MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

AGENDA OF

MEETINGS OF THE MULTNOMAH COUNTY BOARD OF COMMISSIONERS

FOR THE WEEK OF

August 8 - 12, 1988

Tuesday, August 9, 1988 - 1:30 PM

Multnomah County Courthouse, Room 602

INFORMAL

1. Informal Review of Bids and Requests for Proposals:
   a) Regner Road

2. Presentation on Pre-School Screening - Wanda Silverman, Portland Public Schools

3. Informal Review of Formal Agenda of August 10

NOTE EARLIER STARTING TIME OF MEETING

THURSDAY, AUGUST 11, 1988 - 8:30 AM

MULTNOMAH COUNTY COURTHOUSE - ROOM 602

EXECUTIVE SESSION

The Board of Commissioners will hold an executive session for the purpose of discussing labor negotiation issues allowed under ORS 192.660(1)(d) - Ken Upton

Thursday, August 11, 1988, 9:30 AM

Multnomah County Courthouse, Room 602

Formal Agenda

REGULAR AGENDA

BOARD OF COUNTY COMMISSIONERS

A R-1 Resolution in the matter of the Board of Multnomah County Commissioners accepting a report of the Metropolitan Human Relations Commission entitled, "AIDS and Discrimination: A Local Government Response" dated July 1, 1988 - Time Certain 9:30 AM

DEPARTMENT OF ENVIRONMENTAL SERVICES

A R-2 Order accepting deed for County Road Purposes from Chaud R. and Deborah J. Spitzer on SE 302nd Avenue

R-3 In the matter of ratification of an agreement for right-of-way services with the Oregon Highway Division for acquisition of required property and/or right-of-way for various County projects as authorized in the approved budget and/or by Board Order; and authorizes the Director of the Department of Environmental Services to request services and deposit required funds in accordance with the agreement

R-4 In the matter of ratification of an intergovernmental agreement with the Tri-County Metropolitan Transportation District (Tri-Met) to establish conditions for removal of unused railroad facilities and reconstruction of abandoned crossing on SE Division Street at approximately SE 198th Avenue

DEPARTMENT OF JUSTICE SERVICES

R-5 In the matter of ratification of an Intergovernmental Agreement with Portland Community College and Sheriff's Office to allow for GED testing for inmates at the Multnomah County Correctional Facilities

DEPARTMENT OF HUMAN SERVICES

R-6 In the matter of ratification of an Intergovernmental Agreement with Oregon Adult and Family Services Division, whereby the dates for the distribution of savings to County are extended an additional three months from August 31, 1989 to November 30, 1989

R-7 In the matter of ratification of Amendment #17 to the State Mental Health Grant whereby Social Services Division will receive an additional $2,603,511 to provide Community Integration Project services to severely, multi-disabled DD clients for FY 88/89

R-8 Budget Modification DHS #3 reflecting additional revenues in the amount of $2,569,155 from State Mental Health Grant to Social Services, various line items, and adds employees, to implement Amendment #17

R-9 Order in the matter of approving a Request for Credentials and Requests for Proposals for Emergency Ambulance Service (Continued one week from August 4)

Thursday Meetings of the Multnomah County Board of Commissioners are recorded and can be seen at the following times:

Thursday, 10:00 PM, Channel 11 for East and West side subscribers
Friday, 6:00 P.M., Channel 27 for Rogers Multnomah Fast subscribers
Saturday 12:00 PM, Channel 21 for East Portland and East County subscribers

Thursday, August 11, 1988 - 1:00 PM

Multnomah County Courthouse - Room 602

Board of Commissioners sitting as Policy Committee

to discuss issues related to

three standing committees

0397C.27-31

52
J161

August 11, 1988

The Board of Commissioners held an executive session for the purpose of discussing labor negotiation issues allowed under ORS 192.660(1) (d); and authorized Ken Upton, Employee Relations, to continue with negotiations as directed.

50
5161

MULTNOMAH COUNTY OREGON

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JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Ms. Gladys McCoy, Chair of the Board
1021 SW Fourth, Room 134
Portland, OR

Dear Ms. McCoy:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

In the matter of the Board of Multnomah County Commissioners accepting a report of the Metropolitan Human Relations Commission entitled, "AIDS and Discrimination: A Local Government Response" dated July 1, 1988 R-1	RESOLUTION #88-139

Commissioner Kafoury moved, duly seconded by Commissioner Casterline, that the above-entitled matter be approved.

Gregory Gudger, Multnomah Human Relations Commission Executive Director, read the Resolution, and requested the Board accept the report, and approve the Resolution. He agreed, at the request of Commissioner Kafoury, that the MHRC would review the Board's response to the report, and make comments or recommendations to the Board.

Jeanne Gould, Health Services, agreed to provide copies of the report to the public, and said the information will be covered in County employee AIDS training sessions.

Commissioner Kafoury said this was an extensive and complicated project which the Board appreciates, and commended the Commission for its good work.

At this time, the motion was considered, and it is unanimously

ORDERED that said Resolution be approved.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin
Jane McGarvin
Clerk of the Board

jm
cc: Commissioner Kafoury
Metropolitan Human Relations Commission

TIME CERTAIN 9:30 a.m.

DATE SUBMITTED 8-3-88

(For Clerk's Use)
Meeting Date 8-11-88
Agenda No. R-1

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: Resolution accepting a report of MHRC entitled "AIDS and Discrimination: A Local Government Response

Informal Only* 8-9-88 (Date)

Formal Only 8-11-88 (Date)

DEPARTMENT Non Departmental DIVISION BCC

CONTACT Bill Vandever TELEPHONE 248-3738

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD Gregory Grudger, Ex. Director, MHRC

BRIEF SUMMARY Should include other alternatives explored, if applicable, and clear statement of rationale for the action requested.

In the matter of the Board of Multnomah County Commissioners accepting a report of the Metropolitan Human Relations Commission entitled, "AIDS and Discrimination: A Local Government Response" dated July 1, 1988.

88-139

(IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REVERSE SIDE)

ACTION REQUESTED:

☐ INFORMATION ONLY ☐ PRELIMINARY APPROVAL ☐ POLICY DIRECTION ☒ APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA 15 min.

IMPACT:

☐ PERSONNEL

☐ FISCAL/BUDGETARY

☐ General Fund

☐ Other _____

BOARD OF COUNTY COMMISSIONERS
1988 AUG -4 AM 9:49
MULTNOMAH COUNTY
OREGON

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER:

BUDGET / PERSONNEL _____ /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts) _____

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

(8/84)

REPORT OF THE METROPOLITAN HUMAN RELATIONS COMMISSION

AIDS AND DISCRIMINATION
A LOCAL GOVERNMENT RESPONSE

July 1, 1988

Written by:

Claire Levine
Marsha Spellman

MULTNOMAH
COUNTY

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I. INTRODUCTION

I. INTRODUCTION

Two-hundred and forty residents of Multnomah County have been diagnosed as having AIDS since the county began keeping records about this illness -- 131 of those people have died. AIDS cases in Multnomah County represent 67 percent of the people known to have AIDS in the state.

The State Health Division projects that by 1991, 1689 individuals in Oregon will have been diagnosed as having AIDS. If the concentration of cases in Multnomah County holds up, we can expect to see nearly 1000 more cases of AIDS appearing in the Portland area in the next three years.

Clearly, the extent of the disease has not reached crisis proportions in Oregon, as it has in other parts of the nation. However, the continuing increase in AIDS infection promises to put stress on the full spectrum of human resource services--from health care providers to counselors, to providers of housing, food and other emergency services.

However, one of the greatest challenges to advocates and governments at all levels is to manage and minimize the fear that accompanies the AIDS virus -- a fear that often breeds hatred and anger. A byproduct of that fear is discrimination.

The number of people with AIDS in Oregon is small compared to the numbers reported in other parts of the nation. Consequently, the number of reported cases of discrimination is small, as well. However, as the AIDS problem grows in Oregon,observers expect the growth of fear and resulting

increases in discrimination to accelerate as well.

In addition, evidence demonstrates that many Oregonians are unaware of their legal rights with respect to AIDS. It is possible that discrimination occurs regularly but is not reported, because the individual involved is afraid of exposure to publicity, because he or she lacks awareness of existing protection against discrimination, or for a combination of reasons.

In recognition that problems related to AIDS will likely increase greatly in the next few years, the Metropolitan Human Relations Commission undertook research on AIDS-related discrimination. The goal was to review existing policies and procedures involving such discrimination and to look at activities the MHRC can undertake or promote to combat AIDS-related discrimination in Multnomah County.

While the MHRC realizes that the public health care policy issues of the AIDS epidemic must be examined and addressed, this is not the intent of this report. The short and long term medical care of people with AIDS is only discussed in the context of potential medical discrimination.

The following report details federal and local government activities relating to AIDS and discrimination. It also reviews the variety of areas in which the MHRC can advocate for public and private activities aimed at ensuring that Multnomah County represents both a safe and a non-discriminatory environment for all its citizens.

IV. NATIONAL OVERVIEW

II. NATIONAL OVERVIEW

ISSUES

AIDS is not the first epidemic in America's history to cause panic and concern. The "social hygiene" movement of the early twentieth century sought scientific advancements and moral strategies as a way of combating the hysteria around the rise of venereal disease.[1] The community response to the venereal disease epidemic included fear of contagion and unsubstantiated panic about casual transmission. Public health strategists tried to protect the health of the general population with little regard to the civil liberties of the sick individuals. [2]

While the public response to the two diseases are strikingly similar, what is different is the public health strategies and civil rights protections afforded the two groups. Compulsory testing and quarantine (including the internment of prostitutes) were central to public health policy during the turn of the century. Constitutional rights were second to the fear of the disease and its assumed effect on the general population.[3]

Medical advances in understanding the issues of disease transmission and concern for the rights of the individual have modified the implementation of public health procedures. Constitutional protections ignored during previous epidemics have been extended to cover individuals with infectious diseases such as AIDS.

AIDS as a Handicap

Several court decisions have established an individual's rights in AIDS-related public health policy. In the most noted of these, Arline v. the School Board of Nassau County:

> The U.S. Supreme Court determined that people who suffer from tuberculosis can be protected from employment discrimination by the Rehabilitation Act of 1973...The court held that a person afflicted with tuberculosis was a "handicapped individual" within the meaning of the Act...The Court concluded that "the fact that a person with a record of physical impairment is also contagious does not suffice to remove that person from coverage under [the Act]."[4]

While the implications of this decision as it applies to AIDS are not totally clear, the Supreme Court ruling on this case has set a precedent for determining that an infectious disease can create a handicapping condition, warranting legal protection of the individual so handicapped.

Many civil rights advocates and legal advisors believe that people with AIDS are included under existing laws offering protected status to people with handicapping conditions. The Rehabilitation Act of 1973 reads:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance...

A "handicapped individual" is further defined as:

> [A]ny person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.

To determine whether people with AIDS fall under the jurisdiction of this law, one must examine the five requisite elements of section 504. These key phrases are:

1) handicapped individual
2) solely by reason of handicap
3) otherwise qualified
4) excluded from the participation in, denied the benefits of, or be subject to discrimination
5) program or activity receiving federal financial assistance. [5]

By examining each element of section 504, most legal experts believe people with AIDS meet the requirements of section 504 and are therefore protected against discrimination under the law. Robert P. Wasson, Jr., in his review of legal protections after the Arline decision, wrote, "People with AIDS who are discriminated against by recipients of federal assistance should be able to obtain redress for such discrimination under section 504." [6]

It is important to note that since the Court did not specifically address AIDS as a handicap in the Arline decision, there is some discussion as to whether a conservative court would rule against AIDS as a handicapping condition. A controversial memorandum published by Charles J. Cooper of the U.S. Department of Justice, argues that

> ...persons who are infected with the virus but have no symptoms of the disease are not handicapped... Though these persons carry the virus, they suffer no physical impairments...So although they have a physical condition and even a physical imperfection, they do not have a physical impairment,...and thus not handicapped within the meaning of Section 504.[7]

Furthermore, two Reagan administration Supreme Court appointees supported this position in the Arline case. Chief Justice Rehnquist, basing his comments on Pennhurst State School and Hospital v Halderman (451, US1), was joined in a dissenting opinion by Justice Scalia. Chief Justice Rehnquist wrote:

> ...of the language of the Act, regulations and legislative history are silent on the issue...of whether discrimination on the basis of contagion constitutes handicap discrimination, it is therefore clear that the protections of the Act do not extend to individuals such as Arline." [8]

Clearly, while most legal experts believe that AIDS is a handicap meeting the requirements of section 504, it is important to recognize the future possible challenges to this belief.

AIDS and Discrimination

An executive of a multinational corporation, fired for having AIDS; a gay salesman at a department store terminated after he caught a cold which his supervisor feared was AIDS; a mother barred from visiting her children because as a nurse she treated HIV infected patients; and children denied entrance to their school classrooms because they carry the AIDS virus. These real-life scenarios indicate that discrimination against people with AIDS is a very real and growing problem.

From testing and confidentiality to employment, housing,

medical care, insurance and education -- numerous cases of blatant discrimination have been documented.

Not only are discrimination cases reported by people infected with the HIV (AIDS) virus, but there are many incidents of AIDS discrimination reported against people perceived as having AIDS. Such instances include discrimination against homosexuals and minority individuals because of their membership in groups viewed as having a high risk of infection. In a lengthy discussion of AIDS-related discrimination, a Report of the AIDS Discrimination Unit of the New York City Commission on Human Rights (November 14,1986) documents numerous cases of discrimination against individuals "perceived as having AIDS."

Testing and Confidentiality

The possibilities for discrimination resulting from widespread testing for the HIV-antibody has been greatly discussed since the ability to test became widely available. While voluntary testing programs, along with appropriate counseling measures, can successfully screen for the HIV antibody and provide important preventive information, many civil libertarians believe that mass screenings can be problematic.

> The hard truth is that antibody status can be a very dangerous piece of information. If their status becomes public knowledge, people who test positively for HIV antibodies may be exposed to discrimination ranging from loss of employment, or housing, to denial of insurance to serious physical abuse. [9]

The release of ELISA test kits in 1985 has given public health agencies greater access to testing. The ELISA test, designed to be used by blood banks to screen for infected blood, is highly sensitive, and, according to an article printed in the Harvard Law Review, false positive results often occur.[10]

Federal Food and Drug Administration labeling on ELISA test packets warns that "it is inappropriate to use this test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population."[11] Despite this warning, many policy makers advocate for general testing, depending on ELISA as the best testing tool.

In a 1987 Harvard Law Review article, Benjamin Schatz lists some of the potential dangers of mass HIV testing. This includes insurance companies using testing information to avoid covering medical care for HIV-positive individuals, the discrimination against members of high-risk groups by mass testing certain populations and the risk of emotional difficulties without providing the proper and necessary counseling.[12]

Similar concerns have been raised by the notion of "contact tracing," -- tracing and notifying sexual partners or those who have shared needles with the HIV positive person. Two problems can arise with non-voluntary tracings.

The first is the accuracy of the process. Unless a person wants to tell all about his/her sexual (or drug use) history, there is little an official can do to get accurate information. Secondly, an appropriate tracing program requires investigators

who are sensitive to the issues of confidentiality and possible discrimination if such information becomes public knowledge.[13]

At the federal level, some protections exist against the discriminatory use of information gathered by testing procedures. The Protection of Human Subjects Regulations, affecting public health activities administered by federal agencies, require that "informed consent procedures include a description of the extent to which the confidentiality of records will be maintained.[14]

Regulations also provide some protections against breeching confidentiality in contact tracing. Section 318 of the PHS ACT, which authorizes programs for preventing sexually transmitted diseases, was amended in 1985 to include AIDS. This legislation places explicit limitations on the disclosure of information obtained under these programs. [15]

These measures have been supported by recent court cases, including a case that upheld the "right to privacy of research subjects from unconsented disclosures."[16]

Of great concern in this debate is the issue of the civil rights of those that may have unkowningly become infected by past sexual relations or needle sharing with an HIV positive person. This of special concern because of the potentially long incubation period of the disease. Numerous cases have been reported of women who have unknowingly contracted AIDS in this way and then passed the disease to their unborn children.

The central question raised is that while it is important and necessary to protect the civil rights of those who are HIV positive, what are the rights of the partners of these people? How can their partners be informed in a way that does not violate the rights of the HIV infected person?

