Portland Physician Scribe

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ROSTER UPDATE
. . . to be published soon. See page 10.

Three HMOs apply for profit status

By Diane Lund

Three health maintenance organizations have lost no time filing for profit status with the State Insurance Commissioner's office.

Network, PacifiCARE of Oregon and Capitol Health Plan disclosed plans to become for-profit entities. During the 1985 legislative session, changes were made in the law to allow HMOs this status.

Several HMOs denied any interest in pursuing for-profit status. They include Northwest AmeriCare Health Plan, Physicians InterHospital Health Plan, Bestcare, Kaiser Permanente and the Eugene Clinic Health Plan.

Terry Meagher, assistant chief examiner in the state commissioner's office, gave no indication how long it would take to process the applications.

"Since this is a new law, there is no normal or regular time," he said. "Applications are in the process of review now."

The three HMOs filing for profit status are reviewed below:

Network

Network became a wholly-owned subsidiary of Blue Cross-Blue Shield of Oregon in December, according to Dick Woolworth, executive vice-president. Until then, the HMO was jointly owned by the insurance company, Good Samaritan, Portland Adventist, Tuality and Forest Grove hospitals, and physicians from those hospitals.

"We felt we needed more control over the dollars," Woolworth said. "We're willing to share the dollars we earn with our providers. We'll pay them incentives if there is good utilization."

John Santa, M.D., had chaired Network's board of directors. Now that role has shifted to Sol Menashe, president of Blue Cross-Blue Shield.

However, physicians and hospital groups are still in the picture. They have representation on the HMO's board.

"We anticipate a good mutual relationship with the doctors," Woolworth said. "It's not been easy, but they agreed to allow us to work it out."

Blue Cross-Blue Shield plans to invest a minimum of $1 million from its capitol reserves to develop a for-profit entity called Network Health Plan. Recently an application for federal qualification was filed.

Until the HMO has that status, Blue Cross-Blue Shield will continue operating Network and has applied for profit status with the State Insurance Commissioner.

"Now that we're in the transition period; in time everything will be transferred. There may not be a need for Network," Woolworth said. "That's based on the assumption that everyone in the HMO rolls into the Network Health Plan."

With 12,000 subscribers and 450 physicians, Network is close to the break-even point financially, Woolworth said. He hopes to double the subscriber base by year end.

"To run smoothly and consistently, that's what we would need, 20,000 to 25,000 subscribers," he said. "Then I would say we were reasonably successful."

Within a month Blue Cross-Blue Shield plans to hire a chief executive officer to head Network Health Plan. Until then, Woolworth is acting administrator.

On the HMO's new board will be three representatives from Blue Cross-Blue Shield, the chief executive officer, six representatives from the hospital and physician groups and five consumers.

Federally qualified HMOs must allot one-third of their board seats to consumers.

PacifiCARE of Oregon

Once this HMO gains for-profit status, very little will change. Since organizing in Oregon, PacifiCARE could have channeled profits through a separate management corporation to its owners, Pacific Health Services in Cyprus, Calif.

"It seemed simpler to convert. It eliminated the middle man," said Steve Bennett, president of PacifiCARE of Oregon. "It won't have any effect on doctors. What doctors make is tied to their ability to control health care costs."

Doctors will continue receiving payment on a capitation basis. Their rate structure remains the same. Bennett has heard of no plans to offer physicians equity in Pacific Health Systems, a privately-held corporation, which owns the HMO.

"That decision is made by the people in Cyprus, not by us," he said.

One year old, PacifiCARE of Oregon is still running in the red. With 4,000 subscribers, the HMO needs to quadruple that number before realizing a profit, Bennett said.

"I anticipate earning a profit when we have 17,000 to 20,000 enrollees, sometime in 1987," he said. "Everyone in the HMO business loses money during the first years. Survival depends on how deep they are willing to reach into their pockets, how much the sponsoring agency is willing to pump in."

Pacific Health Systems has HMOs in southern California, Oklahoma and Texas.

"They're all for-profit except us," Bennet said.

Capitol Health Care

Known as an HMO, Capitol Health Care is organizing the first statewide for-profit PPO, called Preferred Health Northwest.

Originally the HMO wanted to convert its status and become a for-profit, but its doctors waved a red flag.

"We couldn't get the doctors to understand. They feared a loss of control with a for-profit HMO," said Roger Lyman, president. "We offered doctors 25 percent of the stock for 10 cents a share. We would have gone public for $8 or $9."

To start its PPO, Capitol is using $1.5 million in reserves. Initially it plans to market the HMO in Salem and Corvallis, moving to Eugene and Roseburg within a year.

"The PPO will be wholly owned by Capitol Health Care," Lyman said.

During its first year, Lyman expects the PPO to enroll 3,000 subscribers and have a substantial physician base, with most doctors from the HMO choosing to participate.

"Our studies show that 25 percent of the people want an HMO," Lyman said. "The benefit design is rather rich and the HMO structure rather rigid. Not everyone wants an HMO."

Organized 10 years ago, Capitol Health Plan has earned a profit for the past two and a half years. Its reserves stand at $6 million. The HMO has 32,000 subscribers and 350 participating physicians in Marion, Polk and Linn-Benton Counties.

With reserve funds, it has built a birthing and surgical center and pharmacy.

"We think we're doing it right," Lyman said. •

Inside

F.Y.I.

— ITEMS OF INTEREST FROM THE OMA —

ST. PAUL INSURANCE, THE COUNTRY'S LARGEST commercial writer of malpractice insurance, has announced it will not write any new policies for physicians, hospitals, nursing homes or most other health care providers, effective immediately. Current St. Paul policyholders will not be affected by the move, but the company has announced that its professional liability premium rates increased by 45 percent, effective December 31. St. Paul writes claims-made policies only, and has not indicated price increases for excess levels.

St. Paul's nationwide moratorium on new policies affects several Oregon physicians and clinics previously insured through CIGNA and other carriers who had planned to convert their occurrence policies to St. Paul claims-made in the next few months. The action also reduces to three the number of carriers in the state who will accept new business: CNA, Northwest Physicians Mutual and ICA. CIGNA has ceased writing medical liability insurance.

CONGRESS EXTENDED THE MEDICARE REIMBURSEMENT FREEZE until March 14 in an emergency

continued on page 12

State to launch hepatitis public awareness campaign

By Diane Lund

Public health officials are worried that the Hepatitis A epidemic will worsen unless people take serious counter measures.

Statewide figures back up their fears. During the first 18 days of January 182 Hepatitis A cases were reported. That compared with only 95 cases during the same time last year.

The disease is expected to strike most heavily in Washington, Clackamas and Marion Counties this year.

To stem this tide, the State Health Division is launching a massive public awareness campaign in early February, encouraging people to wash their hands before touching food.

Most hepatitis spreads from casual contact among family members and friends, not by eating in restaurants, day care centers or schools, said Jacquelyn Polder, nurse epidemiologist with the State Health Division.

People who ate at Rose's Restaurant in Beaverton felt differently. Following disclosure that several restaurant employees had contracted Hepatitis A, 3,500 people flocked to the Washington County Health Department's immunization clinic for free innoculations. That cost the taxpayers close to $18,000 for manpower, gamma globulin and syringes.

Others frequented Kaiser Permanente's Beaverton Clinic, which gave 621 innoculations, and Good Samaritan's Immediate Care Center, which had 400 people turn out.

"Rose's didn't pay for any of this cost," said Mary Sorenson, who directs Washington County's Public Health Department. "We never penalize restaurants when there's a food problem."

Sorenson encouraged physicians to give appropriate blood tests when their patients complain about hepatitis-like symptoms.

"These symptoms shouldn't be passed off as mild intestinal flu," she said. "There's no other way to rule out hepatitis other than a blood test. We don't want to intrude on the physician's practice, but we need to recognize the enormity of this problem."

Often physicians are lackadaisical about reporting hepatitis cases to county health departments, Polder said. Her office learns about these failures by talking to hepatitis victims who mention that their friends also have the disease, yet their names are not on any record.

"We can't do our job unless we know about these cases," Polder stressed. "It's very important that physicians report so we can give gamma globulin to contacts."

Hepatitis A reached epidemic proportions two and a half years ago with an outbreak in Douglas County. The disease spread quickly to southeast Portland, particularly among adolescent and post-adolescent IV drug users.

"It spread through poor hygiene," said Charles Schade, M.D., Multnomah County Health Officer. "People weren't paying attention to hygiene. Before the disease is eradicated, it will burn itself out and everyone will get immune. Right now we have a community epidemic." •

Starr named St. Vincent Heart Institute directo

By Diane Lund

Albert Starr, M.D., won't loosen his surgical ties by becoming an administrator.

Named medical director of the Heart Institute at St. Vincent Hospital & Medical Center, Starr's intent on keeping his hands in surgery.

He'll continue leading the heart transplant team at Oregon Health Sciences University where he's chief of cardiopulmonary surgery. At St. Vincent, Starr isn't giving up cardiac surgery.

However his entry into the management arena does mean he'll become intricately involved with top-level decisions affecting the Heart Institute such as allocation of resources, appointing staff and setting long-term goals.

