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Physician Wellness

Family physician Katrenka Rember helps create a financial safety net for those with cancer, fulfilling her late fiancé's vision. ***—See page 5***

Focus on Patient Care

A year after launching a local version of a physician-owned and directed coordinated care association, The Portland Clinic has seen the new entity it created grow exponentially. ***—See page 9***

MSMP course helps MAs get certified to meet 'meaningful use' requirements

By Jon Bell
For The Scribe

The last standardized test that **Susan Rossetto** had to take was her SAT. Considering that she's been working as a medical assistant for more than 30 years now, you can guess that it's been a while. And even when she first became a medical assistant, she never had to take any kind of organized exam.

"I am an old-school, on-the-job-trained medical assistant," said Rossetto, who works at The Oregon Clinic's Minimally Invasive Surgery Division, primarily with the colorectal team.

So when Rossetto found out that she'd have to become a credentialed medical assistant to help the clinic meet the "meaningful use" clause of the American Recovery and Reinvestment Act of 2009, which encourages the use of electronic health records, she got a little nervous.

"I must say, when the certification issue came up, everyone, myself included, was upset," she said. "It covered so much material that I have never had to perform."

Luckily for Rossetto, the Medical Society of Metropolitan Portland had gotten out in front of this issue and created a helpful review course for people just like her.

After the Centers for Medicare & Medicaid Services issued its final ruling about the new certification requirements last August, **Paula Purdy**, general manager of the MSMP's Medical Society Services and herself a CMA, began receiving calls from local health care employers wondering how they could get their medical assistants certified. Under the CMS rule, only licensed professionals and certain unlicensed ones, including "credentialed medical assistants," would be permitted to enter medication, laboratory and radiology orders into an EHR system, a key way for providers to meet "meaningful use." Clinics that demonstrate meaningful use can qualify for a financial incentive.

"If the clinic is participating in meaningful use, the medical assistants must have a credential," Purdy said. "So we put together a review class for those who need to go over what they learned in a school program before they take their exam."

The course is also designed for people like Rossetto, who may never have had formal schooling for their work as medical assistants, and also for people who may have gotten their credential straight out of school but who have let it lapse.

Medical assistants have a few credentialing options, including the American Association of Medical Assistants' Certified Medical Assistant and the American Medical Technologists' Registered Medical Assistant certificates. Purdy said the MSMP's course offers a thorough review that can help bring candidates for either exam up to speed.

At present, there are two different course offerings, both of which use a review book and require a minimum of 10 students. Two instructors teach the classes: Tiffany Little, who was a program director at a proprietary school in Beaverton, and Kate Pillar, a practice manager at OHSU and an adjunct teacher for another school in Salem.

One course is for individuals looking for a review; those are held at OHSU's Richmond Clinic. The other is held on-site for clinics that have staff in need of the refresher. The three-week Saturday class offering meets for four hours each Saturday, while a Wednesday evening course runs for two hours each night over five weeks. Several of the classes, which average about 25 students per class, have already been held and finished up, but Purdy said she anticipates that more will be put on the calendar soon.

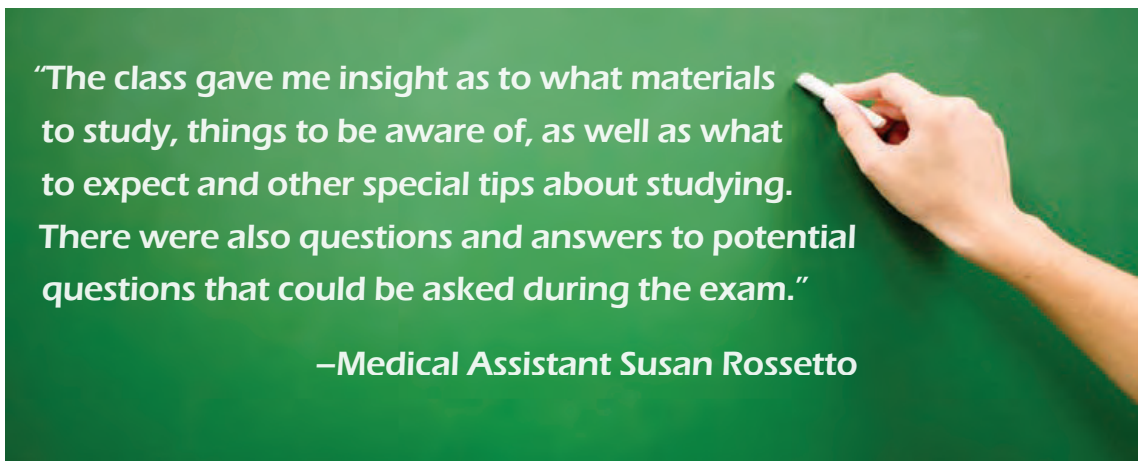
The first part of the course covers general knowledge, followed by administrative topics, clinical areas, other important subjects to know and exam preparation.

"The class gave me insight as to what materials to study, things to be aware of, as well as what to expect and other special tips about studying," Rossetto said. "There were also questions and answers to potential questions that could be asked during the exam."

So how did she do on her test?

"I am happy to say, after taking the class and hours of studying, I passed the RMA 207-question, two-hour exam with a 98 out of a possible 99," Rossetto said. "I am so grateful." •

For more information about the MSMP's review courses, contact Purdy at 503-944-1128 or paula@msmp.org.



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Connected to the past through building

Craig Turner, MD, spends his time away from his practice making period furniture and utilizes many of the same skills in woodworking as he does in his urologic practice. He is particularly attracted to 18th-century European furniture and has built several period pieces.

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The simple quest for a perfect delivery

Editors' note: This is the last in a two-part series on home births. Part one appeared in the April 2013 *Scribe*.

