cost of health care, and others note that the gains from increased insurance would not be evenly distributed among providers and health care systems. All members recognize the physician shortage in Oregon, and that a provider tax may make recruitment and retention more difficult.

Finally, some members feel that the

Providing health insurance for everyone will result in timelier, cost effective medical care and lead to lower health care costs.

additional revenue should come from a new layer on the personal income tax. Oregon's maximum income tax rate is nine percent for income over \$7,150. Essentially, Oregonians pay a flat tax on their income. Oregon has the fourth highest income tax assessment in the United States; the majority of state revenues already come from this source.

The Finance Committee's final recommendations are available online at <http://healthfundboard.oregon.gov/>. ●

Health Equities Committee

By Michelle Berlin, MD, MPH, a Portland obstetrician/gynecologist and director of OHSU's Policy Advisory Toward Health (PATH) for women

HEALTH EQUITIES COMMITTEE members represented a wide spectrum of constituencies, including providers in private practice and public settings; spokespersons for underrepresented groups including rural dwellers, women, racial/ethnic minorities and persons with disabilities. Several key health systems were represented, as were local universities, community-based organizations and governmental entities.

While all of the HEC recommendations are germane, several are of immediate interest to physicians. These recommendations fall into 3 categories:

1. Preventing Health Disparities Before They Occur: Health Promotion and Chronic Disease Prevention and Management

The Committee recommended (a) an on-going, substantial investment in population-based public health activities, (b) the design of a mechanism to assist clinics who primarily serve vulnerable populations to work with health-focused community-based organizations in providing culturally-specific health promotion and disease management services, and (c) that the State create a Wellness Account for individuals participating in the Oregon Health Fund program who receive a subsidy.

The HEC also recommended the need for health policies with affordable cost-sharing, as high deductibles and out-of-pocket costs disproportionately hurt low-income individuals' ability to obtain needed care.

This account is modeled after Enhanced Benefit Accounts that are currently being implemented in several state Medicaid programs, and would help participants receiving subsidies to cover their costs for wellness activities.

2. Reducing Barriers to Health Care

The Committee recommended the implementation of universal eligibility, indicating that to "maintain the health of that workforce, it is fair, wise, and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents." Recognizing the political and fiscal implications of this recommendation, the HEC suggested a subsidy mechanism be developed within the

Oregon Health Fund Program for legal immigrants who have been in the U.S. under 5 years, and individuals without documentation who cannot afford to purchase health care. Industries employing non-qualified Oregon residents could be directed to contribute through the 'play or pay' requirement of the employer mandate.

The HEC also recommended that, consistent with current practices in the private marketplace, citizenship documentation not be a requirement to participate in the Oregon Health Fund program, and that a federal waiver be obtained to exempt Oregon from federal citizenship documentation requirements. The HEC also recommended the need for health policies with affordable cost-sharing, as high deductibles and out-of-pocket costs disproportionately hurt low-income individuals' ability to obtain needed care.

3. Improving the Quality of Care

The Committee recommended that the elements of the integrated health home model (also known as the "medical home") which have been demonstrated to reduce health disparities be encouraged. The HEC recommended increased reimbursement for and removal of financial barriers to preventive services, chronic disease management, patient education programs, and after-hours/walk-in primary care. Language access was addressed, by suggesting that Oregon create a state-wide pool of qualified, certified interpreters and organizations to use telemedicine and telehealth technologies and that Medicaid matching funds for interpreter services be sought.

I came away from this process heartened by the commonality of interest among my fellow Committee members: no matter what our background or declared representative group, all were committed to determining how best to help Oregonians achieve and maintain good health. We will all follow the subsequent proceedings of the Health Fund Board closely, and fervently hope a workable solution to providing adequate health care for Oregonians is achieved.

The Health Equities Committee's final recommendations are available online at <http://healthfundboard.oregon.gov/>. ●

WHILE YOU CONCENTRATE ON PATIENT NEEDS, ALLOW US TO CONCENTRATE ON YOURS.