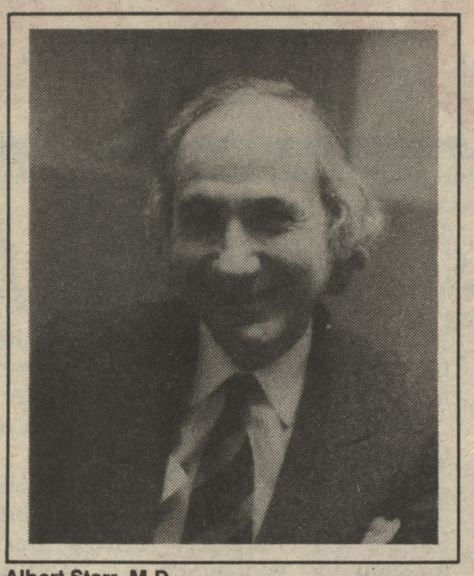
"I'm going to function as a catalyst to bring out the creative energies of all the people who work here," Starr said. "My job is to create an environment in which all the energies of the people involved are better utilized and more focused."

From a physician's perspective, the institute may look no different than what already exists at St. Vincent. Coronary bypass surgery, complex valvular surgery and dilation of coronary arteries will continue unabated. The institute never plans to compete with OHSU by doing heart transplants.

An umbrella management team of administrators, cardiologists and cardiac surgeons, led by Starr, is running the institute.

That team is developing treatment protocols to manage complex medical and surgical situations. There'll be other protocols for shorter hospital stays and to manage patients with heart attacks.

Although the institute doesn't intend to conduct research, it is utilizing the latest technological treatment methods, using an interdisciplinary planning process.



Albert Starr, M.D.

"We're talking about providing a delivery system that will provide all the major elements in treating heart disease," Starr said. "At the same time the latest developments will be encouraged and supported by the institute structure."

When St. Vincent opens its critical care building in the fall of 1986, the institute's capacity will double. That $12 million structure is under construction.

Once inside its new quarters, t institute can do 1,500 open he surgeries a year, compared to 1,0 surgeries currently. St. Vincent do one-third of all heart surgeries Oregon.

Education won't be bypasse Major medical symposia and public tions will share the latest informati with paramedics, nurses and phys cians. A public education progra will stress prevention, diagnosis a treatment of heart disease.

Starr hopes the institute becomes national center, caring for patie beyond the Pacific Northwest. Sp cific areas will be targeted as potential source of patients throu insurance carriers, HMOs and PP and direct contracts with employe

"We want to be a center for t treatment of heart diseases whe patients from far and wide will wa to come," Starr said.

The institute can accomplish goals because physicians and admi istrators are working collaborative Starr said. Traditionally these grou were at opposite ends of the spe trum. Times are changing. Starr b lieves it's incumbent on physicia and administrators to pool their r sources.

"There's a common interest in wor ing together," he said. "Physicia cannot set themselves adrift and allo the environment in which they pra tice to be someone else's total pr rogative. And they have to be ve interested in the economic aspects what they do so they can convin themselves and their patients that, fact, things are being done in a co effective manner."

Since the open heart surgery bega in 1964 at St. Vincent, its medical sta and administrators have worked t gether, in an atmosphere of mutu trust and understanding, Starr said.

"If there were an adversarial rel tionship, it would never have be possible to even think about the hea institute," he added. •

Scribe

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HO RAILROADED WHO?

ubsidized clinic forced me out, says Vernonia's last M.D.

y Cliff Collins

Veronia, a small logging town in olumbia County, lost its only physian in December. The doctor who ulled out says he was driven out by federally subsidized health clinic ith which he could not compete.

Richard R. Selvaggi, M.D., a family hysician, set up his first practice a ear and a half ago in a location he lt was ideal for a young physician terested in a rural practice. Within vo months after hanging up his hingle, Selvaggi had a "falling out," s he called it, with the nurse practiioner, Pat Sommers, with whom he hared facilities. Sommers, a federal mployee, works in a health clinic stablished seven years ago after the wn was unable to attract a physian and was declared a Health anpower Shortage Area (HMSA).

The dispute was not a personal difrence. Selvaggi said he was "tired f competing with government-subsized health care," and that it was inancially not feasible" for him to emain. "For me to survive there I had see X number of patients per day," aid Selvaggi.

Selvaggi argued that the commun should have a choice between a rivate physician and a free clinic, nd insists that was his motivation for iring an attorney to request that the MSA designation be reviewed. He as angered by a circular accusing m of trying to shut down the subsided clinic, charges which he denies.

But Vernonia's mayor, Wallace aughn, said "you'd be hard-pressed convince me or anyone else" that elvaggi was not trying to have the inic closed. "It's my personal feelg that the community needed and eserved both the facilities," said aughn. "The nurse practitioner fills need as did he. If he felt he couldn't nction here, I'm sorry for that."

Vaughn said the town would have een "in a world of trouble" if Selaggi had succeeded in closing down e clinic and then not remained in ernonia.

The disageement caused by a hange in population figures used for e HMSA review finally severed the ord. Selvaggi said there were 3,052 esidents listed in the district when e arrived. He said 3,500 residents re allowed two primary care providrs under the HMSA rule. When the .S. Public Health Service returned e necessary 3,500 figure by includg the entire Vernonia School District, Selvaggi was convinced he was being conspired against.

"According to statistics the government used for seven years, (the district) can justify only one health care practitioner," said Selvaggi. "I'm not willing to work where the government is paying her salary, and for the equipment, immunizations and so forth."

Though he was assured the community wanted a physician, he believes he was "driven out by a small group of people; it became clear to me these people were competing against me."

Sommers' version differed markedly. She said Selvaggi was not ambiguous about his intentions: "After two or three months he said, 'I like you but I can't make a living up here as long as you are here, so you are going to have to go.'" Sommers said Selvaggi had the clinic evicted from its premises. "He took over our building. He leased it out from under us, so we moved across the street."

Then, said Sommers, "things went from bad to worse. When people found out we had been moved out, they got in an uproar." Rep. Les AuCoin's office received 400 letters protesting the fact that the clinic "was being railroaded out of town," Sommers said.

Sommers admitted Selvaggi's complaint that the rules were changed to come up with 3,500 residents was correct, but added: "It was perfectly legal and should have been counted that way originally." She argued that the inclusion of the entire school district represented an accurate count of the patients actually seen by the clinic, but Selvaggi disputed this, saying the new areas included Timber and Clatskanie, which are "closer to a hospital than to my office."

The nearest hospital to Vernonia is Forest Grove Community, about 35 miles away "on winding roads that are hard to drive, especially in winter," according to Sommers. Sommers said the clinic saw 10-14 patients a day when she arrived two years ago, but that number doubled her first year. She said she saw 4,000 patients this year, "too much for a nurse practitioner," and added that a physician would be an asset to her and to the town.

The clinic treats a large number of Welfare and non-paying patients in an area afflicted with poverty and layoffs from closed lumber mills. She noted that the community sincerely wanted a doctor, and that she felt she had many patients who required the care of a physician, but said the area was afraid of losing the subsidized clinic.

Sommers said under the expanded designation the clinic could qualify for a Public Health Corps physician, but predicted that might take another year to achieve. The clinic takes in around $4,500 a month, "which is nowhere near what we charge." Sommers said a single primary care provider will get "burned-out here," because there is no relief.

Vaughn said he thought a retired physician or one nearing retirment who wanted a part-time practice would be ideal for Vernonia. But Sommers added: "Some people have told me a private physician can't make it up here. Whether there are enough patients who could pay or have insurance, I really don't know." •

Opinion

Above all else. . .

By Don Young, M.D., MCMS pres.

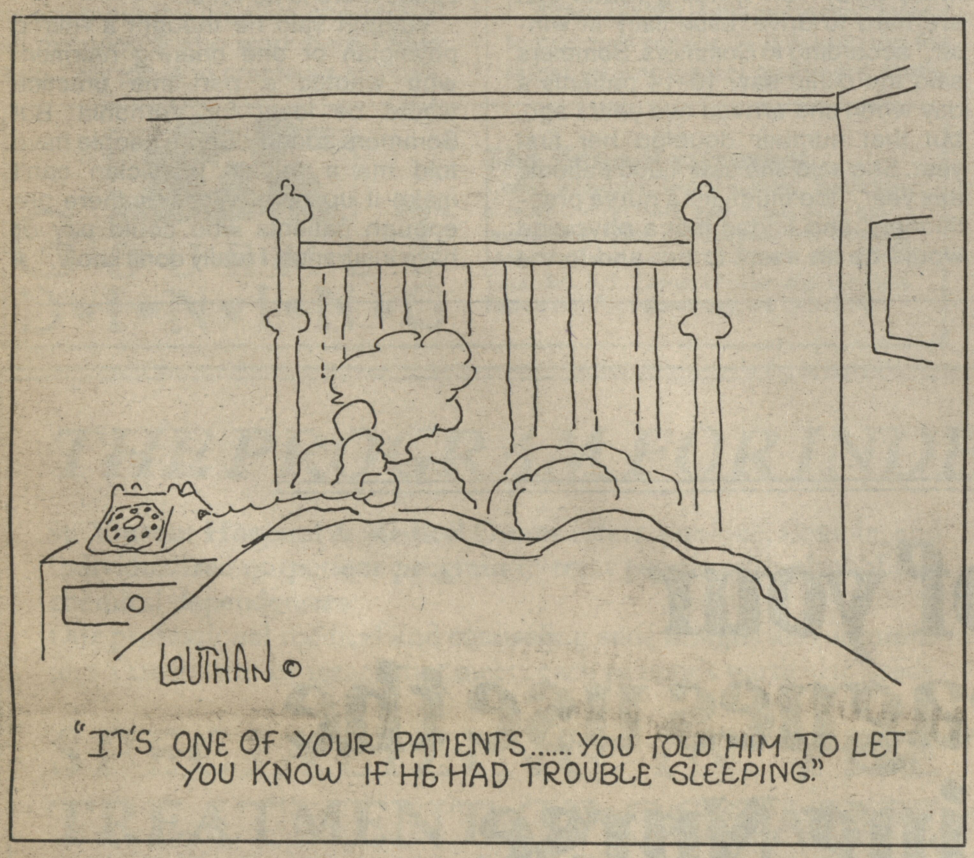
Today with the multitude of ADS, PPO, and HMO indemnity contracts and plans, we physicians must remember our basic relationships are with our patients.