By Brenda Kehoe, MD, MSMP Board President
For The Scribe

The parents draw up the birth plan: Miles Davis or the Decemberists on the computer, soft lights, a bevy of quiet well-wishers, a soothing bath. The midwife smiles, rolls up her sleeves and lights candles. Water gushes into the plastic tub so the parents can gently introduce their child to the world. They ready themselves to welcome a new life, with every brilliant possibility a shining star in the firmament. Everything will be lovely, because it always is.

Meanwhile, I, the physician, draw up a battle plan. I organize an assault on injury, death and disease, fortified with technology, scalpels and statistics. I will use every tool at my disposal to predict and prevent harm, knowing that being ever vigilant, I will not always succeed. My plan is to safeguard and preserve health and life, and I am unapologetic in my determination. Then everything will be lovely. Maybe.

Home birth? Hospital delivery? Is this solely safety vs. choice? The goal is the same, delivering healthy babies to healthy moms. But in an era when childbirth safety is seemingly taken for granted, the issue has extended to the quality of the birth experience. Can safety be taken for granted? Is choice as important as the physical health and well-being of mom and baby?

Despite the vicious cycle of antagonism among doctors who don't understand why mothers take their lives and the lives of their babies into their hands to deliver at home, and midwives who don't understand why doctors are so reluctant to embrace the "natural," and mothers who don't want their deliveries "measured, monitored, calibrated and medicalized," some understanding must be reached. After all, more than 40,000 women in the U.S. give birth at home each year.

Maintaining control?

Home birth is about maintaining control over one's body and birth. Women who make this choice feel empowered, safe and cozy. In reality, we have pitifully minimal control over our fate. Home births are mostly chosen by married women, older than 35, in their second or third pregnancies, over 37 weeks, with some geographic and ethnic differences but mostly white, non-Hispanic.

Lindgren's 2010 study looked at how women view childbirth risks at home and in a hospital, concluding that women do consider but don't want to talk about the risks.

In hip Portland, the cache of home delivery must be considered. The influence of one's hip, young neighbors who had a successful and uneventful home delivery looms large. As the number of home births grows, so do the tragedies. Without discussion and an informed evaluation of risk, the decision to have a home birth is most often made in conversations among friends, not doctors.

Women fear intervention. The issue of intervention is important, common and misunderstood. The U.S. cesarean section rate was 4.5 percent in 1965 when first measured (Taffel et al. 1987). During that year, infant mortality was 29/1,000 and maternal mortality 35/100,000. After steeply increasing over more than a decade, the cesarean section rate leveled off at 32.8 percent in 2010 and 2011 (Hamilton et al. 2012). One mother in three now gives birth by cesarean section.

Home birth safety has been difficult to research because it is private, dependent primarily on attendants' record keeping, and charged with personal significance to key groups including doctors, nurses, midwives, non-midwife attendants, mothers and their families. Data has been poorly collected and often the wrong questions are asked. Some women pay the ultimate price for delivering at home, in a hospital or in a barrio. Indeed, pregnancy and childbirth are among the leading causes of death among women worldwide. One woman dies per minute during or immediately after childbirth, and 10 million to 15 million suffer injuries or complications. The causes of death are sepsis, hemorrhage, hypertensive disease and unsafe abortion—the same causes common 70 years ago.

Institutional practice guidelines, physician qualification requirements for hospital privileges and improved access to obstetrical interventions, along with new drugs, antibiotics, safe blood transfusions and medications to manage hypertension, have contributed to almost eliminating risk for moms. Guidelines and qualification requirements on the same scale do not exist for home delivery in Oregon, and few interventions are available. In addition, anyone can attend a delivery, including unlicensed midwives.

In Oregon in 2011, 45,485 babies were born, 31,437 vaginally, 903 VBACs and 13,144 by cesarean. Of those, 974 were planned home births, about 2 percent. Ten women died as a result of pregnancy and childbirth, and 110 infants died of perinatal causes.

In 2012, Oregon's home birth rate was 4.8 percent. Oregon now has the most complete and accurate collection of data for outcomes of planned out-of-hospital births of any state. The term neonatal and intrapartum death rates for out-of-hospital births is 9/1,995, a rate of 4.5/1,000; direct entry midwife neonatal intrapartum death rate is 7/1,235, or 5.6/1,000. In-hospital term neonatal and intrapartum death rates, including infants with anomalies, was 25/39,984, for a rate of 0.6/1,000. These are real numbers. Despite safety improvements for the fetus, childbirth is still about 100 times more dangerous for babies than for mothers, and neonatal mortality is 6 to 8 times greater for out-of-hospital births.

Denial of science

"*Science isn't perfect and suffers from biases, fads, and fraud. But the upsides outweigh the dangers.*" –A. J. Jacobs

People believe what they want to hear. Opinion is often viewed as valid as scientific facts. In addition, the "Internet effect" presents an instantaneous and questionable resource; many believe that four hours on the Internet can inform them as well as 24 years of education, four years of residency and 20 years of experience.

The home birth debate has been framed as purely about scientific evidence. Do doctors (scientists) and other providers need to engage in a different conversation that includes values? Is there a way to have a discussion such that transport to a hospital is not delayed, where high-risk situations are recognized and appropriately triaged, where information is shared, and where mothers and babies are protected?

Hospital delivery can be as close to a home delivery as desired, but where options are readily available: pain relief, management of nausea, vomiting and dehydration, and cesarean section. Women who choose autonomy ultimately eliminate these options. However, interventions are sometimes necessary, useful and life-saving.