At both the federal and the state level, agencies are attempting to balance these public health considerations with the need for confidentiality. Their goal is to prevent discrimination against those who test HIV positive while protecting the health of the community at large.

Employment

The area of employment discrimination is obviously of great concern. A person who loses a job because of discrimination also loses his rent payments, grocery money, and more often than not, pension and health care benefits. AIDS advocates also feel that the loss of a job can be an emotionally devastating experience, making it harder for a person to physically combat his or her physical problems.

The main federal provisions for countering employment discrimination, under which people with AIDS are likely to be protected, is the Rehabilitation Act of 1973. As previously mentioned, this legislation protects the rights of handicapped individuals dealing with federally assisted programs. While this does not protect millions of workers in private employment, it does affect "federal employees, federal contractors, and (those working in) programs receiving federal financial assistance." [17]

Sections 501, 503 and 504 of the Act are the most applicable to redress employment discrimination. Section 501 requires the development of an affirmative action program for handicapped persons who apply for or are employed in federal jobs, including the Postal Service. In addition, a federal employer must provide reasonable accommodations that will allow the disabled employee to carry out job duties.[18]

Section 503 requires that any federal contract over $2,500 contain a provision "requiring the contractor to undertake affirmative action to employ "qualified handicapped individuals." [19] Section 504, the most broadly applied section of the Act, prohibits every kind of handicap discrimination, including employment discrimination, in programs or activities that are recipients of federal assistance.

Insurance

"Access to health insurance is synonymous in the United States with access to quality health care. Any policy that might result in denial of coverage to a large group of individuals must be given especially close scrutiny."

Jeffrey Levi/Ben Schatz

Some sources indicate that "insurance companies are taking steps to limit their liability in the face of health benefits and life insurance claims by AIDS patients...(by) identify(ing) AIDS patients in order to place them in a special category of

insurance applicants and devis(ing) policies that will limit costly claims." [20]

For the most part, federal legislation does not regulate the insurance industry. This is a function of state government. And several states have chosen to use their regulatory authority to eliminate the possibilty of discrimination against people who have been exposed to the HIV virus. California and Wisconsin, as well as the District of Columbia, do not permit insurers to use HIV antibody tests for underwriting purposes.

One area of concern that falls within the federal government's jurisdiction is that of "public" insurance; i.e. Social Security Disability and Medicaid.

Technically, AIDS patients who are unable to work are entitled to monthly benefits. However numerous complaints to agencies like the San Francisco Human Rights Commission and the Presidential Commission on the Human Immunodeficiency Virus Epidemic indicate that obtaining the deserved benefits is often easier said than done. A general consensus seems to be that if the policy of the present administration toward other disabled persons are a guide, "those administering SSI will be taking steps to limit the use of funds by persons with AIDS." [21]

A combination of outdated Social Security policy and insufficient training at the line worker level has created a variety of complaints from people with AIDS and related illnesses attempting to get assistance. The agency continues to treat people with HIV-disease differently from those with AIDS,

continuing to use the definition of "ARC" (AIDS Related Complex) even though the Centers for Disease Control have formally eliminated the use of that term. Furthermore, despite the claims of Social Security administrators that they have created training programs, many people continue to report discriminatory or fearful behavior on the part of Social Security Administration case workers.

Medicaid is available to anyone who receives assistance under the Social Security Disability program. Because of the intensely expensive medical care required by AIDS patients, "it is likely that at some point a person with AIDS will qualify for medical assistance ...since they will most likely "spend down" their assets until they have almost no assets left, thus qualifying them for medical coverage." [22]

Medicaid is administered by individual states. The MHRC research team heard of no complaints from individuals concerning provision of Medicaid benefits.

Medical Care

People who are HIV positive, like all U.S. citizens, are entitled to quality medical care. However, many medical personnel, like the general public, have succumbed to an irrational fear of the disease. Many healthcare workers have refused to treat people with AIDS or those who are HIV positive. AIDS specialists believe, however, that routine precautions in preventing exposure to contaminated blood will protect health

care workers from infection.

While people with AIDS deserve quality medical care, federal law, however does not ensure such access. Federal law views the relationship between a private doctor and a patient as a consensual agreement. Federal law, therefore, maintains no legal requirement for a physician to treat a patient that he or she does not want to treat.[23]

This is not the case with physicians working in hospitals or clinics receiving federal funds. Section 504 requires public facilities receiving federal funds to treat handicapped individuals, including AIDS patients. This applies equally to nurses and other health care workers in such facilities. The Region X Office of Civil Rights in Seattle interprets as "discriminatory actions" the practice of separating AIDS patients from other patients in nursing homes or other facilities.

However, it should be noted that under the Occupational Health and Safety Act, employees regulated by this act may refuse to do anything that threatens their safety. While the risk of HIV infection is negligible when routine precautions are taken, an employee may use this loophole as a basis for refusing to care for an AIDS patient.[24] This is especially true since OSHA has not taken a position on AIDS, even though Congress has asked for such regulations. Such a position will probably not be taken until a more sympathetic administration is in place in Washington.

Education

Because of the special nature and sometimes unexpected behavior of children, the issue of AIDS in schools has been an extremely controversial subject of debate. Concern for their child's health has created hysteria among otherwise rational adults. Simply put, many parents are fearful that their children will get AIDS from another child in the classroom.

Scientific data has demonstrated that AIDS is not transmitted by casual contact, and that pediatric AIDS cases are either those born to infected mothers, are hemophiliac or have received tainted blood transfusions. However, public anxiety remains high.

In August 1985, the Centers for Disease Control in Atlanta issued guidelines for the education of children testing HIV positive. These guidelines are merely advisory, but serve as a model for policy makers. Components of the policy are:

- The guidelines apply to all HIV positive children. This includes children with HIV-disease (formerly called ARC) and asymptomatic children.
- HIV transmission among school-aged children who do not manifest neurologic or behavioral impairments is "apparently nonexistent." These children should be allowed to attend school.
- For most HIV positive children, the benefits of an "unrestricted setting" outweigh the risks of

complication from childhood diseases such as chicken pox.

- o A more restrictive setting would be appropriate for pre-school aged children, neurologically handicapped children who lack control of their body secretions or who display behavior such as biting and children who have uncoverable lesions.
- o A case-by-case evaluation of each infected child should be handled by a team of professionals to determine the "risks and benefits to both the infected child and to others in the setting."
- o This team should attempt to respect the child's right to privacy and confidentiality.
- o Mandatory screening of all children is unwarranted.
- o The CDC proposes the development of routine procedures for handling the blood or body fluid of all children, regardless of known health status.[25]

For those children who test HIV positive, the Education for All Handicapped Children Act of 1975, also called EAHCA (PL 94-142), mandates support services for all qualified children between the ages of five and eighteen who attend public schools. "EAHCA requires states to cooperate with the handicapped child and his or her parents in preparing an `individualized education plan' for the child."[26] Also, an automatic appeal mechanism to challenge any change in the "individualized education plan" must be provided by the state.

Housing

Civil Rights agencies in New York, San Francisco and Boston have all reported an increase in the number of AIDS related discrimination cases. Denial of housing or eviction is often the complaint by those with AIDS or members of one of the AIDS high risk groups. [27]

The Fair Housing provision of the 1968 Civil Rights Act (Title VIII) was enacted to fight discrimination and give people the right to live where they choose. At this point, no language in the act includes discrimination against the handicapped (which, since Arline, would include people with AIDS.) Legislation pending in Congress (S.558) would amend the Fair Housing provisions of the Civil Rights Act of 1968 and add the handicapped to the list of protected groups.

While most private housing complaints fall under state jurisdiction, section 504 of the Rehabilitation Act covers any public housing that receives federal financial assistance. This includes HUD loan or mortgage guarantees, houses built with HUD development money, federally subsidized housing certificates or vouchers. While mandated to develop regulation for the implementation of section 504 under the area of housing, the U.S Department of Housing and Urban Development has yet to do so. [28]

DISCRIMINATION AGAINST HIGH RISK GROUP MEMBERS: GAYS AND MINORITIES.

Gay Men

Initially, AIDS was seen as a `gay disease.' Many morally self-righteous people saw it as not as the terrible illness it is, but as a punishment from God. The gay community, struggling for years to gain respect and civil rights protection in mainstream America, now had to fight a more deadly battle. While the years have shown that AIDS can affect anyone, the stigma of AIDS as a gay disease remains.

In many circumstances, AIDS has provided an excuse or a "justification" for anti-gay behavior. Not only are gay men with AIDS targets of discrimination, but civil rights organizations reports numerous cases of discrimination and harassment against gay men because these men are perceived to have AIDS or be HIV positive.

The implications of these attitudes are serious. First, it implies that only gays are at risk for AIDS and second, since gay men are going to get AIDS, discriminatory treatment of all gay men is permissable. These perceptions not only hurt the targets of the discrimination, gay men, but can be extremely harmful to the general population.

AIDS and People of Color

The fastest rising group of people to develop AIDS is that of intravenous drug users. This is especially true in cities

such as New York. Unfortunately, a great proportion of these people are people of color.

Furthermore, Hatians were reported among the first groups of individuals in which the AIDS virus appeared in this country. African nations, extrememly affected by the AIDS virus, continue to report horrifying numbers of individuals contracting AIDS. These circumstances combined to exacerbate existing fears and discrimination against people of color. As with gay men, cases of discrimination against minority group members perceived to be HIV positive are not uncommon.[29]

The greatest number of women who have contracted AIDS are women of color. The special situations that these women must face make discriminatory practices ever present. According to a report by the New York City Commission on Human Rights, "It has been alleged that in certain parts of the country, women are routinely screened for HIV antibodies with neither their knowledge nor their consent." [30] Additionally, with the growing numbers of HIV positive women of childbearing years, there is talk of developing policies mandating abortion or sterilization. Such policies indicate the disregard for the rights of these women. [31]

FEDERAL LEGISLATION

Existing

1. Rehabilitation Act of 1973

As discussed in the previous section, the Rehabilitation Act is the model discrimination statute on which state and local laws are based. The act has limited application since it only governs programs and agencies receiving federal money, including contractors receiving more than $2,500.

The act defines "handicapped individual." This definition has been accepted by the Supreme Court to include infectious diseases, including tuberculosis. While most legal experts believe that the protection of this act can be applied to people with AIDS, there is some debate over its application.

2. The Civil Rights Restoration Act of 1987

Recent decisions and opinions by the Supreme Court had narrowly defined the application of Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title VI of the Civil Rights Act of 1964. The 1987 act amends the language of previous civil rights acts to conform with Congress' original intent.

Under section 504, this act broadens the definition of "program or activity" to include all the operations of any agency, organization, college or cooperation that receives federal financial assistance.

It also contains a section on "Clarification of Individuals with Handicaps in the Employment Context." "For the purpose of section 503 and 504, as such sections relate to employment, such term does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job."

3. Education for All Handicapped Children Act (EAHCA)

This legislation mandates special educational services to "handicapped children" including those considered "other health impaired," which has been interpreted to include children with AIDS.[32] This act is especially important for these children because it mandates that states must provide an appeal mechanism in cases where these children are excluded from mainstream programs.

4. Employee Retirement Income Security Act of 1974 (ERISA)

ERISA is a comprehensive law intended to protect participants and beneficiaries in employment benefit plans. Two sections are especially relevant to people with AIDS. Section 502 allows a participant or beneficiary to bring a civil action to recover benefits due under the terms of the plan. Section 510 provides that "it shall be unlawful for any person to discharge,

fine, suspend, expel, discipline or discriminate against a participant or beneficiary ... for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan....Terminating an employee to prevent vesting of pension or other benefits is prohibited.[33]

Pending

1. The AIDS Federal Policy Act

Two companion bills, S.1575 and H.R. 3071 were introduced in July 1987 by Senator Edward Kennedy and Rep. Henry Waxman. The legislation contains provisions regarding anti-discrimination measures for people with AIDS and a provision relating to confidentiality and disclosure of information. If adopted, this legislation will represent a substantial increase in federal protections for individuals with AIDS and related conditions as it will require compliance with anti-discrimination laws by private individuals and companies, not simply those receiving federal funds.

Anti-discrimination provisions of the legislation state:

> A person could not discriminate against an otherwise qualified individual in employment, housing, public accommodation or governmental services solely by reason of the fact that the individual is or is regarded as being infected with the AIDS virus. A person could not discriminate against an otherwise qualified individual in the provision of benefits under any program or activity that receives or benefits from federal financial assistance solely by reason of the fact that the individual is or is regarded as being infected with the etiologic agent for AIDS

Additional provisions of the proposed bill authorize financial penalties for violation of the anti-discrimination provisions. The bill also prohibits any business that provides life or health insurance from requiring testing to determine whether the applicant is infected with the AIDS virus.

The Senate bill is currently in the Human Resources Committee. With the number of conservative senators ready to attempt blockage of its passage, it is not certain whether it will ever reach the Senate floor.

TO FILE A FEDERAL COMPLAINT

Individuals who believe they have been discriminated against by an organization receiving federal funds may file a complaint with the U.S. Office of Civil Rights. The Seattle office of Region X of the Department of Health and Human Services handles complaints from Oregon residents.

To file a complaint, an individual can call the office and request a complaint form or write a detailed letter to the Seattle office. After the initial information is acquired, an investigation of the complaint will be undertaken.

The Civil Rights Office will try to resolve the claim by negotiating with the two parties. If such resolution is impossible, legal steps will be taken.

The address of the office is:

U.S. Dept of Health and Human Services

Office for Civil Rights

2901 Third Avenue

Seattle, Washington 98121

III. STATE POLICIES AND PROCEDURES

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STATE CIVIL RIGHTS POLICY

With respect to AIDS and discrimination, Oregon has become somewhat of a trend-setter, despite the fact that very few civil rights complaints have been filed around the AIDS issue in Oregon. Fewer than 10 AIDS-related discrimination claims have been logged at the Bureau of Labor and Industries.

The civil rights statutes prohibit discrimination in employment and public accommodations. O.R.S. 30.675 defines public accommodations as "any place or service offering to the public accommodations, advantages, facilities or privileges whether in the nature of goods, services, lodgings, amusements or otherwise." Elements of discrimination are defined by O.R.S. 30.680 as including race, religion, sex, marital status, color or national origin. O.R.S. 659.425 prohibits discrimination against handicapped persons in employment or public accommodations.

An early interpretation by the Bureau of Labor and Industries' Civil Rights Division included people with AIDS and related conditions under handicapped protections. This in itself established a national precedent. Furthermore, Bill Gregg, hearings manager of the bureau, says that BOLI policy would consider that people "perceived as having AIDS," (e.g. gay men, IV drug users) are also protected by handicap law, a philosophy that has yet to be adopted by the U.S. Department of Justice, although individual agencies in the federal government use this broad interpretation of handicap protection.

In addition, Labor Commissioner Mary Wendy Roberts issued a definitive statement of acceptable medical practices when she announced that, according to Oregon law, dentists are considered a "public accommodation," and therefore subject to civil rights law. Furthermore, she found that dentists are prohibited from charging more for services to a patient who is HIV positive. Implicit in this ruling is that all private physicians services are considered "public accommodations."

In a third statement, a hearings examiner determined that a self-insured employer excluded AIDS treatment from employee health benefits, finding that such exclusion is unlawful sex discrimination, having a disparate effect on males. The administrative determination recognized that more than 90 percent of Americans infected with AIDS are male. This includes not only male homosexuals but also hemophiliacs and intravenous drug users, the bulk of whom are male.

Ed Reeves, one of the attorneys for the complainant in the case concerning the self-insured employer, said he believes that this finding will have some validity for "some time." However, as the proportion of women with AIDS increases, this argument may lose its validity.

CIVIL RIGHTS DIVISION PROCEDURES

The Bureau of Labor and Industries is Oregon's enforcement arm for civil rights laws. Under this process, citizens may file a complaint without the services of an attorney, although

complainants have the option of filing a civil suit. Civil Rights Division staff investigates and attempts to resolve a potential discrimination suit through negotiation. If negotiations do not result in a positive outcome, the case ultimately will be submitted to a hearings examiner.

Washington State defines "insurance" as a public accommodation, and therefore insurance issues are considered within the civil rights statutes. In Oregon insurance is handled by a separate agency. (In both states, federal law pre-empts certain types of insurance regulation).

