Roll Call & Introductions

Andrea Fletcher, Chair, began the meeting at 10 AM.

Members in attendance: Gary Brooks, DMD, Pam DeVisser, FNP, Wayne Endersby, Andrea Fletcher, Heather Lewis, Kevin Miller, DO, Ted Molinari, Candye Parkin, And Charles Wardle, OD.

Oregon Office of Rural Health (ORH) Staff: Robert Duehmig, Hilary Henderson, Julie Hoffer, Eric Jordan, David Senft, and Annalee Venneri

Guest: Diane Lund-Muzikant

Q = Question, A = Answer, C = Comment

Approval of October Agenda

The October 2014 Agenda was moved and approved, with one change: members departing early were allowed to make their reports shortly after lunch.

Approval of July Minutes

The July 2014 Minutes were moved and approved as written.

Introduction of New ORH Staff

Mr. Duehmig introduced new staff at ORH: David Senft, PA-C, MPH: Clinic Technical Assistance Specialist, and Annalee Venneri: Workforce Services Coordinator. Both staff members provided background and insight into their work.

Old Business

Future of Public Health Task Force

Mr. Senft provided an update on this task force. When he reviewed their previous minutes, he was looking for public input and rural concerns. In his findings, public input was fairly limited, and seemed to be primarily from public health professionals. As a result, ORH provided input, which was accepted into the record.

There was also consolidation at the county level, which seemed to be addressed in the considerable flexibility in implementation of the new model. A multi-county approach was also allowed should that be appropriate.
The Task force recognizes a funding shortfall. Oregon currently ranks 46th in public health funding.

Q: Are we ranked so low because of state or federal funding?
A: It seems to be at the state and local level.

Two Task Force members did mention in their final meeting that rural has special considerations.

Q: Was there any place in the document where you saw reference to which good programs are currently existing in rural and frontier?
A: I don’t feel like we got to that point, but there is built into the plan an analysis of strengths and deficits.

Q: Will the Legislature dissolve or continue the Task Force?
A: It looks like it will be repurposed as an Advisory Committee for the Legislative session. So far as rural health is concerned, there is specific mention of rural health being represented on this new Advisory Committee. Additionally, there will be four counties that will be beta pilots for the program, with rural designation as a specific criterion for selection of some pilot sites.

Q: Have they determined the selection criteria for the counties?
A: It is enumerated, yes.

Q: Did you see anything in those initial attempts that were specifically sensitive to rural and frontier?
A: Only generally as it pertains to the pilot site selection.

Q: Is there a timeline for the roll-out?
A: Ten years was mentioned, in verbal comments, during the final meeting for the complete roll-out of the process, but no real specifics are stated in the plan as it currently exists. There was some concern regarding the lack of specifics and potential for multiple tracks.

Q: Do they outline when version 2.0 of the Task Force will launch?
A: No, nothing specific.

Q: What are the goals of this Task Force?
A: Define foundational public health capabilities that state public health should address, which roll out into subsections for implementation as services.

C: When I read the document, I did not find any evidence of them identifying what is working and should be supported in rural or frontier, only they were looking for a paradigm that would be better suited to a more populated area.
C: My experience is that each county is already addressing their needs and that a cookie-cutter model might hamper efforts already working well.

Q: Did they address or mention Douglas County relinquishing mental health authority to the state?
A: My impression is that would no longer be an option.

C: My reading is the cookie-cutter happens at the foundational level, leaving the counties to be able to address their needs.

Q: Does the term “public health” mean that each county will have to form a taxing district and “public health” entity, or is there recognition that these needs might already be met within the county?
A: Two years ago there were four counties that had signed their public health over to other agencies. Columbia County, with its private foundation overseeing public health, was one of those four. Last year the Department of Justice determined we had to re-negotiate our contract between the county and the foundation, which resulted in fewer dollars going to public health.

Workforce Team Update

Ms. Hoffer, Ms. Henderson, and Mr. Duehmig presented an overview on ORH’s Workforce Services.

