



Tri County Communities in Charge

**Blue Ribbon Panel
on
Health Care Access;**

***Creating a Health Care
Safety Net Authority***

**The formal report of a tri-county board appointed panel
charged to address the issue of health care access regionally.**

**Final Report
Spring 2002**

**Submitted by:
Multnomah County Health Department
1120 SW 5th, 14th floor
Portland OR
97204**

CommunitiesInCharge
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Executive Summary

In January 2001, the tri-county Portland metropolitan area (Clackamas, Multnomah, and Washington) counties received a three-year implementation grant from the Robert Wood Johnson Foundation under the “Communities in Charge Initiative”. The purpose of the grant was to implement approaches for improving health care access for low-income uninsured community residents identified under a one year planning grant. Through a process involving a wide array of parties interested in health care, three key approaches were identified:

1. Improving enrollment in state-subsidized insurance programs (e.g., the Oregon Health Plan);
2. Enhancing systems for access to charitable care provided by hospitals; and
3. Establishing a health care “safety net authority” – an organization providing integration and planning services to align health care safety net providers into a *system* of care for low-income and uninsured people.

The focus of this report is the third approach: development of a regional Health Care Safety Net Authority (HCSNA).

In December 2001, the County Boards of Commissioners of Clackamas, Multnomah and Washington counties appointed a Blue Ribbon Panel to develop a policy level recommendation to improve health care access for the low income and uninsured through structured leadership and responsibility. The 38-member panel, made up of business people, advocates, consumers, health system representatives, health care providers and elected officials met five times over a six-month period to consider the issue in an open forum. The forum’s topics included; 1) The current state of health care access for the low income and vulnerable 2) Financing Care 3) Potential structures for assuring access regionally 4) The necessary work to be completed for improved access to care and 5) Final discussions and recommendations.

The culmination of the panel’s meetings was a recommendation that the issue be approached from a regional perspective and through a structure called a Health Care Safety Net Authority. This authority, lead by government through intergovernmental agreement, will allow for all concerned to impact the direction, finance and activities of the assurance process. This work will be carried out under a vision and goals which are as follows:

Vision:

Low income and uninsured people of the tri-county area get the basic health care they need, when they need it.

Goals:

1. Assure that the Health Care Safety Net is able to collect demographic and utilization data so that these data can ultimately be used for system planning and management.
2. Assure that adequate financial support is available to provide care for the low-income and uninsured.
3. Assure that the local health care safety net has adequate clinical capacity.
4. Assure that the health care safety net provides care that meets quality standards as described by Medicaid.

This monograph serves as the formal record for the work that was done by the panel and the staff who supported it.

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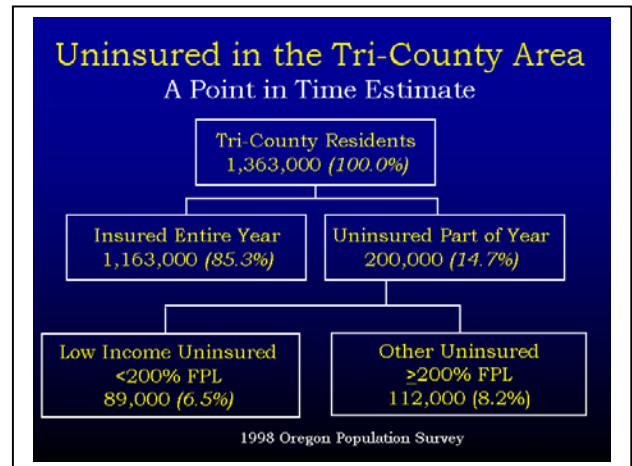
Introduction –

More than 400,000 Oregonians are without health insurance. This means one in seven are uninsured and lack access to care. We know that health insurance is important yet not everyone has it. In the Portland Metropolitan region, more than 140,000 are uninsured. Of those, 90,000 have incomes of less than 200% of the federal poverty level. This is equivalent to supporting a family of four at a job that pays about \$12.00 an hour.

Traditionally, health insurance has been a benefit offered by employers. However, over 70% of the uninsured in our community do work, yet a health insurance benefit is not available to them.

For the past ten years, Oregon has responded to the uninsured through The Oregon Health Plan (OHP). The OHP provides basic health insurance to our state's poorest residents, however, the family of four described above would not be financially eligible for OHP. As Oregon experiences rising unemployment and an economic downturn, the number of uninsured is increasing at the same time state funds available to support OHP are decreasing.

Even in the face of these challenges, local communities are taking action. This is the record of how the Portland Metropolitan Region took action, recommending that a Health Care Safety Net Authority (HCSNA) be established.



Preparing for High Level Consideration-

The initial planning process determined that establishing the HCSNA would require broad participation and support by government, health care providers, consumers and advocates. To implement this broad strategy and develop the best ideas for high-level consideration, a [core group of 17 health care and community experts](#) was convened to research various approaches, and identify those that could be effective locally.

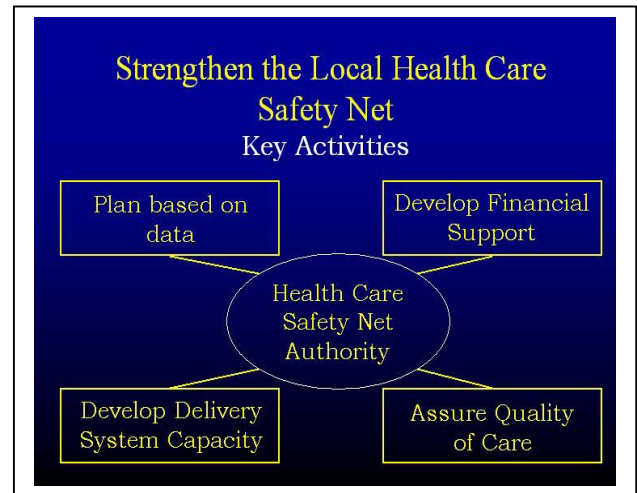
The core group researched national models for providing and financing health care access including those implemented in Hillsborough County Florida, Marion County Indiana, and Washington State through the Basic Health Plan. Additionally, the core group researched models for governance and financing used to assure necessary public services. The result of 14 months of work was a series of three potential models for governance, an actuarial assessment for determining the cost of care, and potential methods for financing care.

The work of the core group was presented to each county board and later to the community at a series of five meetings of the Blue Ribbon Panel on Health Care Access (described below).

What is a Safety Net Authority?

A Health Care Safety Net Authority is defined in this process as a governing body that is charged with assuring access to health care services delivered by safety net providers. The functions of a [Health Care Safety Authority](#) were identified by the

core group and adopted by the Blue Ribbon Panel. Additionally, the core group identified three structural models through which the HCSNA could operate. These included 1) [A non-profit organization](#), 2) an [Intergovernmental Agreement](#) (created under Oregon Revised Statutes - ORS 190), and 3) a [Health District](#) (created under ORS 440).



The Blue Ribbon Panel on Health Care Access-

The three County Boards of Commissioners appointed a [Blue Ribbon Panel](#) of 38 high level leaders for final discussion of the core group's research and synthesis. In preparation for the panel's work, the County Chairs sent a [letter of appointment](#) and a [charter](#) for the panel's work to each appointee inviting their participation. The charter outlined three guiding principles for the panel's work. These principles were: 1) access to quality, affordable health care improves the health of individuals and the community, 2) it is an appropriate role for local government to convene community representatives to address improving access to care, and 3) it is necessary to include representation from a wide range of stakeholders to address the problem of access effectively.

The chairs of the three counties charged the Blue Ribbon Panel to:

- **Consider the benefits of establishing a safety net authority** as a mechanism to assure access to high quality medical services for low-income and uninsured residents in the tri-county area.
- **Evaluate alternatives for the structure, governance and operations** of such an authority.
- **Make recommendations to the boards of commissioners of the three counties** regarding the establishment of a health care safety net authority, and its structure, governance and operations.

Specific desired outcomes of the process included: 1) developing the scope of authority of the safety net authority, 2) recommending an authority structure that is anticipated to best carry out the authority's mission in the short and long-term, and 3) identifying appropriate and sustainable funding strategies.

The panel was expected to provide its recommendations to the boards of county commissioners of the three counties. These boards would then decide whether and how to establish a health care safety net authority, and consider what governmental and non-governmental actions would be necessary and desirable to carry out their decision.

Panel Meetings and Process-

Five meetings were called to cover a variety of topics related to the development of the Health Care Safety Net Authority. Between each meeting, a member of the core group was made available to each of the panelists by assignment. The purpose of the staff assignment was to further prepare panelists for future meetings, to research and answer questions, and to generally support their participation in the work of the panel. This process proved effective

in managing the content of the meetings and assuring that panelists were able to fully participate in each meeting's topic within the allocated meeting time.

The themes for each of the five meetings were:

1. "Defining the Problem of Access and the Health Care Safety Net." In this meeting panelists were oriented to the most current information about the low-income and uninsured, how they get care, and the environmental factors that make accessing care problematic ([notes](#) are in Appendix 6).

2. "Defining the Possible Solutions through Regionalized Approaches." This meeting focused on the research of the core group and their assessment of other, national approaches to health care access ([notes](#) are in Appendix 7).

3. "Functions of a Health Care Safety Net Authority." The four areas for function were articulated and adopted as follows:

- Data- Assure that the Health Care Safety Net is able to collect demographic and utilization data so that this data can ultimately be used for system planning and management.
- Finance- Assure that adequate financial support is available to provide care for the low-income and uninsured.
- Capacity- Assure that the local health care safety net has adequate clinical capacity.
- Quality- Assure that the health care safety net provides care that meets quality standards as described by Medicaid.

The meetings outcomes and discussion are included in the [notes](#) and in Appendix 8).

4. "Outlining the Work and Possible Financing for a Health Care Safety Net Authority." This meeting shared work plan strategies with cost and potential outcome after implementation ([notes](#) are in Appendix 9).

5. "Clarification and Final Recommendations." The final meeting was dedicated to clarification and final deliberations for panelists. A final recommendation was made at this meeting ([notes](#) are in Appendix 10).

The Final Recommendation-

Though there was initial concern by panelists that they may not be prepared to make a recommendation after five meetings, this did not prove to be the case. In meeting number five, after much deliberation with regard to structuring the HCSNA, a recommendation emerged. The final recommendation was this:

“The Blue Ribbon Panel recommends that Clackamas, Multnomah, and Washington Counties enter into an intergovernmental agreement to establish a framework for a comprehensive approach for improving access to health care for low-income, uninsured people in the tri-county area.

Recognizing the necessity of working with diverse stakeholders in ways that ensure their genuine participation, this framework should include opportunities for partners to define their participation and specific commitments to achieving the vision and goals adopted by the Blue Ribbon Panel and delineated in the tri-county intergovernmental agreement.”

This recommendation was made with this vision and mission and these goals in mind generally.

Vision-

"Low-income and uninsured residents of the tri-county area get the basic health care they need when they need it."

Mission-

"To assure access to primary and preventive health care services for the low-income and uninsured of Clackamas, Multnomah, and Washington counties in an appropriate and cost-effective manner."