Oregon law, however, does consider self-insurance by employers as an employment issue, rather than an insurance issue. Consequently, BOLI has jurisdiction over employers who self-insure.

The goal of the Civil Rights Division's process is to "make the complainant whole" -- that is, to help the complainant return to work or receive compensation for lost wages. The division does not impose "fines" per se, but requires an employer or other respondent to compensate the complainant for a dollar value associated with the civil rights violation (cost of relocating, etc.).

A recent change in Oregon law allows civil rights suits in the court system to be heard by jury trials, offering plaintiffs the option of suing for damages. The potential to sue for larger amounts of money may result in more people going through the courts directly rather than through the Bureau of Labor and

Industry's administrative process. (Current law allows individuals to go through the BOLI process first and then take advantage of the right of private action within 15 months of filing with the bureau.)

Approximately 95 percent of the civil rights cases tried by the Civil Rights Division are employment discrimination cases. The remaining cases cover housing and other "public accommodations."

During the last two years, the bureau has attempted, through statutory changes and internal review, to streamline the process it uses to investigate and hear cases. Most specifically, the division is less dependent on the attorney general's office to try cases, thereby speeding up the process. The bureau is amending other administrative rules to allow its investigators to perform more efficiently.

Furthermore, a recent survey of the division identified a number of problems that had been existed within the agency for some time. The major problem identified was that various division personnel held varying interpretations of civil rights law and division policy. The division has made a commitment to increase employee training to eliminate these inconsistencies and generally better serve its constituents.

According to Mr. Gregg, the average case is completed seven months after a complaint is filed with the Civil Rights Division. Although some cases may be solved satisfactorily with a few days, others may drag on for several years. Mr. Gregg said the

division has no specially-expedited process for AIDS-related discrimination cases.

To date, four cases have been filed with the bureau. One, in which the hearings officer accepted the claim of sex discrimination when an employer refused to cover an employee's health care costs, has been reopened. Three other cases remain open. The Commissioner's statement on dental practices was the result of information passed informally to the division, not as a result of a formal complaint.

It is interesting to note that the Civil Rights Division has received slightly more inquiries on AIDS-related discrimination than it has received actual filings. However, the AIDS Hotline, administered through the Cascade AIDS Project, received ten such questions in one month alone. Apparently, the Bureau of Labor and Industries is not visible as the first place to approach for questions on civil rights.[34]

OTHER STATE LAWS

During the 1987 session, the Oregon Legislature responded to growing concerns about AIDS by passing a number of AIDS-related bills. The legislation largely grew out of recommendations from the HIV/AIDS Policy Committee, under the direction of Kristine Gebbe of the Health Division. The recommendations established state policy for a variety of AIDS-related issues. In the discussion of pending legislation this report will refer to

recommendations by the policy committee, as they have a record of success in impacting legislative activity in the past.

Communicable disease statutes. In 1987, the Legislature repealed the venereal disease statute and amended O.R.S. Chapter 433 to cover HIV-related considerations. This means that AIDS, and all other sexually transmitted diseases, are now treated as communicable diseases.

Reporting/Confidentiality. Most communicable diseases must be reported to the state Health Division accompanied by the name of the individual seeking treatment. While AIDS must still be reported by name, HIV seropositivity and HIV disease may now be reported anonymously under most circumstances, according to changes in Oregon law. The Oregon Health Division is drafting rules that define the extraordinary circumstances, which involve a finding that the individual's name must be revealed to allow tracing and notification of others who may have been exposed through contact with the tested individual.

Quarantine. The HIV/AIDS committee recommended, and the Legislature adopted, an amendment stating that public health officials should exercise quarantine authority only as a last resort. The language included in the HIV/AIDS policy recommendations states quarantine may be authorized, "in rare instances where a person infected with HIV, ARC or AIDS knowingly and willfully exposes another to the infection in a manner or under conditions not likely to provide notice of potential exposure." A minority of the HIV/AIDS committee supported

language that would prohibit any authority for quarantine. However, the majority's language was adopted, both by the committee and by the Legislature.

Insurance and the Risk Pool. O.R.S. 746.015 prohibits discrimination in insurance.

> (1) **No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life,** or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.
>
> (2) Discrimination by an insurer in the application of its underwriting standards or rates based solely on an individual's physical handicap is prohibited, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

However, as evidenced by continuing battles at many government levels, there is no easily-drawn line between underwriting and discrimination. Even the Oregon chapter of the American Civil Liberties Union has shown a reluctance to become involved with the current debate from a civil liberties standpoint.

Reflecting this difficulty, interested parties have maintained a heated dialogue over the obligations of insurers toward people who are HIV positive and those who have AIDS.

The HIV/AIDS Policy Committee entered the 1987 Legislature hoping for a coordinated effort involving regulation of insurance companies and creation of a state risk pool. While some activity occurred on both fronts, a truly satisfactory solution to

protecting people with AIDS from losing the right to private insurance coverage -- and remaining independent of public assistance -- does not yet exist.

During the 1987 session, a group of health care advocates introduced the idea of a "risk pool" to provide insurance to individuals who otherwise would not be eligible for insurance as a result of pre-existing conditions, like hemophilia and cystic fibrosis. Advocates for people who have tested HIV positive or those who have been diagnosed as having AIDS hoped that this growing group of individuals would be able to benefit from the presence of such a risk pool.

The Legislature authorized the state Finance and Insurance Division to devise rules governing such a pool and allowed them to assess insurance companies up to $150,000 for start-up costs. However, this sum has proven too small to actually start up the program. To date, the risk pool has not gone into effect, and observers believe that risk pool advocates may need to return to the Legislature for more funds.

In addition, some AIDS advocates fear that the premiums (150 percent of the cost of an average policy) would prohibit many people with AIDS from taking advantage of the program once it goes into effect.

While attention was focused on the risk pool, the state insurance administrator was preparing draft rules to regulate insurance underwriting with respect to HIV seropositivity. Those rules went into effect on May 9, 1988.

Fundamentally, the rules do not preclude use of HIV testing by insurers. They do regulate how those tests and similar information is used.

The administrative rules state that HIV seropositivity alone cannot be called a pre-existing condition as a basis for refusing insurance coverage. The period of exclusion for HIV infection claims, when physical symptoms were present before the coverage date, shall be no longer than that for other pre-existing diseases.

The rules also state that insurers may not require an HIV test unless they are requesting tests for other diseases at the same time. In addition, the rules contain an informed consent clause governing use of a test for the HIV virus.

Neither Oregon statutes nor the administrative rules strictly prohibit testing or inquiries about HIV tests in underwriting for any kind of insurance. Existing policies simply limit the circumstances under which inquiries and tests can be made. The effect is to allow insurance companies to discriminate against individuals with AIDS.

The HIV/AIDS Policy Committee's subcommittee on insurance is discussing language that would read, "...Legislation (should) be enacted to prohibit cancellation or non-renewal of insurance policies because of a change in health status."[35] Such language would serve to protect individuals who develop AIDS from losing their coverage.

Also under discussion is draft language for consideration by the insurance administrator that states, "Until the risk pool is operational, we believe that the Insurance Division should issue a ruling that neither HIV testing nor inquiries about HIV test results shall be permitted in underwriting for any kind of insurance."

Schools

In 1986, the Oregon Health Division adopted guidelines for policy development in public schools involving children who are HIV positive. These guidelines have been distributed to school districts around the state and have served as the basis for local policies.

More recently, the Oregon Department of Education adopted a set of rules calling for schools to develop AIDS-related curricula. Appended to those rules were directions of policy development in local school districts.

According to people who have worked in school districts, the establishment of policies is an excellent idea. However, it is impossible to evaluate the policy beforehand because circumstances and the commitment of teachers and administrators to that policy really determine its effectiveness. It is important to note, however, that two state agencies are encouraging policy development and training.

Policy development at universities, state colleges and community colleges has been handled on a case by case basis.

Chemeketa Community College has been an aggressive advocate for policy development, and sponsored a conference on policy-writing for other community colleges throughout the state.

IV. LOCAL GOVERNMENTS AND CIVIL RIGHTS ACTIVITIES

IV. LOCAL GOVERNMENTS AND CIVIL RIGHTS ACTIVITIES

THE ROLE OF THE MHRC -- EXISTING POLICY AND PRACTICES

The City of Portland has no civil rights ordinances on the books. Therefore, the role of the MHRC has been one of advocacy and intervention, rather than enforcement.

Individuals who feel they have been discriminated against frequently approach the MHRC for assistance and direction. When the executive director believes a violation may have occurred, he refers the complainant to the state Civil Rights Division, a government affirmative action officer or the federal Office of Civil Rights, as appropriate. In addition, the executive director works with the individual to prepare material necessary for filing a complaint.

When an individual reports to the MHRC about situations that don't fit precisely under civil rights statutes, the executive director uses his discretion in determining the appropriate response. He may work with that individual in a number of ways. Sometimes he will contact an employer, landlord or social service provider to discuss the situation and seek to resolve the problem, when appropriate.

If an individual feels his or her job or advancement potential is threatened by discrimination, the executive director will assist that person in developing documentation that can later be the basis of legal action, if mediation and intervention are not successful.

The executive director reports that he has worked with social service agencies and other service providers on a number of occasions to help individuals obtain energy assistance, rental vouchers and other benefits. Furthermore, he offers assistance with advocacy and organizing in cases where legal recourse is not available.

For example, discrimination against homosexuals is not prohibited by law and therefore cannot be pursued by the state Civil Rights Division. Therefore, the executive director works with a person complaining of discrimination to develop strategies to call attention to such discrimination.

At the current time, the MHRC staff consists of the executive director, one disability project coordinator, one full time clerical position and one person on contract, who has been responsible for updating data files. The MHRC's capacity to investigate and intervene in civil rights complaints is quite limited, as the executive director is the only staff person available to assist with such complaints. Furthermore, the executive director is responsible for administration, public information and advocacy, other time-consuming duties.

ACTIVITIES OF LOCAL GOVERNMENTS THROUGHOUT THE COUNTRY

A growing number of local governments are taking action to address discrimination problems resulting from the AIDS crisis. Several cities have adopted specific ordinances prohibiting discrimination related to AIDS. Others have local handicapped

rights ordinances that have been interpreted as protecting people who are HIV positive. Still other communities have ordinances prohibiting discrimination on the basis of sexual orientation.

All the communities with such ordinances already have in place some mechanism for investigation and/or enforcement of civil rights complaints. The enforcement bodies are usually responsible for enforcing all civil rights complaints, not simply those related to AIDS. The exception to this is Los Angeles, which has in addition to the AIDS discrimination ordinance, only an ordinance prohibiting discrimination on the basis of sexual orientation.

San Francisco

The City of San Francisco maintains a civil rights investigation department, dating back to the early 70s. The Human Rights Commission traditionally has investigated discrimination claims based on age, sex, and race. In 1978 the city adopted an ordinance prohibiting discrimination against those with physical disabilities. As AIDS-related discrimination complaints increased -- from two in 1982 to 64 in 1985 -- the city decided it needed to establish a separate resource to investigate reports of this type of discrimination.

In 1985, the city adopted an AIDS-specific anti-discrimination ordinance. In conjunction with this ordinance the city created a separate AIDS investigation unit.

San Francisco decided to establish a local ordinance for several reasons. First, the state of California, with a statute protecting the rights of people with handicaps, had no administrative process to deal with handicapped rights violations. Individuals pursuing such complaints under state law had to go through the courts at the time San Francisco's ordinance was passed.

Secondly, the existing state civil rights process is very slow. The city determined that people with AIDS could not wait for a year or two to have their claims investigated...many would not be alive to see the claims resolved.

A third reason was the sheer number of people with AIDS living in the city limits. AIDS is a statewide problem, but it is undeniably centered in San Francisco.

According to city staff, the state is now beginning to pre-empt local governments by developing statewide anti-discrimination policies on AIDS.

"What we've demonstrated in San Francisco is that education and anti-discrimination programs can be effective. We are seeing a decline in both transmission of AIDS and the accompanying hysteria and fear." says Norm Nickens of the San Francisco Human Rights Commission. According to Nickens, reported discrimination cases have fallen slightly since the ordinance went into effect.

In San Francisco, the human rights staff investigates and mediates on AIDS discrimination cases. They enlist the assistance of the city attorney's office for enforcement.

Los Angeles

David I. Schulman, an attorney with the City Attorney's Office in Los Angeles, was the first local AIDS discrimination investigator in the nation. His role is to investigate, mediate and enforce AIDS discrimination cases. During his first year in the new position, from February, 1986 to February, 1987, Mr. Schulman handled 93 complaints and fielded 120 additional inquiries.

During the second year of his office's operation, complaints dropped significantly. He believes this is as a result of his office's outreach activities, which had the effect of teaching people what behaviors were discriminatory, and therefore actually decreased the number of incidents of discrimination.

Mr. Schulman has made an excellent case for anti-discrimination laws at all three government levels: local, state and federal.[36] He says, "Only highly flexible, locally-based government units can intervene quickly enough, and draw on the relationships of mutual trust and respect which can best insure successful rapid resolution of AIDS discrimination cases."[37]

Seattle

The City of Seattle's Human Rights Commission maintains a staff of up to ten people to investigate civil rights violations. They investigate AIDS discrimination under the authority of the local ordinance prohibiting discrimination against individuals with handicaps. In addition, the city has an ordinance

prohibiting discrimination based on sexual orientation. A citizen of Seattle has a choice of filing with the city or the state for protection under the handicapped laws, but only the city has a gay rights ordinance.

Only ten AIDS-related cases of discrimination have been filed with the Seattle commission. Dixie Shaw, a civil rights field representative, feels that people who are ill with HIV-related diseases are unlikely to involve themselves in civil rights fights. She said the nature of the process is not conducive to helping people with AIDS, although the commission expedites investigation of all AIDS-related complaints.

However, she stated that the presence of the ordinance prohibiting discrimination on the basis of sexual preference has helped to prevent AIDS-related discrimination as employers, landlords and others were aware that the law prohibited discrimination against homosexuals. As more people are aware that people with AIDS are protected by civil rights laws, the gay rights ordinance has become less useful, according to Shaw.

New York City

The City of New York maintains an AIDS Discrimination Unit within its Human Rights Commission. As of late 1987, that unit had handled more than 750 complaints of AIDS-related discrimination. The commission bases its work on existing human rights laws, including protection for people with physical

handicaps and those discriminated against on the basis of sexual orientation.

Seventy-five percent of the complaints filed with the NYHRC have been settled by advocacy and intervention. In some cases, individuals complaining to the commission chose not to pursue legal suits; for example, individuals who had lost family members or lovers frequently complained about refusal by funeral homes to accept people who had died with AIDS. When the bereaved individual felt unwilling to pursue the case, the commission became the complainant in the legal process.

The commission also undertook an extensive public information campaign, using posters and pamphlets declaring that "AIDS Discrimination is Illegal." Commission staff has placed intake workers in health care centers and has made presentations to a variety of community-based and health care organizations.

As in San Francisco, the commission staff investigates and mediates. If a satisfactory solution cannot be achieved through these means, the commission enlists the city attorney's office to enforce the ordinance.

Raleigh, North Carolina

The Raleigh, North Carolina Civil Rights Units maintains two separate investigative divisions: one for civil rights housing violations, the other for employment problems. The housing division has enforcement authority, but the employment division staff only has the authority to intervene and attempt to mediate

on discrimination cases. When further action is necessary, the city staff turns the problem over to a state office that enforce statewide anti-discrimination laws.

Last year, the Raleigh Human Rights Commission recommended that the city pass an ordinance prohibiting discrimination on the basis of sexual preference. The goal of this ordinance was to put the city on record as opposing the spread of violence and hatred directed against homosexuals. In January of this year, the city council passed the ordinance.

However, the ordinance is not backed up by a city enforcement program: it is only supported by the mediation efforts of the Civil Rights - Employment staff. Bobby Broadaway, the civil rights/conciliation officer for the city, reports that he has received no complaints under the new ordinance to date. He said the limited staff has allowed little opportunity for public outreach or information efforts.

Mr. Broadaway had no information on the impact of the local gay rights ordinance on the problem of AIDS-related discrimination.

