Roll Call & Introductions
Andrea Fletcher, Chair, began the meeting at 10:12 AM.

Members in Attendance
Gary Brooks, DMD, Oregon Dental Association (ODA); Bruce Carlson, Oregon Medical Association (OMA); Andrea Fletcher, Consumer – Eastern Oregon HSA #3; Heather Lewis, Consumer – Community <3,500; Ted Molinari, Consumer – Community <3,500; Candye Parkin, Oregon Association for Home Care; Michael Patrick, Oregon State Board of Pharmacy; Judy Peabody, Oregon Association of Naturopathic Physicians.

Oregon Office of Rural Health (ORH) Staff
Scott Ekblad and Eric Jordan.

Guests
Diane Lund-Muzikant, The Lund Report; Tami Ticknor, West Valley Fire District.

Q = Question, A = Answer, C = Comment

Approval of January 2015 Agenda
The April 2015 Agenda was moved as written by Mr. Molinari, seconded by Dr. Brooks, and approved unanimously.

Approval of October 2014 Minutes
The October 2015 minutes were moved as written by Mr. Molinari, seconded by Dr. Brooks, and approved unanimously.

ORH Updates

Apple A Day Update
Mr. Ekblad outlined the Apple A Day (AAD) Advisory Group meeting, which discussed two items: the latest round of applications for agency training grants, and a review of this grant program from its inception to present time.

The group decided to fund all five agency applicants in this round of awards.

Regarding the review of the program, a concern has arisen that a relatively few individuals and agencies are applying repeatedly. While we know that there are far more in the state that could be eligible, these others are not responding to our efforts to help support them.

Q [Ms. Lewis]: Is there an opportunity to change the criteria so that HPSAs are weighted heavier?
A [Mr. Ekblad]: Yes, that is entirely possible. It should be noted that we already prioritize towards the most remote, and in need agencies.

C [Dr. Brooks]: I think that if you looked at who all has been receiving these grants, you would see that they are indeed truly rural. No one in a metropolitan setting is receiving these grants.
Q [Ms. Parkin]: Do we think that there are fewer volunteers? Are they having trouble with recruiting people to volunteer in this way?
A [Mr. Ekblad]: Yes. That is why we decided to create this grant program. We were beginning to hear about the lack of volunteers, or the problem of retaining them, so decided this would be a way to offer assistance directly to those volunteers.

**Field Staff Update**

One ORH Technical Assistance (TA) position is currently open for hire. The two TA field staff positions were restructured along the lines of our funders’ and constituents’ needs. Maeve Trick stepped into the Program Manager: Rural Health Systems position. The Program Manager: Rural Health Outcomes position is the one that is currently open.

**Conference Planning**

ORH is planning the Annual Rural Health Conference a bit differently this year. We held a call for proposals from potential presenters, and received many excellent responses. We were able to fill the conference agenda almost entirely with the session proposals received.

**Community Paramedicine: West Valley Fire District**

Tami Ticknor, Paramedic, presented on the Community Paramedic Program in West Valley Fire District. Ms. Ticknor provided a brief background summary on her own path towards paramedicine, as well as an overview on Community Paramedicine as a concept and its evolution to how it exists today in rural Oregon.

Q [Mr. Molinari]: You are an employee of West Valley Fire District, and there are certain levels of care that you are able to provide that a normal paramedic cannot?
A [Ms. Ticknor]: Yes, that is essentially it. There is a separate set of protocols that I must follow as a Community Paramedic.

Q: [Mr. Molinari]: In Wheeler Co, we have the Asher Clinics, but no paramedics that I know of. Is there some set of criteria that outlines a community profile for this type of program? Wouldn’t there be some level of competition between Community Paramedics and an established clinic?
A [Ms. Ticknor]: I have spent time in your community on fire lines, so am aware of your situation. It is a little more challenging there, certainly.

C [Dr. Brooks]: Community Paramedics only work on referrals. So the Asher Clinic would have to refer to a Paramedic. It’s my understanding that as long as you stay in the parameters of scope of license, it could be done by other EMTs.

Ms. Ticknor noted that each Community Paramedic program is developed to the needs of each community – no two are the same. The program is also so new that new questions pop up all the time.

