

OREGON PUBLIC HEALTH ASSOCIATION

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THE Probe

Quarterly Newsletter of the Oregon Public Health Association

Fall 2003

Office of Rural Health promotes

Health services on the Oregon frontier

BY TERRY HAMMOND

Huddled in a windowless attic room above the dean's office at Oregon Health and Science University, School of Medicine, Community Services Manager Paul McGinnis of the Office of Rural Health (ORH) scrutinizes a dense table of tax rates, while Data Coordinator Emerson Ong sits poised at his computer pulling up maps of the state. "In Lake County, for example," says McGinnis, "the property tax per thousand dollars is two dollars and three cents for the Lakeview Health District. That pays for a hospital."

Oregonians on that far southern frontier of the state have chosen to tax themselves to help pay for the Lake District Hospital, with 21 beds, one of Oregon's 59 hospitals and one of the 16 designated "critical access" hospitals that receive special cost-based reimbursement from the feds for Medicare patients. Critical access is right. The nearest

hospitals from Lakeview are in Ashland or Burns, both over 100 miles away.

McGinnis moves his finger one row down on the table of numbers. "The tax is eighty-five cents for a clinic in North Lake County. That's Christmas Valley."

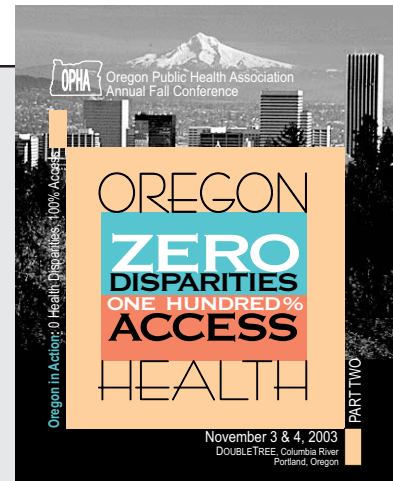
He turns to another, lengthier set of tables of property tax statistics from the Oregon Department of Revenue, clearly pleased with his ability to master the numbers, and finds the page that shows the assessed value of all property in Lake County, amounting to only \$393 million. This second table allows him to calculate what tax rate is necessary to come up with the funds for a publicly managed health-care facility.

A recent vote on the farthest frontier of Oregon, in Jordan Valley, Malheur County, demonstrated how the numbers work. The required property-tax rate per \$1,000 there was \$3.81, to raise \$85,000 for a health clinic. Considering the huge size of some of the ranches in the area, the burden was simply too great, spread among too few residents for too little benefit. The voters rejected it.

Health Service Districts

Health service districts are a little known feature of Oregon's healthcare delivery system. McGinnis himself is only just beginning to systematize what he

(continued on page 4)



Annual meeting of the Oregon Public Health Association

Monday, Nov 3

Tuesday, Nov 4

Featuring:

Public Health or Medical Care?

Community Health: Diverse Populations and Diabetes

Nursing and Prenatal Access

Promoting Physical Activity and Healthy Eating for Healthy Kids

Adolescent Risky Behavior

Ways & Means Sociodrama

Exhibits, Speakers, Breakout Sessions, Forums, Networking and More

(See Page 17 for more information)

Special Issue: Summary of New Oregon Laws for Health (Page 6)

OPHA Mission

- *Protect and promote the health of all Oregon residents*
- *Educate and support public health workers*
- *Advocate for just and equitable health policies*

Zero disparities in health care a protean target

Race, ethnicity and gender are common targets for evaluating disparities in relation to a number of social conditions in the USA. Health and health care is a new frontier for this kind of critical attention. Identifying the root factors of health disparities, however, is a tricky business full of confounding variables. Historical discrimination lends support for quickly turning to a "suspect class" of persons (as the Supreme Court defines it), but the question for health policy is whether these traditional categories are the best measures for understanding disparities.

Apparently the single most pervasive factor influencing health disparities is illiteracy, which affects both physician behavior and the ability to self-manage one's own health. Astonishingly, nearly half of the population in the USA is functionally illiterate in matters of health, as Ruth M. Parker and colleagues remind us in the July/August issue of *Health Affairs* (147-153). A significant portion of the problem is due to a 50 percent increase in the non-English speaking population over the last 10 years, accounting for 21 million people, according to a news report earlier this month. Integrating a capacity for Spanish and other languages in hospitals and clinics can help; but Parker points out that health literacy is not solely related to language ability. "The majority of adults with poor literacy are white, native-born Americans." Disadvantaged groups of any race or gender face higher risks.

Quotation of the Quarter

"If you are among those who found stopgap alternatives to services or benefits you lost last spring, don't give them up yet . . ."

Message from Oregon Dept of Human Services Director Jean Thorne (Sept 2)

(See related story, Page 18)

Another huge factor of health disparities in the USA is income difference – not just poverty, but magnitude of inequality. A new study by James Dunn and Nancy Ross reemphasizes this point, comparing the USA to Canada in a follow-up to an earlier study that appeared in the *British Medical Journal* in 2000 (320; 898-902). As appears in many areas of medicine, the causal pathway is not

known in this case, but the empirical correlation is incontestable.

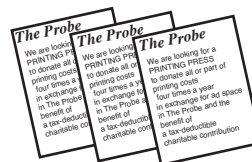
Both of these critical features in health disparities combine to implicate the concept of class as a decisive factor. We apparently believe class is an ancient condition we transcended when we crossed the ocean, for we ignore it almost completely. In the protean face of health, we may find that we ignore it at our peril.

– TERRY HAMMOND

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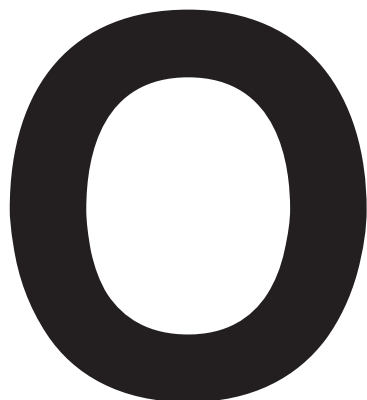
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Editor Terry Hammond at **503-282-1242** or at terryh@pdx.edu



Obesity: doom of our nation

Agencies prioritize weight control in Oregon

BY LESLEY RUSH

Research indicates a link between obesity and numerous chronic diseases such as diabetes, heart disease, and most recently cancer. Maintaining a healthy weight through physical activity and a proper diet not only helps to keep the human body functioning properly, but also reduces the risk of serious illness. Many people are trying to reach optimal size – consider the diet crazes and workout boom – but something is not working. The state of Oregon has a plan, making an effort through policy and environmental change to help the people of Oregon reach a healthy weight.

Joan Ottinger, nutrition and physical activity consultant for the office of Health Promotion and Chronic Disease Prevention in the Department of Human Services (DHS), described the proactive approach the state is taking in order to make the healthy choice the easy choice. Two major campaigns are targeted to help children begin making healthy choices.

One upcoming event is international Walk to School Day on October 8. This promotional event encourages everyone to walk to school. The event also encourages children to complete a walkability checklist that highlights the problems or strengths of the route they take to school. This connects nicely with the implementation of Oregon's Safe Routes to School law. Cul-de-sac neighborhoods often force children to take much longer routes to school, often along busy thoroughfares. The law is intended to encourage safe walking routes for every student. This may mean more sidewalks, and even aesthetic considerations like trees overhead. Oregon children partici-

pating in Walk to School Day can play an active part in the realization of this law.

Ottinger suggested we do not live in an environment that encourages weight loss. Huge portion sizes on 11-inch plates, and muffin tins four times the size of their predecessors just 20 years ago, facilitate overeating. Research shows that people eat the food placed in front of them. Another contributor to the obesity epidemic is the pervasiveness of television. The more television a person reports watching, the more food he or she will consume.

Ottinger emphasized the importance of taking blame off of the individual and finding ways to make it easy to reach and sustain a healthy weight. Providing healthy options increases the likelihood of healthy choices. A salad bar with fresh fruits and vegetables appeals to students and workers in comparison to greasy fried sandwiches and accompaniments. A pleasant, safe neighborhood encourages individuals to get out and enjoy a walk. In some respects, Portland represents a positive environment. For one thing, shorter city blocks help people feel as though they have covered more distance, making a walk seem less daunting.

Policy changes are underway for Oregonians, too. The Oregon Coalition for Promoting Physical Activity, a voluntary group of organizations and individuals committed to promoting and increasing physical activity in Oregon, received an Active Living by Design grant from the Robert Wood Johnson Foundation. With this money, researchers will try to develop livable community designs.