Goals-

1. **Data-** Assure that the health care safety net is able to collect demographic and utilization data, so that these data can ultimately be used for system planning.
2. **Finance-** Assure that adequate financial support is available to provide care for the low-income and uninsured.
3. **Capacity-** Assure that the local health care safety net has adequate clinical capacity - e.g., providers, other staff, facilities, equipment and supplies, etc.
4. **Quality-** Assure that the health care safety net provides care that meets quality standards as defined by Medicaid

Next Steps

The next steps for the implementation of the panel's recommendation remain with the boards and staff of each county. The process for implementing their recommendation will include:

- Developing and implementing the Intergovernmental Agreement with an organizing governance structure, financing and work plan objectives
- Inviting community constituents to define their role as a partner in the HCSNA and the identified functions
- Initiating task groups for each of the identified functional areas and their work plan objectives

Thank You-

A final note to thank those who participated in the panel process at all levels.

Specifically, thank you to the panelists who considered all options placed before them and had the courage to recommend one strategy ([complete panelists list](#)).

Thank you to the elected officials who sponsored the Blue Ribbon Panel's work;

- ❖ Commissioner Michael Jordan, Clackamas County
- ❖ Chair Diane Linn, Multnomah County
- ❖ Commissioner Dick Schouten, Washington County

Thank you to the core group for their dedication to finding a range of local solutions to the issue of access.

Thank you to the Robert Wood Johnson Foundation for catalyzing the process through a generous grant.

Finally, thank you to Arthur Himmelman, of Himmelman Consulting, for his professional facilitation and staff support.

Appendix 1 TCCIC Core Group

Members:

Alan Melnick (E-mail)	melnicka@ohsu.edu	503 494-0756
Carole Romm (E-mail)	rommc@careoregon.org	503 416-4100
Colleen Russell (E-mail)	colleen.m.russell@co.multnomah.or.us	503 988-3674
Ellen Pinney (E-mail)	scotchbrum@aol.com	503380-2488
Gary Oxman	gary.l.oxman@co.multnomah.or.us	503 988-3674
Gil Muñoz (E-mail)	gil@vgmhc.org	503359-8503
Joel Young (E-mail)	joel.young@state.or.us	503 731-4000
John Duke (E-mail)	jduke@outsidein.org	503 535-3804
Laura Brennan (E-mail)	laura.j.brennan@state.or.us	503 731-3005 x354
Laura Grandin Ph. D (E-mail)	laura_grandin@co.washington.or.us	503 846-5740
Marina Stansell (E-mail)	marinasta@co.clackamas.or.us	503 655-8478
Mary Lou Hennrich (E-mail)	hennrichm@careoregon.org	503 416-4100
Mary Stoneman (E-mail)	mstoneman@providence.org	503 215-4709
Michael Sorensen	michael.e.sorensen@co.multnomah.or.us	503 988-3674
Nancy Stevens Ph. D. (E-mail)	Nancy.H.Stevens@kp.org	503 813-3828
Susan Irwin (E-mail)	susan_irwin@co.washington.or.us	503 846-4402
Tom Fronk	tom.r.fronk@co.multnomah.or.us	503 988-3674

Appendix 2 List of Panelists

Tri-County Communities in Charge BRP Contact List- (Portland, Oregon)

	<i>Contact Name</i>	<i>Company Name</i>	<i>Title</i>	<i>Work Phone</i>	<i>Ext.</i>	<i>Fax Number</i>
<i>B</i>	Becker, Michael	Regence Blue Cross of Oregon	Vice President	(503) 220-6124		(503) 225-4882
<i>C</i>	Cochran, Beryl V.	Bureau of Primary Health Care	Service Area JD	(503) 615-2264		(206) 615-2500
	Cruz, Serena	Board of County Commissioners	Commissioner	(503) 988-5219		(503) 988-5440
<i>D</i>	Delf, Robert	Medical Society of Metropolitan Portland	Executive Director	(503) 222-9977		(503) 222-3164
	Drake, Rob	City of Beaverton	Mayor	(503) 526-2480		(503) 526-2571
	Duke, John	Outside In	Clinic Director	(503) 535-3804		(503) 223-6837
<i>E</i>						
<i>F</i>	Freeman, Lorey	Oregon Law Center	JD	(503) 224-2414	122	
<i>G</i>	Gaines Jackie Gilmore, D'Anne	Providence Milwauke Hospital Coalition of Health Purchasers	CEO Executive Director	(503) 513-8419 (503) 631-4416		
<i>H</i>	Hancock, Bill	Multnomah County Community Health Council	Consumer	(503) 493-1783		
	Henrich, Mary Lou	CareOregon	CEO	(503) 416-3630		(503) 416-3721
<i>J</i>						

<i>Contact Name</i>	<i>Company Name</i>	<i>Title</i>	<i>Work Phone</i>	<i>Ext.</i>	<i>Fax Number</i>
Jay, Roy	African American Chamber of Commerce	CEO	(503) 244-5794	44	(503) 293-2094
Jordan, Michael	Clackamas County Board	Chair	(503) 655-8581		(503) 650-8944
<i>K</i>					
Kast, Barry	State of Oregon, DHS	Health Cluster Director	(503) 945-9499		(503) 378-3796
King, Susan	Oregon Nurses Association	President	(503) 293-0011		
Kohler, Peter	Oregon Health & Sciences University	President	(503) 494-8252		
<i>L</i>					
Leung, Holden	Chinese Service Center	Executive Director	(503) 872-8822		(503) 872-8825
Linn, Diane	Board of County Commissioners	Chair	(503) 988-3308		(503) 988-3093
Lowe, Ellen		Consumer	(503) 294-0659		(503) 471-5902
<i>M</i>					
Mambourg, Floss	Portland Veterans Administration Hospital	Director of Medical Center Operations	(503) 220-8262		
McClave, Don	Portland Metropolitan Chamber of Commerce	President & CEO	(503) 552-5639		(503) 228-5126
McKeever, Corliss	African American Health Coalition	President and CEO	(503) 413-1850		(503) 413-1851
Melnick, Alan	Clackamas County Health & Human Services Division	Health Officer	(503) 494-0756		(503) 494-4496
Mercer, Jackie	Native American Rehabilitation Association	Executive Director	(503) 621-1069		
Munoz, Gil	Virginia Garcia Memorial Clinic	Executive Director	(503) 359-8503		
<i>P</i>					
Palmer, Scott	Willamette Falls Hospital	Assistant Administrator for External Affairs	(503) 650-6809		
Pinney, Ellen	Oregon Health Action Campaign	Executive Director	(503) 581-6830		(503) 337-7630
<i>R</i>					
Rice, Everette	Commission on Black Affairs	Executive Director	(503) 945-9008		
Russell, Tom	Adventist Health	Senior Vice President	(503) 251-6150	6162	(503) 261-6628

S

<i>Contact Name</i>	<i>Company Name</i>	<i>Title</i>	<i>Work Phone</i>	<i>Ext.</i>	<i>Fax Number</i>
Schouten, Dick	Washington County Board	Commissioner	(503) 846-8681		(503) 846-4545
Scott-Munroe, Donna	Neighborhood Health Clinics	Executive Director	(503) 280-1751		(503) 280-1752
Simantel, Marcus	Virginia Garcia Memorial Clinic	Board Member	(503) 219-9211		
Speight, Barney	Kaiser Permanente	Director of Public Policy & Government Relations	(503) 813-3952		(503) 813-3944
Sten, Erik (Bob Dursten)	City of Portland	Commissioner	(503) 823-3589		
Stenson, Dick V.	Tuality Healthcare	President and CEO	(503) 658-1562		(503) 681-1608



Boards of County Commissioners; Clackamas, Multnomah, Washington Counties

Michael Jordan, Chair
906 Main Street
Oregon City, OR 97045
(503) 655-8581
FAX: (503) 650-8944

Diane Linn, Chair
501 S.E. Hawthorne Blvd. Ste. 600
Portland, Oregon 97214
503/988-3308
Fax: 503/988-3093

Tom Brian, Chair
155 N. First Avenue, 300, MS 22
Hillsboro, OR 97124
503-846-8681
FAX: 503-846-4545

Tri County Communities in Charge

November 19, 2001

Dear Panelist,

We are writing to invite you to accept appointment as a member of the *Blue Ribbon Panel on the Health Care Safety Net*. The *Panel* will make recommendations to our county boards about establishing a "safety net authority" to create a *system* of health care for low-income uninsured people in the tri-county area.

You have been chosen because of your ability to create positive change in the community, and your skill and interest in health care. The *Blue Ribbon Panel* is part of our ongoing Tri-County Communities in Charge project to improve health care access. You can find more information in the enclosed documents.

We recognize that health care cannot be addressed solely at the local level. At the same time, there are important steps we can take, particularly if we work together to address the issue as a region. This is where your leadership will play an important role.

Your participation on the *Blue Ribbon Panel*" will involve attending a series of five (5) two-hour meetings with a sixth option if needed. Here, you, other community leaders, consumers and advocates will consider establishing a regional health care safety net authority - an organization to meld health care safety net providers into a *system* of care for low-income and uninsured people. Naturally, the discussion will address documented need, benefit to the greater community, financing, and organizing strategies.

The proposed meeting schedule, locations and topics are on page 2.

Meeting #1

December 5, 2001, 3:00-5:00PM @ World Forestry Center, 4033 SW Canyon (Near the Zoo)

- *Orientation to the Process*
- *Presentation on Community Need*
- *Benefits of an Organized Safety Net System*

Meeting #2

January 9, 2002, 3:00-5:00PM @ Crowne Plaza Hotel, 14811 SW Kruse Oaks Drive

- Considering Structural Alternatives 1: Functions of a Safety Net Authority

Meeting #3

February 6, 2002, 3:00-5:00PM @ Kingstadt Conference Center, 3800 SW Cedar hills BLVD.

- Considering Structural Alternatives 2: Powers of a Safety Net Authority

Meeting #4

March 6, 2002, 3:00-5:00PM @ Crowne Plaza Hotel, 14811 SW Kruse Oaks Drive

- Considering Structural Alternatives 3: Implementing a Safety Net Authority

Meeting #5

April 3, 2002, 3:00-5:00PM @ World Forestry Center, 4033 SW Canyon (Near the Zoo)

- Crafting Recommendations

Communities in Charge staff will be available to you for a pre-briefing and support throughout the *Panel* process.

Please confirm that you are willing to accept appointment by calling us through our lead staff person, Michael Sorensen at (503) 988-3674.

Thank you in advance for your contribution to this important public policy issue.

Sincerely,

Diane Linn
Multnomah County
Board Chair

Michael Jordan
Clackamas County
Board Chair

Dick Schouten
Washington County
Commissioner

Encl; Panel Charter
Communities in Charge Background
List of Panelists



Boards of County Commissioners; Clackamas, Multnomah, Washington Counties

Michael Jordan, Chair
906 Main Street
Oregon City, OR 97045
503/ 655-8581
FAX: 503/ 650-8944

Diane Linn, Chair
501 S.E. Hawthorne Blvd. Ste. 600
Portland, Oregon 97214
503/988-3308
Fax: 503/988-3093

Tom Brian, Chair
155 N. First Avenue, 300, MS 22
Hillsboro, OR 97124
503/846-8681
FAX: 503/846-4545

Tri County Communities in Charge

Charge for the Development of Recommendations for a

Health Care Safety Net Authority

Introduction - In January 2000, the tri-county Portland metropolitan area (Clackamas, Multnomah, and Washington counties) received a one-year Robert Wood Johnson Foundation “Communities in Charge” planning grant. The purpose of the grant was to identify approaches to improve health care access for low-income uninsured community residents. Through a process involving a wide array of parties interested in health care, three key approaches were identified:

1. Improving enrollment in state-subsidized insurance programs (e.g., the Oregon Health Plan)
2. Enhancing systems for access to charitable care provided by hospitals; and
3. Establishing a health care “safety net authority” – an organization to meld Health Care Safety Net providers into a *system* of care for low-income and uninsured people.