TPG's Leadership Team

The Partners Group specialty health care division, Kerr-Cruickshank, is one of the largest providers of Health Welfare and Retirement programs for medical clinics in the Northwest. As a Sponsored Representative of Oregon Medical Association (OMA) since 1995, Kerr-Cruickshank puts the buying power of over 7,000+ OMA members to work for individual physicians. We uniquely offer proprietary insurance programs that cannot be obtained elsewhere.

Not only can we meet the needs of your clinic, but also your individual life. Physicians have very different concerns and requirements than those of the general population. In order for TPG and Kerr-Cruickshank to be a truly holistic solution in the medical community, we have created programs that can specifically address those individual needs. And because we are all under one roof, you know that your business side and personal side are working together for your best interest.

Individual Physician Services: Financial Planning, Disability Insurance, Life Insurance, Long-term Care, Individual Medical, Business Owners Package, Directors and Officers, Home, Auto, Boat/Yacht, Liability Insurance

Clinic Services: Medical Insurance and self-funded health plans, Dental Insurance and self-funded dental plans, Flexible Benefits Plans, Retirement Plans, Short & Long term Disability Programs, Life/AD&D Coverage, General Liability and E&O Programs, Voluntary Benefit Programs



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Clarke v. OHSU

Elimination of Oregon Tort Claims Act Protection and Possible Solutions

By Michael D. Crew and
Thomas E. Cooney

IN LATE DECEMBER 2007, the Oregon Supreme Court issued its decision in *Clarke v. OHSU* which essentially eliminated the protections of public employees and public entities under the Oregon Tort Claims Act. While the liability of the public entity, OHSU, remains limited under the OTCA, because of the statutory duty of the public entity to indemnify its employees for liability they may incur within the course and scope of their employment, the *Clarke* decision eliminated not only the protection of the OTCA as to public employees, but also the entity itself. All interested parties recognized immediately that the *Clarke* decision created an “economic crisis” for public entities and their employees due to the limited resources of entities such as school districts, county and city governments, etc.

Concurring Opinion in *Clarke*

Justice Thomas A. Balmer wrote a concurring opinion in the *Clarke* case which was joined by Justice Rives Kistler. His opinion suggested that the problem with the OTCA was not with the concept of limited liability, rather that the limit of liability was wholly inadequate with regard to medical malpractice cases. To support that conclusion, Justice Balmer cited the fact that nearly all physicians in the State of Oregon carry professional liability policies with limits of at least \$1 million, and many carry coverage with limits of \$3 or \$5 million per occurrence. Thus, he suggested that because people recognize that liability in medical malpractice cases generally results in damages much greater than the current statutory limits under the

OTCA, that the legislature should modify the law to provide for higher damages (limits) for public entities such as OHSU.

The concurring opinion recognized that the plaintiff would argue that “any” statute that imposes a limit on damages that a plaintiff could have recovered at common law violates the Remedy Clause, however the opinion made clear that at least two members of the Oregon Supreme Court believed that placing a \$1 million cap on medical malpractice claims for employees of governmental entities like OHSU would not offend the Remedy Clause and would be constitutional under Article I, Section 10.

Unfortunately, what the concurring opinion did not address was the “jury

issue” conundrum created by the *Lakin v. Senco* case, which held that the cap (\$500,000) on non-economic damages created by the 1987 legislature, which covered all physicians, was unconstitutional not because of a violation of the remedy clause, but rather because it violated the right to have all matters determined by a jury. It is unknown how Justice Balmer would analyze the *Lakin* issue, but even if the legislature were to increase the OTCA limit to \$1 million for medical malpractice claims, any injured plaintiff whose damages exceed \$1 million would argue not only that the remedy was inadequate, but also that they were denied their right to a jury trial much like the plaintiff argued in the *Lakin* case.

Legislative Response— 2008 Session

In recognition of the need for multiple inputs on this complex issue, legislative leaders created the Joint Interim Task Force, and Governor Kulongoski created an informal work group to review the options all with the goal of reporting back to the 2008. At the May 29 meeting of the Joint Interim Task Force, the conclusion was that their function would be limited to determining “the right number” to suggest for amending the OTCA. Thus, it appears that the Joint Interim Task Force is focusing upon what was suggested in the concurring opinion in *Clarke*.