V. RECOMMENDATIONS

V. RECOMMENDATIONS

The goal of the Metropolitan Human Relations Commission has been to identify the gaps in civil rights protection for individuals who have AIDS, test positive for the HIV virus, are diagnosed as having HIV disease or are "perceived as having AIDS." A further goal is to develop a strategy for filling those gaps through activity at the local level and through support for legal and policy changes at the state and federal level.

The following pages identify a variety of steps that the MHRC can take in concert with other public and private agencies, to decrease AIDS-related discrimination and increase public awareness of civil rights protections.

The MHRC believes that Oregon law and current federal policies offer protections against many forms of discrimination. However, we believe problems remain, and require a three-fold approach. The challenge is: 1) to inform at risk individuals of their rights; 2) to inform employers, landlords and others of their obligations toward people who are protected by handicapped rights laws; and 3) to make the system accessible enough so that people who are frightened, ill and without resources can take advantage of it.

In addition, problems such as protecting confidentiality are not easily solved by legislation. Fundamental protections of individual's privacy and confidentiality require statutory, administrative and educational responses.

The MHRC has attempted to avoid making recommendations that would demand expansion of existing staff or call for activities outside the scope of the commission's budget. However, some of the recommendations included may still be beyond the capability of current staff levels. The following recommendations will serve as a basis for development of future work plans, and will be implemented to the extent that budget and staff time allow.

SUMMARY OF RECOMMENDATIONS

The MHRC recommends the following activities relating to AIDS and discrimination. The recommendations cover MHRC activities for the next fiscal year, as well as activities of other government, private and non-profit organizations.

1. Creation by the MHRC of public education and outreach efforts about rights and obligations related to AIDS:
    - o Create an informational brochure on AIDS and discrimination.
    - o Create an on-going public information campaign.
    - o Assist in preparing bilingual material, outreach to non-English speakers.
    - o Target employer groups, medical providers and others who should be made familiar with the civil rights aspects of AIDS.
    - o Establish a method to track AIDS-related discrimination cases.
    - o Serve as clearinghouse for information on civil rights legislation, statutes, ordinances and administrative rules.
2. Establishment by the City of Portland of an employee policy on communicable diseases.
3. Passage of a county resolution supporting creation of communicable disease policies by private employers.
4. Passage of state legislation prohibiting discrimination on the basis of sexual orientation.
5. Examination of potential local legislation prohibiting discrimination on the basis of sexual orientation.
6. Development of anti-discrimination policies by private organizations.

7. Creation of a Bureau of Labor and Industries (BOLI) outreach project to inform people of their rights and obligations with respect to AIDS-related discrimination, and to publicize the Civil Rights Division process.

8. Creation of an expedited process of AIDS-related civil rights claims.

9. Planning for better distribution of AIDS-education material.

10. Support for federal anti-discrimination legislation, including AIDS-specific protections and protecting against discrimination on the basis of sexual orientation.

11. Monitoring of Social Security Administration activities, contacting Congressional delegation to encourage improved policies and training.

12. Prohibiting use of HIV anti-body tests for insurance underwriting purposes. It may be appropriate for government to assist with health care costs related to the AIDS disease in addition to appropriate insurance industry responsibility.

13. Improving school district policies, training, as necessary.

14. Bar association groups' participation with the Cascade AIDS Project and other advocacy organizations in developing knowledgeable pool of attorneys.

15. Establishment of policies throughout city, state and local governments to protect the confidentiality of individuals who have tested HIV positive.

The following pages outline in more detail specific recommendations and activities.

DISCUSSION OF RECOMMENDATIONS

The following pages describe the activities to be undertaken by the MHRC and discuss recommendations to other entitities with respect to AIDS and discrimination. The recommendations do not address the issue of AIDS and public health policy or the medical concerns of AIDS as a disease, except as they relate to discrimination.

1. Creation of public education and outreach efforts

The MHRC has identified the major gap in the existing civil rights system as one of public awareness. At a hearing before the commission, one woman who tested positive for HIV stated that neither she nor any of the women in her HIV-support group were aware of any of their rights under civil rights/handicap law. The low number of inquiries to the Civil Rights Division and conversations with advocates involved with AIDS and related illnesses also reflect a lack of knowledge about existing law.

Apparently, no organization in the state is doing outreach on the issue of AIDS-related rights and discrimination. The one state agency that deals specifically with civil rights -- the Bureau of Labor and Industries -- has very little budget for outreach of any kind.

That agency's public information service involves production of one basic brochure discussing civil rights legislation that is updated every few years, and providing training to employers about their obligations under the civil rights statutes. The

existence of the Civil Rights Division is not publicized.

The Cascade AIDS Project relies on information created by a national gay rights organization: the brochure does not discuss Oregon law. Public information from the state Health Division has focused on transmission and has not incorporated information on civil rights.

There is, clearly, a gap in the information being disseminated about AIDS. The Metropolitan Human Relations Commission has the opportunity to fill that hole by developing public information materials about state and federal anti-discrimination laws and their application to AIDS. Furthermore, the MHRC can adopt the role of coordinator to work with state, federal and private non-profit agencies in disseminating information on AIDS and discrimination.

To the extent that budget and staff time permits, the MHRC will pursue the following activities:

- Creation of a brochure providing a basic review of existing protection against AIDS-related discrimination. Five hundred copies of a brochure will be produced as a portion of the existing MHRC contract.

- Creation of an on-going public information campaign, in cooperation with other agencies. Elements include creation of a theme and logo emphasizing civil rights and obligations; development of print ads, radio and television

spots and a speakers bureau. The campaign will inform individuals at risk of discrimination that current laws protect them from discrimination; will provide phone numbers of agencies that work with discrimination cases; and inform employers, landlords and others of their obligations under state and federal handicap protection laws. MHRC staff will become familiar with the various agencies already involved in AIDS-related training and serve as a referral source not only for people who have experienced discrimination but for businesses and individuals seeking assistance in policy development.

The MHRC can work with the Cascade AIDS Project, BOLI, the Health Division, Multnomah County Health Division, the Red Cross and other agencies to print and disseminate materials. Furthermore, MHRC will work with other organizations that produce AIDS-related materials to see that those materials contain some mention of civil rights. For example, all collateral material might carry the phrase, "Do you know your rights under Oregon law? Call the Civil Rights Division at 229-5350 for information."

The MHRC will attempt to target agencies that work with minority populations for literature and speakers on discrimination and AIDS. In addition, the MHRC can facilitate outreach to people who cannot or do not read:

television, radio and assistance by caseworkers and care givers will be essential to reach this group of people.

In preparing public information materials, the MHRC may advertise its phone number as a contact point for people wanting information. The commission staff can continue to assist and direct people toward the appropriate agency. However, the existing staff size is unlikely to be able to accommodate any major increase in the number of inquiries.

- Preparation of bilingual material, outreach to non-English speakers. As the spread of AIDS affects disproportionate numbers of minority men and women, the community has a responsibility to provide information about the disease to non-English speaking populations. Organizations like the Oregon Council for Hispanic Advancement and the International Refugee Center of Oregon are already doing outreach on AIDS with non-English speakers. The MHRC will make a particular effort to work with these and other agencies working within minority communities to alert non-English speakers and other minorities of their civil rights regarding AIDS.

- Target employer groups, medical providers and others who should be made familiar with the civil rights aspects of AIDS. Recent surveys of the medical community indicate a

strong inclination to overlook civil liberties when faced with a "public health" crisis. The MHRC will target the medical community, as well as landlords and employers, to educate them about the need for confidentiality and other civil rights considerations related to AIDS.

- Establish a method to track AIDS-related discrimination cases. The Cascades AIDS Project supports an AIDS information phone service, the AIDS Hotline. Hotline personnel regularly receive calls about discrimination cases and refer individuals to a variety of resources. Hotline staff expect to go on-line with computer resources during the next fiscal year. The hotline offers the potential to follow discrimination cases, to track the responsiveness of state and federal agencies and provide the community with an accurate scenario of Oregon's experience with AIDS-related discrimination. This community resource seems a likely partner in tracking AIDS-related discrimination claims. If the hotline is able to purchase computers from other grant sources, the MHRC may be able to contract for tracking services at a relatively low cost.

- Serve as clearinghouse for information on civil rights legislation, statutes, ordinances and administrative rules. The Oregon Legislature, the Health Division, the Insurance Division and other agencies continue to refine policies with

respect to AIDS. The commission will, in addition to monitoring these activities, be responsible for informing the public about the on-going process, advocating for better protection for people who have tested HIV positive and encouraging involvement in the decision-making process.

Other Government Efforts

2. City policy on communicable diseases. The MHRC will work with the City of Portland to develop an employee policy on communicable diseases and a thorough training program for city employees. The training program should be comprehensive and designed to help the many city employees in very diverse roles understand how the HIV virus is transmitted and what types of precautions are necessary. In addition, the program should inform city staff of rights and obligations of employees, and their obligations to clients who are HIV positive.

3. County resolution supporting creation of communicable disease policies by private employers. With its responsibilities for public health, the county commission can encourage private employers to develop workplace policies. Such an action, while non-binding, would likely be accompanied by local publicity that could alert employers to the importance of developing such policies. The emphasis on "communicable diseases" can serve to inform employers about the risks of hepatitis as well as the HIV virus.

County Compliance with Recommendations of the Report of the Metropolitan Human Relations Commission on AIDS and Discrimination

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- The county Department of Human Services has taken an active role in encouraging private employers to develop workplace policies. The Health Division has an active AIDS Prevention program which has provided education to more than 150 local businesses and organizations since November, 1987. Most of those have included emphasis on policy development. ($50/charge to businesses)

  . AIDS program staff have helped to write policy for both large and small businesses, public and private schools, and many small private nonprofit employers.

  . A letter has gone out from Dr. Oxman to every school district in the county encouraging them to develop clear policies and offering consultation with policy development.

  . Guidelines for workplace policies have been mailed to many businesses and agencies on request.

  . The AIDS program will be working this fall with Howard Klink, DHS director of public affairs, to develop a marketing strategy for the AIDS in the Workplace education package.

  . A packet of materials which can be used for policy development is left at each workplace where education is provided.

  . An excellent video which helps employers understand confidentiality and civil rights issues has been purchased and is in use.

  . Protection from other communicable diseases, including hepatitis, is included in all presentations.

  . The Health Division would be available to provide education to City of Portland employees on contract.

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  . The Health Division has developed a policy regarding confidentiality of communicable disease information with specific emphasis on HIV disease.

  . Release of information forms have been revised to provide HIV specific information.

  . No information is released without specific consent.

- All managers have been educated regarding the implementation of Multnomah County Executive Order 192. Managers have relayed this information to employees.

- By October 1988 all county employees will have received AIDS in the Workplace education.

- Confidentiality and civil rights are primary considerations in all community education presentations and in all policy development consultations.

- Health Division staff have taken an active role in development of administrative rules governing confidentiality of HIV status.

[3179K-w]

4. Support state legislation prohibiting discrimination on the basis of sexual orientation. During its April hearing, the commission heard testimony in support of state and local ordinances prohibiting discrimination on the basis of sexual orientation. Many other cities have such ordinances, and there is evidence that these local laws have resulted in cutting down discrimination -- if not against people who are actually HIV-positive, then at least against gay men who are "perceived as having AIDS."

Kristine Gebbie, administrator of the Oregon Health Division, has said that homophobic behavior and homosexuals' fear of discrimination has proven to be a major barrier in public health agencies' ability to combat the AIDS epidemic. She is on record as advocating a statewide gay rights statute based on public health concerns.

The MHRC is already on record in support of such legislation. It will continue to advocate for a statewide anti-discrimination ordinance.

5. Pursue possibilities of local legislation prohibiting discrimination on the basis of sexual orientation. The introduction of an ordinance in Portland making illegal discrimination on the basis of sexual orientation presents a variety of issues for discussion.

- In Portland, a question exists as to whether the city has the authority to enact a piece of civil rights legislation affecting the private sector. A city attorney's opinion will be necessary to clarify this point. (For a city attorney's opinion on a related issue, see the appendix to this document.)

- Most cities that have local anti-discrimination ordinances also have in place an enforcement mechanism with staff responsible for investigating civil rights claims, believing that a right of private action is not a satisfactory solution to civil rights violations. Generally, these enforcement systems are in place for enforcement of all types of civil rights claims, either through a local human rights commission or through the city attorney's office.

  For Portland to adopt a local anti-discrimination ordinance would require creation of a new system to pursue such claims. Without such a system, the community would benefit only from the publicity accompanying city council action and allow individuals the right of private action. The MHRC is not now staffed to fully investigate and pursue discrimination claims.

The commission has several options in approaching the issue

of this type of anti-discrimination ordinance once the question of the city's authority to establish such an ordinance has been settled. The options are:

- o Support immediate passage of a gay rights ordinance; set aside a portion of MHRC budget available to contract with a part-time investigator to pursue complaints.
- o Support immediate passage of a gay rights ordinance; work with Right to Privacy PAC, Cascade AIDS Project, Commissioner Blumenauer's staff and other city and county personnel to discuss creation of an enforcement mechanism; investigate outside funding sources; investigate passage of other local civil rights ordinances.
- o Work with Right to Privacy PAC, Cascade AIDS Project, Commissioner Blumenauer's staff and other city and county personnel to discuss future passage of local ordinance and creation of an enforcement mechanism; investigate outside funding sources; investigate passage of other civil rights ordinances.

The MHRC will investigate these options to evaluate the need, the effectiveness and the potential for implementation of such a local ordinance.

6. Encourage development of private anti-discrimination policies. The MHRC will encourage private organizations like

the Oregon Medical Association, the Oregon Nurses Association, Associated Oregon Industries and the Chamber of Commerce to develop anti-discrimination policies, with respect to both sexual preference and communicable diseases. Policies preventing discrimination based on sexual orientation will serve to prohibit discrimination and, in addition, remove some of the barriers to dealing with the HIV virus from a public health standpoint.

7. Create a BOLI outreach project to inform people of their rights and obligations with respect to AIDS-related discrimination. The Civil Rights Division of the Bureau of Labor and Industries has limited public information funds and virtually no money for outreach. The public should be made aware of the excellent policies already established by the bureau, and the division should develop a higher profile, particularly among groups with a high percentage of HIV infection. Development of such a program will require an increase in the bureau's budget by the 1989 Legislature.

8. Create an expedited process of AIDS-related civil rights claims. In a more perfect world, all civil rights claims would receive immediate attention with immediate resolutions. However, given limited budget and personnel, plus the built-in delays of any legal process, the average civil rights claim submitted to the Oregon Civil Rights Division is completed about seven months from filing.

The AIDS virus has its own time constraints -- people with AIDS rarely live more than three years after diagnosis, and the average life expectancy is closer to two years. A time-consuming, drawn-out process may in itself act as a deterrent to a person who is extremely ill and who has many other problems to face on a daily basis.

For the Civil Rights Division to work effectively on behalf of victims of discrimination, it should establish a priority system for dealing with cases involving AIDS or HIV disease.

9. Plan for more appropriate distribution of AIDS-education material. Some minority advocates have expressed concern that funds for AIDS education and outreach have not been directed sufficiently at minority communities -- communities that will likely see the greatest increase in AIDS cases in coming years. The MHRC encourages state agencies, like the Health Division, the Department of Education and other agencies responsible for disseminating information or funds, to attempt to provide minority communities with adequate attention with respect to AIDS-related information and outreach. State agencies should remain aware of the changing demographics of the AIDS epidemic and respond accordingly.

10. Monitor and support, when appropriate, federal anti-discrimination legislation. Senator Ted Kennedy and Congressman

Henry Waxman have both introduced anti-discrimination legislation in Congress. The proposed legislation would broaden the scope of federal anti-discrimination laws to cover the private sector--not simply federal agencies or recipients of federal funds. Opposition by powerful Congressional forces threatens to slow down -- or halt -- passage of such legislation. The MHRC will monitor the progress of these bills and advocate as necessary for their passage. Passage of either bill will represent significant advances for civil rights protection from the federal government.

Federal legislation to prohibit discrimination on the basis of sexual orientation is also essential to protect individual rights, to prevent AIDS-related discrimination, and, from a public health perspective, to slow the spread of AIDS.

11. Monitor Social Security Administration activities, contact Congressional delegation to encourage improved policies and training. AIDS advocates report that people with AIDS and HIV disease often have difficulty obtaining assistance from the Social Security Administration. (See earlier discussion of Social Security claims.) The MHRC will keep informed of complaints about the Social Security Administration through contact with the AIDS Hotline, other advocacy organization and regular hearings on discrimination. When appropriate, the commission will contact the Congressional delegation to notify lawmakers of poor agency policy or inappropriate behavior on the part of federal personnel.