Q [Ms. Fletcher]: This is a great program. Can you work with your local Coordinated Care Organization (CCO) to help deliver the best, most efficient care, be it supplied by you, home health, or other practitioners that might make home visits?
A [Ms. Ticknor]: Yes. The Forest Grove Fire Chief and Scappoose EMS Chief have both contacted us...
Rural Health Coordinating Council (RHCC)
April 16, 2015, 8699 SW Sun Place, Wilsonville, OR

to model our program. The program in Redmond is working closely with their CCO. In our program, we are actually filling in the home health gaps in Polk and Yamhill counties, where home health has been over-referred.

Q [Ms. Parkin]: Do you see a lot of patients being non-compliant as a result of mental health issues?
A [Ms. Ticknor]: Yes, we do. We have a few programs that we can refer to, so those help in some ways, such as peer support and exercise.

Q [Ms. Fletcher]: Do you feel that you have a good support network for referrals or anything else that might come up?
A [Ms. Ticknor]: Yes, and it has grown since I started in November. Mostly this is really great for CCO patients, but with Medicare patients, there still is not that level of support. In discussions with the CCO concerning this shortfall, they had already identified this problem and are working to remedy it.

Q [Ms. Lewis]: Are there regulations surrounding developing programs like this that require this work to be done only by Paramedics, or can other EMTs work within their scope of license to provide some level of these services?
A [Ms. Ticknor]: It’s still so new that there is not any one set of standards. It also depends on the physician advisor and what the patient community needs are. Reimbursement through insurance companies concerns are also an issue at this point. If you can get the local CCO on board, that helps tremendously with varying levels of EMTs.

C [Dr. Brooks]: If we went to a smaller, more rural town, the community clinic would need to decide if referring to a non-Paramedic is appropriate.

C [Mr. Patrick]: Redmond’s program is also running well. They keyed in on the frequent flier patients and are getting the repeat visits down. It really seems to be meshing well with home health in our community.

**2015 Legislative Session**

*ORH Legislative Update*

Mr. Ekblad discussed the challenges faced by the owners of Orchid Clinic in Oakridge as they established that federally certified Rural Health Clinic (RHC). The law currently requires that professional corporations organized for the purpose of practicing medicine must be majority owned by a physician. Neither of the entrepreneurial owners are physicians, and had to recruit a physician as a silent partner. Orchid’s owners had Senate Bill (SB) 880 introduced to remove this requirement for RHCs and businesses that provide only palliative care.

Dr. Carlson has looked into this along with Mr. Ekblad and cannot find any rule that actually stipulates physician ownership – it seems to be a by-product of them forming as a Professional Corporation. Other types of legal business that an RHC can be, say LLC, do not have this requirement.

Q [Ms. Parkin]: Who is providing the care at this clinic?
A [Mr. Ekblad]: They have a PA or an NP, who has a supervising physician.
Q [Ms. Fletcher]: Is the bill just for this clinic, or is there a need elsewhere in the state for this legislation?
A [Dr. Carlson]: What they are trying to do is change the law for Professional Corporations. So it would apply across the board for all of these business types. At one point, they identified 22 different communities in Oregon that could benefit from this type of clinic.

**Rural Practitioner Tax Credit (SB 37 & HB 2125)**

These bills simply extend the sunset date on the tax credit. The general consensus is that there has not been a thorough evaluation of this or other rural incentive programs, such as loan forgiveness and loan repayment. The goal is to extend the sunset date for this program, and allow a third party to analyze the incentive programs during the interim and report back to the Legislature on how well these programs meet the needs of the state.

**Health Care Workforce Data Collection (SB 757)**

This bill would fund the evaluation mentioned above, and require an annual report to the legislature on state incentive programs.

**Loan Repayment (HB 3396)**

The Legislature created a loan repayment program in 2013 for primary care providers who serve Medicaid patients in rural and underserved urban areas. This program needs funding in order to continue, which was not requested by the Oregon Health Authority (OHA) in their budget. HB 3396 would move the program to the ORH and combine it with Loan Forgiveness funds. An advisory committee would then determine how the funds would be distributed among the two programs on an annual basis.