As medical professionals, we have ethical responsibilities to patients, society, other health professionals and ourselves. The respect for the right of patients to make choices about their health care (autonomy) is fundamental. This leaves the ball in the court of moms to make responsible, appropriate, and well-informed decisions for the best possible outcomes. •

Dr. Brenda Kehoe earned her MD from OHSU in 1985. She has been board certified by the American Board of Obstetrics and Gynecology since 1992.

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'It's important for everyone to have an advocate'

Family physician Katrenka Rember helps create financial safety net for those with cancer, fulfilling her late fiancé's vision

By Katrenka Rember, MD

Physician Wellness

This article is part of a series of personal essays exploring life challenges of Portland-area physicians. It is a part of MSMP's goal to connect members of the region's medical community. **To share your thoughts and respond to this essay online, please visit the Forum section of the MSMP website at www.msmp.org.**

Life rarely turns out like you think it will and less often as you planned. These twists and turns help us learn about ourselves and what we are made of, teach us how important others are in our lives, and give us new perspectives. I'm grateful for the lessons and tools learned during my difficult times. Those experiences have shaped how I practice medicine, and led to the founding of **Komak**, a nonprofit that provides financial assistance to low- to middle-income families whose lives have been disrupted by cancer.

My life took a big turn soon after I was engaged several years ago. My fiancé, Hamid, and I were busy building a life together when he was diagnosed with advanced colon cancer at the age of 39. His prognosis was that he had two to three months. He lived two and half years, thanks to my medical colleagues in this community and the fact that Hamid had a pretty good doctor and medical advocate at his side. Within a year of his diagnosis, I was also diagnosed with colon cancer. The experience of being a patient, dealing with the medical system and insurance companies, having potentially life-threatening medical complications—some, in part, due to medical mistakes—and being a caregiver and medical advocate quickly taught me a great deal.

When Hamid and I got sick, it made me see things a little differently as a physician. I've always been respectful with patients, but I now share things with them that I learned. I encourage them not to lose the joy of the moment by being worried about the future, and to let go of the past. I understand how important it is for everyone who faces an illness to have an advocate in the medical system. There's a spirituality to my practice that's very important to me. I want to be present and ask what I can do for people and truly mean it. I find working part time allows me to do that. I also give a lot more hugs.

Hamid and I had an amazing support network when we were sick. We had friends and family who would cook, clean and shop for us. My colleagues in the medical community were fabulous. My partners at Pacific Medical Group were there for me at all times, treating me and Hamid like family and making sure I got paid.

I quickly learned what an issue the cost of medicine can be. Our medical bills were between $20,000 and $40,000 a month for three and half years. No matter how well you are insured, there are co-pays and things that aren't covered. It's really expensive to be treated on an ongoing basis, especially for those who cannot work.

During chemo treatments, Hamid and I overheard patients making decisions to not get their anti-nausea medicine because they needed to pay their mortgage or other bills. Hamid and I knew we were so lucky to have the support system we did and were well aware most did not. Hamid would say, "For people who work every day, who are doing the right thing and get cancer, their quality of life seems to be the worst as there are no resources available to them." He really wanted there to be a foundation to help low- and middle-income people with cancer so they would not fall off the cliff financially during this prolonged illness. Hamid lived to see his wish become real, as Komak was incorporated in December 2006.

Co-founding Komak was a positive place to channel my grief after Hamid died. Komak is a Persian word that means help, aid or assistance to one in need, sickness, pain or distress. Komak is all-volunteer, and it changes people's lives. We want people to survive cancer, and survive economically, too. We pay people's bills for three to six months during their cancer treatment, until they're back to work and can move on. We've now helped 68 families in the Portland

*See **ADVOCATE,** page 7*

ZoomCare expands services, gears up for health care reform

By Jon Bell
For The Scribe

Seven years ago, there was no such thing as a smartphone and ZoomCare was but a single on-demand neighborhood health care clinic in Tigard offering fairly simple treatment for injury and illness.

Today, the smartphone is everywhere, and while ZoomCare isn't quite that ubiquitous, it has grown up in both size and services. The company, founded in 2006 by business partners **David Sanders, MD**, and **Albert DiPiero, MD**, is now up to 15 locations in Portland, Salem and Vancouver, Wash., three in Seattle and one in Boise. Last October, ZoomCare added limited pharmacy services, and in the past

Photo courtesy of ZoomCare

ZoomCare, founded in 2006 by business partners David Sanders, MD, (pictured) and Albert DiPiero, MD, has experienced considerable growth. Among other things, the company has expanded its specialty offerings and added an e-diagnostic service.

few months, the company has expanded its specialty offerings to include gastroenterology, dermatology, orthopedics, physical therapy and naturopathic medicine. It's also added an e-care diagnostic service it calls TakeOut Visit and enhanced its scheduling so that patients can make same-day appointments directly from their computers or smartphones.

"We really set out over the last couple years to move from being a provider of illness and injury and preventative care to being a complete neighborhood and smartphone-based health care provider," Sanders said. "We've really been spending time perfecting our service offerings and our model."

As a further sign of how far ZoomCare has come, Sanders noted that in early June the company hosted its seventh anniversary party at Grand Central Bowl in Portland with 175 people. "Back when we started, just a few people showed up," he said. "A lot has changed."

The ZoomCare model is fairly straightforward and is built around customer service, timely appointments and transparent pricing. The clinics blend the elements of an urgent care center with lab, X-ray and other services and cover everything from allergies and bladder infections to burns, fevers, lacerations, dislocated joints and more. Clinics are staffed largely with certified physician assistants and nurse practitioners but also several MDs who float between clinics.

Self-paying patients pay a set $105 fee for illness or injury visits, while those with insurance pay $135, with the increased cost covering the additional paperwork required of insurance plans. There are also set prices, posted on the website and in the clinics, for a range of tests—$20 for mono, strep or pregnancy, for example—and vaccinations and injections.