The initial planning process determined that establishing a Health Care Safety Net Authority would require wide participation and support by government, health care providers, consumers and advocates. The *Blue Ribbon Panel* is intended to provide a forum for:

- Examining alternatives for the structure, governance and operations of a Health Care Safety Net Authority; and
- Making recommendations to the County Boards of the three Metropolitan area counties about establishing such an authority.

The remainder of this document describes the charge of the *Blue Ribbon Panel*, and provides a brief summary of background information.

Charge of the *Blue Ribbon Panel*-

The chairs of the boards of county commissioners for Clackamas, Multnomah, and Washington counties have agreed to appoint a group of community leaders to a *Blue Ribbon Panel* to consider developing a safety net authority for the Portland Metropolitan area. The chairs have based their action on recognizing that 1) access to quality, affordable health care improves the health of individuals and the community, 2) it is an appropriate role for local government to convene community representatives to address improving access to care, and 3) it is necessary to include representation from a wide range of stakeholders to address the problem of access effectively.

The chairs of the three counties have charged the Blue Ribbon Panel to:

- **Consider the benefits of establishing a safety net authority** as a mechanism to assure access to high quality medical services for low-income and uninsured residents in the tri-county area.
- **Evaluate alternatives for the structure, governance and operations** of such an authority.
- **Make recommendations to the boards of commissioners of the three counties** regarding the establishment of a Health Care Safety Net Authority, and its structure, governance and operations.

Specific desired outcomes of the process include: 1) developing the scope of authority of the Health Care Safety Net Authority, 2) recommending an authority structure that is anticipated to best carry out the authority's mission in the short and long-term, and 3) identifying appropriate and sustainable funding strategies.

The panel will provide its recommendations to the boards of county commissioners of the three counties. These boards will then decide whether to establish a Health Care Safety Net Authority, and consider what governmental and non-governmental actions are necessary and desirable to carry out their decision.

Panel Operations and Leadership

The *Blue Ribbon Panel* will begin its work in November 2001. It is anticipated that the group will meet four to six times to gain appropriate background, discuss relevant issues, and develop its recommendations. Each meeting will be two hours in length, and will be conducted by a professional neutral facilitator.

The Communities in Charge staff of the three counties will provide substantial staff support for *Panel* members. In addition to receiving materials and off-line briefings, each panel member will be assigned a "touchstone" to act as a liaison to other panel members and staff, and to provide background support on specific issues.

During its initial meeting, the *Panel* will agree upon a decision-making process. The *Panel* will have co-chairs selected by the chairs of the Clackamas, Multnomah and Washington boards of county commissioners.

Time Line: It is expected that the *Blue Ribbon Panel* will complete its work by the end of April 2002, and deliver its recommendations for implementation of a Health Care Safety Net Authority to the boards of county commissioners by May 2002.

Background - Although the Oregon Health Plan (OHP) has been successful in improving access to medical care to some tri-county residents, many people are either not eligible, or do not stay enrolled in the Plan. Despite the OHP, there are about 140,000 low-income residents in the tri-county area who do not have continuous health insurance coverage. These include many of our most vulnerable residents (low-income wage earners, young families, and pregnant women).

The implications of being medically uninsured are significant. The uninsured have greater difficulty obtaining access to needed medical care. They are generally less healthy than those that have medical coverage; they miss more days of work and/or school; have higher rates of treatable diseases; and place greater demands on the health care system when they do finally receive care. Lack of health care negatively impacts people's ability to participate in the workforce. It also negatively affects children's ability to be successful in school, and prevents some of our elders to live in health and comfort in their later years.

Our low-income and uninsured populations currently depend heavily on the compassionate services of local Health Care Safety Net providers (non-profit clinics and county health services) for medical care.

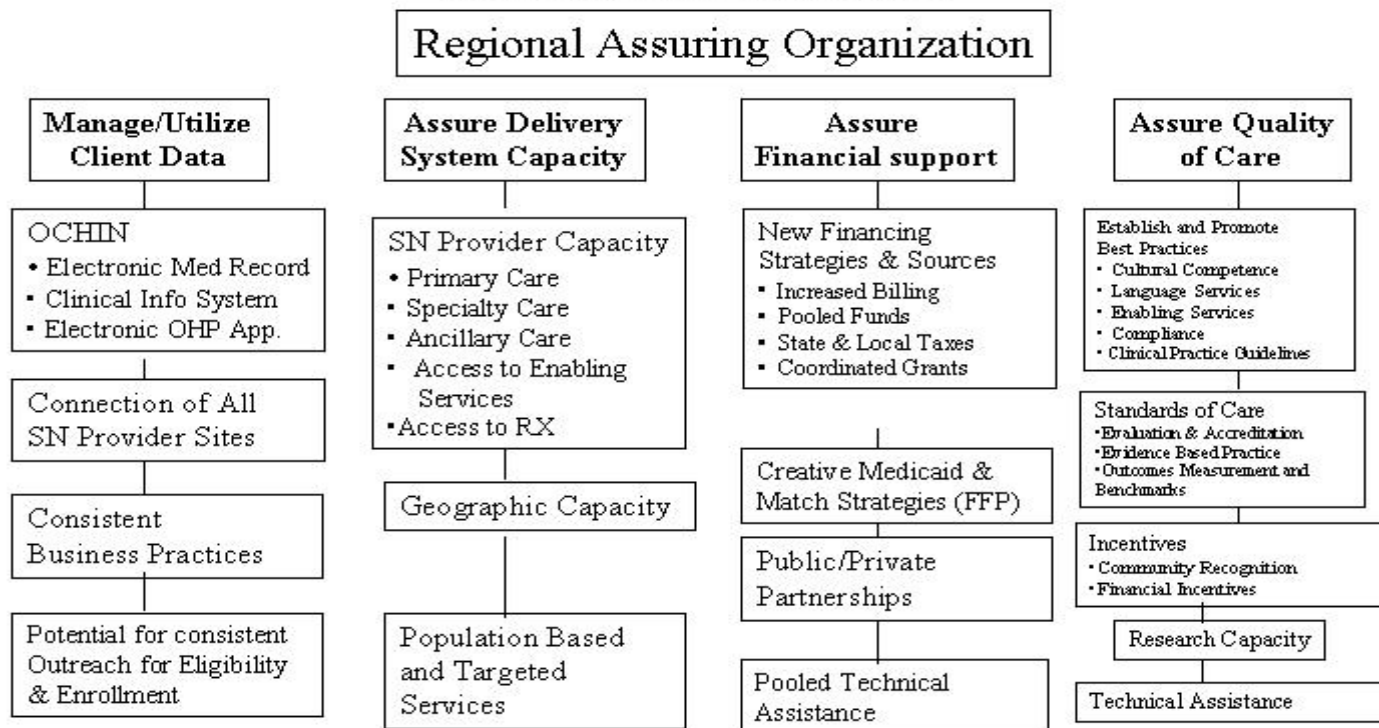
These populations also depend upon the charity of local hospitals for catastrophic care. Our local safety net system has limited capacity that is overwhelmed by demands for care. In addition, safety net providers lack the infrastructure and resources that would allow them to efficiently provide quality care to people in need.

The initial Communities in Charge planning process found that providing insurance to the underserved was not likely to be an effective strategy for most of the community's remaining low-income uninsured people. The reasons for this finding are many and include language and cultural barriers, lack of stable housing, inability to navigate the application processes, inability to understand the processes related to using and maintaining insurance.

Thus, providing care through the safety net is a central strategy of the community's consensus approach on improving access to care. A mechanism for improving the capacity, efficiency and effectiveness of the safety net is critical in achieving improved access.

Health Care Safety Net Authority

Draft Functional Diagram



Manage / Utilize Client Data: The ability to better understand and plan for the needs of those using the services of the safety net would be made possible if the Oregon Community Health Information Network were utilized across provider organizations. Additionally, the providers of the safety net would see improved care continuity, improved business practices and savings as a result of consistent business practices.

Assure Delivery System Capacity: The safety net is able to provide some care to about 50% of the uninsured population. This focus of this functional area serves the purpose of considering needed services and determining location and population to be served based on data and finances. It will also consider the human resource needs of the safety net and work to assure a pool of potentially eligible employees.

Assure Financial Support: The Purpose of this functional area is to consider current and potential financing strategy in order to assure the safety net is adequately funded. This would include improving business practices, building partnerships, and collaborative approaches to grants and waivers.

Assure Care Quality: Assuring care quality is an effort all providers undertake based on their specific models for care and ability to monitor and make improvements in care outcomes. This functional area will focus on assuring that all safety net provider organizations are able to monitor health care outcomes, take advantage of combined training opportunities for providers and support staff, and respond as a system to care improvement strategies.



Boards of County Commissioners; Clackamas, Multnomah, Washington Counties

Michael Jordan, Chair 906 Main Street Oregon City, OR 97045 (503) 655-8581 FAX: (503) 650-8944	Diane Linn, Chair 501 S.E. Hawthorne Blvd. Ste. 600 Portland, Oregon 97214 503/988-3308 Fax: 503/988-3093	Tom Brian, Chair 155 N. First Avenue, 300, MS 22 Hillsboro, OR 97124 503-846-8681 FAX: 503-846-4545
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Tri County Communities in Charge

**Blue Ribbon Panel
Meeting #1
NOTES**

December 5, 2001, 3:00-5:00 PM
World Forestry Center,
4033 SW Canyon (Near the Zoo)

PURPOSE OF THE MEETING: Provide an overview of the region's Health Care Safety Net, access issues and potential for action.