Q [Dr. Carlson]: Will this program still be Medicaid slanted? It seems like most of the money in this program is going to urban settings.
A [Mr. Ekblad]: If it comes directly to our office, we could change the parameters of the program. Most money in this program is likely going to urban, as that is where the majority of the Medicaid patients are located.

**Rural Malpractice Subsidy Program**

This program is funded in OHA’s budget, so there is no bill needed to continue it.

**Telemedicine (SB 144)**

This would allow for reimbursement of telemedicine services when a patient is not actually in a clinical setting. The service could be provided when the patient is in other locations, such as school or one’s home. There is no cost to the state on this one.

**RHCC Member Legislative Update**

**Heather Lewis, Consumer - Community <3500**

Funding for Student-based Health Centers (SBHC) is also before the legislature. Some feel that those health centers are in competition with community clinics, but what we have found in our
community is that they are highly collaborative with each other. There can often be a greater continuity of care from one to the other.

Michael Patrick, Oregon State Board of Pharmacy

SB 520 has passed the Senate and is on to the House; it would lower the pharmacist immunization rate to age 7. Representative Buehler announced an amendment to allow pharmacists to dispense birth control without a physician’s prescription. There is also a couple of House bills to increase prescription monitoring databases. There is also a bill to add pharmacy technicians to the Board of Pharmacy.

Bruce Carlson, MD, Oregon Medical Association

The Oregon Medical Board (OMB) submitted legislation to become a quasi-state agency. This will allow their budging process to be a bit more nimble. Legislation was introduced to add a Physician Assistant (PA) to the OMB and dissolve the PA Advisory Committee. Dr. Carlson worries that rural concerns will be unintentionally excluded should this advisory committee be dissolved.

RHCC Member Reports

Bruce Carlson, MD, Oregon Medical Association

Eastern Oregon CCO

We are still seeing an increase in numbers in our 12 counties, with some still on direct Medicaid. There was a CCO profit report which reflected that none are running a deficit.

Pendleton

We have a new case manager in Pendleton. The Independent Physician Association has 60-70 members. We are working with an outreach manager for the members and programs. She’ll be working with the ORH on problematic practices. In running a solely Medicaid practice, we sometimes have to check the jail roster for our no-show patients. In our community, there is some slight competition with the School-based Health Centers (SBHCs).

Christmas Valley

The Nurse Practitioner (NP) there will be taking over for me on July 1. They may or may not remain an RHC.

And on a sad note, Dave Jones, former RHCC member, and rural PA and EMT, passed away at the end of January.

Candye Parkin, Oregon Association for Home Care

One big focus is partnering with physicians’ offices and hospitals to minimize readmissions in hospitals.

Home health signing by NPs is still a national problem that we are chipping away at. We appreciate those that visited DC in taking our concerns to the federal level.
Heather Lewis, Consumer - Community <3500

We are expanding our relationship with Pacific University in Columbia County, working with the Schools of Psychology and Physical Therapy. We are also reaching out to other teaching institutions to do rotations in our clinic.

We will be opening a new SBHC in Clatskanie next month, with Coastal Family as its medical sponsor. Scappoose will have one in the fall.

Michael Patrick, Oregon State Board of Pharmacy

Oregon State University Pharmacy students were able to go to the state capitol and help with immunizations. I retired from my pharmacy at the end of March.

Gary Brooks, DMD, Oregon Dental Association

EMS

State Forestry and Bureau of Land Management have signed contracts for summer fire relief work, which could be in-camp support.

Overall, contracting EMS with the CCOs seems to be working well.

Dentistry

Dentistry has been going through a big re-organization in the past 18 months. Utilization is up, but provider numbers are remaining flat. Fortunately, some of the bigger corporate players are stepping in to fill these gaps.

Andrea Fletcher, Consumer - Eastern Oregon HSA #3

There is a new project ramping up that is due to the Community Health Improvement Program (CHIP) we had five years ago. This project is a SBHC in Ione. The EOCCO formed a fundraising effort and decided to hire an Executive Director to move this kind of development forward beyond the Medicaid population.

Adjourn

Ms. Fletcher adjourned the April meeting of the Rural Health Coordinating Council at 1:53pm.