With help from numerous state agencies and associations, Oregonians are becoming aware of a new set of choices of vital importance. For public health, the

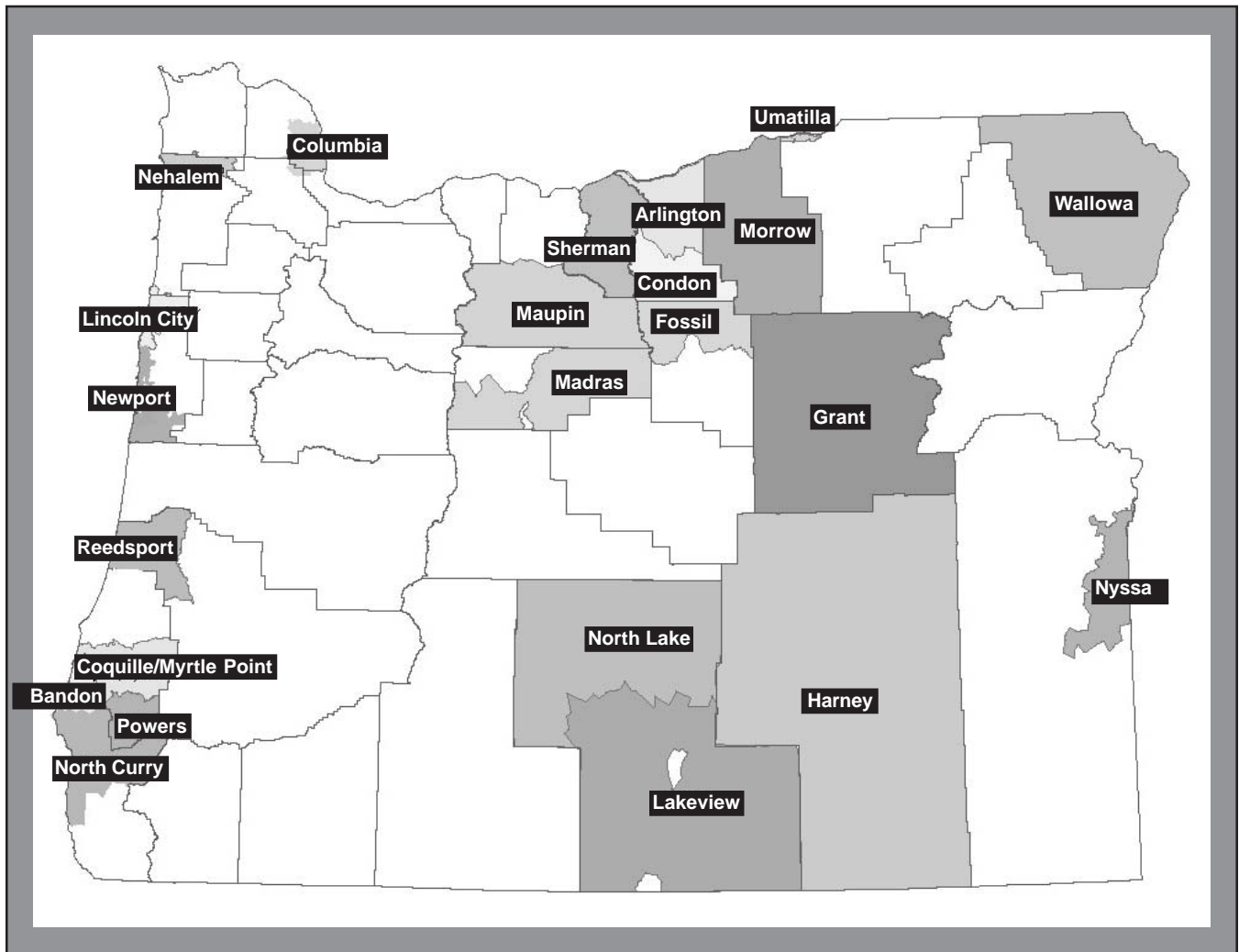
goal is to make the healthy choice the easy choice.

Walk to School Day October 8

**For information or
promotional materials,
call DHS at 503-731-4273**

The uproar in July over the Joint Ways and Means Committee rejecting a grant request from DHS for over \$2 million from the Centers for Disease Control to help reduce obesity in the state aroused a debate asking whether government should be addressing "a personal problem of dietary habits," as Co-chair Rep. Randy Miller called one of Oregon's top health problems. DHS was planning to use the funds to begin a research consortium to identify those at highest risk and prioritize an action plan to promote healthy lifestyle choices. Momentum for healthy choices to fight the obesity epidemic remains strong from a variety of sources.

- An "Obesity Town Hall Meeting" was sponsored on September 20 by the OHSU Center for the Study of Weight Regulation.
- "Healthy, Active Kids: A Community Forum on Childhood Obesity" is being sponsored by Kaiser Center for Health Research and Northwest Permanente on September 23 and 30 (503-528-3909).
- With a more general theme, a "Child Health Open House" is being sponsored as a networking event by the DHS Office of Family Health to honor National Child Health Day on October 6. (For more information, contact Astrid Newell at astrid.marie.newell@state.or.us)



Map 1 Health Service Districts

Awareness of health service districts is a new development

(from page 1)

knows. Personal contact with rural providers, canvassing the state by phone, was the first step. Now, a little over a year later, he is finding rural providers are calling him back for advice on how to establish a health district in their areas. That's when he decided he needed the tax tables.

One thing he has found is that it is much easier to establish a district that conforms to an already existing tax district, because the property is already surveyed and assessed. Otherwise, the assessment procedure can be expensive..

According to the new map produced by Ong, Oregon has 23 health districts supported by a tax base. A recent state law requires new health districts to have a tax base, which means an independent health

district like the one running Bay Area Hospital in Coos Bay is no longer possible. Coos Bay is not on the ORH map.

Keeping a consistent dataset is part of the reason for the exclusion. The question that is beginning to interest McGinnis, and others around the country facing similar developments, is why some areas choose to tax themselves and others not. "What makes them care?" McGinnis asks.

While discussing the health districts and the variety of facilities they maintain, McGinnis says repeatedly so it sinks in: "Availability is not accessibility."

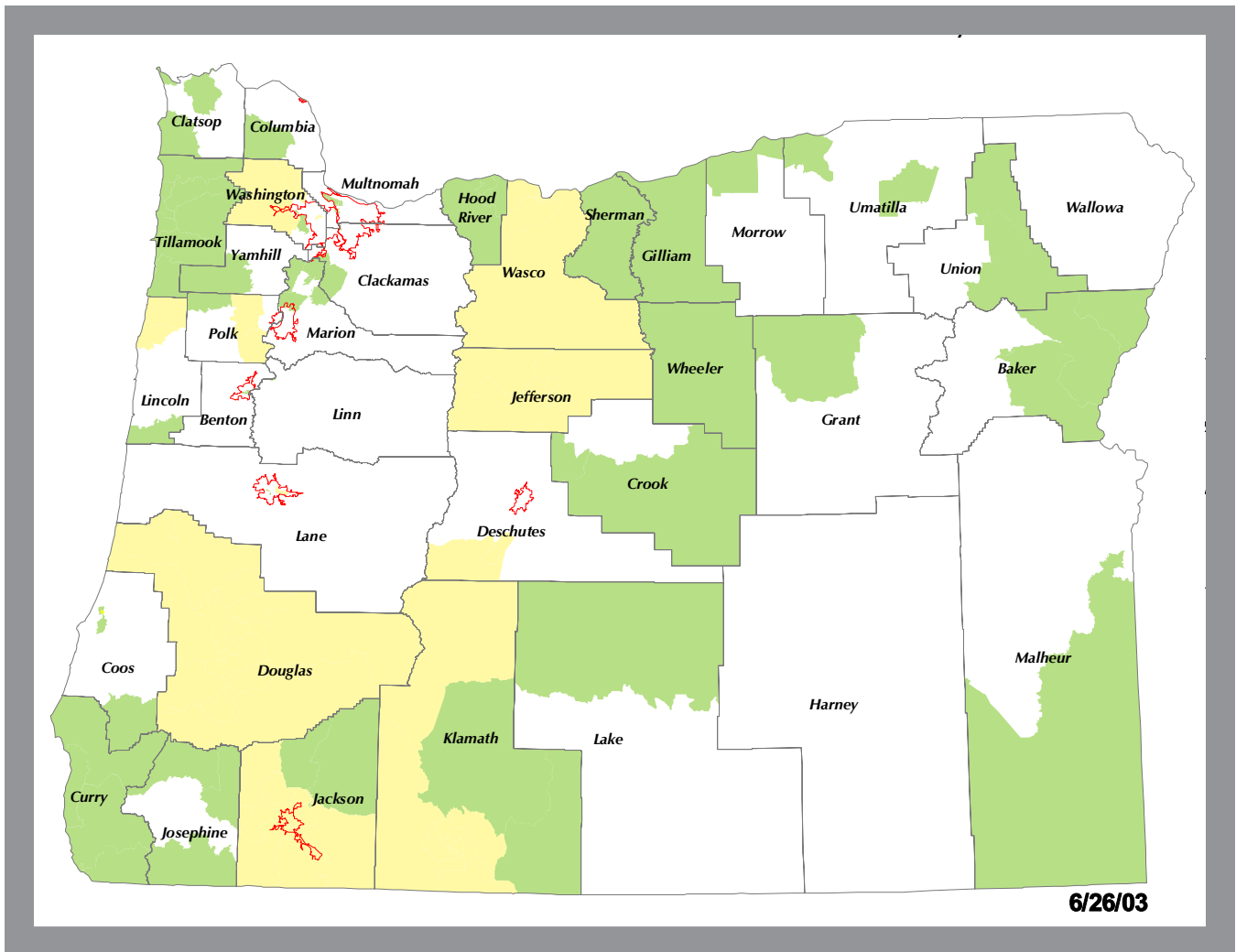
Sure, he admits, they probably all take people regardless of ability to pay, but they tend to have aggressive collec-

tion practices that can make it unpleasant for the uninsured. So far, health districts provide facilities, but they do not represent a rational health system for the local population.