Last year, the Oregon Legislature passed **Senate Bill 1565**, which allows physician assistants at ZoomCare clinics to dispense bottled, non-narcotic medication. Clinics now offer more than 100 over-the-counter and prescription medicines, half of which are $10 or less and most of which are less than $20.

The recent rash of service expansion comes after years of quietly perfecting the different offerings for patients inside ZoomCare's clinics. Sanders said the company is currently busy honing other service areas and will continue to roll them out in the near future.

He also said some 150,000 people in the metropolitan region regularly use ZoomCare for "a portion of their care," numbers that have helped fuel the company's expansion in the Portland area.

"I think we're continuing our path from a number of years ago to bring it to all the great neighborhoods in Portland and Oregon," he said.

ZoomCare opened its first Seattle clinic in December of 2011, and the Emerald City continues to be an area of focus. Idaho's first clinic opened last December, and Sanders said that other states are on the radar as well. So are other patient populations. For example, ZoomCare doesn't currently accept Medicare or Medicaid, but Sanders said that he hopes it will be able to someday.

"We certainly understand how important public-sector and publicly-funded populations are," he said, "but we're still trying to understand a lot of the complexi-

*See **ZOOMCARE,** page 13*

Coordinating crisis response

Communication, need for broad MSMP participation among key lessons from anthrax attack exercise

By John Evans, MD
For The Scribe

At 8 a.m. on Thursday, May 23, the **Health/Medical MAC** (Multi Agency Coordinating) group met at the Washington County Law Enforcement Center to respond to a hypothetical biologic terror attack. A primary goal of the Health/Medical MAC is to make policies for issues likely to arise during large-scale emergencies. The MSMP has participated in the region's Health/Medical MAC group for several years, with our community- and small clinic-based preparedness efforts coordinated by Aaron Troyer. The goal has been to complement and coordinate crisis responses by hospital systems and public health officials with MSMP's clinic and office sites.

Members of the Health/MAC group included: **Kathryn Richer, Kristin Tehrani, Brian Mahoney** and **Lisa Kulkarni** with the NW Oregon Health Preparedness Organization; **Adrienne Donner**, Washington County; **Michael Patterson**, VA; **Janice Hogue**, Adventist Health; **Justin Denny, MD**, Tri-County Health Officer; **Don Houghton**, All Hazards Program; and myself, representing MSMP. There were also representatives from most health care systems operating in the tri-county area.

The hypothetical crisis presented was an anthrax event linked as an act of terrorism, with the FBI investigating. Two sites had been exposed in the tri-county area, with active prophylaxis programs being set up. Through the day, multiple real-time updates were introduced requiring the Health/Medical MAC group to respond by prioritizing policies and then acting on them with the limited resources at hand.

The exercise involved the complete spectrum of first responders, including public health agencies, multiple individuals and hospital systems that would normally respond to such a real-world crisis as it evolves. There was a potential treatment, the need for prophylaxis with ciprofloxacin or doxycycline; although a luxury, this created the conflicts of who, where and when citizens would receive prophylaxis. There was an exposure of upwards of 27,000 people already affected, leading to further issues being addressed by the Health/Medical MAC, such as the allocation of personnel and equipment to different hospitals and clinic systems.

Many lessons were learned from this anthrax exposure disaster exercise event.

A key one is the testing of the communication across a large number of public health agencies, responders and hospital systems, as well as the communication within a small group such as the Health/Medical MAC as they debated and compromised in an effort to do the most good for the most citizens of our community.

Another is identifying the niche of the Health/Medical MAC in a large event. As we saw in the real-time use of the Health/Medical MAC during the H1N1 response, and now the anthrax event, setting policy decisions on painful and challenging issues with input from multiple different health systems, public health agencies and physicians can ethically allocate precious and scarce resources in a fair, just and publically understandable manner. Clearly, more work needs to be done on the issues of changing standards of care as resources, both human and equipment, are exhausted.

A key take-home lesson is the necessity for all of us within MSMP to make the effort to be signed up and credentialed to assist in a crisis. Some state and local resources include the **State Emergency Registry of Volunteers in Oregon** (serv-or.org) and multiple local **Medical Reserve Corps** (www.medical reservecorps.gov).

Lastly, our involvement and response as a medical society is dependent on communication during an event with our society's member offices and clinics. So please anticipate and assist us, and our metropolitan medical community, in that endeavor as we update and keep current our lines of communication. •

Anesthesiologist John Evans, MD, is an at-large member of MSMP's Board of Trustees.

ADVOCATE *from page 5*

area. The medical community has been a great support, in some cases writing off Komak clients' bills.

I'm at a point now where I'm doing well. I'm past the five-year mark without cancer, and I never worry about it coming back. It either will or it won't. I'm proud of the fact I have come out of this without being bitter, angry or unhappy. I think I came out a better person and a better doctor. I gave myself five minutes a day to feel sorry for myself, then spent the rest of the time doing what I needed to do to get better. It was a lot of work to get here. I feel very happy, content and joyful. I'm really ready for a new chapter in my life, to do and explore new things.

There's a song called "I Hope You Dance" that my mom has been singing to me for a couple of years. I feel like this year I started to dance again. My hope is that through Komak, we are helping others take an important step toward doing the same. •

Katrenka Rember, MD, has been a family physician in private practice since 1990. She practices at Pacific Medical Group in Tigard. For more information about Komak, please visit komakcares.org. She can be reached via email at katrenka@comcast.net.

Columbia Wound Care Consortium educates, advocates for improved patient care

Melody Finnemore *For The Scribe*

Enoch Huang, MD, has long found the concept of "medicine without walls" intriguing. Huang, medical director of the Wound Healing and Hyperbaric Medicine dept. at Portland's Adventist Medical Center, would attend national conferences and wish that his entire staff could hear the lectures on the latest advances in wound care.