We are here to serve and treat our patients. Our primary relationship is a contract — with the patient, not the insurance company or the ADS. We are the advocate of the patient.

Our fees should be primarily a matter between the patient and us, not between the insurance company and the patient, or between the insurance company and us. We are responsible for competent care; the patient is responsible for payment for our services.

Despite the numerous plans available, the patient should continue to make partial or full payment directly to their physician to keep in mind the contract they have with us.

Subrogration to third party payers by us or the patient can destroy the direct relationship we have with each other. And above all else, we must preserve the doctor-patient relationship •



Strategic Plan Task Force members laude

The MCMS and MSC gratefully acknowledge the help of the following people, who together with the executive committee and board of trustees forged the society's Strategic Plan Outline.

Co-authors of the MCMS/MSC Strategic Plan Outline: Donna Anderson, John Anderson, M.D., James Asaph, M.D., David Billstrom, M.D., Carol Bogardus, M.D., Michael Brodeur, M.D., Maurice Comeau, M.D., Marcia Darm, M.D., Don Dobson, M.D., William Edlund, M.D., Tom Flath, M.D., George Gross, M.D., Larry Hagmeier, M.D., Keith Hansen, M.D., Mark Hattenhauer, M.D., Ivanhoe Higgins, M.D., Tom Hoggard, M.D., Marge Hoo Joanne Jene, M.D., Martin John M.D., John Kendall, M.D., J. Hal Kennedy, M.D., Stephen Kimbe M.D., Robert Kimbrough, M.D., Ar Kracke, M.D., Hal Lee, M.D., Spe Meighan, M.D., Stuart Morgan, M Frank Parker, M.D., Max Parrott, M Christina Peterson, M.D., Tho Reardon, M.D., Gary Rothenber M.D., John Santa, M.D., Mich Schwabe, Joel Shilling, M.D., J Tarnasky, M.D., Elizabeth Tin M.D., John Ulwelling, Al Ver M.D., John Webber, M.D., Les Wr M.D., Barbara Zavanelli-Mor M.D., Richard Zimmerman, M.D.

MCMA to hold Ronald McDonald House benefit

A very special event will take place Tuesday, February 11 at the OMA to benefit the Ronald McDonald House. Called "Shape Up for Life 1986," it features outstanding speakers, a wonderful luncheon and good times.

Jo Reimer will tell us how to pack and prepare for traveling, and she has planned many personalized buying tours. Gloria Sherfey will present exercises to keep us in shape: "Pumping Lite." "Shape Up with the New American Diet" will be Sabine Artaud-Wild's theme and Ethel Harms will help you express your individuality in her subject "Accessories."

Reservations are requested. The cost is $13.75, payable to MCMA, with $7.00 tax-deductible. Send to: Becky Kalez, 2862 N.W. Cumberland Road, Portland OR 97210.

For more information you may contact Marianne Vetto at 223-3337, or Mary Evelyn Smith at 643-5393. •

— Mary Anne Wolfe, president

Letters

Staff important for PR, too

To the Editor: I appreciated content of Ms. Lehnhoff's article physician public relations in the J uary 1 issue. PR for physicians important, but as important — if more so — is the ability and com ment of the physician's front of and nursing staff to good public r tions. They stand in his stead to patient in a myriad of situations. W and who he is and aspires to needs to be nutured and grown in medium of his office staff. These special people express who he i the way they conduct his busin They represent him to all onlook well in advance of his opportunity show his professional and perso qualities to these same patients se ing his care.

A physician's office staff needs be his best expression of conc control, compassion, and human as well as financial — understandi Whether we like it or not patients the treatment they receive from s in a physician's office is an accur reflection of the individual(s) for wh the office staff works.

In today's competitive market, you sure your "PR staff" is doing a should toward your success?

Sincerely,

— Beth Baltz, R.N.

Krippaehne Memorial creat

To the Editor: A memorial fund been established in memory of William Krippaehne, former Pro sor of Surgery and Chairman of Department of Surgery at OHSU died June 18, 1985. The purpos the fund will ultimately be to endo chair in his memory. Before the f reaches an amount sufficient to dow such a chair, some of the ea ings will be used for a visiting pro sorship in his memory.

Checks should be sent to the OH Department of Surgery made ou "OHSU Foundations — Surgery C in Memory of Dr. William Krippaeh Gifts to the OHSU Foundation tax-deductible.

— John R. Campbell, M.D.
Professor & Acting Chairman
OHSU Dept. of Surgery

The Scribe welcomes your comments!

The Portland Physician Scribe welcomes letters from our read ers, either to comment on a ston or express an opinion. Letters should be typewritten, double-spaced, and addressed to: Edi tor, *Portland Physician Scribe* c/o Multnomah County Medica Society, 4540 S.W. Kelly Ave Portland OR 97201. Letters mus include the name and address of the writer. Letters may be edit ed for clarity or brevity. •

PAS Q&A:
What's happening at the answering service?

The Physicians' Answering Service (PAS) has converted one-third of its accounts to a new computerized billing system. The remaining accounts are still housed at the old building on Park Place, and are still on the old cord board system. The completion date for the staff move and equipment switchover is slated for April 1 of this year.

With the computerized system, several questions have surfaced regarding potential problems and differences in the two services.

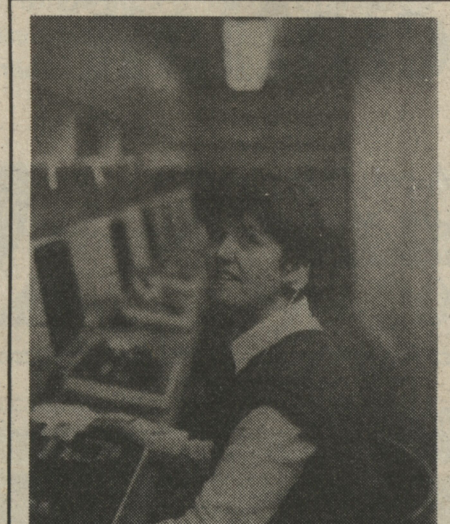
The following questions and answers address the most frequently voiced concerns that PAS doctors have about the new service. If these explanations do not address your particular concern, please contact Joye Richards, PAS director, at 222-9977.

Q: Why is the system converting now?

A: The cord board system is an obsolete system; there are no companies that manufacture parts for the system any longer. Therefore, a change was necessary for future operation of PAS. The time coincides with the move to the new MCMS location at 4540 S.W. Kelly.

Q: What should I do with my office stationery with the old PAS number?

A: You will have to change the phone number and order new stationery. The phone numbers on your existing stationery will still access an operator or recording until November, when the new phone directories are printed, so callers to your old number will receive the new number.


PAS operator Lolli Myers answers a call.

Q: What will the equipment change mean for PAS doctors?

A: • During the conversion period and a training period (three to six months), some adjustments will have to be made. In the long term (after six months) the new equipment will mean a more efficient handling of messages and record-keeping.

• Even though PAS operators are adapting to the new system, their speed is not yet the same as on the cord board. Therefore the phone rings for a longer period of time.

• Callers never receive a busy signal, as they did on the old system, because the calls are automatically routed to another terminal. This also means that calls are stacked up on the terminals.

Q: Why does the phone ring 12-15 times before it is answered? My patients have been complaining about not reaching anyone at the answering service.

A: On some lines, the caller hears four or five rings before the operator hears one ring. This problem (which is being corrected) is combined with the fact that calls are stacked in the terminals (rather than the caller getting a busy signal). Also, the system backs up when a caller lets the phone ring eight-10 times, gives up, and redials immediately. The service is receiving, at times, twice as many calls per hour as on the old system.

Q: What are the benefits?

A: • Calls will be routed to the first available operator (rather than a busy signal);

• Doctors' names will be identified to the callers;

• Speed dialing will connect physicians to their patients faster;

• Information will be electronically stored and processed.

Q: As a client, what can I do to help during the short-term adjustment period?

A: • When calling PAS for messages, make sure you know the last four digits of your assigned code so the operator does not have to look it up.

• Your patience with the transition into the computer age will be the greatest help. •

Roster corrections:

Since publication of the 1986 *Roster*, the MCMS has been contacted by the physicians below with corrections to their listings. The MCMS apologizes for these errors and thanks these members for their understanding and cooperation.

A *Roster Update* will be published shortly. *(See corrections form, page 10.)* In the interim, please note these corrections, and take a moment to review your own listing for any errors or changes.

ALLEN, Richard
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97225 (228-9206)
2222 N.W. Lovejoy 297-8771
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3874 N.E. Alameda
97212 284-5153

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97205
1125 S.W. Westwood Ct.
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2455 N.W. Marshall No. 7 223-0139
97210 (294-1712)
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97225 297-8771
2222 N.W. Lovejoy No. 511
97210 297-8771
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97203 289-5131

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97225 (228-9206)
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97210
3939 S.W. 41st Pl.
97221 228-2848

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97225 (228-9206)
2222 N.W. Lovejoy 297-8771
97210
2676 N.W. Overton
97210 223-8933

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510 N.E. 49th No. 222 222-1615
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97210 228-1768

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7920 S.W. Crestline Dr.
97219 245-5691

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OTO* Indiana '47
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97210 228-9497
3020 N.W. Monte Vista Terr.
97210 223-7244

MOORE, David W.
Janet
OBG Western Reserve '47
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97205
1572 S.W. Highland Dr.
Lake Oswego, 97034 635-3378

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Evelyn
IM* Duke '40
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2547 N.E. 30th
97212 287-2160

PETERSON, Christina E.
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STRATEGIC PLAN OUTLINE

OF THE MULTNOMAH COUNTY MEDICAL SOCIETY & THE MANAGEMENT SERVICES CORPORATIO

The reason why any business entity should attempt to develop a strategic plan is to stay or become relevant to those clients or members which it serves. If it loses its relevance, it loses its reason(s) to exist. In the instance of organized medicine, it follows that since its members are undergoing profound change as the fabric of healthcare delivery changes, then organized medicine must be responsive to the new and/or heightened needs of its members caused by that change.