12. Prohibit use of HIV anti-body tests for insurance underwriting purposes. California, Wisconsin and the District of Columbia have already created statutes and ordinances that set the precedent of prohibiting use of HIV test information in insurance underwriting. The MHRC recommends that the state of Oregon follow suit.

The Commission recognizes that the insurance industry cannot be expected to maintain the full financial responsibility for the costs of AIDS-related medical care. The Commission encourages federal and state governments to help people with AIDS and HIV-disease receive adequate medical care through risk pool development, Medicaid and other financial assistance.

13. Continue to develop and improve school district policies, training, as necessary. The Portland Public School District has established a policy for responding to HIV infection in the schools and has set up training sessions for large groups of school personnel throughout the district. The district is to be commended on its early recognition of a problem that has yet to become visible in the Portland schools, but is almost certain to gain attention in the coming years.

At the forum held on April 15, participants heard from school district administrators who had dealt with the situation of having an HIV-positive student or teacher within the district. These speakers indicated that the written policies may not anticipate the actual needs of teachers, parents and students

adequately. Therefore, administrators must be prepared to adjust the policy to reflect the specific needs of the district and the realities of working with the fear associated with AIDS.

The MHRC will monitor the activities of the Portland Public Schools to observe how well the current policy works in practice. Through newspaper articles, interviews with staff and parents and contact with AIDS advocates, the MHRC will determine the effectiveness of the policy and, if problems arise, the MHRC will coordinate informational sessions using resources like Scott Mutchie of the Glide School District, Ken Upton of Multnomah County, Greg Asher of Chemeketa Community College and other policy specialists to assist the district in redirecting its policies.

14. Encourage local bar associations to work with the Cascade AIDS Project in its attempt to create a pool of attorneys. This attorney pool would be willing and prepared to work on AIDS-related discrimination cases. AIDS causes unexpected crisis situations for many too ill with the disease or too poor because of the incredible medical expenses to hire a private attorney. Competent, AIDS-knowledgable lawyers are needed to help these people.

15. Establishment of policies throughout city, state and local governments to protect the confidentiality of individuals who have tested HIV positive. The state Health Division, the state

County Compliance with Recommendations of the Report of the Metropolitan Human Relations Commission on AIDS and Discrimination

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- The county Department of Human Services has taken an active role in encouraging private employers to develop workplace policies. The Health Division has an active AIDS Prevention program which has provided education to more than 150 local businesses and organizations since November, 1987. Most of those have included emphasis on policy development. ($50/charge to businesses)

  . AIDS program staff have helped to write policy for both large and small businesses, public and private schools, and many small private nonprofit employers.

  . A letter has gone out from Dr. Oxman to every school district in the county encouraging them to develop clear policies and offering consultation with policy development.

  . Guidelines for workplace policies have been mailed to many businesses and agencies on request.

  . The AIDS program will be working this fall with Howard Klink, DHS director of public affairs, to develop a marketing strategy for the AIDS in the Workplace education package.

  . A packet of materials which can be used for policy development is left at each workplace where education is provided.

  . An excellent video which helps employers understand confidentiality and civil rights issues has been purchased and is in use.

  . Protection from other communicable diseases, including hepatitis, is included in all presentations.

  . The Health Division would be available to provide education to City of Portland employees on contract.

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  . The Health Division has developed a policy regarding confidentiality of communicable disease information with specific emphasis on HIV disease.

  . Release of information forms have been revised to provide HIV specific information.

  . No information is released without specific consent.

- All managers have been educated regarding the implementation of Multnomah County Executive Order 192. Managers have relayed this information to employees.

- By October 1988 all county employees will have received AIDS in the Workplace education.

- Confidentiality and civil rights are primary considerations in all community education presentations and in all policy development consultations.

- Health Division staff have taken an active role in development of administrative rules governing confidentiality of HIV status.

[3179K-W]

Department of Finance and Insurance, school districts and other state agencies continue to create administrative rules and policies governing testing for the AIDS virus and other aspects of AIDS. Whether the framework is a workplace policy, establishment of testing rules, consideration of seropositive teachers or students -- all policies should hold confidentiality as a primary criterion.

The MHRC is not recommending adoption by the City of Portland of an AIDS-related anti-discrimination ordinance or a more general ordinance prohibiting discrimination against people with handicaps. Quite simply:

- The State of Oregon has taken an aggressive position in considering AIDS and related conditions as covered by existing handicapped rights laws.
- The position of Health and Human Services has been to interpret broadly section 504 of the Rehabilitation Act of 1973. The Office of Civil Rights has acted to intervene on AIDS-related civil rights issues, and, when necessary, enforce the federal law.
- At this point, the city has no suitable process for investigating and enforcing civil rights claims.

A memo to the Office of Commissioner Blumenauer from Deputy City Attorney Nancy E. Ayres reads,

> ...it is our opinion that such specific statutes are possible but not necessary, because the currently existing statutes prohibiting discrimination against handicapped persons are broad enough to include AIDS patients. This opinion was also expressed by Oregon Bureau of Labor and Industries Commissioner Mary Roberts."

A copy of the complete memo is attached in the appendix to document.

The MHRC will monitor the activities of existing state and federal enforcement organizations. If future review indicates that the state has developed a backlog of AIDS-related discrimination cases, or if future policy makers narrow the definition of handicapped protection, the MHRC may find a need to advocate for a local ordinance directed at preventing AIDS-related discrimination and take action to develop an enforcement arm for civil rights cases. Until that time, the MHRC will continue its strong advocacy and public information role concerning AIDS and discrimination, dedicating time and resources to informing the public of existing rights and obligations with respect to AIDS and civil liberties.

1. Allan M. Brandt, "A Historical Perspective, " AIDS AND THE LAW, ed. H. Dalton, S. Burris and The Yale AIDS Law Project (New Haven and London: Yale University Press, 1987) p. 37

2. Brandt, p. 41

3. Brandt, p.40

4. Robert P. Wasson, Jr., "AIDS Discrimination Under Federal, State and Local Law After Arline," FLORIDA STATE LAW REVIEW, Vol. 15:221, p. 221-222

5. Wasson, p. 234

6. Wasson, p. 248

7. Charles J. Cooper, Esq., "The Justice Department's Perspective," LEGAL, MEDICAL AND GOVERNMENTAL PERSPECTIVES ON AIDS AS A DISABILITY, The American Bar Association Commission on the Mentally Disabled (Washington, D.C., 1987) p. 17

8. "Summaries of Key Court Decisions," LEGAL, MEDICAL AND GOVERNMENTAL PERSPECTIVES ON AIDS AS A DISABILITY, p.47

9. Larry Gostin, "Traditional Public Health Strategies," AIDS AND THE LAW, p. 56

10. Benjamin Schatz, "The AIDS Insurance Crisis: Underwriting Or Overreaching?", HARVARD LAW REVIEW, Vol 100, No. 7, May 1987. p. 1784.

11. Schatz, p. 1785.

12. Schatz, p. 1799-1801

13. Gostin, p. 56

14. Gene W. Matthews, JD, and Verla S. Neslund, JD, "The Initial Impact of AIDS on Public Health Law in the United States--1986," reprint from the Journal of the American Medical Association, Vol. 257, June 16, 1987, p. 345.

15. Mathews, et al., p. 346

16. Mathews, et. al., p. 346.

17. Arthur S. Leonard, "AIDS In The Workplace," AIDS AND THE LAW, p. 110

18. John Parry, "AIDS As A Handicapping Condition," MENTAL AND PHYSICAL DISABILITY LAW REPORTER, Vol.10, No. 1, Jan-feb., 1986. p.3

19. Leonard, p.110

20. Parry, p.5

21. Parry, p. 6.

22. Parry, p.6

23. Taunya Lovell Banks, "The Right To Medical Treatment," AIDS AND THE LAW, p.176

24. Lovell, p. 179

25. Frederic C. Kass, M.D. "Schoolchildren With AIDS, AIDS AND THE LAW, p. 176

26. Wasson, p. 256

27. Holly D. Ladd, "Fair Housing Law and Practice," AIDS PRACTICE MANUAL: A LEGAL AND EDUCATIONAL GUIDE, ed. P. Albert, L. Gaff, B. Schatz, (National Gay Rights Advocates and National Lawyers Guild AIDS Network, 1988) p. v-1

28. Ladd, p. v-3

29. "AIDS And People Of Color: The Discriminatory Impact," Report of the AIDS Discrimination Unit of the New York City Commission on Human Rights, Nov. 14, 1986. p. 6

30. New York, p. 13

31. N.Y., p. 14

32. Wasson, p. 257

33. Wasson, p. 258-259

34. According to a log of phone contacts from the AIDS Hotline, six of the ten calls in one month were referred to Legal Aid offices. None was referred to BOLI.

35. Minutes of the HIV/AIDS Policy Committee Meeting, April 21, 1988. The reader is advised that this is preliminary language which, at this writing, has not been approved finally by the committee.

36. Testimony Before the Presidential Commission on the Human Immunodeficiency Virus Epidemic, March 16, 1988 at Vanderbilt University, presented by David I. Schulman.

37. Ibid.

APPENDIX A

MINUTES OF HEARING BEFORE METROPOLITAN HUMAN RELATIONS COMMISSION

AIDS AND DISCRIMINATION

APRIL 16, 1988

METROPOLITAN HUMAN RELATIONS COMMISSION
HEARING ON AIDS-RELATED DISCRIMINATION
APRIL 16, 1988
CITY COUNCIL CHAMBERS

Commission chair John Heflin called the meeting to order at 10:05 a.m.

Larkey De Neffe was the first person to testify. He told the committee that he has been diagnosed as having HIV Disease Stage III. HIV Disease was formerly referred to as AIDS Related Condition (ARC). Stage III usually develops into AIDS.

Mr. De Neffe said that he, as a hemophiliac, believes he has experienced a form of institutional discrimination necessitating him to stay "poor and single" in order to obtain the best medical care. To be able to purchase the best medical care, he must remain on government assistance. If he were to take a job and depend upon private insurers, he would be uninsurable within several years because of the cap on how much money insurance companies will spend on a single individual.

He, like 800,000 other hemophiliacs in the nation, must use large quantities of blood products each month to stay healthy. Most of these people are continually exposed to the HIV virus. Doctors are still recommending contaminated substances for patients with hemophilia.

Mr. De Neffe explained that three types of blood products are currently on the market. The first is not treated for contamination. The second is treated, but he doubted the effectiveness of that type of treatment. The third type is purified. However, because the third type is so expensive, many doctors hesitate to recommend it for Medicaid patients. Mr. De Neffe's doctor has been prescribing it because his doctor feels that Mr. De Neffe's life expectancy is short and he should have the best care available.

Private insurers will pay for the purified blood products only until a person reaches the $1 million limitation, which would be a matter of just a few years for someone spending $200,000 on blood products alone.

Mr. De Neffe said the system should be analyzed so that we are not preventing people from working and becoming taxpayers, instead forcing them to be "tax users" by staying on public assistance for medical care. He said that the answer lies in looking at the long term costs of forcing people to stay on public assistance, as well as the cost of exposing young children to HIV-contaminated substances. He said someone must be coordinating this effort, looking at the big picture.

Furthermore, people must become informed of the $1 million life-time coverage limit imposed by health insurers.

He suggested that a monitoring agency modelled after the Red Cross Blood Policy Commission could evaluate the process by which people receive treatment for life-threatening diseases.

Commissioner Heflin asked Mr. De Neffe what agencies he approached in trying to get assistance for his condition.

Mr. De Neffe said he called the Centers for Disease Control in Atlanta, he asked professors where he attended college, contacted vocational rehabilitation organizations, insurance carriers, the Social Security Administration, Adult & Family Services, Medicaid, Blue Cross/Blue Shield and a variety of health maintenance organizations, as well as other sources. He realized at that time that he must either give up getting the highest quality medical care or apply for public assistance and hope that Medicaid would cover all his medical expenses.

Mr. De Neffe said his primary concern today was for the babies born with hemophilia who were not HIV positive now but ran the risk of receiving contaminated blood products. He said the technology is available to purify blood, the problem is access to the good products.

John Baker, chair of the Right to Privacy PAC: Mr. Baker listed a number of cases of discrimination that had occurred throughout the nation, discrimination against individuals perceived as having AIDS as well as those who are symptomatic.

Mr. Baker recommended for local government action:

- Development of an AIDS education program for City of Portland employees as well as development of a general program for employees of private companies;
- Development of guidelines for dealing with AIDS and related illnesses in the work place;
- Support for the Bureau of Labor and Industry's view of AIDS as a handicap;
- Creation of a legislation package on AIDS and civil rights;
- A city statement reinforcing the right of individuals with AIDS or perceived as having AIDS to remain in the work place;
- Creation of an ordinance protecting the individual's right to sexual preference.

In response to a question by Rodney Page as to what more the Legislature could do on this issue, Mr. Baker said he felt that the Legislature and the Bureau of Labor and Industries must repeat and reinforce existing policies.

Commissioner Mata asked Mr. Baker if he knew of people who had to move to Portland in order to be able to get medical care because it was unavailable in rural areas.

Mr. Baker said he was familiar with instances of insurance companies "red-lining" certain geographical areas, refusing coverage to people living in certain urban communities because of high incidences of AIDS. Also, he had heard of companies refusing to cover treatment by doctors who were known to treat people with AIDS.

Commissioner Heflin asked Mr. Baker if he had any suggestions about the creation of an ordinance protecting the right of sexual preference.

Mr. Baker said that more than 50 cities have banned such discrimination already. He said such an ordinance would make it easier for people to fight discrimination on AIDS-related issues.

Roger Hitsman said he suffered from HIV Disease and that he had to apply for Medicaid to get the best medical care. In applying for state medical assistance he was also required to apply for social security disability. Instead of granting him the disability and giving him benefits, the Social Security office insisted he visit a psychiatrist and began treating him for depression.

Mr. Hitsman said he had worked as a waiter but had been forced to quit as a result of a severe case of contact dermatitis and the fact that he rapidly developed immunities to the antibiotics he was using. He applied for social security in December and as of the hearing date there had been no decision.

Nancy Lawson told the commission that she had seen the same dentist for 14 years. When she found out she was HIV positive she notified the dentist immediately. He told her that if he treated her she would have to promise not to let any of his patients know she was HIV positive. In addition, he said he would have to double the cost of each visit to cover costs of extra sterilization of equipment and additional precautions.

Ms. Lawson said she had not returned to the dentist. She had just signed up with a new health insurance company and did not know how she would be received by other medical providers.

Ms. Lawson said she knew of others who had lost their jobs when they found out they were HIV positive. In addition, she knew of people who had been turned down for drug rehabilitation treatment because they were HIV positive.

Commissioner Mata pointed out that refusal to provide treatment to drug users who are HIV positive would exacerbate the problem of spreading AIDS.

Ms. Lawson said that several centers, specifically the DePaul Center and Hooper Detox Center, were accepting HIV positive people for treatment.

Commissioner Mata asked Ms. Lawson if she and her friends were aware of their legal rights with respect to handicap laws.

Ms. Lawson said she was only aware of existing federal laws that did not cover most situations. She said she didn't believe that people generally were aware of their legal protections. The women in her support group are "terrified of being found out," she said. She said they worry about their parents, their neighbors and their children's teachers finding out.

She told the commission that her friends who are suffering from HIV disease and AIDS are on welfare, "because they get better treatment" that way.

Mimi Luther, Oregon Women's Aids Network. Ms. Luther said that the network was begun out of an awareness that many women who were testing HIV positive felt they had no resources in Oregon, and many were told that they would need to call San Francisco for information.

Ms. Luther said that so far in Oregon, the AIDS picture was quite different from that in other parts of the country. Whereas women comprise 12 percent of the total number of people who have died from AIDS throughout the nation, in Oregon that figure is less than 3 percent. However, that percentage will increase as gay men begin to represent a smaller percentage of the overall AIDs cases.

She said that in New York City, AIDS represents the number one cause of death among women between the ages of 25 and 35.

Ms. Luther stated her major concern as being access to care for women with AIDS, women who are HIV positive and those identified as having HIV disease.

