

OREGON HEALTH FUND BOARD

January 15, 2008
11:30am (Digitally Recorded)

Port of Portland, Commission Room
Portland, OR

MEMBERS PRESENT: William Thorndike, Chair
Jonathan Ater, Co-Vice Chair
Eileen Brady, Co-Vice Chair
Thomas Chamberlain
Charles Hofmann, M.D.
Raymond Miao
Marcus Mundy

OTHERS PRESENT: Ellen Lowe, Chair, Eligibility and Enrollment Committee
Ella Booth, Chair, Health Equities Committee
Susan King, Chair, of the Benefits Committee
William Smith, OHPR

STAFF PRESENT: Barney Speight, Executive Director, OHFB
Jeanene Smith, M.D., Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Research Analyst
Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Nora Leibowitz, Acting Director, Health Policy Commission
Darren Coffman, Director, Health Services Commission
Nathan Hierlmaier, Policy Analyst
Brandon Repp, Research Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst

ISSUES HEARD:

- Call to Order/Introductions/Review and Approve Meeting Agenda and Meeting Minutes with Working Lunch
- Oregon Health 101
- Community Mental Health Overview
- Introduction to Community Health Clinics and Other Safety Net Providers
- Oregon's Community Collaborative
- Invited Testimony and Public Testimony
- Other Business and Discussion

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

(Digitally Recorded)

Chair Thorndike I. **Call to Order/Introductions/Review and Approve Meeting Agenda and Meeting Minutes with Working Lunch.**

- There was a quorum. Board, Committee Members and staff introduced themselves. October 2 meeting minutes were reviewed.

Motion to approve the October 2, 2007, meeting minutes was seconded.
Motion passed unanimously.

The following individuals were submitted for approval as Committee Members:

Eligibility and Enrollment:

- Felisa Hagins, SEIU Local 49, Portland
- Noelle Lyda, Ed Clark Insurance Inc., Salem
- Eric Metcalf, Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians, Coos Bay
- John Mullin, Oregon Law Center, Portland
- Susan Rasmussen, Kaiser Permanente Northwest, Portland

Finance Committee:

- Fred Bremner, DMD, Portland
- Judy Mushcamp – Confederated Tribes of Siletz

Federal Laws:

- Cheryle Kennedy, Confederated Tribes of Grand Ronde

Health Equities:

- Holden Leung, Executive Director, Asian Health and Service Center, Portland
- Joe Finkbonner, Executive Director, NW Portland Indian Health Board, Portland
- Laurie Powers, PhD, MSW, Professor, Portland State University, Portland
- Melinda Muller, Physician, Legacy Health Systems, Portland

Motion to approve the appointments to the assigned committees was seconded. **Motion passed unanimously.**

**Jeanene Smith,
M.D., OHP**

**Jim Edge, DHS,
Division of
Medical
Assistance
(DMAP)**

**Kelly Harms,
Office of Private
Health
Partnerships/
Family Health
Insurance
Assistance
Programs
(FHIAP)**

II. Oregon Health Plan 101 (see Power Point Presentation)

Jeanene Smith, M.D., provided information on the historical backdrop of the Oregon Health Plan (OHP); the prioritized list of Health Services maintained by Health Services Commission (HSC) and criteria for ranking services; and OHP 2.

Jim Edge, DHS, Division of Medical Assistance Programs (DMAP).

- Reduction of Oregonians in Standard Program due to Federal action.
- Approval to expand Standard program to 24,000.
- Ellen Lowe, Chair, Eligibility and Enrollment Committee, urged involvement in getting eligible individuals to sign up for expansion.
- Dialogue on per member costs for an individual in Plus package, child in SCHIP program and adults in Standard program, and capitated rates as calculated by independent actuary.
- Administrative fees, loss of provider tax and tax strategies discussed.
- Maps of OHP enrollments in Fully Capitated Health Plans (FCHP), Physician Care Organizations (PC), Dental Care Organizations (DCOs), and Mental Health Organizations (MHOs).
- Annual calculation of federal matching rates.
- Discussion on SCHIP allotment amounts carried forward and potentially reaching a ceiling in three years.
- Oregon operating under waivers due to demonstration projects which requires budget neutrality.
- Budget neutrality trend line and dollars available. Revenue resources for Medical Assistance Programs.

Kelly Harms, Policy and Legislative Liason for the Office of Private Health Partnerships, provided an overview of Family Health Insurance Assistance Program (FHIAP) (see Exhibit Materials 3).