A Case for Broader Tort Reform

If the Task Force limits its function to determining “the right number” to raise the OTCA limit to, it is missing an opportunity to clarify the function of the legislature to “adjust Oregon law to changing circumstances by creating, eliminating or altering causes of action or providing defenses or immunities to the causes of action.” Since the *Lakin* decision, it has been recognized that

a constitutional amendment will be necessary to impose a cap on damages for the private practice of medicine.

On two occasions, Measures were presented to the people, and both were rejected—the last one in 2004—by a fairly narrow margin. The close election should make the Task Force recognize that many Oregonians would support a limit on damages in all medical malpractice cases. Because of the scope of authority of the legislature has made it difficult to adjust remedies to meet changing times, the Task Force should propose an amendment to the Oregon Constitution which would provide that notwithstanding Article I, Sections 10 and 17, the legislature can, on a case-by-case basis, place into law limitations of liability which are necessary to protect the interests of the public. While the legislature may not agree that a broader cap is appropriate at this time, that may change in the future; thus, it would have the power

to adjust remedies in light of the public interest.

A national debate regarding health care will be central to the upcoming national elections. The issue of limiting damages and thus lowering the cost of health care is a legitimate part of that debate. Going back to “the people” every time the Oregon legislature wants to adjust a cap, whether it is for malpractice liability, or any other liability is expensive and slow. The legislature should be given the flexibility to address these issues when necessary, without fear that the interest of the individual plaintiff will override the public interest. ●

An expanded version of this article, including a discussion of the substance of the Clarke vs. OHSU case, is available online at www.theOMA.org/MiO.

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Let's Join Forces to Fix Health Care

By Senator Ron Wyden

I'M NOT TELLING MEMBERS of your association anything new when I say that our health care system is broken. But one piece of news is that this Senator and at least 13 others understand that we'll only be able to cure our health care ills if we have doctors at the forefront of the battle to fix it.

Every day on the job, you see how our system fails both patients and health care providers. Only you have the real life knowledge of the holes in our system and the ridiculous hoops you have to jump through to treat patients. That knowledge will help us map our way out of this health care jungle.

Finding solutions to fix the health care mess is a top priority for me in Congress. That's why I've worked to create a bipartisan coalition of seven Democratic and seven Republican Senators—the first bipartisan coalition for universal health care in the history of the Senate—as co-sponsors of the Healthy Americans Act (S. 334).

The Act takes the best parts of both political parties' philosophies about solving our health care problems. It weaves together the Democratic idea that we need to give every single person in the country health care coverage and the Republican belief in a private-market approach.

The Healthy Americans Act modernizes employer-based health care. It guarantees portable private health insurance for every American, providing them with health coverage as good as what Members of Congress receive regardless of age, pre-existing health conditions, or place of residence. Through the HAA, we would change tax laws so they benefit the small business person with the hardware store down the street instead of the millionaire getting a designer smile.

In addition, as only Congress can, we would also change the law so that insurance companies could no longer cherry pick whom they would cover. The Healthy Americans Act is



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predicated on the principle that you have to cover everyone, no exceptions, if we are going to improve quality of care and control costs.

On the cost front, we got great news recently from the Congressional Budget Office (CBO) and the Joint Committee on Taxation—the government’s go-to officials for budgeting and taxes, who issued a joint analysis that found that our universal coverage bill will not cost any additional federal money once it’s up and running and, in fact, will save taxpayers money in the future.

Best of all, the bill puts our health care focus on keeping Americans healthy through preventive care by giving insurance companies a financial incentive to encourage healthy behaviors. This bill also would provide financial reimbursements to Medicare providers who manage their patients’ chronic care needs. In addition, it requires health plans to designate a health care provider to monitor each patient’s health, coordinate their health care and establish a care plan to maximize their health. The bill would also lend a hand to doctors by reforming medical liability laws to reduce defensive medicine, freeing you up to treat and prescribe without fear of frivolous lawsuits.

As I mentioned earlier, the Healthy Americans Act will need the support of doctors like you to become a reality. One thing I’ve seen throughout my career is that the best things in our country don’t come from the top down, they come from the grassroots up. Leaders lead best when they follow the needs of their constituents. The momentum we need to accomplish health care reform will have to come from groups like the Oregon Medical Association working with us on the ground in our state to create the foundation for the changes that need to happen.