Prostitutes. She said that one of the major problems that she identifies as discrimination is the treatment of prostitutes, who are being separated out from the rest of the population who are at risk of being infected. She wants to make sure that prostitutes are treated fairly and with full access to screening and medical care. To that end, her organization is developing cards that would provide access to free screening and counseling for prostitutes.

Health Care Providers. Ms. Luther said that she is quite concerned about the attitude of physicians and other health care specialists who choose to look at the AIDS problem strictly as a public health dilemma and who ignore the civil liberties aspects inherent in the problem. She said that many physicians want to be able to test freely, disregarding civil rights issues, and that physicians must be educated about protection of civil liberties.

Lack of facilities for women and children. Because many services were originally designed for gay, white men, services are not in place for women and families who are now beginning to be affected by AIDS in large numbers. For example, HIV testing that is relatively accurate for men is not accurate for women, and only one pharmaceutical company is working on that problem.

Ms. Luther said that until recently, a woman with AIDS was able to get housing and medical care for herself but not for her dependent children. Adult and Family Services has recently begun to take corrective action on this issue, however.

Ms. Luther said that systems must begin to change to accommodate the needs of women and people of color.

Ms. Luther told the commission about the Neighborhood Health Clinic, of which she is the coordinator. The clinic provides access to care for individuals who need extended health care, and they often refer people to Multnomah County and the Providence Primary Care Clinic.

Julia Hale Harbaugh, AIDS Project Coordinator, Office of Civil Rights, U.S. Department of Health and Human Services, Seattle.

Ms. Harbaugh said that her office is just beginning to receive complaints of civil rights violations from Oregon. For example, many nursing homes won't accept people with AIDS, claiming they need substantially different care from others who have chronic, debilitating diseases. This is untrue and effectively discriminatory, she said.

She said that some physicians have refused care to gay men or have demanded patients take tests for HIV before receiving care. Some hospitals have separate wards for AIDS patients. These patients often end up ignored and poorly treated by non-professional staff members who refuse to serve them.

In response to the question asked about a food service worker, "Is it all right to make a person who tests positive for HIV wear gloves in the work place?" Ms. Harbaugh's response is, "Why not just train all employees to wash their hands regularly, rather than segregating out the one individual for different treatment."

Ms. Harbaugh said that any type of action taken by the MHRC should look toward plugging loop holes in existing law. For example, in Washington State, if an employer does not receive federal funds and has fewer than eight employees, neither state nor federal law covers that employer with respect to civil rights enforcement.

Ms. Harbaugh mentioned the problem of insurance coverage, that some people with AIDS pay for their AZT themselves rather than listing it for their insurance carriers to cover, for fear that their insurance will be cancelled if the carrier finds out why they are being treated.

She mentioned the fact that AIDS would soon be an increasing problem among the general population, and cited increases in the number of sexually transmitted diseases that have been reported recently. The need for multilingual educational efforts will be critical, as more minorities become at risk of infection.

Ms. Harbaugh said that one frightening aspect of the AIDS epidemic is the fact that cases may be seriously under-reported, especially among minorities who may not recognize the disease or recognize the need to report it.

Ms. Harbaugh's major piece of advice was to step up education efforts. Information about AIDS should include anti-discrimination information. Ms. Harbaugh said that any ordinance or statute protecting the rights of handicapped individuals should be expanded to include AIDS. She said that local ordinances against discrimination on the basis of sexual orientation will be effective in some kinds of AIDS-related discrimination.

When asked about the specific case where Social Security Administration personnel apparently discriminated against a person with AIDS, Ms. Harbaugh said that her office does not have jurisdiction over the Social Security office. She said that her office has received other complaints about Social Security. And in the past her office has intervened to work out solutions even if they do not have jurisdiction over a certain agency or employer.

She said a new policy from the director of Social Security should help to alleviate these problems. The key, she said, is to educate social security personnel about their responsibilities.

With respect to insurance, Ms. Harbaugh said she felt HMO's should be prohibited from refusing to cover certain conditions.

She said that Washington Law treats insurance the same way it treats public accommodations, giving the state an added control over discrimination.

In some cases, she said, state laws have not been enforced until local ordinances were put in place to reinforce the concept. She used as an example the issue of sidewalk ramps for wheelchairs that were developed as a result of local initiatives.

Ms. Harbaugh said that her office receives 20 to 30 calls a week asking about issues related to discrimination. Emphasizing the need for education, she said it's critical to let the public know that government is serious about enforcing civil rights, and it's equally critical to let consumers know what their rights are. She said that enforcement agencies have barely made a dent in the incidence of discrimination.

The commission began a discussion of public information opportunities. They were told that KGW-TV has made a commitment to prepare public service announcements on AIDS and related subjects.

Ms. Harbaugh said that the Washington Human Rights Commission has created some good ads on civil rights.

APPENDIX B

MINUTES ON AFTERNOON WORKSHOPS
AIDS AND DISCRIMINATION CONFERENCE

APRIL 15, 1988

NOTES FROM EDUCATION POLICY GROUP

People Participating in Group

Bill Flood, Facilitator
Jane Williams, Cascade AIDS Project
Mike Vermillion, Beaverton Schools
Donna Noonan, OSHD
Linda Pfohl, Sauvie Island School District
Chris Weekly, Cascade AIDS Project
Ann Shelton, Portland Public Schools
Holly Skelton, Peninsula Children's Center
Tim Kurilo
James Lundemann, CCD-OHSU
Scott Mutchie, Glide Public Schools
Kriss Dluhy, Portland Public Schools
Greg Asher, Chemeketa Community College
Roberta Hutton, Oregon School Board Association
Edith A. Hintz, Reynolds #7 School District
Paula Radloff, Oregon Health Division
Kim S. Moreland, M.H.R.C.

Notes

After a brief introduction by Bill Flood, all present introduced themselves. Bill identified the goals of the workshop:

- to exchange information in order to promote the development of stronger AIDS related policies, and
- to develop a list of key issues blocking policy development

Mike Vermillion began by describing the experience of the Beaverton schools in dealing with a teacher with AIDS (Fall of 1986). Mike stressed the issue that the school district did not identify the teacher by grade level, gender or school. He believes that confidentiality is of paramount importance. At the teacher's request, he/she was identified within the school to other teachers. Mike feels that the school was very successful in not identifying the teacher to the public. Even the press were cooperative, except for one reporter who was persistent in trying to identify the teacher.

Scott Mutchie of Glide discussed his experience in working with the two students with AIDS in his school. Prior to the students being identified as having AIDS, the school had adopted an AIDS policy. However, once it was discovered that the children were infected with AIDS the policy had to immediately be updated. The policy was inadequate to deal with real children with real AIDS.

This situation is typical of schools. Many schools (school boards) are looking to someone else (such as the State Health Division) to solve their problems. They don't really think a student or teacher in their district with contact the AIDS virus. Their policies many times reflect this unrealistic view.

Glide has ended up serving as a model school for the nation. When Scott first found out about the condition of the students, he felt that he and the staff must deal with the issue very directly. Everything indicated that the students should remain in school. They were in no way a threat to other students or teachers.

When the children transferred to Roseburg, the Roseburg school was unprepared to deal with having the children in their school. They had no policy, and they were unable to resolve community issues surrounding the children.

Scott noted that as a result of their situation in Glide Oregon law has recently been changed to allow a school board to hold an executive session for the purpose of discussing medical records.

Scott noted that at this time, school districts have had ample opportunity to write AIDS policies. He suggested that two separate AIDS policies should be written--one for teachers, and one for students. He also suggested that policies be simple and brief and capable of changing as needed. The policies should be backed up with strong implementing regulations and procedures guided by the regulations of the State Health Division.

Scott noted that AIDS is not the only disease of concern; other communicable diseases such as hepatitis also deserve policy and procedural attention.

Edith Hintz discussed the gradual process she has gone through with her superintendent and school board to update their AIDS policies. Edith feels quite strongly that strong administrative procedures (dealing with issues such as how to clean up body fluid spills) are needed to inform people how to implement their student and staff policies. She is now working on writing, adopting, and educating school staff on these procedures. Her board was for some time not comfortable with establishing an AIDS policy and procedures for employees. Like Scott's experience with the early Glide policy, the board was having a difficult time facing the issues of AIDS. They adopted a policy, but when it was time to develop the procedures for implementing the policy, the board felt uncomfortable in being specific.

Edith has been involved with training administrative staff about AIDS so they will feel comfortable following the health procedures. She developed a question/answer list about AIDS for school staff and board members. She feels that educating school board members and staff is the key to developing and implementing strong policies and procedures.

Edith advised that people at all levels within the school should be involved when developing administrative procedures. Procedures should be reviewed by several different people. This further helps people to know what will be expected of them.

Edith also mentioned that she helped with a week long program about AIDS developed by students.

Paula Radloff announced that the Oregon Department of Education now requires all school districts to develop AIDS related policies for employees and students as well as curriculum. Donna Noonan has been hired by the Health Division to help schools develop policies.

Ann Shelton discussed the Portland Public Schools student and personnel policies relating to AIDS. She also agreed that infection control procedures need to be well integrated into the policies. She feels strongly about two issues:

1) Leaders in the district must take a stand. Dr. Prophet took a very strong stand backing the PPS AIDS policies. It is as important that every principal understand and stand behind these AIDS policies.
2) Training of staff is very important.

Linda Pfohl of Sauvie Island School District described the process her school is going through to adopt a policy. She is leading this process, and without her the school would probably not be actively pursuing a policy. She faces a large curriculum problem--they are not teaching sex education. She feels that sex education must be taught to set the proper context for discussing AIDS. Several other participants of the workshop agreed with her.

Scott Mutchie described past school administrators as conservative and not wishing to pursue the teaching of sex education in their school(s). Scott now sees increasing pressure from the public calling for the teaching of sex education in the schools. He feels that superintendents will change as public sentiment is changing.

Roberta Hutton of the Oregon School Board Association also said that her association is still "mixed" on the teaching of sex education. She remarked that to teach sex education one needs a commitment from school board members.

Greg Asher, Chemeketa Community College, noted that people are better than their jobs. They want to do what is right, but their positions hold them back. He noted that students and staff want to develop and implement policy, but they need top-down support to accomplish this.

Greg's advise was to keep the pressure on administrators to adopt policy and procedures. While the new Oregon regulations require schools to adopt AIDS policies and curriculum, schools can implement these in virtually any way they want.

James Lundemann of the Oregon Health Science University discussed the need for AIDS education for the developmentally disabled. He is in touch with a group developing such curriculum. Edith Hintz earlier discussed a similar need in her school district--for curriculum to reach those students in high risk groups who are sexually active.

Flood's Summary of Major Issues

• Confidentiality is the #1 concern. The identity of an HIV infected teacher should only be given at his or her request.

• The education of school board members, teachers, and all school staff (even bus drivers) is the key to building the willingness to develop sound policies and procedures as well as building the support necessary to carry out the policies and procedures.

• Strong leadership among school board members, superintendents and principals is very important and greatly needed. These people need to support the development of strong policies and procedures. The way in which school administrators communicate about AIDS issues with staff, students, parents, and community members is very important. They must be firm about the rights of the infected person yet try to calm the fears of other people.

• The process of convincing administrators and school board members of the need for policies and procedures is usually a gradual one. Continued, gradual education and subtle pressure should be applied to the administrators and school board members.

• Many schools have developed only bare minimum policies. They have borrowed policies from other districts and made a few changes. In doing so, they are not preparing to deal with the issues of AIDS specific to their school(s).

• AIDS policies should be simple, brief, and capable of changing as needed. Policies should be backed up with strong implementing procedures guided by the regulations of the State Department of Education and Health Division. School staff at all levels should be involved in the development of the procedures.

• Teaching sex education in schools is important for setting the context to discuss/teach about AIDS.

• Participants of the workshop remarked how much they benefitted from the exchange of information.

NOTES FROM WORKPLACE POLICY WORKSHOP
APRIL 15, 1988

Ben Merrill, a private attorney in Portland, addressed the workshop first. He addressed the group on the importance of policy-setting for work situations.

Ben told the participants to be aware that the treatment of the first person with AIDS or the first HIV-positive person in the workplace would set the tone and standard for future instances. It is critical, therefore, to be prepared, and to avoid making hasty decisions that could be detrimental to the affected employee, other employees and the employer.

It's critical to get all the information and facts available on the particular employee and on safety and transmission levels and to work closely with the personnel director before making a decision on how the infected individual will be treated.

It's very important to have in place an "information control standard" -- that is, confidentiality of the infected person is of utmost importance. An employer should develop strict standards for how that confidential information is managed. The company needs to establish in advance who will be trusted with the information and how that knowledge will be treated.

Dr. Ceilous Williams is a physician with Pacific Northwest Bell. He provided workshop participants with a copy of the company's guidelines on communicative diseases. Pacific Northwest Bell is widely recognized as having an excellent policy and training program on communicable diseases. Dr. Williams emphasized that AIDS must be treated as any other communicable disease and should not be treated as a unique problem.

Ken Upton, with Multnomah County Personnel, was responsible for developing the executive order on communicable diseases that directs county policy toward employees and clients. Mr. Upton gave the group very specific recommendations about developing and implementing a policy.

- Be sure to understand the needs of your specific organization. Multnomah County has many employees with diverse roles. There is a strong union and the employees are highly political. Furthermore, there are "many leaders" in the county (e.g. the sheriff, the district attorney, each commissioner and the county chair). Any policy must be able to accommodate the specific needs of the organization, in this case, a very diverse and broad-based group of people.

- o Don't stop at the policy document. The policy "must be a living document. That means an organization must use all its resources to make sure each individual understands and can apply the guidelines.

  Mr. Upton said that, despite all the information available on AIDS transmission, it is a frightening issue even for the most knowledgeable. He quoted a nurse as saying, "When you take your first blood sample from a person who is HIV positive, you get a very interesting, emotional reaction."

- o Involve people in policy development. Mr. Upton worked with unions in developing the communicable disease policy. He also sought approval of the state's HIV/AIDs Policy Committee.

- o Test it out. Test small groups of employees for their reactions to the training program, and adjust it as necessary.

- o Multi-lingual training is essential in some cases. The county contracts with independent contractors, many of whom employ Asian refugees, for a variety of purposes. These people must be trained as well.

- o Be prepared for all eventualities. Any number of out-of-the-ordinary occurrences can arise creating the possibility of employees contacting body fluids of strangers. For example, a road crew might be at work at the scene of an auto accident, or a park attendant might assist a person from drowning. How do you handle resuscitation? Client delivery must be considered in any policy document, as well as employee to employee contact.

- o You've got to go through it five times. Mr. Upton said that experts believe people must receive the information five times to be able to deal with the problem in an open and rational way.

Ben Merrill emphasized the importance of keeping the opportunity open for people to continue working if they have AIDS or are HIV-positive. "Keeping them working is keeping them living." He said it's the people around them, friends in the workplace, that often help people stay motivated to continue fighting. "That's a perspective that should be built into policy development."

He said that personalized case discussions help make the point during training.

Mr. Merrill, Mr. Upton and Dr. Williams recommended the video tape "Epidemic of Fear: AIDS in the Workplace," produced by the San Francisco AIDS Foundation, (415) 861-3397; P.O. Box 6182, San Francisco, California 94101-6182.

The video costs $275 and comes with a manager's guide book and a booklet on developing policy.

Dr. Williams cautioned that the film should not be distributed without a speaker who can clarify certain issues. The film can be very disturbing.

The panelists recommended various sources of information. They mentioned the Centers for Disease Control (CDC) in Atlanta. The Multnomah County Health Department is an excellent source of information, as is the Oregon Health Division of the State of Oregon Department of Human Resources.

October Adamson-Woods told the workshop participants about the State of Oregon's committee on AIDS in the workplace on which she served. The committee contained representatives of a number of state agencies and the employee benefit boards. The committee developed a policy which had been reviewed by the CDC and the Surgeon General's Committee.

Ms. Adamson-Woods said that, asked to develop such a policy in the future, she would make an attempt to get the top-level policy makers involved, to advise on questions of budget, policy for disseminating information and other issues that were out of control of the committee members.

Ms. Adamson-Woods recommended to the workshop the books "The Screaming Room," and "And the Band Played On," for background information about the AIDS epidemic.

She said that four elements are necessary for preparing workplace guidelines. They are:

- AIDS 101: a basic lesson about transmission, risk reduction behaviors, skills and awareness.