Primary Care Service Areas

Although knowledge about health service districts in Oregon is a new development at ORH, the agency's impressive catalogue of "Primary Care Service Areas" is now 20 years old, begun in 1983. The procedure for defining the areas is described in detail on the ORH website ("What is "Rural" in Oregon?" at www.ohsu.edu/oregonruralhealth). A variety of impressive maps can be found there, too, like the ones shown here.

ORH groups zip codes throughout the



Map 2 Medically Underserved Areas (MUA) and Populations (MUP)

state into 130 service areas, with 104 designated as rural. Defining the level of service and need in these areas serves an important function. Critical Access Hospitals are defined by the service area, which makes them eligible for special funding for Medicare and Medicaid. Also, since 1989, the state repays student loans for up to 10 years for licensed physicians, physician assistants and nurse practitioners that settle in defined areas of unmet need. ORH research produces an immediate, practical effect in the Oregon health system.

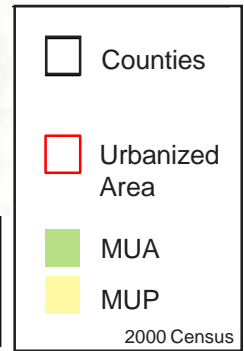
The federal government has its own methods for determining shortage areas across the country, based on census tracts. The definitions do not always coincide with the local view from the state. ORH takes a sanguine view to the conflict, but

relatives in California are not so easy about it. In March, the California Rural Health Association requested the California Rural Health Policy Council to send a letter to the feds asking them to follow the state definitions. The methodologies vary just enough, according to the testimony, that "rural California continues to miss out on getting its fair share of federal funding."

In this debate, McGinnis has two arguments that favor the state. First, the rankings in Oregon should not necessarily be compared with rankings in Mississippi or elsewhere. By that standard we might be viewed as too well off. Second, as a matter of local awareness vs. abstract numbers, McGinnis asks: "Do you know your census tract?" Of course not. "But everyone knows their zip code."



Maps by
EMERSON ONG
Oregon Office
of Rural Health



- *MUAs* are areas designated as having a lack in access to health care.
- *MUP's* are populations within communities that can not afford basic health care and lack access to health care.
- *HPSA's* (Health Professions Shortage Areas, map not shown) are areas designated as having a shortage of health care providers.

New Oregon laws aim for flexibility,

The Oregon State Legislature concluded its lengthy 2003 session at the end of August. As always, a number of new laws have been enacted related to health. Many refer to administrative matters, making incremental changes or extensions to existing laws. Some align state law to existing federal law. The following list of health-related laws passed by the legislature this year and signed by the governor is not comprehensive, and does not conform to strict inclusion criteria like a systematic review, but covers those issues that appear original or most consequential for public health. The policy decisions embedded in various finance bills are excluded.

The descriptions for each law are abridged from staff summaries of the original measures (available online at www.leg.state.or.us/billsset.htm), which may differ slightly from the final bills enrolled into law. The goal here is to be informative without yawning, offering a relatively brief journey through the labyrinths of current health policy in Oregon.

We can get a running start with a list of useful acronyms.

BME	Board of Medical Examiners
CMS	Centers for Medicare and Medicaid Services (fed.)
DAS	Dept of Administrative Services
DCBS	Dept of Consumer and Business Services
DHS	Dept of Human Services
FHIAP	Family Health Insurance Assistance Program
IPGB	Insurance Pool Governing Board
OHP	Oregon Health Plan
OHPR	Office for Oregon Health Policy and Research
OMAP	Office of Medical Assistance Programs
OMIP	Oregon Medical Insurance Pool
SAIF	State Accident Insurance Fund

HEALTH AUTHORITY

HB3653 Establish New State Health Policy Commission

Establishes the Oregon Health Policy Commission. Specifies certain members of the commission have voting privileges. Adds nonvoting legislators as members. Abolishes the Oregon Health Council (OHC). Requires the new commission to develop and monitor implementation of a state health policy, review State Medicaid Plan, and modifications in Medicaid protocols and rules proposed in the medical assistance program. Requires OHPR administrator to consult with and be advised by commission. Authorizes OHPR administrator to manage the Medicaid Advisory Committee. Requires DHS to work with commission to resolve concerns that commission may have on Medicaid-related actions or other agency healthcare programs.

BACKGROUND

The original OHC, within OHPR, was established as the policymaking body for the statewide data clearinghouse of data received from healthcare providers, other state and local agencies (including the state Medicaid program), third-party payers, and other sources, for the purpose and intent of the

Legislative Assembly; provide a forum for discussion of healthcare issues facing Oregonians, identify and analyze significant healthcare issues affecting the state, and make policy recommendations to the governor; annually prepare and adopt a state health plan; advise the state agency generally on the performance of its functions; and act as the primary advisory committee to the OHP administrator, the governor and the Legislative Assembly. OHPR is the state agency that directs health policy for Oregon by coordinating OHC, the Health Resources Commission, and Health Services Commission. In addition, OHPR collects, reviews and analyzes financial and utilization data from hospitals, nursing homes and ambulatory surgical centers, and analyzes the uninsurance numbers from the Oregon Population Survey.

HB2159 Adjust IPGB Authority Over FHIAP

Grants IPGB authority to administer FHIAP without contracting with a third-party administrator. Adjusts statutory references to eligible adults receiving subsidies from FHIAP.

BACKGROUND

The 1997 Oregon Legislature approved HB2894 that created FHIAP, the program that subsidizes low-income Oregonians so they can afford private health insurance. FHIAP subsidizes or pays for a significant portion of a member's health insurance premium, based on the member's monthly income. FHIAP members who have health insurance available to them through an employer are required to enroll in that coverage if the employer pays for any part of the premium. The new law modifies current language from "adult" to "eligible individual" to follow existing FHIAP statutes, and allows IPGB the choice of retaining or outsourcing administrative functions as needed.

HEALTH INSURANCE (PUBLIC)

HB2511 Codify OHP Benefits

Identifies groups of persons and describes the benefits they are eligible to, and must, receive under OHP. The measure addresses three groups of eligible persons.

1. Those who are categorically eligible by virtue of being eligible for other social service programs, as well as pregnant women with incomes not exceeding 185% of the federal poverty level (FPL), and children living in households with incomes up to 200% FPL.
2. Those adults who have incomes up to 100% FPL (the Standard population).
3. Those persons eligible for a medically needy program described in section 11 of the bill.

Describes the OHP benefits each group is eligible to receive and the benefits each group must receive. DHS may periodically limit enrollment to the medically needy in order to stay within the budget. In the event of insufficient resources, the population of eligible persons receiving health services may not be reduced

accountability, access and quality

below the population of eligible persons approved and funded in the legislatively adopted budget for DHS. The prioritization of eligibility groups requires approval of necessary waivers from CMS.

BACKGROUND

OHP has been providing healthcare services to low-income Oregonians since 1994, involving efforts to ration healthcare services in order to provide health coverage to more people. During the 2001-03 biennium, Oregon submitted an OHP2 waiver application to CMS that truly rationed services, and allowed Oregon to drop certain benefits all together for the Standard population. As the state's budget situation worsened, certain Standard benefits were eliminated, including dental coverage, alcohol/drug and mental health treatment, and for a short time, pharmaceuticals. During the 2003 Legislative Session, legislators extensively discussed OHP in light of the budget shortfall. The new law describes the eligible OHP populations and codifies the benefits each group may receive and those benefits they must receive.