Many people don’t believe Congress can run a two-car parade, much less fix something as complicated as our troubled health care system. But

at every forum of doctors and health care professionals you attend. Don’t be afraid to talk to reporters and the media too.

Many people don’t believe Congress can run a two-car parade, much less fix something as complicated as our troubled health care system. But Americans do trust their doctors.

Americans do trust their doctors. They listen to you and follow your advice. And since Oregon has been a leader on health care issues in the past, I believe Oregon’s physicians are poised to be the grassroots leaders on reforming our health care system now and for the future.

I hope you’ll go to my Web site at wyden.senate.gov/haa, read the bill, and then start speaking out about it

It will take the concerted efforts of us all to get all parts of our health care system working together on solutions. Let’s join forces so we can hand the next president a plan for health care reform in 2009. I hope you’ll agree the Healthy Americans Act is the way to go. ●

Senator Wyden (D-Ore) has served in the U.S. Senate since 1996. He has worked extensively with the OMA to help shape his bipartisan, bi-cameral Healthy Americans Act, which will likely be considered in 2009.

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Free Program Makes it Easy

for Eligible Oregonians to Save on Prescriptions



LIKE THEIR COLLEAGUES IN other parts of the country, physicians and other healthcare professionals in Oregon are seeing an ever-increasing number of uninsured patients as 17 percent of the state population does not have healthcare coverage.¹ To help these individuals access the medicines they need to take care of their health, leading pharmaceutical companies sponsor the Together Rx Access[®] Program. This free prescription savings program provides eligible individuals and families with immediate and meaningful savings on hundreds of prescription products. In fact, about 10,000 people across the country are enrolling in the Program each week.

How Physicians Can Help Uninsured Patients

Following are simple ways that physicians can help educate their uninsured patients about Together Rx Access:

- ◆ Determine eligibility by reviewing the Together Rx Access Card qualifications together
- ◆ Direct eligible individuals to the website TogetherRxAccess.com to enroll online
- ◆ Provide the Together Rx Access toll-free number 1-800-250-2839 to eligible individuals
- ◆ Distribute quick start savings cards to eligible individuals
- ◆ Organize an onsite clinic or hospital enrollment program

Individuals may be eligible for the Together Rx Access Card if they do not qualify for Medicare, do not have public or private prescription drug coverage, have a household income of up to \$30,000 for a single person or \$60,000 for a family of four (income eligibility is adjusted for family size), and are legal residents of the United States or Puerto Rico.

The Card is accepted at the majority of pharmacies nationwide and in Puerto Rico. Cardholders simply bring the Card to their neighborhood pharmacist along with their prescription, and the savings are calculated right at the pharmacy counter. There are no enrollment costs, monthly dues or hidden fees.

Most cardholders save 25 to 40 percent² on brand-name prescription products. Savings are also available on generics. Medicines in the Program include those used to treat high cholesterol, diabetes, depression, arthritis, asthma, and many other common conditions. The Together Rx Access Card is free to get and free to use.

There are three easy ways to enroll:

- ◆ Visit TogetherRxAccess.com
- ◆ Call 800-250-2839
- ◆ Complete a short paper application and return it by mail

A Together Rx Access quick start savings card is also available. Potential enrollees simply detach the Card from a brochure, and call the toll-free number to find out if they are eligible, enroll and instantly activate their Card. To receive a supply of quick start savings cards, contact Amy Niles, Chair, Medical Relations and Advocacy, Together Rx Access at amyniles@aol.com. ●

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- 1 State Health Facts website: www.statehealthfacts.org accessed May 5, 2008.
- 2 Each cardholder's savings depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change.

Clear Comparisons

2008 athenahealth PayerViewSM Rankings Released with Aetna Assuming Top Ranking

FROM ITS SECOND PLACE position in 2007, Aetna has attained the first place ranking among national commercial insurers in athenahealth's 2008 PayerViewSM Rankings. PayerView is the industry's first quantitative report addressing the fundamental pain points currently existing between insurers and providers. Its goals are to quantify the challenges practices face in collecting for their services and to create an industry-wide dialogue on how breakdowns in the insurer and provider relationships can be addressed.