"Economics don't make that possible, so I started thinking about bringing that content to my staff instead," he said. "Not only would it benefit my colleagues, but it would also benefit everybody else performing similar functions within their organizations."

To that end, Huang began a grassroots movement to encourage Portland's wound care specialists to educate each other rather than relying solely on national conferences and speakers. The group evolved into the Columbia Wound Care Consortium (CWCC), a group of about 150 inpatient and outpatient wound care providers, hyperbaric specialists, and other physicians and nurses from the Portland-Vancouver area.

CWCC's mission is to raise awareness about scientific advances in the rapidly changing field of wound care. With **Geoff Cameron** as executive director, the organization also serves as a resource to wound care providers through education, consultation and the promotion of evidence-based, advanced wound care practice.

Its members receive wound care updates, information about courses, and access to discussion forums and an online Resource Guide. Any clinician who practices in the wound care field is eligible to become a member at no cost. All members of the medical community are invited to attend its events, including its quarterly symposiums.

Focus on Patient Care

Huang, president of CWCC's board of directors, called the group a "multi-organizational effort."

"Even though I came up with it, it really is predicated on participation and the idea is that a rising tide floats all boats. The more education we have as medical professionals, the better care we can provide for our patients," he said. •

*The Columbia Wound Care Consortium will host its **2013 Q3 Symposium from 8 a.m. to 12:30 p.m. July 27** in Souther Auditorium, Providence St. Vincent Med. Ctr. East Pavilion, 9155 SW Barnes Rd. For more information, please visit www.columbiawound.org.*

Private-practice organization aims to improve care, costs

Area coordinated care association sees exponential growth

Focus on Patient Care

By Cliff Collins
For The Scribe

A year after launching a local version of a physician-owned and directed coordinated care association, The Portland Clinic has seen the new entity it created grow exponentially.

To **Mike Schwab**, chief executive of The Portland Clinic, that spurt signifies that the concept and timing of the Portland Coordinated Care Association were on target.

"The changes in health care delivery, health care reform, the need for computerization, coordination of care—I think we came at a pretty good time with the idea," he said. "I think doctors were ready for it. To do all this on your own is difficult, if not impossible; you have to be part of a larger organization."

That was one of the main purposes of forming the **Portland Coordinated Care Association**, or PCCA, in May 2012: to allow physicians to retain some control over their own destiny by remaining partly independent, and to help doctors meet care quality improvement standards that are becoming expected under health reform, such as the Triple Aim and patient-centered medical homes.

"It's an organization put together to do a better job for the patient, to make sure we're plugging all the holes," Schwab explained. To meet quality goals and improve care, physicians must take into account "all the changes in a person's health care life, to make sure there is really good coordination and continuity of care. We're putting out something pretty positive to do what's best for patients, and finding ways to bend the cost curve."

During the past year, PCCA has grown to 20 primary care locations consisting of more than 200 physicians, 120 of whom are primary care doctors. In addition to The Portland Clinic, member groups include Northwest Primary Care, Cascade Physicians, Pediatric Associates, Westside Internal Medicine, South Tabor Family Physicians, Compass Oncology, Starr-Wood Cardiac Group and Rose City Vein Center.

In addition, PCCA signed a contract with PacificSource, effective July 1, to serve as a network for that health plan. PCCA is in discussions with other insurers, as well, said **Sil Pienovi**, PCCA's executive director.

'We have set a very high bar'

A separate corporation from The Portland Clinic, PCCA differs from a Coordinated Care Organization or an IPA, Pienovi said. The concept and legal structure of PCCA are similar to an IPA, but IPAs generally consist of individual physicians or small groups banning together, whereas PCCA is comprised of group practices that each have its own shareholders but also send representatives to serve on the PCCA board, and medical group members are shareholders in PCCA.

Also, in contrast to CCOs, which are intended, at least initially, to address the Medicaid market, PCCA will focus exclusively on the private, commercial market, he said. Still, it will be part of the Oregon Health Insurance Exchange offerings in 2014, he said.

Ralph A. Yates, DO, president and medical director of PCCA, said the organization is selective in the groups with which it allies. "All the groups we've approached are all like-minded groups" who have pledged to "abide by standards of care agreed on. Please understand we are not looking to partner with everybody. We have set a very high bar with the people we've chosen."


RALPH A. YATES, DO

The association's goal is to expand its medical group network with physicians who share the same philosophy and are professionally managed, with experience using electronic medical records, Schwab said. Current primary care member groups have achieved certification in the state's Patient-Centered Primary Care Home program.

"The medical home totally fits in because it is the foundation of care," helping patients navigate the health care system, Pienovi added.

Member medical groups, such as Northwest Primary Care, are using PCCA "as a vehicle to work closely together" to develop what the patient-centered medical home concept requires, said **Michael Whitbeck**, administrator of Northwest Primary Care. "It's not just financial; it's how to partner with patients and involve them in managing their own health care."

Project managers from each PCCA member group meet monthly to coordinate their efforts to manage high-risk patients such as diabetics, he said. "We coordinate together and then report together as peers."

*See **COORDINATED CARE,** page 14*

Off Hours

Connected to the past through building

Craig Turner hones skills as a period furniture maker

By John Rumler
For The Scribe

After a challenging workday at his urologic practice, **Craig Turner, MD,** often trades his lab coat for a shop apron and safety glasses, utilizing many of the same skills, precision and a meticulous attention to detail in his hobby of woodworking, particularly when replicating classic period furniture.

Born and raised outside Detroit, Mich., Turner grew up swinging a hammer and wielding saws, drills and other hand and power tools. "My father was a carpenter and he could build just about anything. Working with wood came naturally to me," he says.