SB878 Expand OHP Benefits for Native Americans

Individuals who are eligible for or receiving benefits for medical assistance, and are American Indian or Alaskan Native, are eligible for OHP Plus benefits under certain circumstances.

BACKGROUND

HB2519, approved by the legislature in 2001, provided for OHP expansion according to a two-tier benefit plan. Categorically eligible clients (pregnant women, children, and disabled or elderly population) qualify for the richer OHP Plus benefit package. Other clients who qualify for OHP coverage receive fewer benefits in the OHP Standard package. The new law allows American Indians and Alaskan Natives who are eligible for or who are participating in OHP to receive benefits of the OHP Plus package at the OHP Standard "price," since the difference will be made up using federal funds.

HB2537 Expand Offer of Small Employer Health Insurance

Defines terms. Requires IPGB to provide health benefit plans to small employers that are not eligible for subsidy under FHIAP. Allows plans to be offered to small employers who did not offer coverage on July 1, 2003, or to new businesses. Requires IPGB to collect and report data to DCBS, and to the 74th Legislative Assembly in 2007. Sunsets the program on January 2, 2008. Employers can continue coverage purchased before the sunset.

BACKGROUND

Small Employer Health Insurance (SEHI) reform, created by SB1076 in 1991, required regulation of the marketing of health benefit plans to small employers with 2-25 employees. The reform created the Basic Health Benefit Plan with benefits "substantially similar" to OHP Medicaid benefits. SEHI established marketing and underwriting standards, guaranteed issuance, rate band requirements, renewability provisions, pre-existing condition provisions and other requirements. In 1997, statutory changes extended the SEHI Basic Health Benefit Plan to businesses with 26-50 eligible employees.

HB2189 Work to Reduce Assessment on Insurers

Directs IPGB, OMIP and DHS to work cooperatively to obtain additional federal matching dollars for FHIAP, to be used to reduce an assessment that is currently paid by health insurers and reinsurers into OMIP.

BACKGROUND

Persons that apply for private medical insurance and are turned down, because of high-risk health reasons, are eligible for enrollment in OMIP. All health insurers are required to pay an assessment into OMIP to subsidize this high-risk pool. Individuals pay the regular premium, and the additional costs of health care are covered by the industrywide assessment. Some (but not all) of the persons covered through the OMIP assessment also receive premium subsidies through FHIAP. For those who do receive assistance through FHIAP, the new law requires OMIP to bill FHIAP for the total premium and other costs formerly covered by the assessment. FHIAP, in turn, will bill DHS. DHS (through OMAP) will pay FHIAP with federal funds and state general funds, approximately 60% to 40% respectively. OMIP will reimburse the general-fund portion with assessment funding. This arrangement should reduce the OMIP assessment by about 60% (the federal portion of the additional costs that exceed a normal premium payment).

HEALTH INSURANCE (PRIVATE)

HB3431 Allow Flexibility in Offers of Health Insurance

Permits insurance carriers offering individual health benefit plans to limit individual health benefit plans in which the individual may elect to enroll. Makes the individual who was denied coverage under the initial plan eligible to apply for

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2003 Oregon Laws for Health

(from page 7)

coverage under OMIP. Requires carriers to submit data to DCBS for the purpose of assessing the impact of the measure on the insurance marketplace. (See also HB2987.)

BACKGROUND

Currently, if an individual applies for an individual health benefit plan and is approved, that individual is eligible for any individual plan offered by the carrier. If denied, the denial extends to every plan offered by the carrier, with no flexibility to offer different products to different applicants based on health status. The new law allows a health insurance carrier to limit the plans in which an individual may elect to enroll if the individual is accepted for coverage.

HB2987 Health Benefit Plans

The new law includes the following components:

- *A condition specific waiver* – Applies to individuals. Currently, health plans can only “accept or reject” individuals who apply for coverage. If an individual is rejected, that person can apply to the OMIP high risk pool. The new law creates the additional option of accepting a person, subject to a condition-specific waiver, rather than rejection, for up to 24 months.
- *Increase rate bands from 2:1 to 2.5:1* – Applies to groups. Currently, insurers base their group rates on a Geographic Average Rate (GAR). Specific group rates are limited to adjustments from the GAR by approximately 33 percent. The new law modifies the adjustment to approximately 43 percent of the GAR.
- *Participation credit* – Applies to small employers. Currently, insurers can require that a certain percentage of employees enroll for coverage. The bill provides a credit of 5 percent to a small group when all employees enroll for coverage.

Requires carriers to submit data to DCBS to assess the impact of these changes on the insurance marketplace.

BACKGROUND

The stability of the small group and individual health insurance markets in Oregon continues to decline. In response to this development, stakeholders have offered several proposals to assist in stabilizing these markets.

HB2095 Mandate Health Insurance with Child Support

Modifies current state law that requires child-support orders to include healthcare coverage for the child. States that an employer commits an unlawful employment practice if the employer discharges or refuses to hire a person because the person is subject to a medical support order.

BACKGROUND

The federal government has passed new regulations ordering health insurance coverage for children, which require that child support orders include healthcare coverage for children if the obligor parent is eligible for coverage. In order for Oregon to be in compliance with this regulation, we must have new laws in place and must begin using the federally mandated child support national medical support notice by October, 2003.

COVERAGE DECISIONS

SB74 Extend Newborn Metabolic Screening

Exempts statute requiring insurance coverage of certain metabolic disorders from automatic repeal provisions.

BACKGROUND

Phenylketonuria (PKU) is a genetic inborn error of metabolism, detectable during the first days of life with appropriate blood testing (newborn screening). Without treatment, most infants with PKU develop mental retardation. Those with untreated PKU may develop additional neurologic symptoms. It is estimated that PKU occurs in one in 15,000 newborns in the USA.

To prevent mental retardation, treatment consists of a carefully controlled diet begun during the first days or weeks of life. Most experts suggest the diet should be lifelong. A carefully maintained diet can prevent mental retardation as well as neurological, behavioral and dermatological problems. HB2388, approved in 1997 with a sunset in July 2003, required health insurance policies to include coverage for treatment of inherited diseases that involve amino acid, carbohydrate, and fat metabolism.

In a November 2002 report prepared by the Oregon Insurance Division of DCBS, the division identified a total of 22 health benefit or provider mandates in Oregon law. ORS 743.700 puts a sunset on all mandates that became effective after July 1, 1985, unless the legislature specifies otherwise. The new law ensures that the insurance mandate for coverage of PKU will not lapse.

HB2642 Extend Insurance Mandate for Emergency Services

Exempts statute requiring insurance coverage of emergency services from automatic repeal provisions. Clarifies the definition of emergency medical condition.

BACKGROUND

In 1997, the Oregon Legislature enacted SB911, requiring insurers to offer coverage, without prior authorization, for emergency medical screening exams and stabilization of an emergency medical condition. In addition, SB911 requires coverage of services by a nonparticipating provider if a prudent lay person possessing an average knowledge of health and medicine reasonably believes that the time required to go to a participating provider places the client's health in serious jeopardy. SB911 contained a six-year sunset. The new law extends the sunset to 2009.

HB3654 Mandate Coverage for Breast Cancer Patients

Enacts provisions of federal law relating to health insurance coverage for mastectomy-related services. Specifies covered elements of breast reconstruction. Requires single determination of prior authorization for all mastectomy-related services. Requires expedited review of adverse decision by insurer. Eliminates automatic repeal of statute after six years.

BACKGROUND

In the USA, a woman generally has a 13 percent lifetime risk of developing breast cancer. In Oregon, about 2,600 women

per year develop breast cancer. In 1998, the federal Women's Health and Cancer Rights Act (WHCRA) designated new protections for breast cancer patients who elect breast reconstruction with a mastectomy. All group and individual health insurance policies written in Oregon must adhere to the requirements of this federal law. All health plans must provide coverage of prosthetic devices or reconstructive surgery after a mastectomy. The new law specifies covered treatments.

ACCESS

HB2374 Reimburse Prescription Drugs for Rural Clinics

Requires DHS to reimburse certain rural health clinics for prescribing and dispensing prescription drugs. Requires health insurance coverage for prescription drugs dispensed at certain rural health clinics.

BACKGROUND

In many rural communities in Oregon, medical clinics exist with no local pharmacy or limited access to prescription medications. Some patients must travel, in some cases over 60 miles, to obtain urgently needed medication. Currently, insurance companies and OMAP, which both reimburse pharmacies for prescriptions, do not reimburse these rural clinics for dispensing medications. New law directs insurance companies that provide a prescription benefit, and OMAP, to reimburse rural clinics that dispense medication when a pharmacy is not available within 15 miles and the medications are necessary for an urgent condition.

SB646 Authorize Claims by Physician Assistants

Reinstates mandate that insurers cannot refuse claims for the sole reason that they were submitted by a physician assistant.