- Policy: Employees should know about their rights with respect to AIDS and their responsibilities in protecting health and human rights. Managers should be especially well-trained in the policy area.

- Prevention control: Employees should be well-trained in first aid procedures. They should be trained to fight their first instinct upon seeing an injured worker -- to attempt to staunch the flow of blood. People should be taught to avoid other people's blood, and, whenever possible, a worker should treat his or her own wound by washing and bandaging it.

When that alternative is not possible, one should place a piece of clothing over the wound and place a piece of plastic between the wound and the person administering first aid. Some places are beginning to keep plastic bags on the premises routinely for such purposes.

- A list of resources. Employees should be familiar with the variety of available resources.

Ms. Adamson-Woods repeated Mr. Upton's cautions about policy development: it must be appropriate to the specific employee group. Policy developers should be familiar with the types of employees, any cultural distinctions and other aspects that will guide the training process to make it more useful to the specific workplace.

Ms. Adamson-Woods identified five stages of recognition that people must pass through before they can understand and can work with the knowledge that AIDS is a reality that can affect anyone, and before they can deal with the information without fear and hatred.

The stages are:

- Fear and denial, characterized by the phrase, "I'm sick of hearing about AIDS.
- Something or someone of influence catches the person's attention. For example, once employers started insisting that sexual harassment was a real problem, employees began to recognize it.
- Quiet acceptance of the need to learn about AIDS.
- Sincere, open interest about learning about AIDS and an interest in the need to take precautions. At this stage the person begins to move into the realm of fact, beyond belief systems. This stage is the real challenge for educators: how do you move people beyond this stage without the need for them to be exposed to first-hand tragedy?
- Willingness to talk about and work on the problem. This stage is characterized by compassion.

An investment in time and money is required to move people through the five stages.

Ms. Adamson-Woods said that her committee was producing the text for a brochure that could be reproduced for use in the workplace. The state is negotiating with private organizations to finance the production and distribution of the brochure.

After a brief break, the participants returned for a question and answer session.

Wendy Rankin of the Multnomah County Health Department told participants to remember the resources available through the county health departments throughout the state, each of which has a liaison assigned to the state Health Division to stay abreast of AIDS issues.

She told the workshop that the "Quilt Project," a quilt commemorating people who have died of AIDS from around the nation, would be arriving in July. "It's an opportunity to sensitize employers and employees about the reality of AIDS," she said. The quilt is the size of two football fields.

She said that, in training about AIDS, people must recognize the element of grief and the need to support family and friends of those who have died of AIDs.

Claudia Webster of the state Health Division said that the county health departments are the first resource that people should contact for AIDS information.

In response to the question, "Is it a good idea in terms of liability to have a policy on AIDS?" Ben Merrill answered, "The finding that an employer has no policy is prima facie evidence that the employer hasn't dealt with the issue." It is better to have an inadequate policy than none at all.

However, he added, the policy must be flexible for change as needed after the first test case.

Ken Upton said that employers should be clear on their motivation: In developing the county's policy, his motivation was to set up clear standards for how employees would be treated with respect to the HIV virus. The idea of taking any position simply for the purpose of avoiding lawsuits would "probably be counter-productive." If a policy is developed strictly to protect from liability, it probably won't be taken seriously.

He said that it's preferable to have a policy that isn't perfectly developed rather than have none at all.

Dr. Ceilous Williams said that a policy for catastrophic illness that is already in place should already cover AIDS.

Ben Merrill said that there is already case law that says you cannot separate people with AIDS. An employee who refuses to work with an HIV-positive person can be terminated. However, that termination should only be a last resort.

The panelists and audience members discussed the group of individuals who have interrupted training meetings on AIDS because they oppose any type of information dissemination about

AIDS. The panelists and some audience members agreed that these people usually have the effect of annoying other audience members with the effect that people adopt the opposite point of view from the one they are promoting.

However, people who are used to accepting authority without question will probably respond well to the direction, "this is what the law says and you must comply."

In summary, Ms. Adamson-Woods told the participants:

- Use non-value-laden language in imparting information;
- Practice active listening skills; and
- Accept the fact that some people won't change their minds.

WORKSHOP C: AIDS, MEDICINE AND INSURANCE

SPEAKERS:

* ED REEVES, Attorney,
Stoel Rives Boley Jones & Grey Mr. Reeves successfully argued an AIDS insurance discrimimination case based on sex discrimination.

* PATRICK DUNNE, MD.
Good Samaritan Hospital and Medical Center, Chairman for Portland Area Institutional Ethics Committee and Good Samaritan's Institutional Ethics Committee:

* PAUL STARR, MSW
Client Services Coordinator, Cascades AIDS Project

* KATHY ARNOLD, RN
Visiting Nurses Association,
Director of AIDS Education for HealthLink

* JAN WEYENETH, LPN
Founder, Juniper House

MODERATOR:

* TED FALK, Attorney,
Spears Lubersky Campbell Bledsoe Anderson & Young

(The following is a summary of the workshop. Unfortunately, some portions of the taped procedings are unclear and therefore have been disregarded.)

ED REEVES:

Insurance, unlike employers are not regulated to the same degree, to the same limit.

The success of that case (the AIDS/insurance case Mr. Reeves successfully argued on the basis of sex discrimination) and the holding of that case was the idea that employers must not discriminate in terms and conditions of employment. One of the conditions and terms of employment is insurance. So for an employer that provides an insurance policy that is discriminatory on the basis of sex, because of the fact since the majority of AIDS cases are male. is impermissible. It is the same basis that in the past was used to deny pregnancy benefits for women, saying that employers cannot exclude pregnancy benefits because of the dispair impact it obviously has on women, since women get pregnant.

It should hold up, I think. Although it will probably be scrutinized further.

But the notion is that, that's employment. However, most people get their health insurance from their employment. So it is a very significant holding. However it does not address other types of insurance, including life insurance policies or individual health policies. One of the other arguments and why you wouldn't exclude AIDS from group insurance is that there are not these preliminary screenings and tests in other large employer groups that exclude certain peoples. Employers have to provide insurance to all their employees.

However when you get into the individual setting the picture changes. In Oregon, at least to date, insurance is not considered to be a public accommodation. Which means there is not grounds for it to come under the state discrimination statutes. It obviously wouldn't come under the employer theory I was just talking about. However. insurance is also not, public accommodations, in Oregon. That is not true in Washington. In Washington, insurance does come under the public accommodation statutes, so certain challanges as to discrimination would be appropriate.

Q: <u>What is public accommodations?</u>

REEVES: The way our civil rights laws works stems from Title 7 and Federal law on discrimination. Those laws apply to alot of different groups. One of the ways that they are all encompassing is that they say that places of public accommodation cannot discriminate. Obvious public accommodations include restaurants and hotels. What is less known is that in many states, doctors offices, funeral parlors, schools, are public accommodations... all business or services that they offer...

REEVES: Private health insurance ...the law is much less strict. The key issue in private insurance.... is that it is a private bargain between the person and the insurance company. The insurance of the individual is based on the asssessment of the risk....that is how insurance is priced. Is HIV status a relevant issue?

Q: <u>What about laws regulating HMOs?</u>

REEVES: An HMO does receive public money, therefore they would not be permitted to discriminate against a handicapped person, therefore they must take people with AIDS. Although I think this is up to debate.

PATRICK DUNNE, M.D.

What I have seen from a clinical standpoint is that initially AIDS was a novelty. Unlike other parts of the country, we had the time to develop a rapport with the disease over the last five years, and have been able to respond in a responsable,

no-panic fashion. What has changed is AIDS as a novelty, to something that is now commonplace. Not only AIDS, but HIV disease. Not only the physical ailments, but the psycho-social issues, as well.

We are changing in how we are dealing with these patients, i.e. hospice care. AIDS is also the tip of the iceberg for indigent care. AIDS is the prototype for that. Discrimination is occuring because of limitation of resources for these patients with incredible psycho-social-medical needs.

PAUL STARR, MSW

One of the problems in dealing with AIDS discrimination is that everyone who is poor in this country is discriminatied against. The major change needs to be how we approach health care in this country.

People who are HIV positive have special problems. Access to care is is denied HIV positive people. We have not been able to break the nursing home barrier. People with AIDS have a a hard time getting in to the homes. One woman called recently...her 85 year old mother, who is HIV positive, can not get a nursing home to take care of her.

Another area is in-home care. Aging services is served with providing in-home care givers to people who are disabled and need in home care. But people who are HIV positive cannot get someone to go into there home. It's hard enough to get people with AIDS onto welfare and social security and into the system for social services. The system won't respond to their needs.

Another area I have been getting an increase of calls recently is the area of people getting fired from their jobs for their HIV status.

The other area I have been getting an increase in calls is the housing voucher program. In this city, certain people who are disable, elderly, single parent, etc. can get a voucher for emergency housing. When I tell them the agency that I am with, They hang up on me. ...I can get the voucher from the Red Cross, but I can't get a hotel to let me in.

The other issue is the insurance risk pool that passed in the last legislature. We supported it because people who are denied insurance because of their HIV status could go to the risk pool and get coverage. It seems that this is not going to happen right away because it wasn't properly funded. In this state, if you are HIV positive, you can be denied insurance.

It is a serious problem in this state, if you are HIV posititive you can be denied insurance as well as many services that are needed.

Q: <u>Under the civil rights laws, are doctors and nursing homes required to care for HIV patients?</u>

REEVES: Doctors and hospitals are are considered public accommodations.. Their argument is that they don't have the facilities to give public care...unlike the Washington state statute, that lists everything that is a public accommodation, Oregon law is a lot less clear as to what is a public accommodation. However, I believe that nursing homes are a public accommodation...

DUNNE: From a physicians standpoint, the AMA code of ethics, which is not a legal document, originally stated in the 18th century, that the physician had a duty to provide care to their patients, even if it meant personal risk. In the early 1900's, there was a change in this code, that physicians might be able to pick and choose a little bit. With the polio epidemic in the 30's and 40's it was softened a bit more. With the AIDS epidemic, the AMA code was modified twice. The first change said that physicans had the right to pick and choose which patients they wanted to care for. They had no duty to care for AIDS patients. That was softened again last fall, after an uproar about that. Physicians, although they have no absolute duty to do so, the AMA would hope that physicians would provide care and that it was the ethical response to the disease.

KATHY ARNOLD: It was also stated in that last AMA statement that doctors who have patients outside their specialty must recommend them to another doctor who could provide that care.

STARR: One of the things that is also happening is that people from outside the Portland area are moving to this area to get medical care because there are not the physicians to treat AIDS patients outside the Portland area.

JULIA HALE-HARBAUGH (from the Department of Human Services, Region X) There are civil rights protections under section 504 of the federal handicapped laws that do apply to some of the situations we've discussed. Any agency, including HMO's that receive federal assistance cannot discriminate against the handicapped, this includes people with AIDS. (more discussion that is not clear) My phone number is:

STARR: One of the issues we need to deal with is that it is not just patients who are diagnosed, it is also staff people from agencies who are dealing with these issues. I just got a call from someone who works in a nursing home who is losing his job. So if you haven't developed policies in your agencies, you should do so.

KATHY ARNOLD:

As a nurse working for VNA for seven years, as AIDS came onto the scene, I began working with people with AIDS. At the time, many of my peers started to come up with all sorts of reasons not to work with AIDS patients. I began to educate myself to understand the issues of AIDS and transmission. Recently, I was made Director of AIDS Education for HealthLink, which includes VNA and Emanual Hospital

One of the things we have done, over the course of time, is develop an informed consent form that ensures the legal rights of AIDS patients to have informed consent before HIV testing. It also ensures that the results of the tests are kept confidential. I have found that most of the HIV testing done in the Portland area, the majority of HIV testing is being done illegally, for the benefit of the provider. Surgeons are wanting HIV tests to see who do do surgery on, etc.

The intent of the form is to ensure that the law is abided by... the patient is informed before the test is taken, the test result is kept confidential disclosed only with the specific authorization of the patient... and that counseloring is given at the time of testing and then at the time the results are given. This can be mandated to physicans in HealthLink, but not private physicians.

In my position, I feel that a lot of the discriminatory behaviors that I have encounted are based on a lack of knowledge and fear. The best way to reduce that is to educate people. At HealthLink we are implementing employee, system wide AIDS education. With discrimination, I have found that it is not a maliciaous intent. Just a lack of understanding the issues of transmission and fear.

There are cases, in HealthLink, of employees that are HIV positive. While they were not fired, their job description was changed or their job responsibilities were changed. However, people do not want to take on a long fight.

The third policy we have looked at is a human resource policy This looks at the issue of hiring, testing and employment of anyone with HIV disease. HealthLink will hire, they will not fire or alter a person's job based on their HIV status unless a patient will be put at risk by the worker's HIV status.
Guidelines for confidentiality status information must be kept confidential and disciplinary action will be taken if this is not done...There is no mandatory testing policiy.

A primary approach to dealing with discriminatory behavior is an educational process. I have known many medical people whose medical practice I have respected tremendously. But this situation surrounding HIV has made some incredibly intelligent people sound incredibly uninformed. The only way to get past that is with an educational process.

Q: What is the status of people discriminated against because they are gay or perceived to have AIDS?

REEVES: The perception of HIV status would be considered a handicap, which would be covered under Oregon law. I believe if you get a good attorney, you can successfully argue that gay discrimination could be because of the paranoia of AIDS.

JAN WEYENETH:

A year ago some friends and I got together and realized that it was time to do something for people who are living and dying with AIDS...We had a lot of support from people from the community...On May 5 it will have been a year. It is basically a foster care home for people who have HIV disease. We are a hospice setting. So some people come and live there and also die there. Sometimes people stay for awhile and then get better and go home. We are state subsidized. Which means that we can take people who are young and never reach retirement and have just worked...and then lose that ability to work.. and have to rid themselves of everything and go on general assistance..and file bankruptcy to get the help they need. It is quite degrading.

We offer education within our setting. People have to know how to protect themselves. We don't approach anything with fear. But we take precautions. We approach everybody as if they have a communicable disease.

There are two houses, Juniper House and Assissi House.

Q: What about a staffing turnover?

DUNNE: If you have five patients with HIV disease that's all anyone.., that's all I can handle. There is definately an issue of burnout.

WEYENETH: In our situation, we tell people who call about out the job. We ask how they feel about working with AIDS patients. People who say OK, there is no problem. They have no concerns and they're great. People who have a problem, they don't take the job.

ARNOLD: People who are in the health care profession are care givers by nature and if you if you are going to be very demanding in dealing with terminally ill patients, the tendancy is to over give. I think of the pathological care giver. I think it is important in a health care center to learn to take care of yourselves.

STARR: I think it is not the care givers who have the problem, it is the husbands or wives that have a problem. I have heard of husbands who say that if you are going to take care of AIDS

patients, I am going to sleep on the couch.

HALE-HARBAUGH: (Spoke about an AIDS education program that they did that educated not only the employee, but the family of the employee. It was very successful.)

Q: How do you find people you will give good care to HIV patients, especially outside of the Portland area?

STARR: The Oregon AIDS hotline attempts to complile lists of responsive doctors and dentists around the state who will take care of HIV patients. Or contact local county health officials.

ARNOLD: Planned parenthood or sexually transmitted disease clinics. Finding adequate care for people outside this area or the Willamette Vally can be a real challenge. There are counties in Oregon who say we don't have any AIDS cases and we WILL NOT have any AIDS cases.

DUNNE: There is another side of the coin to this issue. That is that patients are entitled to be treated where they want to be treated. However you have to look at the quality of care issue. Not that there aren't competent providers elsewhere throughout the state. But true quality of care comes from experience. They probably would get better care if they were in the Willamette Valley with providers experienced in dealing with their problems. I would encourage them, if they could, to come to Portland to get their care.

Q: What about if they needed emergency services?

Q: Even if it is not AIDS related, like they were in a car accident and they broke their legs?

DUNNE: Again that gets back to the issue of education.

Q: Regarding the public accommodation laws, are there any groups lobbying the legislature trying to make insurance a public accommodation?

REEVES: Not that I know of.

FALK: Since 1975, every legislature has seen a bill introduced, mostly by women's rights groups, trying to define insurance as a public accommodation. It has always failed. I don't think it will ever get anywhere.

Q: What about the risk pool? How is it supposed to be funded and what is it supposed to do?