Turner served as the "gopher" when his father remodeled the kitchen, made a camper for the pickup truck, built tree houses, and did other big and small jobs. So as a youngster, when other boys were playing with Lincoln Logs, Turner was already building forts, Cub Scout derby cars and toolboxes.

His father, James Turner, died in a hunting accident when Craig Turner was only 11, but he still has his dad's leather tool belt.

Turner also took woodshop classes in junior high school. When he was in the Army, stationed in Germany and at Fort Riley, Kan., he spent hours at the base woodshop honing his repertoire of woodworking skills. When he exited the military and began college, he already had built a kitchen table and benches, couches, and a futon for his apartment.

His first project in Oregon was building his own 20-by-30-foot workshop, which is equipped with an impressive array of specialized lathes, band and table saws, drill presses, planers, and an entire wall board of unique and strange-looking hand tools. "My dad never got to finish his own workshop, so I made completing mine a priority," Turner says.

He also became friends with many other woodworkers, a good number who happen to be physicians. **Joe Mandiberg, MD**, an orthopedic surgeon at Multnomah Orthopedic Clinic, has known Turner for 30 years and has been into woodworking since the 1970s.

"I build more modern styles," says Mandiberg, who built his own house and all the cabinets. "Craig takes on really challenging things. He likes to figure out how to conquer problems." Mandiberg admires the way his friend has progressed in his skills. "He plans out his projects and then attacks them. Craig learns a lot because he's willing to experiment."

As soon as the shop was built, Turner put it to good use, making bed frames for his two daughters and progressing to his first genuine period piece, a Queen Anne-style dining room table.

Over the years, Turner has become a connoisseur of different types of hardwoods, but his favorite is Tiger Maple. "All the woods have their own appeal, but when properly used, Tiger Maple is absolutely beautiful."

As Turner journeys deeper into the art of furniture making, he does more research, mostly by reading journals and going on the Internet. He is particularly attracted to 18th-century European furniture.

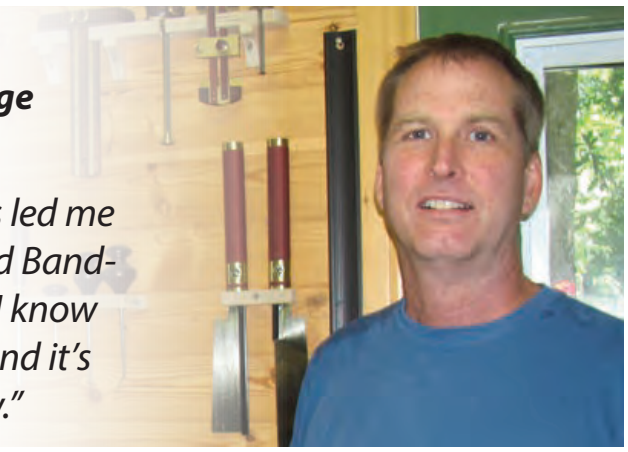
"Those craftsmen did such incredible things all by hand. Their pieces have all stood the test of time, surviving to this day, and they are absolutely durable as well as artistically stunning."

One of the most challenging pieces Turner has made is a Boston tea table that is an exact replica of a museum piece that is more than 200 years old. It took several months of working evenings and weekends, but the piece is a gem.

One project, a gentleman's dresser, took two years because there were numerous dovetails to cut as well as hand-carved

See ***OFF HOURS,*** *page 11*

When not practicing medicine, Craig Turner, MD, often can be found in his workshop making classic period furniture. Turner, whose father was a carpenter, said "working with wood came naturally to me."
Photos by John Rumler



Craig Turner, MD, on his Two-Bandage Workshop Rule:

"After my work has led me to apply the second Band-Aid® to my hands, I know I've lost my focus and it's time to call it a day."

Turner at the forefront of urology

A board-certified urologist at Urologic Consultants on Southwest Barnes Road in Portland, Craig Turner, MD, practices all aspects of adult urology with a special interest in surgical innovations related to robotic, laparoscopic, and other minimally invasive techniques.

Turner, who joined Urologic Consultants in 2003, was initially drawn to urology because of the field's history of innovation. "It's provided a unique opportunity to pursue my interest in advancing surgical technology while delivering compassionate care," he says.

After serving in the U.S. Army from 1980–83, receiving the Army Achievement Medal for his work as a field medic, he graduated from the University of California School of Medicine in 1994. Turner then completed two years of general surgery and four years of urologic training at the University of Chicago Hospital, where he was an American Foundation for Urologic Disease Scholar.

When Turner came to Portland in 2000, laparoscopic urology was not widely practiced. By championing new surgical approaches in the metro area, he positioned himself at the vanguard of urology techniques.

Through the years Turner has trained and supervised many other physicians, and he continues developing new techniques and equipment to bring simple solutions to complex problems.

Turner has published numerous articles in medical journals, including the *New England Journal of Medicine*, and was chosen as one of America's Top Urologists by the Consumers' Research Council of America. *–John Rumler*

Nurse practitioners pay parity bill is law, for now

By Cliff Collins
For The Scribe

House Bill 2902, signed into law in June, resulted in a compromise between medical and nursing groups that ended the latest provider turf battle in the state Legislature.

The bill, introduced at the request of the **Oregon Nurses Association**, states that nurse practitioners and physician assistants in independent practices must receive the same reimbursement as doctors for providing a primary care or mental health service in the area served.

The compromise came about despite the fact that the nurses association and the **Oregon Medical Association** view the crux of the issue in opposite terms.