PayerView not only provides transparency into payers' processes, but providers can also benefit by gaining leverage in payer negotiations and using the data to improve control over practice performance.

In addition to national commercial insurers, PayerView ranks regional payers in the Northeast, Midwest, South and West regions of the United States. The rankings look at payers' performance based on seven metrics comprising scores in financial performance, administrative performance and medical policy complexity, which collectively provide an overall ranking aimed at quantifying the "ease of doing business with the payer." The 2008 rankings evaluated 137 national, regional and government payers.

Aetna's movement to the top of the rankings was realized from a 10.6% reduction in its claims denial rate, which also provided Aetna with the best denial rate across the national payers. Across the other metrics, Aetna either maintained or improved its rank including the fastest payment to providers for the second straight year, which gave it the edge to surpass last year's leader CIGNA Healthcare.

To explain the rankings further and highlight how the PayerView initiative has pushed an industry-wide dialogue on how to address the breakdowns in the insurer and provider relationships, athenahealth offers a complimentary

online webinar. Visit www.athenaPayerView.com for webinar information and the complete 2008 PayerView Rankings.

Additional key findings and trends from the 2008 PayerView Rankings include:

- ♦ Patient liability for the national payers was only up slightly at 0.4% compared to a 19% increase the year prior. Both Humana and UnitedHealthcare launched new real-time adjudication projects with athenahealth in 2007 to address the growing demand on providers to collect payment from patients with new consumer-centric benefit plans.
- ♦ The Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) initiative caused a great deal of confusion for providers in 2007 concerning which payers would adhere to the original, May 23, 2007 deadline, and what each payer's contingency plans were. Payers had varying instructions for providers for how to exchange NPI information, which was needed for a payer to be able to process a medical claim—this resulted generally in increased denials rates and multiple submissions to resolve. While this impact was still small in 2007, the industry may feel the full impact in 2008 when the requirement officially goes into effect.

This year's rankings utilized athenahealth claims performance data from more than 12,000 medical providers representing over 30 million medical charge lines for all four quarters of 2007. The rankings depict athenahealth's experience in dealing with national payers with at least 120,000 charge lines of data and regional payers with a minimum of 20,000 charge lines. The data include medical services billed from 39 states to payers in 45 states. ●

athenahealth is an endorsed member benefit partner. OMA member practices receive a 6 percent discount from athenahealth for its athenaCollector services, provided all physicians in the practice are OMA members. For more information, visit www.theOMA.org/athenahealth.

Medicine's National Voice GROWS LOUDER on Uninsured

WITH THE 2008 PRESIDENTIAL election rapidly approaching, now is a crucial time for change in our current health care system. Through its three-year "Voice for the Uninsured" campaign, which kicked off in 2007, the American Medical Association (AMA) has been

drawing the public's attention to the need to expand health insurance coverage to millions of uninsured patients and the AMA's proposal on how to make that happen.

This proposal, which offers coverage and choices for everyone, centers

around three key principles: to provide all Americans with the means to purchase health care coverage through tax credits or vouchers, give patients more choices for coverage and enact health insurance market reforms to enable this new approach.

The urgency for change in our current health system is growing each day. According to the U.S. Census Bureau, the number of uninsured Americans rose in 2006 by 2.2 million to a total of 47 million. And in Oregon, the uninsured rate is higher than that of the United States. A full 16.6 percent of the state's population lacks health care coverage, affecting 604,000 people. But according to an AMA survey of physicians in fall 2007, the number of uninsured patients affects everyone. The survey showed the problem presents difficulties in providing care, increases in staff workload, a greater risk of medical liability suits and deeper financial obstacles.