- Eligibility, subsidy levels, and application/enrollment process.
- FHIAP Snapshot of Program Activity.
- FHIAP targets low-income, uninsured populations. Children in family must be covered before an adult can be covered. Designed to bridge people from a Medicaid program into private coverage.
- Program has a limited budget and a reservation list.
- HB 2519 passage in 2001, OHPHII waiver bill, resulting in program expansion.
- Is it member dependent or intermediary dependent? There is an agent referral program. Dialogue regarding training provided and outreach efforts to help people move into the best plan for them.
- On the Geographic Trends page of handout, the number in the "Other" category for accessing program by region is incorrect. Kelly will clarify and get the Board that information.
- Barney Speight will obtain information on how these subsidies compare with subsidies in other states.
- Discussion on reasons for failing to make premium payments.
- Individual program is more efficient due to electronic format while the group program is more labor intensive and requires monitoring. This is an important element to look at when considering expansion programs.
- Role of employers in FHIAP group market.

Gina Nikkel,
Association of
Community Mental
Health Programs
(AOCMHP)

Mitch Anderson,
Community
Mental Health/FQHC,
Benton County

Karl Brimmer,
Community
Mental Health
Program/MHO,
Multnomah County

Rita Sullivan,
ONTRACK, Addictions
Contract with
Jackson County

IV. Community Mental Health Overview

Gina Nikkel, Executive Director of the Association of Community Mental Health Programs (AOCMHP) (provided handout)

- Background of the Association, community MHOs and programs.
- Wasco/Sherman/Gilliam/Hood River counties constitute one County Mental Health Program (CMHP) and Morrow/Wheeler are one CMHP.
- MHO's (prepaid, capitated) and community mental health programs.
- Broad level overview.
- One-half of the counties contract out with private nonprofit organizations resulting in a wide variety of models.
- Community Mental Health programs administrative fees is about 2%, 0% for addictions, and, depending on the year, 1½ to 3% for developmental disabilities management while CMHOs get about 8% for administrative overhead. A 2007 survey showed that all MHO's put about half of that back into programs.
- Study by the Oregon Association of Counties and the wide variability on how much counties fund.
- Statutes, rules and service structures.
- In reference to a pie chart on county discretionary funds, the Board asked for a total amount? Gina Nikkel will forward that information.
- Community mental health as part of primary care and medical homes.
- Draft document of the AOCMHP and Public Health recommendations on primary care home which includes primary care homes accommodating various settings and patient characteristics, including severe and persistent mental illness; and supporting a multi-disciplinary team.

Mitch Anderson, Mental Health Addictions and Developmental Disabilities Service Director for Benton County and OHFB Delivery Systems Committee member.

- The role and responsibility of local Mental Health Authorities through statutes and counties.
- The current focus is on the crisis end due to heavy case loads.
- Are these things that can be handed back to state if counties absolutely cannot perform them? Yes, counties may decline, but are reluctant to do that as it is an all or nothing deal.
- Services are aimed at safety net or low income individuals with less focus on preventive services.
- Community mental health services fall into two areas: mental health and addiction services that look like primary care services model and, secondly, a social service arena between mental health and addiction systems that provides connections with out-of-office community supports, e.g. housing.
- Dialogue on the need for a partnership between medical and social service structure. How do we put those two things together?
- Programs built on evidenced based results, but involve some complex partnerships across multiple agencies.
- Putting services under the scope of the Federally Qualified Health Center (FQHC). Provides new funding source and allows for experiments with holistic care that identifies strengths and weaknesses.

Karl Brimmer, Community Mental Health Program/MHO, Multnomah County

- 90% of Multnomah county mental health services consists of nonprofit organizations and one profit and 10% provided through the County.
- Treatment services and addressing housing and employment needs.
- Multnomah's current funding level is 16 millions dollars.
- HealthCare Oregon and Multnomah County working with providers.
- Dialogue regarding the Alaska model demonstrating importance of looking at the whole person.
- Services provided through Central City Concern currently. Pilot project of nearly one year with all services in one location. Serves part of the mental health population but does not serve the severe and persistent mentally ill.
- A cost offset study conducted by the Washington state showed that when a person receives medication and/or minimal outpatient care, there is a savings in medical costs across the board including emergency room services. Offered to provide the Board with a summary of the report.