The nurses association believes services should be paid based solely on the service provided, not on who provided it, said **Susan King, RN**, executive director of the Oregon Nurses Association. The OMA, worried that the bill would end up reducing physician reimbursement, doesn't agree that the background and training of the professional giving the care should not be taken into account when a service is provided, said **James Lace, MD**, a Salem pediatrician who is legislative chairman for the OMA.

King called the outcome of the negotiations an "acceptable compromise. You pay for the service under the codes regardless of who provides it," she said in describing what the law requires. "That was our goal at the Legislature, and that was achieved."

What the OMA got in the compromise legislation was a sunset date for the law of Jan. 1, 2018, and establishment of a task force to make recommendations to future legislatures regarding appropriate reimbursement policies for primary care and mental health provided by physicians, NPs and PAs. "Critically important for our members, the amendments also prohibit achieving the temporary payment parity by lowering physician reimbursement rates," the OMA said in a statement.

What prompted the bill in the first place was several health insurers' reductions beginning in 2009 of reimbursement to NPs and PAs who are in independent practices. These cuts especially impacted those in sole practice, though not all were affected, King said. Nurse practitioners who are part of large groups that can negotiate with carriers were not as affected, she added, and their pay will not change under the bill. "This was never about physicians," she said. "Some physicians alleged if nurse practitioners were paid more, that physicians would be cut also."

But Lace said the OMA opposed the original bill because it called for reimbursing all three types of practitioners the same amount. "It is still an issue of why would someone want to become an MD when you could end up (being paid) the same thing as a PA or NP." He pointed out that many new doctors graduate with a $200,000 debt load because of their advanced training, which he contrasted to the less-extensive training required of NPs and PAs.

"We got what we thought was a reasonable compromise," Lace said. The addition to the bill of a task force was "huge," he said, because "they threatened to cut ours at the same rate. ... The nurses ended up getting a lot out of it."

Tom Holt, director of government affairs for **Regence BlueCross BlueShield of Oregon**, said his company values the role of nurse practitioners. "They often provide a lower-cost point of access for routine care, and in some rural areas they are the only local practitioners available," he said. "However, HB 2902 arbitrarily sets their compensation at the same level as physicians, who treat a much broader group of individuals, particularly those who have complex health conditions that mid-level practitioners are not trained to treat. It is not equal pay for equal work, as proponents contend."

Holt said Regence remains concerned that the final bill, "rather than promoting payment reform," bolsters the "outdated," fee-for-service payment model at a time when more Oregonians will be seeking care under the Affordable Care Act. "We prefer compensation models centered around quality health outcomes that support Regence's efforts to make health care more efficient and affordable for our members.

For its part, the OMA still has concerns about "the possible unintended consequences of the pay-parity law," it said in a statement. But the association added that it would have even greater concerns had the bill passed as a permanent policy requiring pay parity. The revised bill presents "an opportunity that we otherwise would not have had and allows all stakeholders to recommend better solutions to the payment problem." •

Off Hours: Furniture craftsman, Turner

CONTINUED FROM *page 10*

feet and a specially matched veneer.

Turner tries to develop at least one new skill with each piece he builds. For the tea table, he practiced an advanced technique called offset turning on the lathe.

"It was especially challenging since I made it out of Tiger Maple, which is very difficult to turn. I was able to make the entire piece out of the same board, which means to me that the tree it came from now gets to live on as a single entity."

The immersion Turner experiences in a furniture-building project is relaxing and absorbing.

"It connects me to the historical past," he says. "One can get a better, richer understanding of history by studying period furniture. And my kids see that things don't just show up at stores—someone has to actually make them!" •

Marion Krippaehne, MD (1923–2013)

Remembered for dedication to medicine, family and community service

History of Medicine

By Maija Anderson,
OHSU Historical Collections & Archives
For The Scribe

Marion Carolyn Larsen was born on June 22, 1923, in Missoula, Mont. By age 12, she knew she wanted to become a doctor. "It was all so clear in my mind. I knew I wanted to help people," she remembered. A lack of female role models in medicine did not deter her, and her parents lodged no objection to her ambition.

After earning a degree in chemistry from the University of Washington, Marion Larsen enrolled at the University of Oregon Medical School. While she was one of only four women in her class of 68 students, she remembered the atmosphere as warm and collegial, and welcoming to women. It was at this time in her life that she began looking to women physicians as mentors and role models. Because there were very few women faculty at the medical school in the 1940s, women physicians who practiced in Portland reached out to the students. "The women [doctors] in the city would invite the women at the school to their homes, which was very, very nice. It was one of the things that we as medical students in those days really looked forward to … I think the older physicians really felt obliged to support the young medical students, knowing … how few women that they had dealt with in their own medical training." She graduated with an MD in 1948.

While in medical school, she met **William Krippaehne**, who graduated two years ahead of her. After serving in World War II, Krippaehne returned to the medical school as a surgery resident. He eventually became chairman of the Department of Surgery. When they married, the Krippaehnes decided that they would both pursue their respective careers in medicine while raising a family. Their first child was born when they were both in resident training, and they went on to have six more.

Marion Krippaehne completed an internship and residency at Emanuel Hospital. She specialized in internal medicine, enjoying the challenge of diagnosing and treating internal ailments. After her time at Emanuel, Marion Krippaehne returned to the medical school, where she had the opportunity to work in the Department of Experimental Medicine under the renowned hematologist **Edwin Osgood, MD**. Early in her career she worked in quality assurance in the school's outpatient clinic, where students and volunteers treated indigent patients with the support of Multnomah County. She later transferred to the Division of General Medicine, where she served as a teacher and clinician for the rest of her career.

In the 1950s and '60s, Marion Krippaehne was often the subject of lifestyle articles in local newspapers. Journalists marveled at her ability to manage a high-pressure career while also raising a large family. "How does she do it?" asked an *Oregon Journal* writer. Her outlook will still resonate with today's professionals who juggle work and family obligations.