C: Perhaps you could connect with Samaritan’s residency programs.

Q: What is your definition of underserved?
A: There is a federal shortage area definition that we follow.

Q: Does a successful match mean placement?
A: Yes, once the contract is signed.

Q: How many postings do you get in a year?
A: We average 70 postings, although that is increasing and last August we got up to 90.

Q: Was there any serious attempt to take away any funding of these programs?
A: They have sunset dates for review and analysis, but no attempts we know of to discontinue programs.

Q: Regarding the Behavioral Health program, can telehealth be considered?
A: At this time, it needs to be on-site, not performed remotely.
Q: Is the 50% Medicaid enrolled or eligible.
A: It needs to be enrolled, as we require sites to give us their numbers for a previous year.

Q: How many dentists inquire for the various programs?
A: Quite a few! About a quarter of the inquiries are from dentistry.

Q: Do sites have to apply to become eligible?
A: Yes, and we have a site application for our programs.

Q: Do they have to use the match program (SLRP)?
A: No, we help them determine which program is best for them.

Rural Incentive Programs Discussion

Mr. Duehmig facilitated a brief discussion on the rural incentive programs, which are all sunsetting December 31, 2015. Regarding the loan repayment and forgiveness programs, they are still fairly young, so there is not much data available on them yet. This makes it difficult to present a solid case for the continuation of these programs.

Q: Is there any information that reviews the loan candidates’ view of attraction towards one state over another?
A: Not really.

C: When you look at what the tax credit program means in bringing practitioners into rural, versus communities in need that are not recruiting practitioners in, being able to demonstrate the positive financial impact that those practitioners bring to those communities is a very powerful selling point to legislators.

Annual Oregon Rural Health Conference & Apple A Day Fundraiser Report

Mr. Duehmig provided a recap on the annual Oregon Rural Health Conference, as well as the Apple A Day Fundraiser.

We had great success in getting people registered for and engaged during the conference.

The Apple A Day Fundraiser raised just shy of $10,000, and that was with fewer auction items this year.

ORH Staff Reports

Mr. Duehmig highlighted a few of the ORH staff reports.
The Administrative Team has been busy preparing for and pulling off the annual Oregon Rural Health Conference.

Mr. Senft has hit the ground running and helped put together the RHC Workshop at the conference.

Mr. Ong has been updating quite a few data sets, as well as helping Ms. Trick develop a MBQIP database for federal reporting.

Q: Is the MBQIP reporting the same for every state?
A: It is, but the vendors are lagging in the reporting, so the SORHs are stepping up to fill that in.

The Field Services Team, particularly Ms. Trick and Ms. Guardino, are in the midst statewide hospital listening tour, and will be accompanied by partners from OAHHS.

Q: What’s happening with the Telehealth Pilot Grant?
A: Oregon received a federal State Innovation Models Initiative (SIM) grant from CMS, a portion of which funds telehealth pilot projects in the state. The OHA contracted with ORH to administer the pilot project grant program.

Q: What is the likelihood of a small organization being granted, while being up against a big professional organization?
A: It is very good! It is the applicant’s concepts and ideas that matter.

RHCC Member Reports

Candye Parkin, Oregon Association for Home Care

This week is the National Home Health Conference, so many members are attending. The face-to-face requirement is a barrier for patients receiving home health and hospice. As a result, the National Association has filed a lawsuit to strike that.

Pam DeVisser, FNP, Oregon Nurses Association

We recently had a Psychiatrist leave Astoria, but we were able to recruit a Psychiatric Mental Health Nurse Practitioner. There was a Road to Wellsville Grant awarded to Clatsop County. Providence is now providing palliative care to the north coast. Census went from 60 to over 100. Providence’s ElderPlace is also expanding to Seaside. There is a Pediatrician who is expanding her services from Astoria to Tillamook. She is certified in diagnosing Asperger’s and Autism. We’ve been mentoring NP and PA students. A big issue moving forward in rural medicine will be limits on narcotics prescribed per patient. The limit will be 120mg equivalent of morphine a day, while there are some patients on are on over 600-
800mg per day. It seems that CCOs will be limiting what they will reimburse for narcotics as well.