DESIRED OUTCOMES: By the end of this meeting Panelists will:

- Understand the implications of being uninsured
- Be familiar with state sponsored insurance programs
- Understand the Health Care Safety Net
- Be familiar with each county's Health Care Safety Net
- Understand the potential implications and challenges of a regionalized Health Care Safety Net

Topic	Discussion/Process	Outcome/Action
Charge for the Panel <ul style="list-style-type: none"> • Determine need and review structures for the development of a Health Care Safety net Authority • Recommend one structure to the three County Boards 	The charge as written in the letter of appointment was clear at this point of the agenda. Later, questions were raised. These are addressed in the Q&A Section of these notes	Charge accepted
Process agreements and Ground Rules (see memo in section 2)	Arthur Himmelman presented a memorandum outlining roles, responsibilities, and procedures for the group to consider.	Procedures outlined in memo were accepted
Process for Blue Ribbon Panel to decide on recommendations	<ol style="list-style-type: none"> 1. Review access need, purpose for the authority in relation to assuring access to care, review models and structures. 2. Clarified that at the 5th meeting, each panelist will get the opportunity to vote for the structure they believe will meet the ultimate functional 	Proposed procedure accepted with understanding that the process could consider additional options/models.

	needs for the region. – 3 votes total to be split by the individual in any way they see fit	
Touchstones	Each panelist will have one or more Touchstone assigned from the core group. Current assignments listed in section 3 of the program manual were reviewed	Accepted with one change
<i>Presentation: Health Care and the Safety Net; What it means to be on the Oregon Health Plan or Uninsured in the Tri-county area</i>	<p>Major Points of the presentation:</p> <ul style="list-style-type: none"> • Current Health Care coverage and access environments are in crisis <ul style="list-style-type: none"> ○ Growing unemployed ○ Growing number of uninsured ○ State budget shortfall ○ Health professional shortages ○ Safety Net is overwhelmed • Access must be created and or maintained for <ul style="list-style-type: none"> ○ ~133,000 on OHP (OHP not working well) ○ ~2500 on FHIAP ○ ~90,000 uninsured (most of whom work, and a disproportionate number of whom are minorities) • The health care safety net provides the major portion of the care for people who are uninsured or covered by OHP • There is no single body responsible for assuring the safety net's existence or capacity • Funding is a patchwork, no organized approach to leveraging federal resources • Some redundant and duplicative functions across the three counties • Potential Action Areas: <ul style="list-style-type: none"> ○ Change the funding and delivery environment through collaboration and partnership ○ Strengthen the safety net through 	None needed

	<p style="text-align: center;">regionalization and systematization</p> <ul style="list-style-type: none"> • Potential implications: <ul style="list-style-type: none"> ○ Change in administrative practices ○ Challenges to current funding approaches ○ Encourages/forges new partnerships ○ Could \change decision-making, and risks and rewards • Potential opportunities of a systematized regional approach: <ul style="list-style-type: none"> ○ Economies of Scale ○ Consistent leadership for access to care for all ○ Attention to geographic equity ○ Rational approach to planning 	
<p>Discussion: <i>Implications and Challenges of a Regional Safety Net</i></p>	<p>A list of comments and questions were developed from this meeting. They are listed below.</p>	<p>Core Group will answer questions raised.</p>

Comments from Meeting #1

1. Budget crisis across the state is \$720 Million- we need to do something locally or we may lose access to care all together.
2. Collaborative efforts are exciting – Coordinating, giving up identities and becoming something better may be the key. These are difficult and scary times. Do we have the fortitude for a tri-county answer?
3. The process and presentation were intellectually stimulating and the proposed efforts seem logical – question of political will. Would this group want to make this an advocacy part in the political arena?
4. Another reaction is the opposite of #2 above – collaboration doesn’t make it more efficient (didn’t see that in the presentation).
5. Integration of the health delivery system was the goal of the OHP, which is not happening in the Metro area. However, stratification of the health care safety net makes it vulnerable during these economic changes if there is no clear authority. Do we want to legitimize the stratification of the health care delivery system?
6. Trying to be optimistic about seeing three counties collaborate. This goal will require them to give up some turf and in some cases, “rise to the occasion.” One way they could capture some savings is to function together by pooling resources to serve one population. Each county gives out different proportions of money to this issue so, looking for equity will be hard. Glad to see the state is involved. Glad to see bridges being made.

7. We need to make sure our recommendations include economic value – not just rearranging the boxes.
8. What we have ahead of us is so important that we must address how we work on this crisis – we should walk into it with a “Triage” mentality, as this is the next “Mental Health Crisis.”
9. Primary care access within the safety net is the most reasonable cost answer. The return on the investment is potentially greater as it gets folks the care they need up front. The safety net has shown they can often provide the care needed at less than what the open market can provide it at.
10. Discussions today and in the future need to address finances and political will. We should ask for a cost-benefit analysis based on differentiating the effects of insurance aiding access to care, as opposed to not having access (e.g., the cost of providing the care vs. cost to the community if we do nothing). We also need to know what is expected of the panel after the recommendations are made. Do we become the champions of the recommendations?
11. There has to be clear reasoning for the creation of the “Authority”- has to be convincing to all commissioners and community
12. In all my years as an advocate for health care, this has been the best presentation on the topic I have seen.

Questions Raised

Q. The process and presentation were intellectually stimulating and the proposed efforts seem logical – question of political will? Would this group want to make advocacy part of their work in the political arena?

A. The expectation to become an advocate for safety net services is not a part of the formal charge. However, some panelists may find this to be an appropriate role depending on their position and the panel’s recommendation.

Q. Are there models that can support the notion?

A. Meetings 2-4 will address this question. There are national and local models for improving access to care on a local/regional basis. Locally, Metro and Tri-Met are examples of organizations assuring provision of specific services in our local area.

Q. How does the Portland metro area compare against “peer cities” on the issue of health insurance and access to care for the low-income and uninsured?

A. Across the nation, there is very little local level data on access to care for the low-income and uninsured. As of 1998, the Portland area compared favorably to national and state-level data on insurance coverage. However, data for 2000 suggested deterioration in coverage, and recent increases in unemployment suggest that insurance rates will likely fall further. There are no good methods to directly measure access to care.

Q. Is there a way to determine what kind of structure might best suit the functions of the authority idea?

A. The Blue Ribbon Panel will study the pros and cons, and opportunities and implications of three structures in such a way as to allow the panelists an opportunity to judge for themselves.

Q. Will Dental and Mental Health be covered?

A. The focus of Communities in Charge is access to basic medical care. This care includes services to address a wide range of health concerns and health improvement opportunities. Care for acute illnesses, prenatal care, and preventive care are examples.

When considering what specific services should be addressed by the Safety Net, the context of how care is provided is a central consideration. The local Safety Net utilizes care delivery

models that emphasize relationships between patients and general health care providers (not specialists).

Care for some mental health conditions takes place within the general practice model of care – conditions that can be appropriately managed by a general practice provider. This includes conditions such as mild to moderate depression and anxiety. It would exclude many cases of severe and persistent mental illness, e.g., chronic schizophrenia.

Given this, the emphasis should be on:

- 1) Developing reasonable behavioral health capacity within the existing general practice safety net care model; and
- 2) Developing well-functioning linkages to specific mental-health and dental providers.

Q. How have counties worked together in the past?

- Are there models locally or within the state (health or other)?
- What have they gained through their efforts?

A. These questions will be answered further in Meetings 2-4 with briefs and presentations. However, briefly, METRO, Tri-Met and The Regional Drug Initiative are all examples of successful cross county collaboration

Q. Is there any reason that a regional government isn't involved on the panel?

A. Then panel was chosen to balance size, voices and perspective. A regional voice is at the table in many ways. There is potential that another panelist could be appointed if the group recommended doing so.

Q. Do we view the health care crisis as being bigger than mental health crisis?

A. The mental health care crisis is deals primarily with the needs of individuals with persistent and chronic mental illness. Counties are mandated to assure access to mental health services for this population. Access to the needed care is the key for both problems.

Q. Is the request of the panel to determine the political will for their recommendation, to carry on the message... how much is expected of the panel?

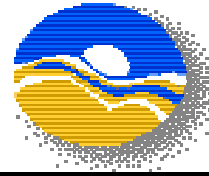
A. The Boards of each county have charged the Panel with considering issues around a Safety Net Authority, and making recommendations regarding this. They did not charge the Panel to advocate. Panelists will do as they and their constituents direct outside of the meetings.

Q. Say that political “buy-in” is there for the Authority – what are the underpinnings around the idea that an Authority is the answer?

A. The observation that the safety net is not organized and does not meet the health care access needs of the region's low-income population is at the core of the conversation around developing an authority. No governmental or private agency is currently charged with assuring health care access. The idea of an authority gained credence because of the perception that an authority could:

- Act regionally
- Coordinate the development of a strong and systematized safety net
- Coordinate the development of new funds
- Deal with geographic variations in access

*A glossary of Terms for Health Related abbreviations was asked for and will in your packets.



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Michael Jordan, Chair 906 Main Street Oregon City, OR 97045 (503) 655-8581 FAX: (503) 650-8944	Diane Linn, Chair 501 S.E. Hawthorne Blvd. Ste. 600 Portland, OR 97214 503/988-3308 FAX: 503/988-3093	Tom Brian, Chair 155 N. First Avenue, 300, MS 22 Hillsboro, OR 97124 503-846-8681 FAX: 503-846-4545
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Tri County Communities in Charge

**Blue Ribbon Panel
Meeting #2**

January 9, 2002, 3:00-5:00PM
Crowne Plaza Hotel,
14811 SW Kruse Oaks Drive

PURPOSE OF THE MEETING: Provide an overview of the potential functions of a local Health Care Safety Net Authority, and the three proposed structures to carry out these functions

DESIRED OUTCOMES: By the end of this meeting Panelists will:

- More clearly understand the Blue Ribbon Panel’s charge and role
- Understand the rationale and history for considering a Safety Net Authority
- Be familiar with the three structural options for an Authority
- Understand the potential benefits and challenges of a Health Care Safety Net as a way to improve health care access in the region

Topic	Discussion/Process	Outcome/Action
Follow up and notes from December 5th	<ul style="list-style-type: none"> • Notes were read and briefly discussed • Panelists discussed political will for the Blue Ribbon Panel process and potential outcomes. 	<ul style="list-style-type: none"> • Notes were approved • Commitment to proceed and explore with an open mind
Presentation: <i>Functions of a Health Care Safety Net Authority</i>	<p>Major Points of the presentation:</p> <ul style="list-style-type: none"> • The current fiscal environment, the OHP market failure, and the increasing numbers of uninsured emphasize the need for local leadership to assure access to Primary and Preventive Care • The community impact of high uninsurance rates and poor health care access are poor health outcomes, and increased health care costs for all • A regional approach is logical because the local health care system functions as a single market from the perspective of both community residents and health care providers. 	<ul style="list-style-type: none"> • None

	<ul style="list-style-type: none"> • There are gaps in current Health Care Safety Net performance when compared to reasonable standards of potential performance. These gaps are seen in <ul style="list-style-type: none"> ○ Planning & data use ○ Capacity to provide care ○ Finances to facilitate care ○ Quality of care • Local and national examples of the three models for assuring service in health and other areas were presented. 	
Discussion/Reaction to the Presentation with regard to the structural models	<ul style="list-style-type: none"> ▪ The panel questioned aspects of the presentation. <ul style="list-style-type: none"> ○ How do the structures get implemented? ○ How is financing going to be developed? ○ How will quality be assured? ○ What are the incentives (rewards and consequences) to participate and what is the authority for each structure? 	The notes section of these notes and future meetings will further address the questions raised.

Comments

General

- 1) The panel is an impressive and powerful cross-section of the concerned community.
- 2) The current economic situation and its impact on access make it important to consider a regional, comprehensive and collaborative effort for health care now.
- 3) It is important to keep our minds open about the structures and financing options as the environment is continually changing in terms of what is needed and what is possible.
- 4) Although care for severe chronic mental illness is not a focus of our work here, venues for its discussion need to be created. If we were to add mental health to the agenda, the problems of that system could paralyze our process. We must come back to it once we complete this process
- 5) Health care access, like education and transportation, is a very important and needed service to help residents thrive. All are people worthy of health care services.

Regarding models/structures

- 6) CareOregon may be the right place for the Health Care Safety Net Authority (HCSNA), but CareOregon is open to the process, and hopeful a solution is possible.
- 7) The different models could either create more problems for area non-profits, or end up facilitating the non-profits' goals. There are likely to be both intended and unintended consequences. Need to make sure there is no harm done.
- 8) The crisis brings us to the table, but where are the "stick" and "carrot" in the process and the structure? If we don't talk about and agree on these issues, it won't matter what three options we talk about.
- 9) The Blue Ribbon Panel (BRP) needs to look at options to decide which creates the greatest possibilities and leverage. Try to stay away from carrot and stick conversation. Within the models, the strategies will be realized and found. At the end, the BRP can choose the one that offers us the most, and then we can talk about the strategies to reach intended outcomes.