"People think I'm highly organized. I just put priorities on demands," she said in a

***CONTINUED ON** page 13*

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1968 interview. She cited the importance of flexible work schedules, short commutes (the family had a home near the campus), domestic help, and the support of her husband and extended family. She cautioned against seeking perfection in every undertaking, but felt strongly that as a matter of professional integrity, a physician should not let family interrupt her career: "If one chooses medicine as a woman, I think you're obliged to stick with it, particularly these days when the information … is expanding so rapidly that to drop out for even five years would put you so far behind you may not catch up." She acknowledged having to sacrifice social activities and leisure time while her children were young.

Outside of her career and family, Marion Krippaehne was dedicated to community service, volunteering at OMSI and fundraising for medical causes. Her professional activities focused on the **American Medical Women's Association**. As state president, she engaged women health practitioners in the area to support students and new professionals. She also was a leader in the medical school's **Faculty Wives Club**, although she was a faculty member herself. She enjoyed the community aspects of the organization, which planned social events on campus and recruited high school girls as volunteers at **Multnomah County Hospital.**

Marion Krippaehne passed away on April 15 after a stroke, with family by her side. She was preceded by her husband, who died in 1985. •

Far Left: Marion Krippaehne, MD, circa 1960s.

Right: Marion Krippaehne, MD, at an Oregon Occupational Therapy Association fundraising event in 1956.

ZoomCare

CONTINUED FROM *page 6*

ties behind it so we get it right. We expect to take care of everybody over time."

As one way to offer care to some of those populations, ZoomCare does host free nights at its North Mississippi Avenue clinic through its ZoomCare Foundation. Every Wednesday night, the clinic makes 20 appointments available for free.

Like others in the health care industry, Sanders and ZoomCare are facing plenty of uncertainty when it comes to health care reform on both the state and federal levels. He's not exactly sure how the reforms expected to kick in next year will impact ZoomCare, but he is sure that already the reform effort is making a difference."

I think it's already had a very large and palpable impact," he said. "It's stirred up and galvanized the energy not only across the country, but in this state."

He likened the current national discussion and endeavor to that kicked off by President Bill Clinton's own attempt at health care reform in 1993. Though that effort came up short, it did spark debate and ideas.

"I think you're seeing the greatest innovation of health care in the last 25 years," Sanders said. "Whether it's effective from a policy perspective or not, it's really created an environment of dynamism that's been further magnified by the fact that this state and its leadership are so innovative."

In the midst of all the transformation, ZoomCare plans to continue expanding and adding more services. It also aims to continue incorporating more technology into its services. The latest addition, TakeOut Visit, lets patients have a medical visit with a board certified provider via Skype for $89. At present, the visits can provide complete diagnosis and treatment plans for nearly 30 conditions.

Expect similar expansions of services and locations to come for ZoomCare, even as the larger health care reform movement begins to move in earnest in 2014.

"I think once some of the changes take hold after the first of the year, we're in for a fascinating year," Sanders said. "We can't wait to be part of it." •

Coordinated Care: Improving care, costs

***CONTINUED FROM** page 9*

Specialty groups also come into the picture when patients need specialized care. Compass Oncology joined PCCA this year after the association approached the cancer group, said its executive director, **Brad Perrigo**.

"One of our fundamental goals is to collaborate with other physicians in the community," he said, explaining his group's motivation for joining PCCA. "Taking care of patients, especially cancer patients, requires a high level of collaboration with other physicians."

Not only that, but PCCA also provides a "vehicle to present a product to the (state insurance) exchange," Perrigo added.

Other specialty groups have shown interest in PCCA, and the association is talking with several of them, according to Schwab.

"The **changes in health care delivery**, health care reform, the need for computerization, **coordination of care**—I think we came at a pretty good time with the idea."

—Mike Schwab, chief executive of The Portland Clinic

Change must 'start with us'

Instead of selling their practices to health systems or individually becoming employees of them, medical groups can turn to PCCA, which provides groups and their member physicians "a viable alternative to be part of a larger organization," Yates said. "The federal government and private industry have challenged us to change, telling us we have to work together to achieve savings. With that challenge, there is an opportunity for us (as) formerly independent physicians to come together and create this entity. It has not been done before in Portland."

Nationally, forming organizations such as PCCA "is a movement that has been actually in place for a good three years," said Yates, who is former chairman of the **Oregon Medical Board.** "Those organizations that are moving forward are those in which those involved have mutual strong relationships."

In order for a coordinated care association to be successful, members also "have to agree to make changes in their own practices," Yates stressed. "That can't be dictated from above. The reason is, we're the ones in the room with patients, assessing disease management. In order for a change to occur in the system, I believe it's going to have to start with us."

Collaborating to make care and care management more efficient "will help us have a better premium in the marketplace," Pienovi said. "The price of that (premium) is directly related to how efficiently we deliver care. Being able to be more efficient will bring us more business. In the current reform environment, that's important."

The Portland Clinic and the PCCA member groups follow the American Medical Group Association's "High-Performing Health Systems" guidelines to achieve better quality care, Schwab said. These principles are designed to help medical groups standardize care, improve quality and patient satisfaction, and reduce cost, he said.

"Many physicians want to retain their private practices but find that challenging because of health care insurance reform and regulations to track and document quality outcomes," Pienovi said. "Instead of having to sell their practice or join a large health system, we're encouraging them to explore this third option, which keeps them somewhat independent while still lowering costs and increasing the quality of care for patients." •

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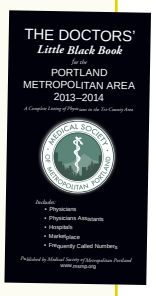

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