BACKGROUND

A physician assistant (PA) provides medical services under the direction and supervision of a licensed physician. The PA exercises autonomy in medical decisionmaking and provides a broad range of diagnostic and therapeutic services. The clinical role of the PA includes primary and specialty care in medical and surgical practice settings in both urban and rural areas. Licensed PAs who do not have a supervising physician are not permitted to practice and their license is considered "inactive."

SB647 Authorize Physician Assistant Prescriptions

Expands types of controlled substances that may be prescribed by physician assistant. Clarifies limitations on privileges of physician assistants to prescribe Schedule II drugs. Clarifies eligibility requirement for prescription privileges.

SB648 Authorize Physician Assistants to Certify Death

Authorizes physician assistant to sign death certificate.

BACKGROUND

Physician assistants (PAs) in rural and frontier regions of Oregon may have limited access to other healthcare providers, resulting in delays while waiting for a physician to sign a death certificate. The new law allows PAs to be added to the list of healthcare providers, including physicians and nurse

practitioners, who are authorized to complete and sign death certificates. By authorizing another qualified healthcare provider to sign death certificates, the final disposition of a person may be expedited.

SB708 Add to Dispensing Authority for Nurse Practitioners

Allows nurse practitioner (NP) to submit applications to the Board of Nursing for authority to dispense prescription drugs. Authorizes the Oregon State Board of Nursing to adopt rules regarding drug dispensing authority for certified NPs. Specifies that the Board of Nursing has disciplinary authority regarding NPs with dispensing authority.

BACKGROUND

In 1975, the legislature authorized certification of NPs through the Board of Nursing. In 1979, NPs received the ability to apply for prescriptive privileges, including Schedule II-V controlled substances. The initial authority was through BME and the Board of Pharmacy, based on a formulary collectively approved by physicians and pharmacists. As of 1997, all newly certified NPs are required to have prescriptive authority. In 1999, NPs obtained the authority to register for Schedule II prescriptive privileges through the federal Drug Enforcement Agency, which was implemented by the Board of Nursing in June 2000. NPs can administer, order, prescribe, distribute samples, and under provisions limited to certain geographic areas, dispense pharmaceuticals. The new law allows rules to be developed to allow certified NPs to dispense drugs without limitations.

HB2828 Extend Authority of Nurse Practitioners in Workers' Compensation Claims

Authorizes certified nurse practitioner (NP) to provide compensable medical services and authorize temporary disability benefits for 90 days for workers' compensation claims. Authorizes NP to release worker to return to regular employment.

BACKGROUND

Currently, NPs are limited to providing care to an injured worker for 30 days from the date of injury, or 12 visits, whichever comes first. After that time, the worker must be referred to a physician for care or for reauthorization of NP services. This time limit on treatment and limit on the number of visits can be considered a barrier to care. At one time, NPs had unrestricted authority to provide care for injured workers, but in the early 1990s, restrictions were placed on many providers. The new law allows NPs to provide services to injured workers for up to 90 days, and authorize time loss for 90 days.

HB3157 Promote Access to Oral Health Services

Authorizes dental hygienist and dental assistant to perform oral health screenings under written training and screening protocols adopted by the Oregon Board of Dentistry. Requires screening results be provided to person screened or to parents or guardian of minor needing dental referral for diagnosis.

(continued on page 10)

2003 Oregon Laws for Health

(from page 9)

Modifies initial education requirements for limited access permit dental hygienist.

BACKGROUND

Dental Hygienists are members of the dental healthcare team that works with dentists in the delivery of dental care to patients. The hygienist provides instructions to patients on methods to prevent oral disease and to maintain good oral health. In Oregon, most dental hygienists work under the general supervision of a licensed dentist, which does not require that a dentist is present when the procedures are performed. Also, the authorized procedures may be performed at a place other than the usual place of the dentist's practice.

PROFESSIONAL DEVELOPMENT

SB800 Coordinate Funding to Address Nursing Shortage

Establishes the Oregon Nursing Shortage Coalition Committee (ONSCC) to coordinate funding and to distribute grants for nursing education programs designed to address state's nursing shortage. Authorizes ONSCC to adopt criteria for receipt of grant funds. Authorizes Oregon Health and Science University (OHSU) and DAS to receive funds for nursing program grants from the federal government and other public and private sources. Directs OHSU to distribute funds received for this program to public and private nursing programs at the state's universities and community colleges. Sets ONSCC membership and responsibilities. Establishes general criteria for distribution of grant funds and allowable uses of these funds.

BACKGROUND

Oregon is experiencing a nursing shortage. This bill seeks to address the nursing shortage by coordinating the funding that is available to expand nursing education programs. Currently, community colleges and OHSU cannot accommodate all of the applicants that apply to enter their nursing programs. The bill establishes a mechanism for the coordination of grant and donation funds that are available to fund statewide programs. No general funds are currently appropriated for the program.

HB3630 Establish Reinsurance for Rural Physicians

Requires SAIF to establish a reinsurance program for medical liability insurance for policies issued by authorized insurance companies between the years 2004 and 2007 to licensed doctors of medicine and osteopathy serving in rural areas who carry at least \$1 million insurance policies. Requires SAIF to submit its plan, by September 30, 2003, for the program to the director of DCBS and the Office of Rural Health for approval, and establishes maximum premium reductions for doctors covered by the program. Sets a limit of \$10 million per year as the obligation SAIF may incur due to providing this coverage. Establishes the Rural Medical Liability Insurance Fund to be funded by SAIF, and directs DCBS to offset the cost incurred by SAIF in providing the insurance against the annual assessment that DCBS charges SAIF. Requires SAIF to select

a consulting firm, with the help of a panel of legislators and experts in the areas of medicine, insurance, insurance litigation, and statistics, to gather and analyze data on the availability, costs and transaction of medical liability insurance. Requires DCBS to report to the legislature and governor on the performance of the program, and requires OHPR and the Office of Rural Health to report to the governor on how to attract and retain doctors in rural areas.

BACKGROUND

Proponents of this measure state that rising medical liability insurance costs have had a detrimental impact on the availability and affordability of healthcare services in rural areas. Specifically, specialists in the areas of obstetrics, pediatrics and neurology have left practices in rural areas, because the costs of insurance outweigh their potential incomes. Additionally, Oregon as a whole is having trouble recruiting new healthcare specialists due to high rates of insurance. Proponents state that this measure would help to reduce the costs of medical malpractice insurance, aiming for maximum premium reductions of (a) 80 percent for doctors specializing in obstetrics, (b) 60 percent for doctors specializing in family or general practice if the doctor provides obstetrical service, and (c) 40 percent for all other doctors.

HB2498 Reduce Interest Rate for Tort Reform

Sets the rate of interest on judgments in civil actions at the so-called "federal funds rate," which is the weekly average one-year constant maturity Treasury yield. Creates exceptions for judgments relating to certain financial transactions and judgments on contracts, maintaining the current nine percent interest rate or the contractual rate for such judgments.

BACKGROUND

ORS 18.560(1) was amended by the 1987 legislature to establish a \$500,000 cap on the amount that could be awarded as non-economic damages for so-called "pain and suffering." The Oregon Supreme Court struck down the cap on the grounds that it was in violation of Article I, section 17, of the Oregon Constitution, which provides in pertinent part that "the right of Trial by Jury shall remain inviolate"; and Article VII, section 3, which states that a jury award cannot be reexamined by the court unless it is not supported by the evidence. *Lakin v. Senco Products, Inc.*, 329 Or 62, 987 P2d 463 (1999). Since the *Lakin* decision, various interested parties have considered ways to approach tort reform in a different manner, within the constitutional confines outlined by the *Lakin* Court. The new law represents one of the proposals made to reduce overall jury awards and litigation costs in tort cases now that a non-economic damages cap has been found to be unconstitutional. Current Oregon law states that a 9 percent per annum interest rate is charged on judgments rendered in civil cases, including any award of attorney's fees and/or costs. This interest rate is considerably higher than a person could receive from a bank or even in the current stock market. Moreover, this interest rate is considerably higher than a claimant would receive in federal

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Oregon Public Health Association
Annual Fall Conference

Oregon in Action: 0 Health Disparities, 100% Access

OREGON
ZERO
DISPARITIES
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HEALTH

PART TWO

November 3 & 4, 2003
DOUBLETREE, Columbia River
Portland, Oregon

2003 Oregon Laws for Health

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court in a civil case; federal court's generally use the so-called "federal funds rate." Proponents state that reducing the interest rate for civil cases to the federal funds rate would preserve a jury's award to the prevailing party as required by *Lakin*, while helping to reduce the overall costs of awards in civil cases and establishing parity between the state and federal courts.