Rita Sullivan, ONTRACK, Additions Contractor with Jackson County

- Treatment works.
- Discussed evidenced based practices, collaboratives and helping people become system independent.
- Breadth of services in addiction treatment may include housing help and instruction on how to be a good tenant.
- Treats people that have complications of poverty, criminality, etc.
- All members of the family participate as social support predicts the success of the client
- Looks at kids who suffer parental interruption and the affect on them.
- New model of foster parents includes involvement of the parents to curb the affects of the interruption.
- Housing with a Purpose involves the elderly as mentors which also assists elderly with independence.
- Help with employment and helping them to be good employees.

- *“There is a high cost of not adequately funding alcohol and drug treatment because it results in higher arrests, higher child welfare, higher foster care placements, emergency room, employment problems. .”*
- How do we identify who has a mental illness, how do they get into the system? A family member could call, through criminal behavior, or hospitalization. It is important to identify problems early.
- Responsiveness of post traumatic stress syndrome from war? There is a need but do not having the capacity.
- If we serve those at 100% to 150% of the FPL would that increase the numbers? Having a broader benefit would ultimately have better results and get more people into system.
- Joint letter by AOCMHP and Council of Local Health officials was presented to the Board and will be submitted to the Delivery Committee.
- Senators Jackie Winters and Margaret Carter are interested in the issue of returning vets and are working with General Caldwell.
- How does the seniors program work and how does this keep them out of the nursing home? Ratio will be two senior families to one returning recovery family. It keeps seniors young. Program idea is from Indiana. Seniors involved are not part of the mental health system.

Panel:
Craig Hostetler,
Oregon Primary
Care Association

Scott Ekbal,
Office of Rural
Health

Jackie Rose,
Oregon School-
Based Health Network

Tracy Gratto,
Coalition of
Community Health
Clinics

IV. The Healthcare Safety Net Panel (see Power Point Presentation)

Craig Hostetler, Executive Director, Oregon Primary Care Association (OPCA)

- Overview of Community Health Centers and Assn of Safety Net Clinics
- If it was fully funded what is the maximum number capacity? Outside-In turns out 25-30 people/day. Physical facilities capacity could expand 25-30%, after which would have to add facilities.

Scott Ekblad, Executive Director, Office of Rural Health, OHSU

- Isolated Rural Health Center Facilities (IRHCF).
- Core safety net – only source of care in community
- Rural Health Clinics, federally certified, located in underserved designations, provide primary care services, and a mid level practitioner 50% of time, and must be able to perform six basic lab services.
- Need access to better data – in order to be a Isolated Rural Health Facility would like to require to provide data to their office and offer a schedule of discounts.
- What is your total clients? Do not have number of people served as reporting is not required.

Jackie Rose, Nurse Practitioner, Oregon School-based Health Care Network (see Power Point presentation)

- Overview of the Oregon School-Based Health Care Network and barriers of children to health care.
- School-based health care (SBHC) is like a doctor’s office in the school.
- Helps decrease health disparities.
- Report on St. Helens’ Elementary school recently added a mental health therapist resulting in a 65% decline in discipline referrals.
- Funding challenges.
- Available on the DHS website: patient satisfaction survey (in DHS School-Based Health Center Annual Services report) and an SBHC cost modeling report by the State’s School-Based Health Center Office.
- A reimbursement study is currently contracted but not yet available.

- How many school-based centers are open year-round? There is a couple; this is something that is being explored.
- Did some of the funding come from universities? OHSU School of Nursing is the medical sponsor of the Beaverton Merlo Station center.
- How does this differ from the role of school nurses of the past? School nurse as liaison to the school, provides information. The school-based health center has a medical provider on site. Both are needed. (Referred to a pamphlet by State Health Division and Department of Education)
- How do schools go about setting up a school-based health clinic?
 - Different communities go about it different ways.
 - The Commission on Children and Families' survey of superintendents found that the single most important need was addressing health needs.
 - Washington County's collaborative efforts to develop a process for setting up a school-based clinic including writing grants.
- Health Centers at a school will accept other students throughout the school district, but there is a capacity issue.
- Involving the community is critical and flexibility on local control issues.