Q: Is that limit for hospice and palliative as well?
A: Yes. Diversion of these drugs is a big problem across all populations.

Wayne Endersby, Oregon EMS Association

We had some training out in Richland with the Mobile Training Unit (MTU). The MTUs are now doing webinars as well as the hands-on trainings. Our agency’s problem is that we do not have a proper set up to hold webinars. My concern with the future of the MTUs is that they are funded through the medical marijuana cards. We need to be proactive in securing MTU funding should recreational marijuana pass. I still wonder what happened with the year of MTU funds that went unused.

C: It’s not just the MTUs that are funded through medical marijuana cards; it is the whole EMS/Trauma system. I know that there are already discussions underway to handle the funding should legalized marijuana pass.

Gary Brooks, DMD, Oregon Dental Association

Dentistry is struggling a bit right now with new graduates going into corporate dentistry rather than private practice. Most mid-levels will most likely be working in public clinics.

Not that this is necessarily dental-related, but, due to full panels at practices, we are having a big problem with patients not being able to see practitioners in their communities, so are having to travel great distances to seek care.

C: I’ve been seeing this on the coast as well. I can’t even get patients into pain clinics in metro areas for over a year as a result of them having already met their OHP/Medicare numbers.

Q: Moving back to dentistry, has "drill and fill" moved into Oregon yet?
A: It’s a program that meets 80% of dental needs, but it has not yet come to Oregon. Mid-level schools have opened in Minnesota and perhaps Massachusetts to be able to meet this kind of service. This is something that has been running for over 100 years in the United Kingdom.

I perceive that the government will need to fund the total cost of mid-levels’ education, then have a service commitment in order to pay it back.
Andrea Fletcher, Consumer - Eastern Oregon HSA #3

A food-borne illness prompted licensure of temporary businesses. Some local places were impacted, including concession stands. While the fundamental premise is sound, I wonder where the need meets the practicality.

Q: Does this apply just to the venue or to the food handlers as well?
A: It applies to both.

Kevin Miller, DO, Osteopathic Physicians and Surgeons of Oregon

Dr. Miller brought up the issue of burn-out in his profession and reported that he has made some potential progress in decreasing the clerical work in his practice. Some clinicians are hiring scribes, but that means additional cost. Dr. Miller then brought up the idea of looking at the prior authorization process, noting the increasing requirements for them by CCOs. He suggested that if a doctor meets a certain level of excellence as measured through the National Committee for Quality Assurance, no prior authorization should be required. This would also push physicians toward higher quality using incentive rather than penalty. Senator Wyden is looking into this at the federal level.

A motion was made, seconded and passed asking Dr. Miller to facilitate a concept paper dealing with preauthorization and its role in quality of care. The motion passed.

Q: Are the prior authorizations for just meds, or procedures, or both?
A: Initially just meds, but really both.

Q: Is this Medicaid/Medicare or insurance?
A: In central Oregon, both.

Q: Did you approach your CCO about this concept?
A: No, not yet.
C: It might be wise to reach out to them, as it could decrease their overhead as well.

Heather Lewis, Consumer - Community <3500

Columbia County has had an increase in rave parties, so there is now legislation at the county level to begin to regulate and permit these on a public safety basis. We were awarded a grant for a School-based Health Center (SBHC) in Scappoose. It will hopefully be up and running next year. We are looking for a new provider in Vernonia at the Community Health Center. We are rotating the SBHC workers through the Community Clinic in order to keep the clinic’s doors open.
Q: Was the implementation of the School-based Health Center already underway?
A: Yes. The Public Health Foundation saw that the funding streams were narrowing. So as a commitment we made as a Board to help support communities where there is a shortage of these services, we began opening these SBHCs in communities without providers.

**New Business/Public Input**

No new business or public input was discussed.

**Adjourn**