HB2151 Create Authority to Retain Foreign Physicians

Creates Physician Visa Waiver Program in DHS. Authorizes DHS to impose an application fee to fund the program.

BACKGROUND

The U.S. Dept of Agriculture houses the J-1 Visa Program, a waiver program that enables international medical graduates to complete residency study in the USA as long as they return to their native country to practice. To address the current physician shortage, federal law allows states to request approval of waiver requirements for foreign physicians to remain in the USA as long as they practice in underserved areas. To accomplish this, states have an option to act as an Interest Government Agency (IGA) and submit applications directly to the State Department. The new law allows Oregon to act as an IGA.

COST CONTROL

SB875 Establish Prescription Drug Purchasing Program

Establishes the Oregon Prescription Drug Program (OPDP) in DAS for the purpose of: purchasing drugs, in order (a) to receive discounted prices and rebates, (b) make drugs available at the lowest possible cost, and (c) maintain a list of recommended drugs that are the most effective at the best possible prices. Requires director of DAS to appoint an administrator for the program. Defines membership of the drug purchasing pool. Requires annual application by participants and requires DAS to issue an identification card. Requires OHPR to develop and recommend an evidence-based preferred drug list. Appropriates monies from the General Fund for the purpose of establishing the program. Requires a report on implementation of the program.

- May apply to state agencies that directly or indirectly purchase prescription drugs: Public Employees' Benefit Board, OHSU, local governments and special districts, enrollees in the Senior Prescription Drug Assistance Program, and residents aged 55 and over who meet certain qualifications. OHP patients are not included in the purchasing pool.

- Repeals rules adopted by DAS to implement the program unless approved by the 73rd Legislative Assembly in 2005.

BACKGROUND

Bulk-purchasing programs in which states pool together people insured for drugs through a variety of programs such as Medicaid, pharmacy assistance programs, and state-employee health plans create a large buying consortium. States then leverage that purchasing power to negotiate discounts with drug manufacturers.

QUALITY OF CARE

HB2349 Create Patient Safety Commission

Creates a new semi-independent state agency called The Oregon Patient Safety Commission, with the mission to "improve patient safety by reducing the risk of serious adverse events occurring in Oregon's healthcare system and by encouraging a culture of patient safety in Oregon." To accomplish this goal, the commission will administer a voluntary Oregon Patient Safety Reporting Program, which will gather and analyze data concerning serious adverse events and the root causes of those events. The commission will use the data to make recommendations for improvement in health care. The semi-independent state agency will have a 17-member board of directors, including the Public Health Officer, and 16 members appointed by the governor, subject to senate confirmation. The commission will have a funding account, and may apply for grants and foundation support, and compete for contracts. The commission may assess fees on voluntary participants to fund the reporting program. Hospitals, long-term-care facilities, pharmacies, ambulatory surgical centers, outpatient renal dialysis facilities, freestanding birthing centers and independent professional healthcare societies or associations are eligible (but not required) to participate.

BACKGROUND

National attention was focused on health system errors after the 1999 Institute of Medicine report, *To Err is Human*. In response, a workgroup in Oregon was formed to consider ways to improve the delivery of health care in the state. The new law reflects a recommendation by the workgroup, establishing a nonpunitive procedure to report and analyze errors in health care. This procedure will hopefully allow healthcare industry participants to be more willing to come forward with errors and to seek recommendations on how they can improve.

HB2165 Define Reportable Conduct by Medical Profession

Requires certain organizations to report information concerning conduct of licensees to BME. Requires healthcare facilities to report official action, incident or event taken against licensees. Requires licensees to self-report certain conduct to BME. Provides immunity from liability for good-faith report. Directs BME to determine by rule what constitutes medical incompetence, unprofessional conduct and licensee impairment.

BACKGROUND

Currently, healthcare facilities, the Oregon Medical Association, Osteopathic Physicians and Surgeons of Oregon Inc., and the Oregon Podiatric Medical Association are required to report to BME any incidents of medical incompetence, unprofessional or dishonorable conduct, physician impairment and a licensee's voluntary resignation or limitation of staff privileges. The new law defines official action and incidents that require reports to BME within a 10-day timeline.

SB434 Encourage Pain Management

Requires certain health professional regulatory boards to encourage multidisciplinary pain management services.

BACKGROUND

Intractable pain is a pain state in which the cause of the pain cannot be removed or otherwise treated and for which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain has been found after reasonable efforts. SB671, approved in 1995, allows physicians to administer or authorize administration of controlled substances to patients experiencing intractable pain, as warranted in the physician's professional judgment. SB1071, approved in 1997, established the Pain and Symptom Management Task Force, which studied and made recommendations on: problems in obtaining relief from pain faced by Oregonians with chronic illness, terminal illness or conditions causing chronic pain; the nature of pain and symptom management practices; resources and remedies available for pain and symptom management; and any policy changes related to pain and symptom management. SB885, approved in 2001, established the 17-member Pain Management Commission within DHS. The commission is charged with the responsibility of: developing a pain-management practice program for providers; pain management recommendations; ways to improve pain management services through research, policy analysis and model projects; and represent the concerns of patients in Oregon on issues of pain management to the governor and Legislative Assembly. The new law requires specific health professional regulatory boards to encourage multidisciplinary pain-management services.

SB436 Facilitate Pain Management

Eliminates requirement for evaluation by physician specialist prior to treatment. Exempts physician from discipline for treating patient with controlled substances for duration of intractable pain. Requires certain records and notices to be in form provided and approved by Board of Medical Examiners.

BACKGROUND

Intractable pain is the only health condition that requires a second medical opinion, and there may be difficulty in finding another physician to give a second opinion. Under existing laws, physicians may also be reluctant to prescribe chronic pain medication. The new law removes the requirement that a patient seek a second opinion on an intractable-pain diagnosis, and clarifies that a physician will not be subject to disciplinary action from BME for prescribing medication with the goal of controlling a patient's pain for the duration of the pain.

SB401 Follow-up Newborn Hearing Screening

Requires DHS to implement newborn hearing screening test registry, tracking, and recall system. Exempts providers of newborn hearing screening tests from liability for providing required information. Directs the director of DHS to appoint a Newborn Hearing Advisory Committee.

BACKGROUND

Hearing loss is one of the most common congenital disorders, affecting 3 of 1,000 babies – approximately 140 babies each year in Oregon. Early identification of hearing loss and appropriate intervention before 6 months of age is essential to

optimize language development. Appropriate auditory stimulation during this time period is necessary for optimal development. HB3246, approved by the 1999 legislature, requires all hospitals and birthing centers with more than 200 births per year to screen newborns for hearing loss. The hospital screening programs and early intervention facilities are required to report total numbers of children screened, total numbers of children with abnormal screens and total number and average age of children enrolled in early intervention. Forty-four hospitals and several smaller facilities have implemented screening programs, and 91.5% of all Oregon babies are being screened soon after birth for hearing loss. The new law authorizes DHS to develop and implement a tracking and follow-up system relating to newborn hearing screening that allows for children with hearing loss to be identified as early as possible, and connect with medical and educational intervention and support services in their communities.

HB2191 Enhance Administration for Quality Child Care

Includes the Employment Department in development of a statewide early childhood system. Adds the director of the Employment Department, or at the governor's direction, the chairperson of the Commission for Child Care, to the State Commission on Children and Families. Requires involvement of local childcare resource and referral agencies in work of local commissions on children and families. Expands definition of "child" for purposes of certifying and registering childcare facilities, to include certain special needs and disabled children under 18 years of age. Excludes certain facilities and parent cooperatives from requirements for childcare facilities.

BACKGROUND

The 2001 legislature enacted HB3659, directing the Commission for Child Care to create an interim Task Force on Financing Quality Child Care, with responsibility to:

1. Gather information about the availability of quality child care.
2. Develop recommendations about how quality child care should fit within the voluntary statewide early childhood system created under ORS 417.748.
3. Develop recommendations to provide financial support for quality child care.
4. Develop recommendations on long-term planning to provide quality child care statewide as driven by local community needs.

The new law implements several of the recommendations of the task force.

PUBLIC SAFETY**HB2251 Improve Preparedness for Public Health Crisis**

Authorizes the governor to proclaim a state of impending public health crisis under certain circumstances. Allows the governor to seek assistance under Emergency Management Assistance Compact during a state of impending public health crisis. Authorizes DHS to take certain actions during a state of impending public health crisis. Authorizes use of immunization

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registry and tracking and recall system as vaccination management and tracking system to assist in preventing spread of certain diseases.