As American healthcare has changed, many parts of the healthcare system have preceded organized medicine in attempting to develop strategic plans to assure their survival. Governments have stretegic plans which include de-funding and withdrawal of programs which they themselves made social policy decades ago. Businesses have strategic plans, through healthcare coalitions and individual enterprise, to reduce their corporate financial commitment to healthcare and to assure that their direct involvement relates only to their immediate employees. Consumer groups are developing strategic plans to assure that they have a say in a system which has become so large as to no longer be personal and so complex as to no longer be understood. Insurers have developed strategic plans to find creative ways to remain in the business of underwriting (and in many instances, controlling) healthcare by developing new financing and delivery mechanisms. Hospitals have developed strategic plans to remain viable, which include offering old and new services beyond their traditional institutional walls. Clusters of physicians, found in hospital medical staffs, large group practices and new economically-configured and motivated assemblies, have strategic plans for themselves to survive.

It seems that only organized medicine, which represents the rich diversity of all physician types and their array of differing issues and concerns, was without a strategic plan — perhaps understandable when one reflects on the fact that economic motivation has not been one of its principal directives — at least in recent times. Too, organized medicine can easily be distinguished from governments and business coalitions and hospitals by the fact that it is capital poor (a point worthy of greater discussion at some other time) and must preserve its resources by not acting precipitously. And finally organized medicine, representing a frustratingly rich array of differences within the profession of medicine, is hallmarked by the fact that it can have no one clear and distinct agenda, and a complex agenda is always slower to evolve.

A strategic plan can only evolve when there is a will to see it evolve. That time has come. The questions which arise are whether the services and products suggested in our strategic plan are those which will help the image and practice of medicine survive, indeed flourish. In part, the purpose of the executive committee and board of trustees reviewing this strategic plan is to determine if it meets the needs of its members. If so, it can be implemented; if not, it will need to be re-worked until it does meet members' needs.

Description of the Process

The strategic planning process was designed to capture the diverse opinions and attitudes that exist within the medical society. This was accomplished by creating a strategic planning task force comprised of 51 members representing a broad spectrum of specialties, geographic locations, lengths of practice, and other characteristics which reflect the rich fabric of medicine. The task force was responsible for coordinating the overall planning process and developing final recommendations.

The task force created two fact-finding committees: one to focus on the activities of the medical society and one to examine the Management Services Corporation (MSC). The MCMS fact-finding committee was comprised of seven members and met five times to review the past and future role of the medical society. The MSC fact-finding committee was comprised of five members and met five times to consider the products and services offered by the MSC, and to evaluate the potential for new offerings.

The discussion phase of the process was managed by a professional facilitator to assure orderly progress and to remove any bias from the proceedings.

The final phase of the planning process requires that the plan be reviewed and approved by the MCMS board of trustees and MSC board of directors.

Goals, and Strategics to Achieve Those Goals

An umbrella theme which was repeatedly addressed during the executive committee retreat was that **MCMS has got to represent and serve the interests of our members and the public at large**.

The task force and fact-finding committees identified three specific goals to be pursued by the medical society:

- **Recognize, accept and represent the diversity within the medical profession.**
- **Promote the economic interests and enhance the competitive strengths of MCMS members.**
- **Enhance the image of the profession** through a variety of public, professional and informational programs and activities.

Goal #1 — Dealing with Diversity

The first goal — dealing with the diversity of physician types now found within the profession — was not embellished with a series of task force recommendations as to how this might be accomplished. It was simply accepted that physicians do practice medicine in a variety of modes, are compensated through multiple reimbursement options, and in general are a collection of independent and diverse professionals. The task force was firm, however, in its commitment that the MCMS should be/must be the forum for all physician types to deal with their differences and resolve them internally. Meeting in retreat, the society's executive committee agreed to:

- Once again receive a staff proposal for **alternatives to the present MCMS board of trustees composition** — there being some feeling that the diversity within organized medicine must be consciously and formally included in its policy-making bodies, as opposed to only represented by other groups.
- Present to the MCMS board of trustees the issue of how to **involve more members in the decision-making processes of the society** — perhaps through establishing an informal county-wide 'house of delegates' or holding at least one annual town hall-type meeting, or inviting members to sit in on board meetings and the like.

Goal #2 — Promoting Members' Economic Interests and Enhancing Their Competitive Strengths

As regards this goal, the task force noted the following:

"Traditionally, organized medicine has focused on the promotion of the 'art and science' of medicine and has only marginally focused on the economic or business component of the practice of medicine. It is recommended that the MCMS and the MSC place increased emphasis on the business of medicine, while maintaining the medical society's traditional role of promoting and protecting the profession."

To reach this goal, the following was recommended:

- MCMS and MSC should **develop products and services that respond to the five phases of a physician's 'practice life cycle.'**

  It is recognized that an individual medical practice evolves to maturity through various predictable phases:

  The **training phase**, in which the basic skills of the profession are learned, while producing no or minimal income.

  The **practice establishment phase**, representing the first three to five years of medical practice. During this phase, the patient base and referral network is established.

  The **mature practice phase**, which represents the fully-established practice (when income is stable).

  The **pre-retirement phase**, which occurs during the last three to five years of active practice and the time when the physician develops stretegies to exit active medical practice.

  The **retirement phase** suggests the continuing of formal or informal ties to medicine, though the practice of medicine has ceased.

- While most, if not all, of the MCMS-MSC products and services do he physicians in the above phases their professional lives, potent new programs which were not that might enhance the society support of its members include:

  Seminars designed to assist phys cians in the evaluation of contrac with emphasis on alternative deli ery system contracts.

  Seminars designed for various se tors of the office staff (nursing, fro desk, billing, etc.).

  MCMS-sponsored practice co sultants or the establishment of practice consulting service, some combination of the two.

  The development of a centraliz data repository holding physici information of value to the hospi medical staff credentialing proce (though MCMS would not partic pate in the credentialing proce and would determine the legality this enterprise before entering in it).

  The development and distributi of a variety of resource brochur dealing with how to select an atto ney, a business bank, accounta financial advisor, et al.

  The development of a no-cost pra tice brokering service to assist ph sicians in the evaluation and bu ing and selling of medical practice (The task force thought the MCM could do more in providing a con dential service to help local med cal groups link their needs to ph sicians in the area who may interested in new opportunities.)

  The development of retireme planning services, including sem nars and workshops and brochure to help physicians through the com plex and many steps of terminati a practice.

  The development of a third party i surance grievance and collectio service to assist physicians resol disputed claims with insurance com panies.

- **Increase and enhance the acti marketing of the MCMS and MS**

continued on page

MCMS board approves road map to future

By Brad Davis

On Wednesday evening, January 22, the MCMS board of trustees approved the proposed MCMS strategic plan which is reproduced on these pages.

The plan is the result of a six-month 'group-think' process which has included many members of the society, as well as the involvement of some key clinic managers, a professional planning consultant, and numerous society staff.

Strategic planning differs from long-range planning (which the MCMS has been doing for years) and is a process quite in vogue today, given the immense changes occurring in healthcare. It differs from long-range planning in that its goals are set to different time frames to meet different needs: some long-range, some mid-range, and many short-range, immediate, must-do type activities.

Strategic planning starts from scratch. It doesn't assume what an organization does is worthwhile. Rather, it begins by asking whether the organization has any value. If so, how can it be improved? If not, can a legitimate role be created? And if not, why not close the doors?

Strategic planning doesn't just focus on goals. It focuses on ways to address challenges, meet needs, and be responsive to an ever-changing environment.

The strategic plan approved by the board contains more than $100,000 in modified and new activities for the MCMS and its subsidiaries to begin this year — all geared to improve and enhance the image and performance of the MCMS and its members.

But as the board was reminded during its meeting by past MCMS president Ralph Crawshaw, M.D., self-enhancement and personal image-making is not now, nor has it ever been, the ultimate goal of this society. The ultimate goal is to serve the best interests of the people — the patients — of this community.

All members are urged to read carefully what MCMS is about to do and offer your comments, either in writing or orally, to any one of the following officers or trustees:

Executive Committee: Don A. Young, Donald Plumb, Richard Allen, Leonard Marcel, J. Victor Vore, Robert Kimbrough, David Silver.

Board of Trustees: Andris Antoniskis, Kathrine Avison, Richard Banner, Bolek Brant, Michael Brodeur, George Gross, J. Gordon Grout, Curtis Macfarlane, J.S. Reinschmidt, David W. Rich, Jane-Ellen Sonneland, John Stevenson. •

Strategic Plan

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Both entities face increased competition from outside entities. If MCMS and MSC are to have the opportunity to provide unique products and services of value to its members and customers respectively, both must learn to better use marketing techniques to survive and hold existing members and customers, and attract new ones.