These are among the many reasons why, in 2007, the initial phase of the AMA's "Voice for the Uninsured" campaign focused on generating awareness of the issue, particularly among voters and candidates in early primary states. Carrying the theme "Because 1 out of 7 is 47 million too many" and depicting real physicians



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and uninsured patients, campaign advertisements ran on television and radio and appeared on pharmacy prescription bags and billboards, in transit stations and around college sports stadiums. Elsewhere, campaign volunteers handed out information

Today, the AMA is working to place its proposal for change in front of presidential candidates and voters during the final stretch of their campaigns. New “Voice for the Uninsured” television ads will begin running this fall, and prior to the Nov.

started, visit www.VoiceForTheUninsured.org to read more about the AMA’s proposal to expand health coverage and each presidential candidate’s proposal for health care reform. Review candidates’ answers to 10 health care reform questions as you evaluate their different platforms, and encourage colleagues, family and friends to do the same before heading to the voting booth this November. Lastly, sign a petition in support of the AMA’s proposal, view photos from campaign events and check out several of the new advertisements that will appear this fall.

...in Oregon, the uninsured rate is higher than that of the United States. A full 16.6 percent of the state’s population lacks health care coverage, affecting 604,000 people.

about the issue at state fairs, college football games and political debates. And www.VoiceForTheUninsured.org—the campaign’s official Web site—extended the reach of the AMA’s message online.

Last January, “Voice for the Uninsured” entered phase two, reaching out to voters across the country with television ads running on a jumbo video screen in New York’s Time Square and on several major cable networks, including CNN, Bravo and the Discovery and History Channels. It also appeared in major publications, such as *Time*, *Newsweek* and *U.S. News & World Report*, and on national websites, including USAToday.com. The official website now offers several new features to inform voters, such as links to explanations of presidential candidates’ health care proposals, an explanation of the AMA’s proposal for voters and a podcast series featuring interviews with uninsured musicians.

In June, the AMA unveiled a new series of print ads in *U.S. News & World Report*. Meanwhile, new television ads ran on a jumbotron at U.S. Cellular Field during a Chicago White Sox-Colorado Rockies baseball game, while hundreds of AMA medical students, as part of their national service project, mobilized to hand out fliers and spread the AMA’s message to fans before the game.

4 election day, the AMA will launch a media blitz across the country. Following the election, the AMA will urge members of Congress to enact legislation based on the principles set forth in its proposal.

All Oregon physicians and medical students are invited to get involved in “Voice for the Uninsured.” To get

One out of seven Americans is uninsured. This isn’t a statistic, it’s a tragedy. Your membership in the AMA will help us make a difference. To renew your membership in the AMA or to join for the first time, visit www.ama-assn.org. ●

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Gus and Jim's Excellent Adventure

By Jim Kronenberg

Forty years ago, even the smallest county medical societies in Oregon met regularly and with great energy and a visit by the OMA president was a highlight for most of the local groups.



AS THE JUNIOR STAFF MEMBER IN PORTLAND, I bore the responsibility for arranging these tours and driving the president around the state. In 1971, then-President Augustus M. Tanaka, MD, and I made our first and most memorable trek together; from Ontario to Lakeview, Klamath Falls, Bend, Burns, John Day, Baker City, LaGrande, and back to Ontario in five days.

Dr. Tanaka is a man of few vices, but he did smoke very large cigars. I, on the other hand, have many vices and one of them was driving very, very fast in those days. Gus rode shotgun as we traveled through a beautiful, largely empty, landscape at tremendous speed. He stared straight ahead and chomped a dozen cigars to gooey ruin. When the terrain forced me to slow down, we talked about everything and laughed a lot.

Gus had been a freshman at Reed College on December 7, 1941. The FBI came for his father, a prominent physician in Portland's large Japanese community, within hours of the

attack on Pearl Harbor. Family photo albums and cameras were confiscated when the agents failed to find any evidence that the Tanakas were members of a suspected fifth column. Although he was allowed to continue his studies, Gus and his family were interned at the Portland Livestock Exposition Center, rechristened the "North Portland Assembly Center," as required by the infamous Executive Order 9066. In the summer of 1942, they all moved to the Minidoka Relocation Center near Twin Falls, Idaho, and the federal government told Gus he could no longer attend school in Oregon.