- 10) If something tri-county is created – if there isn't money coming in, there is a chance that the system will be diluted (as it exists today). Frankly, all three counties will have to decide to fund the HCSNA at some level, either through general funds or some other mechanism.
- 11) Expanded use of the Oregon Community Health Information Network (OCHIN - a computerized practice management system) is good – without this in place, we won't be able to measure quality and control costs by monitoring utilization.
- 12) It feels like from one to two to three (models) it goes from more collaborative and private fundraising to more public. Similar trend regarding longevity and who is responsible.
- 13) Financing is critical to this decision [about structure and governance]. Leveraging resources creatively is important as well.

Questions

- 1) What does “absence of critical processes” mean?
 - A. A critical process is one that assures that the care provided is of high quality and that the practice is able to survive fiscally. One example- clinics may be lacking a practice management system for tracking clients, their utilization, and carrying out billing.
- 2) How will an Authority solve the issue of a lack of critical processes?
 - A. An example is the way that Oregon Community Health Information Network (OCHIN) has been able to pull in funds to create and make a computerized health information system available to safety net providers. There are a number of partners who pool resources and skills to support and stabilize the system, and make it available and cost effective for community clinics.
- 3) Capacity, what was the thinking around how the three models would be able to address the issues of capacity?
 - A. Pooling resources for provider volunteer recruitment and training, building in incentives for retaining individual provider contributions.
 - A. Existing resources aren't being optimally used – a HCSNA could consider allocating provider capacity and influencing clients' utilization so that need and capacity are better matched across the system.
 - A. Finally, obtaining new funds is integral to the charge of the HCSNA; this could be better accomplished through a coordinated approach.
- 4) Different models have different abilities to address the question of how capacity or other functional areas might be approached. How does the Core Group propose the Blue Ribbon Panel assess whether each or none of the models can achieve the goal?
 - A. The Core group will lay out how each structure can address the needs for leadership, financing and governance. It will be the role of each panelist to consider and determine how well each of the structures meet the defined need. Additionally, challenges in the implementation of each structure should inform the choice made by the panel.
- 5) There has to be something to “hammer” this process together to create commitment, longevity and institutionalization of the new entity. The process needs more than goodwill. What is the hammer/stick/incentive/motivation in the process for achieving access to care through a health care safety net authority?
 - A. A mission perspective is driven by our desire to see our clients served better and to see more of them served. [Coalition Clinics] need to participate; this will require us to break down our own barriers and share identities. Hospitals are seeing overuse of ER's , electeds are seeing a growing constituent base without healthcare... these are areas that will give people a reason to participate. The structure needs to have enough power; we see tri-met as an example.

- A. No one will be forced to participate, but we see those that we want to serve (seniors, homeless kids, etc) not getting what they need with regard to health care. The pressure of the recession will create more public outcry – we can either do this the hard way and wait for a crisis, or we can do it this way, working together rationally in the same place. We need to start moving and creating momentum – we have almost reached the tipping point with primary care.
- A. The idea of "carrot and stick" is unique to each of the proposed structures. The carrot to one panelist may be the stick for another. It is important that the panel have a full discussion of incentives and potential ways to share power in the process of access development.

6) What are some examples of sticks and carrots?

A. "Carrots"

- Leadership
- Finances
- A realized mission
- Healthier Community

"Sticks"

- Legislation
- C.O.N. - certificate of need... a process/application that you have to submit to get a new clinic – authority controls.
- Deliverables in exchange for finances (threat of losing finances)

7) Does the authority deliver care? Is this a direct operating entity?

A. The HCSNA brings necessary resources together to make it possible for organizations that meet defined standards to deliver care. None of the structures prohibits the provision of care services but, the current focus of the authority is system coordination, not direct care provision.

8) What is the definition of community in the concept of "community standards"?

A. In the presentation, "community standards," refers to quality standards for care as defined by the federal government (e.g., Medicaid) and other payers. They are also defined in terms of generally accepted medical protocols as well as established procedures for achieving cultural competence and community and patient acceptability.

9) What is the leadership structure of each model?

A. Each structure has a different leadership process.

- Non-Profit. Leadership is provided by a community board that operates under the organization's articles of incorporation and bylaws. Board membership can be self-perpetuating, or elected by constituent organizations. There is flexibility in specifying who sits on the board, and what influences are represented. The board typically has responsibility for financial oversight and for policy setting. There is usually an executive director and staff who carry out the directives of the board.
- Quasi-Governmental Organization- There is a leadership body appointed by the boards of each county under the terms of an intergovernmental agreement. The sponsoring county boards would have flexibility in specifying who sits on the governing body, what influences are represented, and what decision-making

authorities were delegated to that body. Staff of the authority would carry out the direction of the governing board.

- Health District- Leadership comes from an elected governing board chosen by the popular vote of citizens in the district. The board is made up of at least five people coming from the general community as defined by the incorporating charter. While there is little ability to specify the expertise or interests of board members, it seems likely that individuals with an interest in health would be candidates. As is the case for the other structures, staff would carry out the directives of the board.

10) What do [the electeds] see as the potential of the citizens to vote for a Health District?

- A. Depends on several factors- a champion, a crisis, other momentum
- A. Despite how noble, without [the above] chances are "slim to none" for new taxes in today's environment.
- A. The biggest challenge is to make this the most important issue. When folks understand the issue, they vote accordingly. As such, there is reason to be hopeful.
- A. In any case, the answer today is, we do not know [i.e., there are no polling data]. The environment is changing and as a result, we need to be open to all three structures.

11) What are the financing options for each model?

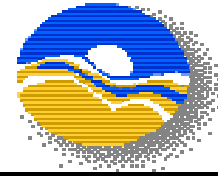
- A. We are in need of about \$30 million as we have met about half of the need. However, all models can:
 - Apply for grants, contracts and awards
 - Facilitate services as directed by local and state governments
 - Gain funding through reallocation
 - Charge fees for services
- Government models can:
 - Potentially obtain new federal funds through federal financial participation and other "government only" matching strategies.
- Health districts can:
 - Levy taxes
 - Issue General Obligation Bonds

12) What other ways can funds be raised locally? Fees, assessments, taxes, grants....?

- A. In addition to the above, the Core Group is further researching the possibility of new funds via new fees and the like. Some suggested options (e.g., mobile phone fees) are not within the jurisdiction of the models outlined currently and may require state legislative action.

13) What about the public corporations structure – OHSU, OPB, is this a structure that is possible to consider under this process?

- A. Those structures were statutorily created and the State Legislature would have to set up the entity. It is doubtful this would be possible since ORS 440 allows for the same outcome. However, the Core Group will further research this suggestion.



Boards of County Commissioners; Clackamas, Multnomah, Washington Counties

Michael Jordan, Chair
906 Main Street
Oregon City, OR 97045
(503) 655-8581
FAX: (503) 650-8944

Diane Linn, Chair
501 S.E. Hawthorne Blvd. Ste. 600
Portland, OR 97214
503/988-3308
FAX: 503/988-3093

Tom Brian, Chair
155 N. First Avenue, 300, MS 22
Hillsboro, OR 97124
503-846-8681
FAX: 503-846-4545

Tri County Communities in Charge

**Blue Ribbon Panel
Meeting #3
Notes**

February 6, 2002, 3:00-5:00PM
Kingstadt Conference Center,
3800 SW Cedar Hills BLVD

PURPOSE OF THE MEETING: To understand the financial implications of improving access to primary and preventive care by considering costs of care, and reviewing current and potential sources of funding.

Outcomes: By the end of this meeting panelists will:

- Understand the costs of providing basic health care through safety net clinics
- Understand current funding sources
- Understand potential funding sources for care, system improvement and expansion
- Understand the authorities/processes needed to leverage new financial resources

Agenda Item	Discussion	Action Needed
<p>Presentation: <i>Financing Care through a Health Care Safety Net Authority</i></p>	<p>Questions were asked regarding the presentation and the validity of some of the data. These questions focused on the following points: Actuarial Assumptions and Process Financing Options Quantifying needs How to address the above questions</p>	<p>Questions and their answers are included in the notes section.</p>
<p>Consider Models with regard to Finance</p>	<ul style="list-style-type: none"> ▪ Discussion about the models focused on financing and the need for new funds. The panel asked that the Core Group return with a clearer picture of how the issue of access might be addressed in short and long term steps. 	<p>Core Group will address the BRP request by generating a short and long term work plan that shows strategies and needed resources</p>

Comments

1. It will be important to understand how to address concerns of clinics that are not FQHC's so as to assure they have a place in the HCSN or can make the changes needed to become FQHC compliant.
2. The health outcomes need to be reconsidered at some point as there will need to be strategies to gain access to specialists and other services that will impact the health of the uninsured if not addressed.
3. If we really want to take this issue on, we need to be concerned with not only "doing no harm" to the safety net but, we need to "do no harm" to the currently insured through their employer. There should be no incentive to reduce commitments to providing insurance.
4. We need to accept the data for need and use as it is because the data we have is the best there is today. This should not be a stumbling block, it should be a reason to initiate better data gathering while seeking to expand care capacity. We will never get good data unless we do something.
5. Given the data we have on need and capacity, we should proceed incrementally, approaching those most in need and where there is "quicker" success.
6. Though Primary and Preventive Care are highly important, there must be some provision, even fee for service, to gain access to specialty & hospital care for the targeted population; even beyond the Charity Care currently provided. We will also need to make sure we can get access to pharmacy for the population as over 60% of primary care treatment is based on pharmaceuticals.
7. Whatever the model we employ to assure access, it needs to be effective, efficient and accountable. To be these things, it must have the authority to require people to play and it must be able to gain new funding.
8. Define for the public the true need of our citizens and we will have no trouble getting new dollars in the system. We have not made a sufficient case yet.
9. A successful approach will be reformation with incremental expansion (vs. revolution). We need to build credibility, go to citizens and make case of squeezing nickels... if they see you are doing to right work, they will support you. This means we must choose the right structure that will give us either the best "spring board" or the best potential be make the case for need to the general public.
10. The group is getting too bogged down in the details of the issue. We all realize there is a problem with health care access, we know addressing it will be difficult as it will need new funding, we know we can not address the issue under the current rubric [jurisdiction and fiefdoms]. We need to get on with developing the vehicle to address these issues, not learn about why they can not be solved right now with new taxes.
11. We need to see what the steps are for addressing the capacity issue before we can move forward with the discussion of a new structure. Not because we do not understand there is a problem but because we do not know the work to be done.
12. We seem to have come together on the issue, can the vision or proposed outcome [end state] be articulated for the group?

Questions-

1. The actuarial analysis:
 - Q. What was the underlying assumption for how many uninsured would use services (penetration)?
 - A. Assumption of 90,000 and 80% would use services.
 - Q. What is the benefit package? Does it include specialty care?
 - A. Limited specialty care is included in the analysis (e.g., OB/Gyn)
2. Potential Resources for Care:
 - Q. Under new resources, FQHC was suggested. How many health clinics don't have this status and why not?
 - A. There are about 12 Core safety net providers that are not FQHC's. Additionally, there are at least 2 supporting safety net care providers who do not have FQHC status.
 - A. Most do not have the FQHC status because they do not currently have a federal grant. Others do not because they are not able to meet the requirements for FQHC status.