- The MCMS/MSC should position itself to **take advantage of the natural alliances that exist within the greater Portland area**. This regional orientation development includes:
  The development of multi-county task forces to consider regional issues.
  The sponsoring of regional meetings among physician leaders.
  Exploring the feasibility of **shared staffing arrangements** for regional programs and services.
  Collective representation with the hospital association. Clearly, the greater Portland area represents a single medical market area and it is imperative that physicians and hospitals within this area have a forum for joint collaboration.
  The consideration of healthcare issues which are urban in nature. New developments and initiatives in healthcare tend to occur in urban areas prior to being noticed systemwide. Therefore, these issues must be considered first by those immediately affected.
  The task force felt that such collaboration should extend to more frequent meetings with hospital medical staffs and alternative delivery system policy-makers — the latter as regards the code of ADS conduct earlier discussed and acted upon by the MCMS executive committee and board of trustees.
  The systematic expansion of MCMS-MSC products and services to include the greater Portland area.
- As public and media relations is a recommended high priority, it is recommended that MCMS/MSC **create a department of public information and media relations**. The department:
  Should serve the community as the primary source of informed opinion regarding medical and health policy.
  Should be the clearinghouse for medical information.
  Should develop annual awareness campaigns, emphasizing both increased individual patient awareness and community education.
- MCMS should explore the feasibility of **joint venturing a number of activities with contiguous county medical societies**. Some of the kinds of joint activities might include:
  A media campaign to enhance the image of medicine and to become the central resource for health-related information.
  Collective representation on various regional bodies (e.g., BGH, Northwest Oregon Health Systems).
  Surveys and research regarding issues affecting the entire metropolitan area.
  Coordinated government relations with legislators and regulatory bodies.
  Combined rosters to facilitate referrals.
  Joint sponsorship of MSC products and services.

Goal #3 — Enhancing the Image of the Profession

There are a variety of recommended activities to accomplish this goal:

- **Create 'issue-oriented' coalitions** to consider and respond to problems of broad-based concern. MCMS already has an extensive network of standing commissions and committees which were established to consider reasonably narrowly defined issues. However, as the socio-political medical environment is in constant flux, it is recommended that MCMS/MSC position themselves to respond to these challenges by creating more ad hoc coalitions to consider 'single' issues (e.g., AIDS, quackery, indigent care). This approach increases the numbers of members who might participate in single issue projects, and is sufficiently without structure that numbers of participants and frequency of meetings are organic — allowing groups to meet with ease, and may be more responsive to the community. (It should be noted here that the executive committee has requested that the earlier established ad hoc sunset committee meet again to determine if their recommendations and the recommendations of the strategic planning task force are in harmony, and if not, to recommend further adjustments to the existing structure of the MCMS to put them in harmony.)
- **Develop an aggressive promotional/public relations campaign.** MCMS/MSC should be perceived by both the print and electronic media as the most reliable, accurate and responsive source of medical news and informed opinion in the region.
  Where possible, promotion should be general in nature and non-duplicative, and combined with other groups to get the greatest participation. (e.g., working with one or more hospitals, large clinics, the osteopathic association, Permanente P.C., in an informative campaign to distinguish medical physician care from alternative modes of care.)
- Other important activities include:
  MCMS should help doctors identify what it is that they are doing that is good, valuable and important to the community, to help doctors feel less put upon and better about themselves and their contributions to the community.
  Physicians should be reminded of the value of building and maintaining their practices through strong relationships with their patients — which is the most important aspect of building a healthy practice.
  Physicians should be reminded of or taught about the importance of personal and caring communications with their patients.
  Physicians should be afforded the opportunity to speak and meet with groups to discuss medicine through a speakers' bureau and through doctors' independent enterprise (which the task force felt is far more effective than the medical society communicating on behalf of doctors through the electronic media).
- **MCMS should expand its communications with the business community** through BGH and other forums, and by requesting employers to post timely healthcare issues on employee bulletin boards.
  The task force was anxious to see **MCMS involvement in health-related public service announcements**, developing a planned series of announcements designed to address community issues to further promote the image of medicine.
  Yellow Pages advertising — As regards this item it was requested that staff determine if MCMS members might be distinguished from non-members sthrough the use of some kind of symbol.
  Throughout the many meetings of the task force and fact-finding committees, the theme of **increasing the value of MCMS to physicians** so that membership was equivalent to a "Good Housekeeping seal of approval" kept cropping up. Not only would good physicians continue to be attracted to MCMS, but doctors in need of correction and help would be less inclined to quit the society simply because trouble had arisen.

MCMS should develop a greater consumer/patient services profile designed to respond to the public at large.

Members of the general public often turn to the MCMS to resolve complaints against physicians or to obtain general information about physicians or the practice of medicine. In addition, organized groups (e.g., AARP) have specific information needs or political and social agendas to which MCMS should be responsive.

Here, **MCMS should formalize and publicize the availability of a consumer mediation service**. The service would be available to respond to customer/patient complaints regarding physicians' fees, quality of care and other issues regarding the patient-physician relationship. The MCMS grievance and medical review committees would be re-oriented to partially meet this need. (The task force felt that there was nearly complete lack of either physician or community awareness of this service, and that great effort should be made to change this situation.)

- Another valuable service is **the physician referral service**, which **should be expanded and publicized to the community**. (The task force felt that there ought to be ways to learn the patient's name so that either the physicians referred to could be notified that MCMS had made a referral and/or the calling patient could receive a follow-up packet of information on the services provided to the community by the MCMS and private physicians. One task force member urged that we remind the calling patient to be sure to tell the doctor's office that it was MCMS which had referred him or her.)
- Another important program is **Tel-Med**, which **should continue to be expanded**. Tel-Med provides free information on a variety of topical healthcare issues.
- It was urged that **MCMS launch a public information and public relations campaign.** With the improving image of physicians, MCMS should increase its efforts to communicate directly with the public. One of the most effective methods of direct communication is through the dissemination of printed information to targeted markets. The following represent the types and topics of literature MCMS could make available (with the brochures being purchased by physicians for distribution through their offices):
  How to Select a Physician
  All about Generic Drugs
  Preventive Care
  How to Shop for Healthcare Services
  Explaining the Cost of Healthcare
  Final Choices: Hospice, Living Wills, Organ Donation
- **MCMS should promote a better working relationship with the media** through the following activities:
  Assuring that all significant media representatives have the opportunity to participate in the Mini-Internship Program.
  MCMS should continue to host periodic 'media dinners' for the purpose of exchanging views on healthcare.
  MCMS physician leaders and senior staff should **systemically develop personal relations with key media representatives** (e.g., *The Oregonian* editorial board).
  MCMS should **develop and sponsor media training programs** for physician leaders so that they know how — and feel comfortable — when dealing with the working press.
  MCMS should **develop and distribute press kits** which brief the media on a variety of health-related issues.
- Governments represent an important target group which must be clearly identified. Then **it must be determined how best to approach each level of government** — with such approaches ranging from volunteer and social contact, to paid lobbyist contact, as defined by: the issue, the level of government, and the amount of support MCMS is or is not receiving from other groups.

> *"MCMS should help doctors identify what it is that they are doing that is good, valuable and important to the community, to help doctors feel less put upon and better about themselves and their contributions to the community."*

Organizational Strategies

- It is recommended that all existing and new MCMS/MSC departments and enterprises should have a formal, written business action plan. This business tool not only focuses our thinking and provides a benchmark against which to measure performance, but forces us to critically evaluate our strengths, weaknesses, opportunities and threats in the marketplace. Such business plans should contain the following elements:
  Background, history and purpose
  Market research and analysis
  Marketing plan
  Operations plan
  Anticipated time tables
  Important risks, assumptions and problems
  Financial plan
- MCMS/MSC should integrate marketing, pricing and corporate image:
  Integrated marketing and pricing: MCMS/MSC should develop integrated marketing and pricing strategies to maximize the interrelated nature of the corporation and to better promote each department offering. For example, MCMS/MSC could bundle PAS services with printing services at a price that would be lower than each would cost separately.
  Corporate image: It is believed that the MSC has little or no corporate identify within the physician community. However, each department within the corporation has developed its own identy/image. It is suggested that the corporate name, Management Services Corporation, could be changed to Medical Society Services, Inc.
  It is recommended that the name of each department within the MSC reflect the association with both MCMS and MSC:
  Medical Soceity Answering Service
  Medical Society Radio Paging Service
  Medical Society Printing Service
  Medical Society Placement Agency
  Medical Society Publications •

Coding profile analysis cuts Medicare claim rejection

By Diane Lund

Physicians can combat Medicare claim rejection and increase cash flow by maximizing their allowable reimbursement. A detailed coding profile analysis tells them how.

Medicare keeps a profile of physician fees. This profile tells them whether a physician acharges the same rate for the same procedure for all patients. Both participating and non-participating physicians are on Medicare's list.

"This profile is very important," said Rita Howard. "It is established individually for doctors under whatever code they use."

To help physicians, Howard began PRN Enterprises in Phoenix, Ariz. last year. She has clients in four states including Oregon. Claim Facilitators, a Portland-based firm, markets the service.

PRN Enterprises captures a physician's Medicare profile, then compares that profile to his current charges and codes and the area prevailing rate for each code by locality and specialty.

"We find out whether the code is appropriate. Eighty percent of the time doctors are not using the best code," Howard said. "That's one of the biggest reasons doctors aren being paid."

Doctors may be listed in the wron specialty for Medicare reimburseme or charge inappropriate customa fees.

"Sometimes we find things lumpe together inappropriately," Howa said. "We clean up their profile, ma ing it as clear as we can."

Doctors receive a list of correct b ling codes and descriptions fro PRN Enterprises, along with Med care guidelines to help them unde stand these codes.