BACKGROUND

Current Oregon statute describes the state's emergency management system and the process for gubernatorial declaration of a State of Emergency. The governor has broad authority following such proclamation. However, there may be public health emergencies or pending emergencies that do not require a disaster declaration, for which response efforts may be improved. The governor has the responsibility to declare a public health alert. The Oregon Department of Justice analyzed the state's emergency powers authority, and the Governor's Security Council examined approximately 15 potential issues relating to public health. The Health Preparedness Advisory Committee (HPAC) reviewed the security council list and identified four issues that require legislative solutions: (a) public health alert, (b) liability and emergency licensing, (c) isolation (quarantine), and (d) access to medical records.

The new law responds to the recommendation relating to public health alert. The law provides the governor with the ability to implement public health measures to address a public health emergency or imminent emergency.

HB2425 Limit Disclosure of Public Records on Security

Limits disclosure of public records pertaining to operational plans made in connection with public safety to include records of a public body, as well as the records of law enforcement agencies. Disclosure would be prohibited if disclosure would (a) endanger individual life or physical safety, or (b) jeopardize law enforcement. Permits disclosure if the public interest requires disclosure. Allows a public body to hold an executive session on discussions of security regarding:

- Nuclear-powered thermal power plants,
- Transportation of radioactive material to or from nuclear power plants,
- Generation, storage or conveyance of electricity, gas in liquefied or gaseous form, hazardous substances as defined in ORS 453.005, petroleum products, sewage, water, telecommunications systems, and data transmissions.

BACKGROUND

After the tragic events of Sept 11, 2001, the Governor's Public Safety Coordinating Council asked the Dept of Justice to analyze Oregon's laws to determine where they were deficient in light of potential terrorist attacks. One area identified was the potential public disclosure – through Oregon's public disclosure laws – of plans made in connection with threats against public safety. For example, local government may ask that the local gas company file its plans for preventing sabotage of the gas system. The gas company may have concerns that by filing its plans, they are now public and then could be used for planning sabotage. Discussions of the new law involved balancing public safety with the public's right to know.

HB3156 Standardize Food Safety

Directs the DHS to establish a foodborne illness prevention program. Requires an intergovernmental agreement between local public health authorities and DHS. Specifies terms of the agreement. Sets license fees related to dispensing food. Terminates county health department authority in matters involving dispensing of food.

BACKGROUND

The Food Protection Program is part of the Office of Environmental Health Services and Consultation. Oregon has over 9,000 restaurants and nearly 17,000 total food-service facilities. Licensing, inspection and enforcement services are provided through the DHS Field Services Unit, or by local health departments. The goal is to work in partnership with local health departments, the food service industry, and the public to reduce or eliminate known causes of foodborne illness.

HB2080 Ease Limitation on Product Liability

Provides that the statute of limitations for a product liability civil action begins to run when the plaintiff first discovered or, in exercise of reasonable care, should have discovered that the death, injury or other damage complained of exists and was the result of a product defect.

BACKGROUND

Under current Oregon law, the statute of limitations on product liability starts to run on the date of death, injury or other damage. In many cases, however, the plaintiff may be unaware of the death, injury or other damage or that it is related to a product defect until long after it occurs. This is generally because either the product defect and/or the damages themselves are hidden, not obvious or otherwise not discoverable despite plaintiff's exercise of reasonable care. The new law states that the statute of limitations in a product liability case does not begin to run until the plaintiff discovered or should have discovered that the death, injury or other damage complained of exists and was the result of a product defect. The new law clarifies the statute of limitations for wrongful death cases resulting from alleged product defects, and provides a limited exception for cases that were previously dismissed by the courts under the case entitled, *Gladhart v. Oregon Vineyard Supply Co.*, 332 Or 226 (2001).

SB795 Require Helmets for Skateboards and Scooters

Requires person under 16 to wear protective headgear when skateboarding, riding a scooter, or using in-line skates. Maximum fine of \$25 for violation.

BACKGROUND

Current law requires a bicycle rider or passenger under age 16 to wear a helmet. Current law makes no provision for riders of any age of nonmotorized scooters, skates, or skateboards. Five other states, including California, have a mandatory helmet law for minors on scooters, skates, or skateboards. Proponents assert that, extrapolating from studies of bicycle helmet use, approximately 85% of head injuries of skaters, scooter riders, and skateboarders could be prevented by the use of helmets.

HB2449 Increase Penalties for Elder Abuse

Increases civil penalties for abuse of elders or incapacitated persons to three times the amount of actual economic and non-economic damages.

BACKGROUND

Proponents of this measure state that abuse of elders or incapacitated persons is an ever-increasing problem, especially with the retirement of the so-called “baby boomers” and the rising number of persons residing in some form of assisted-living facility. The new law aims to discourage abuse of such individuals by increasing the civil penalties.

SB37 Add Option to Shelter Vulnerable Persons from Abuse

Modifies the Elderly and Disabled Person Abuse Prevention Act to allow a guardian or guardian *ad litem* to file a petition on behalf of elderly or disabled person.

BACKGROUND

The Elder Abuse Prevention Act, approved by the 1995 legislature, addresses protective proceedings and abuse of the elderly, disabled or incapacitated. To better address elderly and disabled persons’ needs in obtaining restraining orders, the new law modifies the act to accommodate situations when elderly and disabled persons are victims of abuse, but it is not possible for the elderly or disabled victim to petition for him/herself.

Other laws in 2003, not listed here, made additional administrative adjustments to favor this class of persons (SB17, SB18, SB118, SB470).

PRIVACY**SB618 Genetic Privacy in Research**

Modifies Oregon laws relating to genetic privacy. Clarifies the requirements for genetic research.

BACKGROUND

There is an increasing collection and use of genetic samples in various types of research. In 2001, the legislature appointed an Advisory Committee on Genetic Privacy to study the use and disclosure of genetic information and make any needed recommendations for changes to Oregon law. The new law is the result of the committee’s year-long study. The new law undertakes the following steps to clarify genetic privacy.

1. Clarifies the definition of anonymous genetic research and specifies how the notification requirement for such research is satisfied.
2. Enacts new standards regulating coded research.
3. Permits the use of anonymous or coded research of genetic materials obtained without notification or consent before the effective date of the measure.
4. Adds a transitional clause assuring that genetic research approved by an institutional review board is governed by the law in effect when the IRB approves the study.
5. Adds a membership category to the Advisory Committee on Genetic Privacy and Research to represent the public; and
6. Eliminates any federal preemption problems with Oregon’s genetic privacy law and conforms Oregon law’s terminology to federal Health Insurance Portability and Accountability Act.

OHREC offers research positions for full-time students in health policy

Oregon Health Research & Evaluation Collaborative recently posted fall openings for several research positions for students to work with staff of the office for Oregon Health Policy and Research. The positions allow Oregon medical and graduate Public Health and Public Administration students the opportunity to cultivate professional experience and practical skills valuable to health services research. Only full-time students qualify. Compensation for all positions is \$12 per hour.

Legislative Survey

Improve dissemination of health services data, information and research results to Oregon’s policymakers. Connect with Oregon legislators to assess their health policy data and information needs. Develop a survey instrument, implement the survey and participate in analysis. Approx. 10-12 hours per week, flexible.

Research Briefs and OHP Library

Produce research briefs on the latest research findings relevant to local health service researchers, concerned Oregonians and Oregon policy makers. Work on OHPR’s Oregon Health Plan Evaluation library. Approx. 8-10 hours per week, flexible.

Data Resource Directory

Identify active public and private databases related to health services research. Build upon Access database to catalog databases currently collected at OHPR. Network with state agencies to identify additional data collected, the database administrator(s) and proprietary rules/regulations for data sharing. Meet with staff to identify important data elements to track for OHPR research purposes. Approx. 8-10 hours per week, flexible.

Cohort Research Assistant

Analyze survey research results. Exposure to research regarding local access to health care for low-income Oregonians. Work independently under tight deadlines. Use SPSS to clean, analyze and create reports from survey data; Excel and Word to summarize data, and create graphs and charts; PowerPoint to create presentations. Approx. 10 hours per week, flexible.

Additional opportunities for professional development and organizational experience are also available for students. For more information, contact Lisa Krois MPH at 503-731-3005 x354 or lisa.krois@state.or.us

For the cohort research assistant position, contact Matt Carlson at 503-725-9554 or at carlsonm@pdx.edu

Learn about the ways you can make a difference in the public health of the nation, with a new handbook from Partnership for Public Service.

Red, White and Blue Health Jobs: Using Your Health Sciences skills to Work for America

Contains a sampling of jobs, internships, fellowships and scholarships; facts on federal agencies in health, and health careers in government; profiles of young public servants making a difference, and more.