- A. Others see federal funds and their requirements as being in conflict with their organizational mission.
- Q. What are the ways a clinic can gain FQHC status?
 - A. There are at least three ways
 - o Receive Federal 330 grant funds
 - o Receive Indian Health Service funds
 - o Receive status as an “FQHC Look-A-Like”
- Q. Are there any clinics who could comply with the regulations and gain FQHC status?
 - A. Yes, there are at least 3 clinics that could gain the status if there were some assistance. None of them has the resources needed to make the application.
- Q. What are the most immediate opportunities for increased funding (beside FQHC)?
 - A. Other more immediate (within 2 years) funding potential includes:
 - o Allocation of current county general funds (CGF)
 - o Federal grants (Bureau of Primary Health Care and Community Access Project)
 - o Family Planning Expansion Project (FPEP)
 - o Claiming Medicaid administrative costs (Federal Financial Participation - FFP) by local governments, using local tax funds as match (See meeting book #3 on FFP)
- Q. [Follow up to the above] Why are we not doing this now?
 - A. We are doing some of this now, however, there are complications to conducting the needed work across the region. These efforts include:
 - o Expansion of FPEP
 - o Applying for Federal Grants where possible
 - o Small FFP Projects
 - Barriers include:
 - o Lack of knowledge and skills for the work within each county
 - o Lack of skilled staff to do the work [this is a systems change process]
 - o Lack of regional jurisdiction to initiate and complete the work
 - o Funds for legal and programmatic consultation
 - o Priority; though the work is important, there is competition for and resources within and among providers

3. Current Resources for Care-

- Q. What is the current investment in Care for the Uninsured?
 - A. The current investment in care is estimated to be about \$28 million for the uninsured. These sources include county general fund, federal grants, foundation grants, local donations, and patient fees.
- Q. Is there duplication in the current system that could be reduced, thereby saving money to be reinvested in care?
 - A. Yes, we estimate that there are savings that could be realized in the current safety net that total about \$1 million. However, realizing these savings will require system changes. For example, savings from implementation of the Oregon Community Health Information Network (OCHIN), are 18 or more months off. Capturing savings will require upfront resource investments including:
 - o Staff
 - o Consultant expertise
 - o Expansion of OCHIN membership

4. Expected Resource Needs-

- Q. What is the expected need for new funds?

- A. The need is for \$40-\$60 million depending on the rate used for paying for care.
- Q. Does the cost estimate include the funds needed for new physical clinic sites?
- A. No, new clinics will need to be financed separately.
- Q. Is there any resource to help gain the needed funding?
- A. There are potential resources but none dedicated to the uninsured. Additionally, local leadership to address access to primary care is not consolidated.
- Q. Is there a way we can know/monitor what will be needed in the future?
- A. Yes, generally. We will need to develop our own monitoring capacity if we are to have more accurate/timely data.
- Q. Can the state be a resource in the work the Core Group has outlined?
- A. The state is a resource within its own funding priorities. If the HCSNA were developed, the state could assist with creative OHP expansion (state plan amendments) that would improve care locally. The state can be a technical advisor also. Unfortunately, the state has a weak history of funding care for the uninsured.

5. Delivery Models for providing care and current capacity-

- Q. Are we talking about providing insurance or clinic access?
- A. We are talking about both. The insurance we are talking about is current Medicaid (OHP) and expansions from to state plan amendments. For those who do not qualify, we are talking about creating enough access capacity that the uninsured can get the care they need.
- Q. What clinic models are currently being employed in our Safety Net?
- A. There are really only three models of safety net health care being offered now. These are:
1. On-going Primary Care (FQHC Clinics)
 2. Population and Issue Specific Clinics (e.g., Family Planning)
 3. Urgent Care (by volunteer providers at safety net clinics)
- Q. How many uninsured people are getting on-going primary care services?
- A. About 20,000 of the estimated 90,000 uninsured are getting ongoing Primary Care services. However, other clinics provided another 85,000 visits.

Primary and Preventive Care Visits used per year	Data source
2.5	Local FQHC's
4.8	CareOregon Medicaid
3.2	Federal Target

**Appendix 9-
Meeting #4**



Boards of County Commissioners; Clackamas, Multnomah, Washington Counties

Michael Jordan, Chair
906 Main Street
Oregon City, OR 97045
(503) 655-8581
FAX: (503) 650-8944

Diane Linn, Chair
501 S.E. Hawthorne Blvd. Ste. 600
Portland, OR 97214
503/988-3308
FAX: 503/988-3093

Tom Brian, Chair
155 N. First Avenue, 300, MS22
Hillsboro, OR 97124
503-846-8681
FAX: 503-846-4545

Tri County Communities in Charge

**Blue Ribbon Panel
Meeting #4
Notes**

March 6, 2002, 3:00-5:00 PM
Crowne Plaza Hotel
14811 SW Kruse Oaks Drive
(Off of HWY 217 and I-5)

PURPOSE OF THE MEETING: To understand the work necessary for improving access to primary and preventive care by considering data, finance, capacity and quality.

DESIRED OUTCOMES: By the end of this meeting panelists will:

- Understand the short and long term opportunities for improving access to care by impacting finance, capacity, quality and data.
- Confirm resource needs and challenges to the immediate opportunities
- Initiate a discussion for responding to these challenges and opportunities

Agenda Item	Discussion	Action Needed
3:10 - Follow up from February 6th Meeting	Correction was made to notes from meeting #3 <ul style="list-style-type: none"> • <i>With regard to resources for Care, please add in Charity Care and Community Benefits</i> 	Notes confirmed with change.
3:20 Presentation & Discussion: <i>The Immediate work for expanding access to primary and preventive care</i>	Presentation was made with examples of the work to be done. Panelists were asked to consider the examples as "short-term" work (within 2 years) and to consider how a regional body might work toward the vision of access in the longer term.	None

Next Meeting Dates
April 3, 2002 @ World Forestry Center (near the zoo) – Recommendations
May (TBD)

Comments:

1. Core piece of this discussion [on data collection] is patient management. A consistent data utility and system will enable management of patient care in many ways – it is strategic for long range planning, but also for fiscal control, patient education, care quality and reduction of medical errors.
2. The example of Federal Financial Participation (FFP) is an essential strategy for stretching existing dollars for services. The process essentially frees up other funds that can then be used for care to the uninsured.
3. It seems that a large portion of the uninsured don't qualify for Medicaid and the funding strategies described. This process can't be reliant on Medicaid in the long-term. Local funds have to be a part of the funding mix.

Discussion During Presentation:

1. Using OCHIN for data collection and fiscal management –

- Q. Can the data collection (OCHIN) be done within the 3 models?
 - A. Each model could facilitate the collection of data on the OCHIN Platform
- Q. If we do not chose a model, what would happen to OCHIN?
 - A. OCHIN already exists and is being implemented in the three major FQHC Clinics in our area. If we do not create a structure for long-term access improvements, OCHIN will continue but probably not at a level that could transform low-income care.
- Q. Can OCHIN facilitate the billing function now?
 - A. OCHIN collects the data needed to facilitate billing. OCHIN has the potential to act as the billing agent but currently does not provide this service.
- Q. Are there plans to collect the services provided by hospitals using OCHIN?
 - A. There are two ways that OCHIN could capture this data,
 1. By hospital systems using OCHIN as their platform
 2. By hospital systems reporting data in the appropriate format to the OCHIN Data Warehouse (a collection of similar data that has been stripped of patient identifying data)
 - Q. Does the OCHIN cost estimate include all potential services OCHIN might offer?
 - A. No, the example and its associated costs include only those costs associated with the services OCHIN could bring to 10 clinics generating 55,000 visits. The estimate includes some costs associated with connectivity, hardware upgrades and staff. The estimate assumes an outside subsidy of approximately 30% also.
 - Q. Is the EMR [electronic medical record] a part of the estimate?
 - A. No but, EMR is the next planned phase in implementation for current OCHIN partners. Given adequate resources, this functionality could be provided to others.

2. Assuring finances for care provision.

- Q. Can the state “pick up the cost” for the federal matching and plan amendment process?
 - A. The state as a partner will expend resources to assure local matching processes are valid. As far as paying for the total process, this is unlikely.

- Q. Have employers been involved in the funding estimates for the uninsured and ineligible for Medicaid?
 - A. Employers have been considered, however, the limited benefit package has been undervalued in other states where there has been an effort to sell these packages.
- Q. Can we take the current Medicaid Program and expand it to cover more people?
 - A. Yes, under the state and federal law, there is potential to expand Medicaid. The state is in the middle of an expansion effort. Locally, we could expand Medicaid using tools like state plan amendments, HIFA (Health Insurance Flexibility Act) waivers and the like.

3. Assuring Capacity for Care

- Q. FQHC expansion - is there a limit to what the local community can do with this?
 - A. Yes, FQHC status under any application process should not be seen as the only tool for financing care. All safety net providers locally seek funds outside of Medicaid and the BPHC grant for the uninsured (if they have one). There are already local tax funds and other grant funds in the local safety net.
- Q. How does one get FQHC status?
 - A. There are several ways to earn FQHC status, however, the status has strict requirements with regard to payer mix, community need, and organizational status and governance. The average medical practice could not qualify.

4. Assuring Quality of Care

- Q. Does the quality goal include provisions for case management and other enabling services?
 - A. The examples share were just that, examples. The costing shown in meeting #3 [i.e., cost of care for the 90,000 uninsured of \$40-60 Million] does include enabling services required under the FQHC guidelines.
- Q. The quality question can lead to changes in provider practice, changes in delivery design and shared infrastructure. Is it assumed that the HCSNA could or would do all these things?
 - A. All these examples listed and more are on the lists of potential quality initiatives. It is important to recognize there are many strategies being employed locally and across the nation. The HCSNA will work to make all these quality changes possible.



Boards of County Commissioners; Clackamas, Multnomah, Washington Counties

Michael Jordan, Chair 906 Main Street Oregon City, OR 97045 (503) 655-8581 FAX: (503) 650-8944	Diane Linn, Chair 501 S.E. Hawthorne Blvd. Ste. 600 Portland, OR 97214 503/988-3308 FAX: 503/988-3093	Tom Brian, Chair 155 N. First Avenue, 300, MS 22 Hillsboro, OR 97124 503-846-8681 FAX: 503-846-4545
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Tri County Communities in Charge

**Blue Ribbon Panel
Meeting #5
Notes**

April 3, 2002, 3:00-5:00PM
World Forestry Center, Cheatham Hall
4033 SW Canyon (Near the Zoo)

PURPOSE OF THE MEETING: To develop a recommendation for the establishment and formation off a Tri-County Health Care Safety Net Authority.