"This makes their billing quic complete, easy and it reduces t time it takes to complete insuran forms," Howard said. "We also calc late their co-payment."

Howard encourages physicia who are beginning their practice utilize a coding profile analysis.

"Medicare is so complex," s said. "After we have changed t codes, we don't have any more r jections from Medicare. That pleas me."

Scott Svatora, a computer consu tant and instructor, designed the so ware package for the coding prof analysis.

For six months following the anal sis, Howard tracks physicians, mon toring their coding and billing pr cedures. •

Requiring direct payment may be only a short-term solution

Nora Lehnhoff

Last month, my accountant and I d an interesting discussion about physician's new billing practices. rtin had been seeing this particu- internist for over five years and d referred a number of his clients d friends to the office.

When Martin went in recently for a tine check-up, the receptionist rmed him that the doctor was no ger handling third-party billings d that payment was due at the time service. She explained that the ctor felt it was getting too expen- e and time-consuming for his office process all of his patients' health urance claims. The volume of bill- s he had to carry and the range of urance companies was so great t he felt he just couldn't afford to vide this service anymore.

Martin was taken aback by this ange, but it is far from a novelty in st physicians' offices. Jerome Co- au, president of a medical man- ement consulting firm, estimates t the vast majority of physicians k for payment at the time of service. hough most doctors will extend edit, Comeau says "it is the cus- nary practice in any well-run office ask patients for payment at the time of service."

Although Karen Whitaker, Associate Director of the OMA, feels that this practice is changing due to the current, competitive practice environment, the billing policies of private physicians are one of the strongest consumer arguments in favor of prepaid health care.

After his exam, Martin paid his bill and picked up a "super form," a generic claims reimbursement form that includes most of the standard treatment and diagnostic codes. He was given a receipt to send to his insurance company, along with the claim. And he went home furious.

"Why do doctors think they're different from other professionals in private practice?" he asked me when he recounted this experience. "Lawyers, accountants, architects, all expect to have to absorb the overhead of collection. It's a normal expense of being in business. Why should it be any different with doctors?"

Martin was not impressed with the most common arguments used to explain this billing practice: The excessive amounts of paperwork that are required. The long delays between submission of claims forms to insurance companies and reimbursement. The fact that there are more than 2500 insurance companies in the U.S. which offer medical coverage, and that many of them require their own forms. That processing medical insurance claims is very costly in terms of postage, staff time, filing, duplication, etc., running anywhere from $2 to $4 per form.

Martin, however, was not moved by any of these considerations. He maintained that a well-run physician's office should be able to handle patient billings. If dealing with third-party reimbursers is too difficult, he felt the physician should at least be able to carry patient accounts until the end of the month.

There are several ways in which to deal with patient billings. The phone book is filled with the names of bookkeeping and consulting firms that specialize in handling the billings for physicians' offices. Depending on your practice (number of partners, patients and procedures, types of

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Computer patient billing said speedier, more cost-efficien

By Diane Lund

Quicker payment. Human error eliminated. No paper shuffling.

Sound too good to be true? Companies such as Claim Facilitators can add efficiency to a physician's billing procedures.

Rather than a physician sending a bill to a patient, hoping he will submit it to his insurance company, then pay him, payment is direct.

All the physician needs is a computer compatible with the billing service's hardware. He can then send claims electronically to insurance companies using telecommunication, magnet tape or disks and be reimbursed quickly.

The software marketed by these software companies uses a telephone and modem to send claims to private insurance companies, Medicare and Medicaid.

Physicians pay no long-distance telephone charges. They are not hassled by insurance companies because all claims are transmitted in the evening. By the next morning, physicians know whether claims are going to be paid.

Software sold by Claim Facilitators comes from Indianapolis and is produced by Physicians Practice Management. H. Jerome Noel began the firm with his brother in 1978. Now between 600 and 800 physician offices utilize the software.

Rather than physicians sending the claim director to an insurance company, PPM has a clearinghouse called Claim-Net, which distributes the claims.

"Every insurance company is different in format as to the way data is arranged," said Noel, vice-president. "This system lets doctors do what they're trained to — be doctors. We have the only nation-wide insurance clearinghouse that I'm aware of."

If physicians prefer, most electronic billing companies can process their claims, alleviating them of the need to purchase software. Payment usually is based on the number of claims processed.

"Some doctors have computer phobia," said Nola Cross of Claims Facilitators. "They haven't heard about electronic billing. Sooner or later insurance companies will push them into it. Besides, they can save money and time this way."

With her husband Tom, Cross began the local electronic billing service a year ago. Previously she was the first licensed health claim adjuster in Oregon.

Beyond electronic billing, these billing services offer another software package that does accounts receivable, prints statements and custom collection notices, captures financial and medical statistics and keeps track of appointments.

"This won't do away with man er," Cross said.

Dwyer, Providence merger in discussion

A possible merger of Dwyer and Providence hospitals is in the discussion phase. Last month Dwyer's board of directors announced it had approved a recommendation from its affiliation committee to begin discussions.

The committee has been studying proposals from eight potential merger candidates since last July. "The review process has not been rushed or pressured and considerable research has been put into each candidate's responses. We now feel confident that Providence is one of the best candidates," said Dr. Roy Payne, committee chairman.

During a medical staff meeting in January, Dwyer physicians approved the same recommendation, said Payne.

Roster corrections

continued from

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Is *YOUR Roster* listing correct?

THIS IS THE TIME TO CORRECT or update your 1986 ***Portland Physician Photo Roster*** listing. It's also the first opportunity to ensure that your listing is correct for next year's edition.

ABOUT A MONTH FROM NOW, on March 1 the Multnomah County Medical Society will publish a ***Roster Update***. Anyone who finds an error(s) in his/her — or fellow physicians' — ***Roster*** listing is urged to jot down the correct information in the space below and mail to: Photo Roster Update, c/o Multnomah County Medical Society 4540 S.W. Kelly, Portland OR 97201.

CURRENT NAME

CORRECT NAME

CORRECT SPECIALTY

CORRECT PRACTICE ADDRESS

CORRECT HOME ADDRESS

CORRECT PRACTICE PHONE

CORRECT HOME PHONE

OTHER — EXPLAIN

OTHER — EXPLAIN

OTHER — EXPLAIN

— MUST BE RECEIVED NO LATER THAN FEBRUARY 12, 1986 —

OHSU nephrologist promotes alternative dialysis therapy

y Cliff Collins

A relatively new procedure for pa-ents stricken with acute renal failure coming into use throughout the .S. More nephrologists are using AVH as they become familiar with s value, according to a local physi-an who is knowledgeable about the rocedure.

CAVH, or continuous arterio-ven-us hemofiltration, is most often used s a last recourse for critically ill atients who cannot stand the trauma hemodialysis, said Thomas A. Gol-er, M.D., associate professor of medicine in nephrology at Oregon Health Sciences University. CAVH is a blood filtering process that mimics the kidney's filtration function.

The fact that it is "not a dramatic therapy" like hemodialysis is an advantage, Golper explained. "It's a neat therapy... one that works slowly — an inefficient method. It's inefficiency is its attractiveness. CAVH is ideally suited for those who can't have hemodialysis," such as patients with extremely low blood pressure, he said.

A German physician named Peter Kramer pioneered CAVH as a therapy for total renal failure, although he was not appreciated for his efforts until after his death in 1984. Now, said Golper, "those of us who do (CAVH) have dedicated all we've done to Kramer." Since 1980 most CAVH procedures have been performed in New York City, but after papers came out on the subject, more kidney specialists are trying it.

Golper did his first CAVH in December 1983, and has since performed about 40 at OHSU and Veterans Administration Medical Center. Golper said most nephrologists in Oregon have done at least one CAVH, and he predicts increasing use as physicians become aware of its utility.

"I've seen people live through the use of this that never would have," he said, noting that success rates are not an accurate indication of the therapy's usefulness, since in most cases it is used as a last resort to extend life. "The majority of the patients who get this have no other recourse. We lose three out of four people on this (but) if we didn't have this procedure we'd lost four out of four."

Golper said nephrologists are realizing that CAVH, which employs no pumps but operates through catheters in the femoral artery, can be put to good use if done in place of dialysis before the patient is critical. "Most doctors are using it only on their most critically ill patients, but we've gone beyond that here," understanding that if CAVH is used "early in the clinical course before they are so ill that nothing will save them," the procedure can save lives, he said.

If CAVH is extended to patients who are not as sick, survival rates will go up, Golper maintained. He said the therapy is an additional advantage over dialysis because it allows so much flexibility in maintaining fluid balance. Also made easier is the management of therapeutic drugs, an area Golper has researched extensively.

Since a CAVH patient can be fed unlimited amounts of fluids, Golper sees the area of nutrition as one in which the therapy will play an important role. Use will increase and "more patients who could be traditionally dialyzed will be put on this because people will appreciate the ease with which it can be done," he predicted.

Perhaps the key point to be made about continuous arterio-venous hemofiltration is that it is a bioethical technology, yet another example of our ability to extend life. The cost of CAVH itself is not the issue, according to Golper, who said it is equal or less than that of dialysis.

"But that is not the issue. These patients are in ICU. The issue is the price you pay for survival. It is not uncommon to keep them alive for a week, then they die." If the patient lives because CAVH was used, "there is no argument," said Golper. •

Casino in the Sky' enefits Ronald House

y Carolyn Sayler

From 8:00 p.m. to 12:00 a.m. Saturay, February 15, 'Casino in the Sky' ill entertain you while the city lights parkle from below the 37th floor of e U.S. Bancorp Tower.