For more information, visit www.calltoserve.org or contact Shari Aviva Katz at 202-775-2748 or skatz@ourpublicservice.org

(Book is not yet posted on the website)

Students in public health need mentors

Brief from APHA Executive Director
Georges Benjamin

To enhance leadership capacity for public health, the American Public Health Associations (APHA) sponsors the National Mentoring Program (NMP) – now in its fourth year of operation – to cultivate the leadership skills of students. Since the program's inception, the number of students who wish to participate has increased exponentially. Unfortunately, the number of mentors participating in this program has not matched the increasing demand.

We request the assistance of all APHA members to step forward and serve as an NMP mentor. Registering to be a mentor is an effective and greatly needed service. Registration is open year round, and can be accessed at <http://www.phsc.org> or <http://www.apha.org/ppp/mentoring>

NMP committee members match registrants continuously throughout the year. Matched participants are notified as soon as an appropriate match is made and are invited to participate in the program for one calendar year. For more information beyond the websites listed above, feel free to contact NMP co-chairs, Cynthia Summers and Mary Elizabeth O'Neil, at mentoring1@phsc.org or mentoring2@phsc.org

Nominee for OPHA board steps forward

Election of a new OPHA president is set for early October. No complete list of candidates arrived at The Probe, but we did receive one bio, which we pass along (with some reservation), noticing that others are in the race.

Kimberly Nemeth currently works for Virginia Garcia Memorial Health Center in Cornelius Oregon, a federally qualified health center that aims to provide high-quality comprehensive and culturally appropriate primary health care to the communities of Washington and Yamhill counties. As health services director, Ms. Nemeth is responsible for managing health education and outreach. Both Virginia Garcia Memorial Health Center and Ms. Nemeth place a special emphasis on working with migrant and seasonal farm workers as well as others experiencing barriers to health services.

Prior to her current management position, Ms. Nemeth spent 2 1/2 years working in sanitation, and health education and promotion as a PeaceCorp volunteer in Bolivia. Earlier, Ms. Nemeth worked for health and social service agencies committed to serving underserved populations for over 10 years. She also actively volunteered with the OPHA Community Health Worker Committee as well as the American Diabetes Association's Cultural Diversity Committee.

If elected, Ms. Nemeth's experiences, knowledge and passion for public health – with a focus on culturally competent health services for all – will help further OPHA in pursuing our mission to *protect and promote the health of all Oregon residents by educating and supporting public health workers and by advocating for just and equitable health policies.*

Help needed for adolescent risky behavior

OPHA is interested in starting a new section on adolescent risky behavior, and you are invited to become a charter member. The bylaws state a minimum of 10 members must be willing to join the new section for the board of directors to consider the petition.

The purpose of the new section is to advocate for policies that foster the healthy development of adolescents in Oregon. According to initial proposals, OPHA representatives will develop projects, distribute information, and testify on the public health of adolescents.

If you are interested in becoming a member of the proposed Adolescent Risky Behavior Issues section, please reply to: katie.riley@attbi.com

If you are not already a current OPHA member, an application can be found at www.oregonpublichealth.org or on the back page of The Probe. Indicate your interest in issues of adolescent risky behavior by writing "ARBI" on the application.

For more information, you may contact Katie Riley at 503-494-2556 (W) or 503-640-8689 (H).

Report shows tyranny threatens role of science

A new publication in August, *Politics and Science in the Bush Administration*, composed by congressional staff for Rep. Henry A. Waxman, provides an excellent reference for the abuse of science by Bush and company. The problem was documented in a report by congressional staff last December, with the memorable title, *Weird Science*. The current report expands and categorizes the examples of abuse, showing how the administration is (a) manipulating scientific advisory committees, (b) distorting and suppressing scientific information, and (c)

interfering with scientific research.

The current abuses are a major concern not only for their immediate consequences, but also for the future of health policy. We plainly need government involvement in the healthcare system, and we must rely on a sense of responsibility and trust to secure a social contract that the public will accept.

Both reports are available online at: www.house.gov/reform/min/politicsandscience/ — and — <http://resourcescommittee.house.gov/resources/democrats/hot2002/weirdscience.pdf>

Oregon Public Health Association (OPHA) 2003 ANNUAL MEETING & CONFERENCE

Oregon in Action: 0 Health Disparities, 100% Access – Part 2

at the Columbia River DoubleTree in Portland
November 3-4

Conference Registration Information

Hotel accommodations: Call the Columbia River DoubleTree at **1-800-643-7611**

Registration for the conference is limited. On-site registration will be accepted only if space permits

Early registration fees (received by Sept 20): \$200 for members, \$250 for nonmembers

Regular registration fees (after Sept 20): \$250 for members, \$300 for nonmembers

On-site registration (day of the conference): \$300 for members, \$350 for nonmembers

CME request: \$50 plus registration fee(s) listed above

The Awards Banquet is included in the conference fee
Additional tickets cost \$45 per person or \$325 for a table of eight

Join OPHA: <http://www.oregonpublichealth.org/> (or see back page of *The Probe*)

Register by phone **503-731-6633** (with Visa or MasterCard)
or by fax 503-731-6632 (payment by check requires registration form)

For more information contact Teresa Sielsch at **503-731-6625** or email tsielsch@pcc.edu

The event planner for the OPHA conference is
Portland Community College & Institute for Health Professionals
CPWTC, #208
PO Box 19000
Portland OR 97280-0880
Attention: Teresa Sielsch

Scholarships: A limited number of scholarships may be available.
Please contact **Kimberly Nemeth** at **503-359-8513**



SUPPORT OPPORTUNITIES

We invite you to join us in supporting the OPHA conference. We welcome and encourage participation at any level.

A sponsorship **Donation** entitles you to recognition at the Awards Dinner and your name in the OPHA "day-of" program. Donations over \$700 will include an exhibit booth.

Reserve an **Exhibit Booth** (approx. 6 feet)

Private not profit \$150 Government \$200 For Profit \$400

Includes refreshments and lunch for one exhibitor both days. You may purchase additional 2-day meal tickets for \$45.

Place an Ad in the conference "day-of" program (*included in participants' registration packet*)
1/8 page \$35 1/4 page \$50 1/2 page \$100 Full page \$200

IMPORTANT: Please email your ad to tsielsch@pcc.edu no later than October 7, 2003.

Supply Packet Materials (Inserted in 250 registration packets) \$75

We need your time & energy too! **Volunteer** by calling Kimberly Nemeth at **503-359-8513**

Crisis in Oregon health buried in paper shuffle

The report in August by Robert Lowe MD and associates, presenting emergency department (ED) data from Oregon Health and Science University, showed an upward trend in emergency treatment for uninsured patients, with a corresponding downward trend in treatment for patients on the Oregon Health Plan. The authors of the report interpreted the results cautiously, but presented little more than what many predicted as an inevitable result from state budget cuts earlier this year that left many needy Oregonians without coverage for medically necessary treatments.

The preliminary report, officially presented at the September public meeting of Oregon Health Research & Evaluation Collaborative, designed quantitative charts of the trends, told qualitative stories of tragic individual cases, and concluded: "The rise in ED visits among the uninsured may be due to OHP cutbacks, but it may also be due to loss of commercial insurance or to decreased availability of non-ED 'safety net' clinics serving uninsured patients. Whatever the cause of increased ED visits among uninsured patients, this finding points to a worrisome reduction in access to medical care for uninsured Oregonians."

Meanwhile, the legislature managed to restore funding for certain critical features of the standard benefit package of the Oregon Health Plan, and for services to the "medically needy," but

only on paper. To pay for the restoration of outpatient mental health and chemical dependency services, among other ambitions, Oregon is asking for help from the feds, specifically by submitting a new waiver application to move the line on the OHP priority list from line 549 to line 519. As the waiver request admits, this means a person needs to first become really sick ("worsen") to be eligible for medical attention.

Moving the line means dropping coverage for a "foreign body in uterus" (520), for "osteoarthritis and allied disorders" (522), and for impacted teeth, abscesses and cysts, urinary incontinence, fecal incontinence, benign neoplasm of kidney and other urinary organs, chronic

anal fissure, and so on. Actually, these conditions sound decent compared to earlier fears that cuts would move the line so far that it would omit coverage for treatable cancers.

The waiver application was sent to the federal Department of Health and Human Services on September 5, with the request for an expedited review and an answer by January 1, 2004. The plans on paper for OHP, passed by the legislature, will evaporate if the feds do not grant the request.

Of more concern is the vast crisis left completely unattended. By OHP standards, one needs to be poor or pregnant to be a citizen in the state. As one woman asked, "Why should I need to get pregnant to be eligible for medical care?"

According to a household survey by Oregon Health Policy and Research in 2002, about 90 percent (380,000 people) of the uninsured in Oregon have incomes above the federal poverty level. Of all the "emergency" legislation passed this year in Salem, none came close to dealing with this true emergency facing one of every seven people everywhere around us.

THE
Probe

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