- DESIRED OUTCOMES:**
- By the end of this meeting panelists will:
- Review and consider the need for a regional Health Care Safety Net Authority
 - Understand the potential benefits and challenges of a Health Care Safety Net Authority as a way to improve health care access in the region
 - Come to agreement regarding the establishment and form of a Tri-County Health Care Safety Net Authority

Agenda Item	Discussion	Action Needed
3:15 Review and Assessment of the proposed models	<ul style="list-style-type: none"> ▪ Panel reviewed the three original Health Care Safety Net Authority structural models and a proposed fourth model - the Tri-County Health Care Partnership. The panel removed the ORS 440 Health District and the Not-for-Profit models from their deliberations since there seemed to be minimal support for these models. Discussion centered on the opportunities and challenges of the two remaining options: the Intergovernmental agreement and the Partnership models. ▪ After substantial discussion and careful deliberation, a unanimous consensus was achieved for an Intergovernmental Agreement. 	None
4:30 Solidifying next steps	The Panel agreed that the three county board representatives and their health directors meet to	County Representatives

	<p>work out the specifics for a proposed Intergovernmental Agreement. Note: the date for this meeting is-- May 23rd.</p> <ul style="list-style-type: none"> ▪ The Commissioner Jordan, Chair Linn and Commissioner Schouten will develop an IGA proposal, and take it to the three county boards through usual channels. ▪ Staff will develop a draft final report on the Blue Ribbon Panel process, and will seek Panel review and concurrence. ▪ Implement IGA with a defined work plan with participation of a range of partners. 	<p>Meet and draft the specifications of the IGA and forward to their boards for approval.</p>
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Restating the recommendation from the Blue Ribbon Panel:

The Blue Ribbon Panel recommends that Clackamas, Multnomah, and Washington Counties enter into an intergovernmental agreement to establish a framework for a comprehensive approach for improving access to health care for low-income, uninsured people in the tri-county area.

Recognizing the necessity of working with diverse stakeholders in ways that ensure their genuine participation, this framework should include opportunities for partners to define their participation and specific commitments to achieving the vision and goals adopted by the Blue Ribbon Panel and delineated in the tri-county intergovernmental agreement.

This recommendation was made with this vision, mission and these goals in mind generally.

Vision-

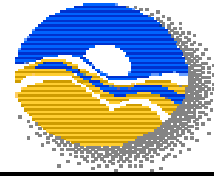
"Low-income and uninsured residents of the tri-county area get the basic health care they need when they need it."

Mission-

"To assure access to primary and preventive health care services for the low-income and uninsured of Clackamas, Multnomah, and Washington counties in an appropriate and cost-effective manner."

Goals-

1. **Data-** Assure that the health care safety net is able to collect demographic and utilization data, so that this data can ultimately be used for system planning.
2. **Finance-** Assure that adequate financial support is available to provide care for the low-income and uninsured.
3. **Capacity-** Assure that the local health care safety net has adequate clinical capacity - e.g., providers, other staff, facilities, equipment and supplies, etc.
4. **Quality-** Assure that the health care safety net provides care that meets quality standards as defined by Medicaid



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Michael Jordan, Chair
906 Main Street
Oregon City, OR 97045
503/ 655-8581
FAX: 503/ 650-8944

Diane Linn, Chair
501 S.E. Hawthorne Blvd. Ste. 600
Portland, Oregon 97214
503/988-3308
Fax: 503/988-3093

Tom Brian, Chair
155 N. First Avenue, 300, MS 22
Hillsboro, OR 97124
503/846-8681
FAX: 503/846-4545

Tri County Communities in Charge

What is a Non-Profit Corporation?

There are many different kinds of non-profit, tax-exempt organizations. This fact makes generalizing them difficult. The state and federal rules governing non-profit organizations vary greatly depending on the kind of organization and its tax-exempt status. In general, there are three “kinds” of recognized non-profit corporations in Oregon: 1) public benefit, 2) mutual benefit, 3) religious¹. However, the corporation does not realize the tax-exempt benefits of the status until the organization completes a federal application process and is awarded the status. The IRS recognizes 25 different non-profit and tax-exempt organizations, each with differing roles, rules and allowable purposes.

Initiating the Process

To meet the purpose of assuring access to primary and preventive care, it is probable that the affected parties would enter into a negotiation process wherein they would work with individual and group legal counsel to agree upon:

- Nature and Purpose
- Mission and Activities
- Articles of Incorporation
- Organizational By-Laws
- Leadership
- Funding Commitments

Creating a Non-Profit Health Care Safety Net Authority

To create a Non-Profit Health Care Safety Net Authority, all three participating counties individually must:

- Enact an ordinance ratifying the development of and filing for the Health Care Safety Net Authority as a non-profit corporation.

- Each ordinance must state the counties' intent to create the Non-Profit,
- Specific public purposes, and the powers, duties, and functions of the Non-profit as they relate to its purpose(s).
- Resource commitments to the purpose(s) of the Non-Profit,
- Make an application to the state and federal governments and execute the HCSNA's development

Non-Profit Governance

A board or directors governs the Non-Profit. The membership of the board is allocated as described by the developing parties in the Articles of Incorporation and By-laws.

Rulemaking Authority

A Non-Profit may adopt organizational policies and procedures necessary to carry-out its mission and duties as specified in the articles and bylaws. These policies and procedures do not have the force of law within the Non-Profit's service district but would have the authority to enforce its policies and procedures among its staff and organizational partnerships.

Revenue

The local governments participating in the development of the Non-Profit would fund the entity through contributions and dedicated revenue streams. A non-profit has no taxing authority or general obligation bond authority. It is assumed that the Non-Profit would seek grants and or contracts from all possible and aligned funding sources.

Example:

1. **worksystems, inc:** A non-profit organization whose purpose is to provide employment support and services to the people of Multnomah, Tillamook and Washington Counties.
2. **United Way of the Columbia-Willamette:** A non-profit organization whose purpose is to support the four-county area (Multnomah, Washington, Clackamas and Clark Counties), in changing lives by providing centralized financial and organizational support.



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Michael Jordan, Chair
 906 Main Street
 Oregon City, OR 97045
 503/ 655-8581
 FAX: 503/ 650-8944

Diane Linn, Chair
 501 S.E. Hawthorne Blvd. Ste. 600
 Portland, Oregon 97214
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 Fax: 503/988-3093

Tom Brian, Chair
 155 N. First Avenue, 300, MS 22
 Hillsboro, OR 97124
 503/846-8681
 FAX: 503/846-4545

Tri County Communities in Charge

ORS 190 - Intergovernmental Agreements

Oregon Revised Statutes, Chapter 190 (ORS 190) authorizes local governments to enter intergovernmental agreements for the provision of services and facilities. An intergovernmental agreement (IGA) is the formal contract between the local governments allocating their authority.

An IGA may assign the responsibility to provide services and facilities to one of the participating local governments or create a new governmental entity. An entity created by an IGA under ORS 190 (a 190-Entity) operates within the limits of ORS 190 generally, and specifically within the terms of the IGA.

How is a 190-Entity created in an IGA?

To create a 190-Entity, all three participating counties individually must:

- Enact an ordinance ratifying the IGA negotiated by county representatives.
 - Each ordinance must state the counties’ intent to create a 190-Entity,
 - the effective date of the IGA,
 - the specific public purposes, and the powers, duties, and functions of the 190-Entity as they relate to its purpose(s).
 - IGA must provide for the duration, termination, or dissolution of the 190-Entity.

Additional IGA terms may be required, depending upon the nature of services, and financing and operations of the Entity. For example, the IGA must address distribution of any funding responsibility, and generated revenues, and the status of any contributed personnel or property.

Governance of an IGA

A board or commission governs a 190-Entity, with membership allocated among the counties through negotiated terms of the IGA. However, the 190-Entity must remain responsible to the

participating counties. The counties are jointly and equally responsible for the debts, liabilities, and contractual obligations of the 190-Entity unless the IGA specifies differently.

The state, through the Department of Administrative Services, may pay a share of the cost and development of IGA planning if the IGA's activities and services are supported or utilized by regionally-located state agencies, and if local tax dollars initially funded the planning. Planning and developing a 190-Entity for health care would appear to meet these qualifications.

Rulemaking Authority

A 190-Entity may adopt regulations necessary to carry-out its powers and duties as specified in the IGA. The regulations would have the force of law within the Entity's service area, and the Entity would have the authority to enforce its regulations. The authority to make regulations is limited to the scope of authority granted in the IGA. For example, a 190-Entity created to build and maintain a multi-county Health Care Safety Net information system would include the authority to promulgate regulations for that information system, but not broader health care policy issues. The participating counties would retain statutory jurisdiction over all health care matters not specifically transferred in the IGA.

Any rules regarding the 190-Entity's budgeting process would be subject to state budget laws. As a governmental entity, the 190-Entity would be subject to open meetings and public records laws.

Revenue

The local governments participating in an IGA could choose to fund the 190-Entity through contributions and dedicated revenue streams. A 190-Entity has no taxing authority or general obligation bond authority. The IGA may grant authority to issue Revenue Bonds; however, this is subject to challenge by referendum. There is also a complex set of shared county and 190-Entity responsibilities for bond default. Finally, the economics of a 190-Entity issuing revenue bonds could be prohibitive. Such bonds would need to pay a higher interest rate to compensate investors for potential risks of nonpayment, and the fact that these bonds are not backed by the guarantee of the counties' taxing authority.

Example:

Regional Drug Initiative: The Regional Drug Initiative (RDI) is a coalition of concerned policy makers from business, education, government, health care, law enforcement, treatment providers and community groups. RDI is committed to establishing a drug-free community.



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Michael Jordan, Chair906 Main Street
Oregon City, OR 97045
503/ 655-8581
FAX: 503/ 650-8944**Diane Linn, Chair**501 S.E. Hawthorne Blvd. Ste. 600
Portland, Oregon 97214
503/988-3308
Fax: 503/988-3093**Tom Brian, Chair**155 N. First Avenue, 300, MS 22
Hillsboro, OR 97124
503/846-8681
FAX: 503/846-4545

Tri County Communities in Charge

What is a health district?

Under Oregon Revised Statutes, Chapter 440, health districts may be formed to accomplish any or all of four specific purposes listed in ORS 440.320(1)(c):

- (A) Providing clinically related diagnostic, treatment and rehabilitative services on an inpatient or outpatient basis;
- (B) Providing outreach programs in health care education, health care research and patient care;
- (C) Serving as a resource for health care providers in the district; and
- (D) Promoting the physical and mental health and well-being of district residents.

The Tri-County Communities in Charge project’s (TCCIC) stated purpose (as discussed in our grant submission to the Robert Wood Johnson Foundation) is consistent with purposes B, C, and D above – “[t]o create access mechanisms for low income, uninsured residents to health care.”

A health district combines features of a municipality and a public corporation.² As a municipal entity, a health district may:

- Levy Taxes (up to ¼% of the real market value pending tax limitations)
- Establish rules and regulations to accomplish its public functions.³
- Issue General Obligation Bonds

Every health district has taxing authority, but is not required to exercise that authority.⁴ As a public corporation, a health district has the authority to own assets, enter into contracts, participate in court proceedings, and incur debt.⁵

What is required to create a health district?

² ORS 440.320(1)(a).

³ ORS 440.360.

⁴ ORS 440.395(1).

⁵ ORS 440.360(2).