This first annual event will benefit e Ronald McDonald House. Only ne and a half years old, the House as served as a home away from ome for 9,000 people from Oregon, Vashington, and surrounding states.

Governor Victor Atiyeh has de-lared February "Ronald McDonald ouse Month." The proclamation eightens the goal of supporters who ave planned fund-raisers through-ut the month. Volunteers hope to etire the $500,000 mortgage on the ouse this year.

The board of directors of Child-en's Oncology Services of Oregon is eading this fund-raiser. Genevieve . Burk, M.D., president of the board, aid "Casino in the Sky provides an pportunity for the OMA members, pouses and friends to have fun and how their continued support of this roject. The medical community has aised one-third of our monies. We an't stop now."

Board members Jeanne Vore, MAA president-elect, and Maurita eemer, OMAA immediate past pres-dent, have included casino scrip, usic, drink coupons, an auction and crumptious hors d'oeuvres in a tax-eductible package; $50 per couple r $25 per person. The public is nvited. Items are still being accepted or the silent and oral auctions.

For reservations and information ontact Carolyn Sayler at 220-5200, r send your check, payable to Ron-ld McDonald House, to P.O. Box 987, Portland OR 97207. •

Direct payment

continued from page 9

third party payers, etc.), contracting with one of these services can cost anywhere from $600 a month on up. If you have a large, complicated practice structure, turning to an outside billing service may prevent some serious office headaches.

Converting from manual to computerized billing is also another way to handle this task. Depending on the software that your office chooses, many of the larger insurance companies (including the "Blues") have computer systems which allow you to do automated billing. Minimal paperwork, no postage, and generally a shorter reimbursement lag time are benefits of this method. However, installing the hardware is a large, one-time expense, and having a computerized billing system will necessitate special training for someone in your office.

If your practice is relatively small, there is no reason that you can't do patient or third-party billings manually. You may have to hire a part-time insurance clerk specifically for this function. However, if it keeps more of your full-paying patients, it will be worth the cost.

Although it can be a real hassle, the third party payment system offers physicians some distinct advantages. If a patient has health insurance, the aging percentage, i.e., the odds of getting paid after a certain period of time, is close to 100. It may take 60 or even 90 days to collect, but if a patient is covered, the physician knows that that bill (or at least a portion of it) will eventually be paid. With more than 93% of the population covered by some third-party payer, most doctors stand a pretty good chance of collecting something on their outstanding accounts.

This is not the case for professionals in practice in other fields. With the exception of criminal and divorce lawyers, very few require a deposit or are paid each time they provide a service. "If I required cash up front from any of my clients," Martin said, "I might have money at the end of the day, but I wouldn't have clients for very long."

While I understand the reasons for requiring immediate payment, Martin does make some legitimate points. As more and more physicians opt out of third party billings, they need to look at the long-range impact this will have on their practice.

Is it fair or realistic to expect your insured patients to carry out administrative functions for your office? Particularly the billing function that you can't pass on to your Medicare or Medicaid patients? And, in the long run, might it not be a false economy, especially if it drives full-paying patients, such as Martin, out of your office?

One physician, who recently started requiring direct payment, said she hasn't noticed a significant patient exodus because of the new policy. But it would be foolish of her to wait until she does. She conceded that she's received a number of complaints, but felt that she had no choice. "It was costing several thousand dollars a year to handle the billings. It's a service we just can't afford to provide."

From an insured consumer standpoint, however, it may be that she can't afford not to provide that service.

For patients, there is no question that dealing with medical insurance claims is a real pain. The jargon is unintelligible. Everything has to be processed in triplicate, and they have yet to invent carbon paper which actually works. If you have a question about your bill, you inevitably have to tell your story to two or three claims processing clerks before you can get an answer. After you've gone through all this a few times, joining an H and making a one-time payment gins to sound attractive, even if don't get to see your own doctor.

Eighty-five percent of the pe who have health insurance obta through their jobs. Which means they have other things to do du the day besides trying to get re bursed for medical expenses. If patients are already feeling fin cially strapped from having to cash for covered medical servi expecting them to bill the insura company is adding insult to injur

If you no longer handle third-p billings in your office, or are consi ing dropping this function, be sur carefully examine the effect this have on your practice. Ask som your patients how they would about it. Talk to other physicians require payment at the time of vice. Think about how you would if you had to write a check each you saw your lawyer, accoun physician, etc.

Requiring direct payment may s your practice money in the short but in the long run, it may be pe wise/pound foolish. •

F.Y.I.

continued from page 1

action Dec. 23. This was the fourth extension of the freeze since it was originally scheduled to expire Sept. 30. In separate action a few days before adjournment, House and Senate conferees endorsed a measure that would have made more than 60 major changes in Medicare and would have cut the program by $11 billion over the next three years. However, Congress failed to act on the measure.

If Congress does not act on the measure, automatic budget cuts contained in the Balanced Budget and Emergency Deficit Control Act, popularly known as the Gramm-Rudman Act, will take effect. Provisions of the Act establish a maximum reduction of one percent in FY86 and two percent in subsequent years for Medicare payments to physicians, hospitals and other providers.

TWO CASES PENDING BEFORE THE U.S. SUPREME COURT may further define the legal obligations of physicians who perform abortions. Under consideration are: 1) whether states can require doctors to give specific information to women seeking abortions and 2) whether, in a late abortion of a viable fetus, the state can require the physician to choose the abo method least likely to kill the fe Attorneys involved in the two ca say neither presents any issue li to reverse Roe *vs* Wade, which le ized abortion in 1973.

THE STATE WORKERS' COMP SATION DEPARTMENT has iss maximum reimbursement conver factors for medical and surgical vices to injured workers during 1 Under provisions of a law passe the 1985 legislature, carriers are ing instructed to pay only up to 75th percentile of UCR and h been provided with conversion tors reflecting the maximum le Previously, the law provided paym up to the 90th percentile. The W ers' Compensation Department published and distributed a rev relative value schedule by wh 1986 conversion factors are to multiplied to determine maxim payments. Physicians should con ue to bill their usual and custom fees rather than reducing bills to c form to reimbursement levels, s the Workers' Compensation Dep ment will adjust conversion fac based on UCR billings annually. *Reprinted from* STAT, *a publica of the Oregon Medical Associat Vol. XVI, No. 1.*

Rehabilitation patients productive after unique program

y Diane Lund

As scientific breakthroughs enable edicine to keep people with trau-atic head injuries alive longer, the edical community faces an onerous sponsibility.

"We need to give these people a uality of life," said J. Halisey 'Spike' ennedy, M.D. "We're keeping peo-e alive longer. Before this people sed to die; now we're saving them. ur responsibility for quality care is rowing."

For the past 15 years Kennedy has eaded the Rehabilitation Institute of regon. He envisions technology will onstantly change rehabilitation treat-ent programs. His only fear is that ederal reimbursement policies could ndanger such programs.

"My concern is about cuts from the ds," Kennedy said. "As the debt ecomes bigger, they are going to ake more cuts. Everything is being crutinized more. We're working with roups going to Congress."

Back at RIO, a new program un-erway for the neurologically impair-d stresses independent skills. Called ommunity Re-Entry Service, those ith mild to moderate head injuries ualify.

"We're teaching people to become dependent," Kennedy said. "A large number of head-injured patients don't make it back to work. They need supervision. Hopefully, with further training, they can be given skills."

The first eight-week session begins in late January. Participants spend their days enhancing cognitive, social, emotional and physical skills. Located off-campus, the program is housed in a small shopping center, walking distance from Portland Community College's Sylvania campus.

Working in groups of eight to 10 participants, no one gets lost in the shuffle. Individual performance goals are set for each skill level.

Not everyone will return to their jobs. For those who can work, vocational assessment and pre-employment skill training is provided. The individualized program incorporates assistance in returning to the original or modified job whenever possible.

"Our goal is for these people to participate functionally in society," said Cheri Hyde, program coordinator. "This program is a relatively new concept in rehabilitation. It makes sense for clients who are often neglected because they don't meet the criteria of the normal population."

During their eight-week outpatient session, participants work in a computer laboratory and also develop memory, lengthened attention span and other cognitive skills in small groups.

Grooming, hygiene and housekeeping are not overlooked. A modified aerobics program keeps them physically fit, along with nearby walking trails and access to Portland Community College's swimming pool.

Participants learn about money management, housing, transportation, shopping and to access community agencies.

For relaxation they can garden, read a book, listen to music, watch birds or play games.

Their caregivers must attend group discussions held twice a week and led by Marilyn Cleland, caregiver educator at Good Samaritan's Neurological Sciences Center.

"Our approach is highly individualized to meet the needs of each person," Hyde said.

Participants can be referred from elsewhere than RIO. The program is acceptable by third-party payers and is Medicare certified. •

AIDS 'panic syndrome' clouds physicians' treatment, diagnosis

y Diane Lund

Those stricken by AIDS aren't the nly casualities. There are two epi-emics running rampant in this coun-y.

"One is the tragic disease AIDS — cquired immune deficiency syn-rome. The other is 'AIPS' — AIDS-nduced panic syndrome," said Mer-yn Silverman, M.D., former director of an Francisco's Health Department.

Silverman spoke at a recent con-erence sponsored by the Oregon IDS Task Force.

Physicians are often misinformed nd misguided about AIDS, making natters worse, Silverman said. In exas, one doctor told his patients not o shake hands with strangers for fear f contracting the virus.

"If you can't believe in your doctor, ho can you believe in?" Silverman sked.

Sexually-transmitted diseases are huffled under the table because the pic creates such anxiety.