Reed arranged for him to attend Haverford College in the east. After his junior year he was drafted as an "Able-bodied American" instead of an "Enemy Alien." How nice. On completion of basic training he was assigned to the University of Minnesota to learn the Japanese language, history, and culture in preparation for joining the Army of Occupation in Japan to teach English to illiterate G.I.s and explain to the troops why they had to be there. The assignment and the training seem disconnected, but it was

the Army. While at Minnesota he was given a rifle and assigned guard duty at a research building that housed studies done for the Air Force. Life is full of ironies, which may explain, in part, Dr. Tanaka's acute sense of humor.

After the war, Gus's father Dr. Benjamin Tanaka joined the medical staff of Holy Rosary Hospital in Ontario. For Gus' wife, Teddy, Ontario was already home, so it was an obvious step to join his father's practice when he finished his surgical training in the late 1950s.

When I met Gus in 1969, he was a Trustee from Malheur County; friendly, enthusiastic about his profession and the organization, and possessed of a wonderful sense of humor and a hearty laugh. Today, at age 84, he still possesses a deep interest in medical affairs, his community, family and life in general. He may be a step or two slower, but has not lost one whit of his intelligence, shrewd insight about the world around him, or his sense of humor.

Earlier this year we resolved to retrace at least part of the treks we undertook nearly 40 years ago. We share an avid interest in history, particularly about small Oregon communities. He long since quit cigars and I do not drive (quite) as fast as I once did so a relaxing tour of the Blue Mountains was agreed to, culminating in a visit to the Kam Wah Chung State Heritage Site in John Day.

John Day is set in a narrow, shockingly green valley surrounded by the Blue Mountains and blessed with breathtaking scenery. Some areas are a bit run down, but Main Street is quite attractive and busy. Each highway in eastern Oregon seems to become "Main Street" as it passes through little towns. Most feature a post office, abandoned gas stations and maybe a general store.



(opposite page) Gus Tanaka and Jim Kronenberg at Kam Wah Chung State Heritage Site in John Day.

(above) Dr. Tanaka inspects the land-locked gold dredge at Sumpter.



Dr. Tanaka stands in front of the dredge bucket line. Each bucket weighs one ton and holds about four square yards of material.

Earlier this year we resolved to retrace at least part of the treks we undertook nearly 40 years ago.

for the rest of the population. We also learned about his partner, a venerable Chinese herbalist doctor who diagnosed by feeling the pulse and dispensed Chinese medicines for a half century.

We broke for lunch and met Ted Merrill, a retired physician who spent nearly 20 years in two stints tending to John Day citizens. He is a slight and unassuming fellow who has weathered the vicissitudes of life very gracefully. He gave me a copy of his memoir, *I Only Dress the Wounds*, made up of vignettes of his life from childhood to Columbia University School of Medicine, with side trips to Viet Nam, Corvallis, The Dalles, and, of course, John Day.

Then we headed back to Ontario, about 60 miles into the Treasure Valley, where we were greeted by Gus's wife Teddy and enjoyed another great dinner. Dorin Daniels, an 80 year-old retired family physician, came over and we didn't call it a night until the wee hours, after rehashing the last 40 years of medical affairs in Oregon and of course solving most of the problems of the world.

Back home in Lake Oswego, I thought a great deal about my old friend, Gus. I treasure this extended time with him and am already plotting another road trip next spring. Maybe Gus and I will re-explore the vastness of the Southeastern quarter of Oregon. Frenchglen, Jordon Valley, Basque Station, the Steens Mountains and Lakeview would be nice in May. Hopefully the food will be as good as it was on this trip, but if not, I know the company couldn't get any better. ●

Jim Kronenberg worked at the OMA for 37 years before his retirement in 2006. He is currently working on a project to catalogue the history of medicine in Oregon.

Creative Outlets

Summer Roses,
Portland International Rose Test Garden
By Carol Sandor, MD



“This is a watercolor using the classical style and accepted method of painting in that medium. I love to be outdoors, and I have been drawing and painting since the age of 18 and have fit in classes in art history, watercolor painting, photography and Chinese painting during all my years of professional training. Most of my workdays are spent at the microscope, a very visual sort of discipline.”

Dr. Sandor is a pathologist in Hillsboro.

*Send your “Creative Outlets” to
Betsy Boyd-Flynn at betsy@theOMA.org.
See complete submission information on page 7.*

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