By law, the process for creating the TCCIC three-county district would be centralized in Multnomah County because it is the county that would have the greatest portion of assessed property

tax value in a tri-county district.⁶ However, as a matter of practicality and intent, creation of a district would require agreement and close cooperation among the counties. The Multnomah County Board of Commissioners (MCBC) would have jurisdiction for conducting the process creating the district, holding hearings and receiving public input.⁷ The county officers of Clackamas and Washington counties are required to cooperate with Multnomah County officers and provide Multnomah County officers with information necessary to create the three-county district.⁸

Several requirements must be met before the vote is called on the question to create a health district:

- preparation of an economic feasibility statement,
- designation of district boundaries, and
- approval of all cities within the proposed district.⁹

The process must also include evaluating the service impact for other non-school governments resulting from the creation of the health district.

How is a health district created?

Either an initiative petition or a county board resolution can be used to start the creation of a health district.¹⁰ A general flowchart outlining the process is attached.

⁶ ORS 198.705(16).

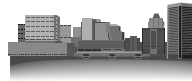
⁷ ORS 198.725.

⁸ *Id.*

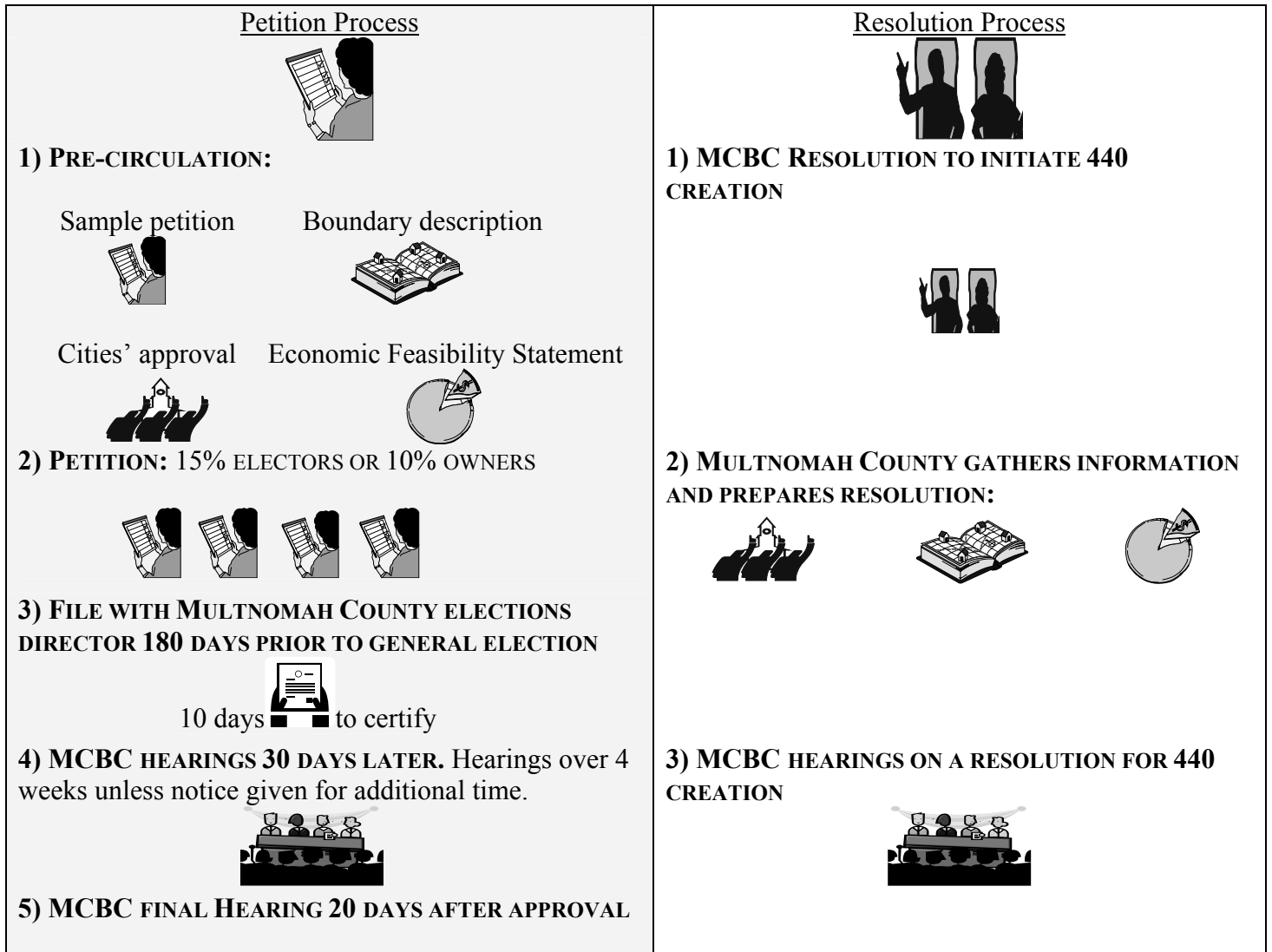
⁹ ORS 198.748; 198.749; 198.750.

¹⁰ ORS 198.745; ORS 198.750.

1. ORS 440 CREATES A MUNICIPAL CORPORATION



2 WAYS TO CREATE



MCBC ISSUES ORDER FOR ELECTION 68 DAYS BEFORE ELECTION

MAY



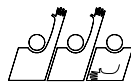
NOVEMBER

APPROVAL MAY REQUIRE A DOUBLE MAJORITY

Majority of electors

AND

Majority of electors participating
(unless general election in even year)



Examples:

1. **Morrow County Health District:** Created in 1995, serves the health care needs of the people of Morrow County. The district provides health services by facilitating a hospital, two health clinics, a nursing home and other health related services. It was developed under ORS 440 and collects taxes as outlined in the statute.
2. **Tri-Met:** Though not a Health District, Tri-Met was developed, as a special transportation district to meet the transportation needs of the residents in the Metropolitan area. The law allowing for the creation of the district also allows for the collection of fees and taxes (business income and others) to facilitate its charge to carry out transportation provision and planning services. The board of Tri-Met is appointed by the state's governor and identified from the region's constituent base.

**Proposal to the Blue Ribbon Panel
To Consider a Fourth, Interim, Option
Prior to Creating a Health Care Safety Net Authority**

Problem Statement

Significant numbers of low income residents in the tri-county area lack health insurance, are enrolled in the Oregon Health Plan but not receiving medical care due to lack of system capacity, or are not enrolled in State-subsidized resources to which they are entitled.

When people lack access to health care their quality of life is diminished, parenting and child development can be compromised, absenteeism from school and work increases, minor and preventable health problems can progress to serious or handicapping conditions, and untreated communicable disease threaten the larger community. Lack of access to economical primary care often results in the unnecessary use of more expensive resources, particularly hospital emergency departments. In addition, delayed treatment results in higher health care costs, such as specialty or in-patient hospital care, when treatment is finally obtained.

The number of low income uninsured, and OHP-enrolled but unserved, is growing, while the resources available to them are shrinking. Rising health insurance costs, decreasing employer-based insurance coverage, decreasing OHP participation by Managed Care Organizations and health care providers, reduced benefits for OHP members, recession driven loss of employment and State and local budget cuts, all converge to place increasing demand on a fraying local health care safety net.

No State law, statute or regulation identifies and charges any specific entity with responsibility for assuring access to preventive and primary health care for Oregon's uninsured.

Current Proposal

The Tri-County Communities in Charge effort posits that a tri-county solution has a greater potential to address the weaknesses in the local health care safety net than if Clackamas, Multnomah, and Washington Counties work independent of each other. The benefits of a tri-county solution include: improved economies of scale; a coordinated approach to funding; geographic equity; sharing of risks and resources; reduced duplication of effort; improved planning for an effective, regional system of care; and one entity for grant-makers to respond to, rather than choosing among applications from the three counties. Creation of a Tri-County Health Care Safety Net Authority has been proposed as the model by which these goals can be realized.

The proposed Health Care Safety Net Authority is expected focus on four areas:

1. Systematizing the gathering and analysis of tri-county data for planning purposes.
2. Analyzing and enhancing current funding sources, and pursuing additional revenues.

3. Expanding service capacity.
4. Developing mechanisms to assure appropriate, high quality care.

Blue Ribbon Panel Members have been presented with three structures by which the Health Care Safety Net Authority could be implemented to address these four needs:*

1. A Non-Profit Corporation (501c3)
2. A Municipal Corporation created through a Tri-County Intergovernmental Agreement (ORS 190)
3. A Tri-County Health District with taxing authority (ORS 440)

A Fourth Option

At the third Blue Ribbon Panel meeting on February 6, 2002, several participants questioned whether enough is known about the nature and scope of the need, and potential solutions, to know what structure will best address the challenge of health care for the uninsured and unserved. They questioned the wisdom of investing the time, effort, and expense required to create one of the above three structures before more ground work has been laid.

They suggested that many preliminary and “less controversial” tasks, AKA “low hanging fruit,” can and should be successfully completed before a new structure can be created. They believe that working together to pick the low hanging fruit will also provide an opportunity to further explore potential models, and allow for the necessary development of effective working relationships among participants.

It is believed that taking more time at this phase of the work will strengthen the case which must be made to the public in order to move forward with an ORS 190 Corporation, 440 Health District, or other more formal structure. With this in mind, a fourth option is offered for Blue Ribbon Panel Members’ consideration.

The Tri-County Health Care Partnership

The name Tri-County Health Care Partnership was offered as a working title. Discussion then focused on what kind of structure would bring necessary and important partners together to focus on the incremental steps, which will be defined collaboratively by Blue Ribbon Panel members. Initially, an ORS 190 Intergovernmental Association was proposed.

ORS 190 is the statute which authorizes Oregon governmental entities to enter into formal agreements with each other. ORS 190 allows the creation of Intergovernmental Corporations, like Health Care Safety Net Option 2, above, or Intergovernmental Associations, which are simply formal agreements among governmental organizations to work together for prescribed goals, in prescribed ways.

Blue Ribbon Panel members discussed the possibility of creating the Tri-County Health Care Partnership through an ORS 190 Intergovernmental Association, a widely used and recognized mechanism. But on further review, an important drawback led this option to be laid aside; i.e., legally, ORS 190 can commit only the governmental partners to the task. Using ORS 190 would put responsibility for addressing indigent

* A description of the three model is available on pages 15-23 in Blue Ribbon Panel Meeting Book Number 2, dated January 9, 2002.

primary health care on the shoulders of the three county governments, without involving the other key players. The preferred structure would bring all interested and contributing partners to the table on equal footing.

The question then arose, what similar formal mechanism could be used to create a Tri-County Health Care Partnership? The proposed structure is an association or consortium created through a series of Memoranda of Understanding (MOU) signed by each participating organization, including the three counties. As envisioned, each participating organization would sign a clear and explicit MOU, some aspects of which would be common to all partners, others would be agency specific.

The work of the proposed Tri-County Health Care Partnership must be defined collaboratively by the Blue Ribbon Panel members. Once that has been done, each MOU would state clearly, in measurable terms, the organization's commitment to the purpose, goals, governance, and success of the Tri-County Health Care Partnership. The MOU also would define organization-specific contributions such as staff time (which staff, with what expertise, how many hours a week, focused on what task, length of commitment), access to agency data (what data, within what time frame), financial contributions (amount, purpose, disbursement schedule), work space, etc.; whatever needs are identified by the whole group and agreed to by specific agencies.

The Tri-County Health Care Partnership would serve as a temporary organization, offering a development framework for accomplishing specific work, defined by the Blue Ribbon Panel. The Partnership would lay the groundwork for the creation, and marketing, of a more formal Health Care Safety Net Authority, when the time is right.