"We could literally stop the spread f AIDS if people got the information nd didn't place themselves at risk," iverman said. "This is a disease of onsenting adults. Let's educate peo-le so they don't make wrong decis-ns."

Although no cases of pediatric AIDS ave been reported in Oregon, the tate isn't immune-free. Martha Rog-rs, M.D., medical epidemiologist, pre-icts children from Oregon will devel-p AIDS. There have been 240 cases eported around the country, mainly rom New York, New Jersey, Califor-ia and Florida.

Most children acquire the HTLV-III irus during the neonatal period. Of nothers infected with the virus, 65 ercent will give birth to babies with IDS. The virus has never been trans-itted from child to mother. Contact etween children and their caregivers oses no risk.

"Physicians need to do a careful amily history to rule out other dis-ases with the same symptoms and ook for congenital infections that are ot AIDS," said Rogers, who is from he AIDS branch of the Center for Dis-ase Control.

Children with AIDS should not be iven live virus vaccines such as easles or polio.

"Therapy requires good support and aggressive treatment of the infection," Rogers said. "To prevent AIDS in children, we need to prevent it in adults."

When treating AIDS patients, doctors should be aware of significant neurological complications, said Robert Miles-Lawrence, M.D., clinical assistant professor at Oregon Health Sciences University and Kaiser Permanente Immune Deficiency Clinic.

AIDS manifests itself in six neurologic syndromes: encephalitis, meningitis, peripheral neuropathies, mass lesions or hydrocephalus, rhinocerebral disease and spinal cord myelopathy.

"Treatment for neurological complications is relatively poor," Miles-Lawrence said. "There's no better than 25 to 35 percent survival. Before treating, think about the trauma you may be creating for the patient and family. Treatment can be painful and uncomfortable." •

Successful clinicals hasten new psoriasis drug introduction

By Diane Lund

A breakthrough drug to treat psoriasis promises dramatic results but has some serious side effects. A New Orleans dermatologist, Elizabeth McBurney, cautions physicians to only prescribe Etretinate for severe pustular psoriasis where people have blisters of pus all over their body.

"This drug shouldn't be used for mild cases of psoriasis because the side effects are so great," McBurney said. "With continuous use, this drug will have some serious side effects."

Known side effects are thinning of the hair, peeling of the palms and soles and birth defects unless women wait at least one year to conceive after stopping treatment.

Hoffman-LaRoche has been developing Etretinate for the past 12 years. It is expected to gain FDA approval within the next six months and be sold under the name of Tegison.

"The clinical trials of this drug have been overwhelmingly successful," McBurney said. "Everyone's going to want some."

McBurney came to Portland recently to participate in a symposium sponsored by the National Psoriasis Foundation, which is based in Portland.

In her private practice, McBurney has gained a national reputation for treating psoriasis. She estimates that 25 percent of her patients have the disease.

"Many people come to me feeling frustrated, angry and with a sense of hopelessness," McBurney said. "Other doctors have told them that nothing can be done; they must learn to live with their disease since there's no cure for psoriasis."

Yet this insidious skin disease can be controlled. One treatment doesn't work for everyone. Treatment depends on the severity of psoriasis and the person's body chemistry.

Babies can be born with psoriasis, particularly if there's a family history. One-third of all cases are handed down, generation to generation.

Physicians should be wary if babies have a persistent diaper rash. They should check family histories for an incidence of psoriasis.

"It's important to get a diagnosis early, to initiate proper treatment," McBurney said. "Psoriasis is a disease that knows no age or economic barriers. It's non-discriminatory."

Drugs used for other disorders can aggravate psoriasis. Lithium, Inderal and Mytralvalveprolapse can make this skin disease flare up.

Every patient undergoing surgery runs the risk of developing psoriasis. So do people playing contact sports, women wearing high-heeled shoes with straps across their ankles, men with hard hats. This is known as the Koebner Phenomena.

"Anything that injures the epidermis can set up a Koebner reaction," McBurney said. "That's why it's so important for physicians to take good family histories, examine the skin and inform their patients about the risks of psoriasis."

Encouraged by ongoing research to combat psoriasis, McBurney is convinced there will be major breakthroughs within the next two decades with new drugs and dietary control measures.

"I'm encouraged by all the money being spent and research being done," she said. "Soon we'll have some good drugs to control this disease, or we'll just find a cure."

A typical psoriasis victim spends $30,000 in his lifetime on treatments, everything from mineral oil to keeping his scalp moistened, to steroids, tar baths and ultraviolet lights.

"Home treatments can help or diminish physician visits if they're wisely done," McBurney said. "I try to make my patients self-sufficient. Once their psoriasis clears up, I don't want to see them again until they have a other problem. Then we'll try a diff ent approach."

McBurney always refers her p tients to the National Psoriasis Fou dation because of its educatio support. Eight million people ha psoriasis. It usually affects peo aged 15 to 35 and breaks out in scalp, on the elbows, palms, so and trunk. Psoriasis has been kno to appear on the mouth and tongu

Besides her private practi McBurney is a clinical associate p fessor of medicine at Tulane Univ sity School of Medicine and a clini associate professor of dermatol at Louisiana State University Sch of Medicine. •

Hospice reimbursemen regs "unrealistic," director insists

By Diane Lund

Stringent governmental regulatio could stifle hospice care, leav physicians with a moral dilemma.

Medicare reimburses hospices seven months of patient care. Only percent of those medical servic can be in a hospital, and patie cannot receive any life support ass tance.

Robert Goldman, M.D., finds the restraints awkward and inhibiti Medical director of the hospice p gram at St. Vincent Hospital and Me ical Center, he advocates pol changes in patient length of stay a delivery of services.

"These regulations are unrealis punishing and awkward," Goldm insisted. "The time a person com into a hospice program should based on when the need exists. Pe ple should be able to come in and of the hospital when necessary."

When a terminally ill cancer patie is in a hospice and develops a seco dary illness such as pneumonia, t disease must go untreated accord to federal reimbursement guidelin

"We aren't supposed to treat th Goldman said. "People could end dying prematurely instead of dy with dignity. Not all patients sho be on 'no code.' At times we beco so regimented by the hospice co cept that we forget all about indiv ual needs."

People should enter hospices at arbitrary point; when physicians c aside all definitive life support me sures, and a more intensive te effort by health care professionals needed.

"Hospices aren't for everyone, b everyone deserves optimal hea care," Goldman said. "Some patie and their families want everything, treatment until the very end. We ne to pay attention to that, at least u the government says we can't do anymore."

Physicians misunderstand hospi care. By referring patients into a p gram, they aren't losing them to nursing team.

"Doctors fear they're giving they feel robbed once a patient is i hospice," he said. "But hospices wo as a team, and doctors are an integ component."

The basics of hospice care — pa control and palliation — should b come instilled in every home hea agency even though not all patie are faced with a terminal illness.

"Hospices shouldn't be separat from home health," Goldman sa "It's what we should be doing for patients."

Although St. Vincent is the lat hospital to enter the hospice mark the hospice philosophy has be practiced by the hospital for 15 yea St. Vincent staff rejected the idea starting a hospice three years ago.

Advance

FEBRUARY

7-9 **MCMS Winter Conference — Salishan Lodge.**

& 9 Continuing Medical Education & March of Dimes, "Sharpening the Focus on Prenatal Care," Red Lion/Lloyd Center, Portland. For more information call OHSU, 225-8700.

-10 Certification Course, "Advanced Cardiac Life Support," Portland Adventist Medical Center, Education Center, 7:00 a.m. - 5:00 p.m.

-14 Continuing Medical Education, 17th Annual Family Practice Review, Red Lion/Lloyd Center, Portland. For more information call OHSU, 225-8700.

12 **MCMS Executive Committee Meeting.**

12 Grand Rounds, "Perspectives on Lung Cancer Screening," Robert Fontana, M.D.; Providence Medical Center, Providence Hall Amphitheater, 8:00 a.m.

12-13 Rabiner Visiting Professor, "General Medicine," Faith Fitzgerald, M.D.; Good Samaritan Hospital & Medical Center. For more information call 229-7454.

13 Presidents' Day — office closed.

19 Grand Rounds, "Uveitis and Systemic Diseases," James Rosenbaum, M.D.; Providence Medical Center, Providence Hall Amphitheater, 8:00 a.m.

20-22 AMA Leadership Conference — Chicago.

22 Saturday Session, "Cardiology Update," Good Samaritan Hospital & Medical Center, Auditorium, 8:00 a.m. - 12:00 p.m.

24-27 Oregon Nobel Laureate Symposium, "Rethinking our Human Environment for the 21st Century;" Linfield College, McMinnville OR. For more information call 472-4121 ext 259 or 434.

27-3/2 Continuing Medical Education, "Update in Rheumatology," Inn of the Seventh Mountain, Bend OR. For more information call OHSU, 225-8700.

MARCH

4 Teleconference, "Vaginitis: Diagnostic and Therapeutic Advances," William J. Ledger, M.D.; Portland Adventist Medical Center, Education Center, 8:30 - 9:30 a.m.

5 Grand Rounds, "Syncope," Nora Goldschlager, M.D.; Providence Medical Center, Providence Hall Amphitheater, 8:00 a.m.

12 **MCMS Executive Committee Meeting.**

12 Grand Rounds, "Phagocytes and Host Defense," Gerald Mandell, M.D.; Providence Medical Center, Providence Hall Amphitheater, 8:00 a.m.

14 Medical Conference, "Current Diagnosis and Therapy of Polymyalgia Rheumatica;" L.A. Healey, M.D., Portland Adventist Medical Center, Education Center, 7:30 - 8:30 a.m.

19 **MCMS Board of Trustees Meeting.**

Classified

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