

Ellen Lowe Statement

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When 15 years ago our Governor asked me to join the Health Services Commission, I was not unaware of the difficulties in expanding access for poor Oregonians to medically appropriate care. I along with many other stakeholders was an observer as the thumb sucking line emerged. But I had also been an observer over the previous 3 legislative sessions as shortcomings of the traditional Medicaid program were illustrated by the sharing of very tragic human stories. The system was broken. In my work with the faith and not-for-profit community, stories of the human and monetary costs of the lack of access to timely, appropriate health services were also frequently shared with me. Both the categorical population and the working poor had unmet health care needs.

I should acknowledge that there were some individuals and groups who feared that this new approach would endanger the current categorically eligible. They weren't very confident that the two birds in the bush wouldn't fly away. They came to our regular meetings as well as to our listening sessions, asked questions and educated us. The openness, responsiveness and the leadership of the process built trust. In fact local health related advocates became the advocates with their national counterparts. I appreciated being able to be part of some of those conference calls.

My work and my volunteer activities gave me access to many individuals with poor health status, but I also spent some time reaching out to folks I thought would not come to an official hearing or have come to the attention of a helping agency. I do not believe I was unique among the Commissioners in this informal fact and value finding. This brought me to several laundromats on Saturday mornings where I tried to engage young families in a conversation about health services as their clothes dried. Granted this wasn't very scientific, but it served to broaden my understanding of the time pressures on young low-waged families. It isn't just what the benefits are, but when and where they are available.

I wish to highlight several services which I do not believe would have had their current placement without citizen requests. This was particularly true of dental care. It had not been part of the adult Medicaid program, so we heard from the Medicaid population. We also heard from the working poor. When asked why dental was not considered a medical service, I was always hard pressed to come up with an answer that satisfied me, let alone them. Our Commission would have ignored the people who came to us with their stories if dental care had been bypassed. Another area was mental health. Tradition in both the private and public system called for continued separation, but the public didn't. Nor did many primary care physicians. Their belief in the efficacy of the integration of mental and physical health services advanced the practice, but institutional barriers, in my judgment, still keep us from full integration. The documented community costs when the Oregon Health Plan Standard population lost mental health services serve as a reminder that anything less than integration is penny wise and pound foolish.

Our Comfort Care line evoked considerable discussion about the meaning of healing. In my age group I had long heard criticism of what was deemed futile, expensive and sometimes painful care in the last months of a terminal illness. Families openly questioned why there was public financial support for aggressive care, but there was no assistance for palliative care. Palliative care does not come without some financial cost; they were seeking modest help for patient choice. With the current acceptance of hospice, it seems strange that just a few years ago, this choice rarely received governmental assistance and often no health insurance support. Our definition of healing had to be expanded and as it was, changes in private insurance plans also began to emerge. Oregon continues to be a leader in hospice.

I would frequently attend the outcomes sub-committee open meetings in an effort to more fully understand health conditions and possible treatments. As the physicians shared their findings and the views of the physician panels they consulted, I was impressed with the depth of their knowledge, but I also heard them acknowledge the need to seek more information. The lack of data could have become an excuse for closing down our project

but it became the impetus for periodic review of the condition-treatment pairs and for stimulating more research on effective treatments. I do not recall using the term evidence based medicine 15 years ago, but that was what we were about – it is what we are still about. The Oregon Health Plan by its very nature is a work in progress.

In the Oregon Health Plan, I believe a real strength is the success of using community based coordinated plans, managed care if you will, for the delivery of clinical and ancillary health services. For the unorganized I have come to know so well and for the time constrained working poor, these plans often work with neighborhood clinics with extended hours. They also simplify access to specialists and work with other community based groups to coordinate access to other vital support services. They are a community resource.

I believe the Oregon Health Plan can be a national resource.

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