Tracy Gratto, Director, Coalition of Community Health Clinics, Multnomah County

- Community sponsored clinics and FOHCs in Multnomah County.
- Definition and identification of community sponsored clinics.
- In Multnomah County about 75% of funding is from local foundations and private donations.
- Do not have as much administrative overhead, but each model is unique.
- Volunteer contributions, faith-based contributions.
- Free Clinics Association.
- What are your recommendations for increasing access to health care without harming Community efforts? Partly, create a financial system allowing for some flexibility and building on models proven to work.
- Concern expressed about relying too heavily on volunteers.
- Barney Speight advised that the Safety Net Advisory Committee will report at the next Board meeting.

Oregon's Community Collaboratives (see Power Point Presentation)

**Panel:
Mike Bonetto,
Zoomcare**

Mike Bonetto, Central Oregon Health Care Collaborative, (COHCC) , Bend (see Power Point Presentation)

- Key elements of community collaboration learned from national models.
- What makes collaboratives work? Overview of eight critical activities. There are 600-700 collaboratives around the nation.

**Susan Stearns,
100% Access
Healthcare Initiative**

Susan Stearns, 100% Access Healthcare Initiative

- 2004 United Way Needs and Assets Survey revealed that the most pressing Lane county needs include access and affordability.
- There has been a dramatic rise in health care needs over past twenty years of the survey.
- 1 in 5 Lane county residents is uninsured compared to 1 in 6 in Portland.
- Coalition is made up of over 50 organizations, the CEO of every major health care organization is on the board, in addition to key business leaders, nonprofit executive directors, government leaders, and other community representatives.

**Tracy Gratto,
CCHS and Project
Access NOW**

- Starting with small discrete projects which is building trust and establishing relationships that will be needed to accomplish universal care.
- Completed a comprehensive analysis of the utilization of emergency department for 2005 and 2006. Data from 2007 is forthcoming and with its analysis will be able to develop three-year trend information.
- Prior to the 100% Access Health Care Initiative, the safety net clinics had never met together.
- Lane county safety net clinics include one FQHC, one Volunteers-in-Medicine Clinic (a national volunteer provider model), a network of school-based health centers, and the White Bird Clinic, a 30-year old collective providing care to homeless, mentally ill and other hard-to-reach populations. Recently added, Center for Community Counseling, a Volunteers-in-Medicine-like model.
- Creation of a laminated card listing complete scope of practices for the uninsured.
- During the initial year, the safety net organizations gathered information and was able to estimate that about 18,000 patients have been covered, about 1/3 of the Lane county uninsured population.
- United Way, Lane County, has been licensed by Stanford University to offer the chronic disease self-management program, a 6-week non-disease-specific model designed for a community, not health care, setting. Offered in both English and Spanish.

VI. Invited Testimony and Public Testimony

- **Tonya Stewart, MD, for the Palliative Care Physician's Roundtable**, presented testimony for the need to include "*. . . reimbursement to primary care providers to have conversations about goals of care or time spent reviewing and documenting the patient's desires regarding the Physician's Order for Life Sustaining Treatment (POLST).*" Written testimony provided.
 - Barney Speight requested contact information for future input.
- Testimony by Ellen Pinney will be deferred to the February meeting.

VII. Other Business and Discussion

- Next meeting is February 19 at Kaiser Town Hall in Portland.
- Two reports on the docket are 1) general update on Board and Committees and 2) overview of the exchange.
- February 19 will include an update from Safety Net Advisory Committee.
- Feedback from Board to Barney Speight revealed a desire for more discussion time at the meetings. He will be providing information on Committee updates.
- Discussion of legislative session format for progress reporting.
- Ellen Pinney joined Ellen Lowe in supporting obtaining eligible individuals to apply in February for expansion of Standard Health Plan.

Chair Thorndike VIII. Adjourn

The meeting was adjourned at approximately 5:05 p.m.

The next meeting for the OHFB is February 19, 2008, Kaiser Permanente Town Hall, Portland.

Submitted By:
Paula Hird

Reviewed By:

EXHIBIT SUMMARY

1. Health Fund Board Draft Meeting Minutes
2. Medicaid Fact Sheet
3. FHIAP Snapshot of Program Activity
4. Community-Created Health Care Solutions in Oregon
5. Map of 2007 Community Collaboratives by County
6. Lessons from Local Access Initiatives: Contributions and Challenges, Commonwealth Fund
7. Collaborative Problem Solving by States and Communities
8. Health Care Safety Net Definition
9. Map of Oregon Safety Net Clinics by County
10. FHIAP Brief
11. FHIAP Benchmark