FALK: The risk pool would sell health care insurance to anyone who cannot get health care on the private market. The reason people can't get health care is that the people who cannot get health insurance are a lot sicker than average. At the same

time, there would be a ceiling on the amount of premium that would be charged. It would be about 150% of the prevailing premium. That's an expensive premium for a lot of people. You have to have alot of money. Still it is a ceiling. To subsidize the difference between the premium and the actual cost, it would have to be an assessment made...on the insurance company. And the insurance company in return would get a tax credit.

I think that in the next legislature, we are probably going to see a more comprehensive approach. The risk pool would have already taken care of a few thousand people, including twenty or so with AIDS. The reason, I believe, the leadership in this state has been silent about a risk pool is because the risk pool strategy might be part of a more comprehensive approach to financing indigent medical care. Fifteen states have risk pool statutes, including Oregon. Fourteen are operational. So it is a workable device. But it does require a subsidy from some source in order to bring the premium down to an obtainable level.

...The Massachusetts approach requires all employers to provide health insurance. Right now the largest number of people who are medically uninsured are workers whose employers do not carry health insurance... Massachusettes just passed a law which requires all employers to carry health insurance...The Kennedy bill would require the same thing...

Q: <u>What do you tell medical personnel that say that they are afraid of getting AIDS and therefore don't want to care for patients that are HIV positive?</u>

ARNOLD: I find the best thing to do is bring people back to the facts. The facts are are this: There is not one health care worker who is known to have died from work related HIV exposure. 300 health care workers <u>every year</u> die from heptitis B exposure. Health care workers should be much more concerned about their hepatitis B exposure. There are only 14 known health care workers that have HIV work related exposures in the world. There are 6 million health care workers in America. That is an extremely, extremely low risk rate. Nonetheless, there is a risk. There has always been a risk in the provision of health care.

I feel that if I choose to not want to take that risk, I should not be in the provision of direct patient care... What is my motivation for being in health care? Am I there to provide a a professional service to people who are ill? Or am I there to provide health care to people who fit in a certain mold?...I am there to provide a service to the public.

DUNNE: (speaking about a study about fear and risk)
The study showed that...even if the true risk may be very small, the perception of risk is just infinite. So that the fear is also infinite. The only way to counteract the fear is through

education. Educate people to try and decrease or change the perception of the risk which can change the fear level.

Q: Regarding foster home care, should people be forced to take someone in their home that has AIDS?

Discussion about forcing people to take care of patients they don't want to care for. Some felt that forcing people to provide care means that people get bad care. Others felt that if you commit to offering care for all, especially in situations that receive federal or state money, peoples attitudes about caring for people with AIDS will change over time.

STARR: "Fighting discrimination ..you have to fight on every level. You don't try to lobby to allow for people to get away with something, but at the same time you don't wait for them to change their minds. What you do is create services for people..."

Q: What about the case that argued discrimination against AIDS and insurance based on sex discrimination?

REEVES: I think that the first line of attack is that discrimination is impermissable...existing laws cover many scenarios. I think that AIDS specific legislation is vulnerable, vulnerable to political times and whims...If you isolate AIDS as a special category of discrimination, it allows people to monkey with it. If you sweep it into handicapped laws or sex discrimination, the consitiuency gets much larger ...and the political support gets much greater.

Q: What about insurance companies discriminating against people with AIDS?

Discussion: private policies v. employer group policies.

REEVES: There are no employer based policies in Oregon that excludes AIDS. They also can't cut off your benefits after you get AIDS. ARISA policies are private and at this point can only be challenged as sex discrimination. Also the new informed consent and confidentiality law covers this.

Any disclosure of HIV or AIDS is an indirect disclosure of an HIV test result and therefore is confidential information that cannot be disseminated without the express permission of the person.

Discussion: Medical personnel from various hospitals talked about the implication of releasing records to insurance companies and the problem of insurance companies finding out about the HIV status of a patient. This included pre-authorization for treatment information that indicates treatment and ultimately gives the insurance companies the HIV status of the patient.

Hosptial personnel talked about ways to keep this information

confidential. Kathy Arnold spoke about HealthLink's forms and procedures and charting procedures for confidentiality. Many others spoke about problems in keeping their charts and information confidential.

REEVES: Under Oregon statutes, from the last legislature, you have to have specific written consent for testing and disclosure of information. Even if it has been disclosed once, the consent has to be gotten for each time. The statute specifically refers to third party payors.

APPENDIX C

EVALUATION SUMMARY
AIDS AND DISCRIMINATION CONFERENCE

APRIL 15, 1988

SUMMARY OF EVALUATION FORMS
AIDS AND DISCRIMINATION FORUM
APRIL 15, 1988

The evaluation forms rated each speaker or workshop on a scale from 0 to 5, with 0 meaning not very helpful, 3 helpful, and 5 meaning very helpful.

The speakers were rated as follows:

	0	1	2	3	4	5
Harbaugh			1	4	8	16
Sampson			1	6	11	14
Falk			1	10	16	5
Gregg	1	4	13	8	4	1
Radloff				7	16	9
Swenson		1	1	12	13	5
Frisch			4	6	15	6
De Neffe				2	12	17
Koberstein				7	8	12
Rockwell				2	5	4

The aggregate workshop tallies were:

				3	14	16

Comments received were as follows:

Appreciate the amount of handouts and encouraged group participation. Ben Merrill, Kenneth Upton and Paula Radloff were very interesting and easy to listen to.

It would have been nice if the volume was higher in the auditorium. It was hard to hear. Otherwise the entire event was excellent.

"Very good."

Of Koberstein, "Real cogent, put a context around everything."

This was excellent. I wish a lot of my colleagues had attended.

Morning panel had too many people so each had too little time. Medical information too simplistic with so many medical people in the audience...overall worthwhile.

It would have been helpful if the afternoon presenters had been present in the morning to hear the content of that portion.

Excellent workshop -- excellent location, excellent that it was free. Good use in a practical sense for direct application to my job and agency.

I found the information very helpful. You had quality people presenting. I will take this information and use it in my job.

Not enough minority issues; lunch was a little pricey. However, all in all a very well rounded, valuable program. Thank you.

Workshop B, along with handouts, provided excellent information re policy development. Pleased I made it for 1/2 day. Regretted I missed morning session.

Well organized -- continue to address this issue. Provide printed materials listing regional and state resources: people, references, training aids.

I feel that Paul Starr, Kathy Arnold, Tom Koberstein, Julia Hale Harbaugh and Jim Sampson contributed coherent, descriptive and humanistic aspects to the conference. I could understand the course of discussion and better follow it when less legal jargon.

"Keep up the good work!"

Almost too much information. A long day compacted with so much. I was exhausted at the end, but have learned a lot and discovered some valuable resources. Overall, great choice of speakers. They were experienced and interesting to listen to.

Personalizing AIDS with an individual account from a PWA was very helpful. However, I was left wondering why, when so many of those profoundly affected by AIDS are people of color and gay men, the speaker chosen was a heterosexual white man. I am concerned about the minimal mention of homophobia and AIDs. Tom Koberstein's speech was excellent -- why was he placed on the schedule to compete with lunchtime chatter? Fear and hatred of gays has increased dramatically with the spread of AIDs and homophobia has an impact on every aspect of AIDS education. Yet even at a conference specifically about AIDS and discrimination, I saw today's speakers unable to openly discuss or even mention "homosexuals" or even sexuality in general.

Morning panel was too large. Needed more time on different issues. Workshop B moderator needed to involve other panel members more and answer questions less.

Need specific ORS numbers: a handout would have been helpful (for Ted Falk's speech).

APPENDIX D

NAMES OF INDIVIDUALS INTERVIEWED FOR RESEARCH REPORT

RESOURCES

The following names are those of people contacted by the consultant team during research on the issue of AIDS and discrimination.

October Adamson-Woods
State of Oregon
Committee on AIDS in the Workplace
378-3200

Greg Asher
Chemeketa Community College
399-5194

John Baker
Chairman, Right to Privacy PAC
653-3090

Bobby Broadaway
Civil Rights Office
City of Raleigh, North Carolina
(919)890-3050

John Brown, M.D.
Physician
Kaiser Permanente, West

Ted Falk
Portland Attorney
Member of State AIDS/HIV Policy Committee
226-6151

Kristine Gebbe
Administrator
Oregon Health Division
Oregon Department of Human Resources
229-5032

Bill Gladden
State of Washington
Human Rights Commission
(206) 464-6500

Miguel Gomez
National Aids Network

Bill Gregg
Hearings Manager
Oregon Bureau of Labor and Industries
229-5350

Christopher S. Hall
National Aids Network

Julia Hale Harbaugh
Civil Rights Division
U.S. Department of Health and Human Services
(206) 442-7483

Marvin Hart
AIDS Coordinator/Legal Advisor
Washington, D.C. Human Rights Commission
(202) 939-8740

George Hendricks
Chairman
Portland Chapter
National Association for the Advancement of Colored People

Commissioner Gretchen Kafoury
Multnomah County Commission
248-5219

Staff representatives
Senator Ted Kennedy's Office
Washington, D.C.

Louis Littlehales
State of Oregon Department of Insurance and Finance
378-4217

Helen Lottridge
Director
Phoenix Rising
223-8299

Keeston Lowery
Office of Commissioner Lindberg
(Former MHRC member)
248-4145

Ben Merrill
Portland Attorney
295-2458

Norm Nickens
Director, AIDS Division
San Francisco Human Rights Commission
(415) 558-4901

Staff representative
Senator Bob Packwood's Office
Portland, Oregon and Washington, D.C.

Wendy Rankin
Information Officer
Multnomah County Health Division
248-3406

Stevie Remington
Portland Affiliate
American Civil Liberties Union
227-3186

Ed Reeves
Portland Attorney

David Schulman
Deputy District Attorney
AIDS Discrimination Unit
City of Los Angeles
(213) 2485-4579

Dixie Shaw
Civil Rights Field Representative
City of Seattle Human Rights Commission
(206) 625-4381

Cathy Siemens
Director
Lesbian Community Project

Burton White
Chair, ACLU Committee on AIDS
639-3535

Staff Representative
Congressman Ron Wyden's Office
Portland, Oregon

APPENDIX E
MEMORANDUM FROM CITY ATTORNEY
RE: LOCAL AIDS-DISCRIMINATION ORDINANCE

CITY OF
PORTLAND, OREGON
OFFICE OF CITY ATTORNEY

Jeffrey L. Rogers, City Attorney
1220 S.W. 5th Avenue
Portland, Oregon 97204
(503) 248-4047

May 23, 1988

INTEROFFICE MEMORANDUM

TO: Bob Stacey, Commissioner's Assistant

FROM: Nancy E. Ayres, Deputy City Attorney

SUBJ: Prohibiting Discrimination Against AIDS Patients

You asked whether the City should enact legislation prohibiting discrimination against AIDS patients in public accommodation and employment.

On December 9, 1985, Jeff Rogers addressed a memo to former Commissioner Margaret Strachan on the topic of whether the City should legislate to prohibit discrimination against AIDS patients. A copy of Jeff's opinion is attached. The following updates Jeff's memo.

The Portland City Code sections 3.100.012 and 3.100.021-023 regarding equal opportunity for handicapped persons have not been amended since Jeff's memo was written. The Oregon Revised Statutes on the same topic, ORS 659.400, 410, 415, 420, 425 and 430 also have not been amended. There is no legislation on the State or City level specifically prohibiting discrimination against AIDS patients. As stated in Jeff's memo, it is our opinion that such specific statutes are possible but not necessary because the currently existing statutes prohibiting discrimination against handicapped persons are broad enough to include AIDS patients. This opinion was also expressed by Oregon Bureau of Labor and Industries Commissioner Mary Roberts. A copy of her March 13, 1986 letter opinion is attached.

On the federal level, the courts have also found the Rehabilitation Act of 1973, 29 USC § 794 as amended, which prohibits discrimination against handicapped persons in any program or activity receiving federal financial assistance, to apply to discrimination against persons with contagious diseases. See Chalk v. U.S. Dist. Court Cent. Dist. of California, 840 F2d 701 (9th Cir 1988), copy attached. The Portland City Code title 3.100, adopts the concept of handicapped defined by the Rehabilitation Act of 1973 as amended.

It is my opinion, that given the remedies provided by existing City, State and federal law, it is unnecessary for the City to adopt additional legislation specifically addressed to discrimination against AIDS patients since existing State and federal law prohibits such discrimination. If such legislation were adopted by the City, it is possible that it would be preempted by the State or federal legislation. If the City decides to pass its own legislation prohibiting AIDS discrimination, the City Attorney's office should work with you to draft an ordinance, which must be done carefully, to avoid conflict with existing law. Please see the conclusion to Jeff's memo regarding this point.

N7:rp

APPENDIX F

RESOURCE LIST

RESOURCE LIST

Policies and Other AIDS-related Information

For information on AIDS generally and assistance with policy development more specifically, Multnomah County offers a number of excellent resources. For information about transmission and how to protect yourself, your family, employees or others from infection by the AIDS virus, contact:

- Multnomah County Health Division
  248-3406

- The American Red Cross
  284-1234

- The Oregon Health Division
  229-5806

For information about Oregon civil rights laws and policies with respect to AIDS, contact:

The Oregon Bureau of Labor and Industries
Civil Rights Division
229-5900

For information about federal civil rights laws, contact:

Civil Rights Division
U.S. Department of Health and Human Services
(206)442-7483

For specific information about policy development in the following subject areas, or to obtain copies of existing policies, contact:

<u>Education</u>

Ann Shelton
Portland Public Schools
249-2000

Greg Asher
Chemeketa Community College
399-5194

Scott W. Mutchie
Superintendent
Glide School District No. 12
496-3521

Paula Radloff
Oregon Health Division
229-5806

Mike Vermillion
Beaverton Schools
591-8000

Workplace/Employment

Ronnie Meyers
American Red Cross
284-1234

Ken Upton
Multnomah County Labor Relations
248-5015

Wendy Rankin
Multnomah County Health Division
248-3406

Dr. Ceilous Williams
Pacific Northwest Bell
242-8503

Medical Care/Insurance

Kathy Arnold
Healthlink/Visiting Nurse Association
220-1000

Paul Frisch
Oregon Medical Association
226-1555

Received —
8/11/88
R-1

COUNTY GOVERNMENT AND HIV INFECTION

TEXT OF THE REPORT OF THE NATIONAL ASSOCIATION OF COUNTIES TASK FORCE ON HIV INFECTION AND AIDS

PREPARED BY THE TASK FORCE
ACCEPTED AND APPROVED BY THE BOARD OF DIRECTORS, AUGUST 7, 1988

When someone uses a vulgar four-letter word in polite company, reactions range from awkward silence to nervous snickers, perverse gee and perhaps outrage. The newest four-letter word in the American vocabulary -- **AIDS** -- provokes the same range of responses. Unfortunately, AIDS can't be ignored. It simply won't go away. No community is immune. No level of government is unaffected.

County governments share a proud tradition of providing services at the grass roots level -- particularly in the public health and health care fields. Some are already straining under the weight of demands placed on their human services delivery systems by this disease. Others are planning for the seemingly inevitable onslaught. All must be mobilized to respond with the same degree of professionalism, compassion and "can doism" that our proud tradition requires.

As county governments' national voice, NACo is obliged to press for federal attention to the problems AIDS is causing county governments. As county governments' only national leadership organization, NACo is obliged to prepare its members for the work that must yet be done.

INTRODUCTION

Infection with Human Immunodeficiency Virus (HIV) has reached epidemic proportions on both global and national scales. Today, over 60,000 Americans meet the Centers for Disease Control clinical definition for AIDS. Barring a miracle, all will die. So it is virtually certain that more Americans will be lost to AIDS in this decade alone than were killed in the Vietnam conflict. With hundreds of thousands -- perhaps more than a million -- infected with HIV, the toll of AIDS could be larger than all of the ward America has fought.

The disease was first recognized in 1981 but public concern was much later in coming. Its initial dismissal from the national conscience can be traced by recalling its first four-letter acronym -- GRIO -- (Gay-Related Immunodeficiency Disease). The incidence of this new malady seemed limited to white, gay and bi-sexual men from large metropolitan areas. Moreover, it was becoming clearer that their homosexual behavior was a key factor in its spread. So in a nation still deeply divided over more conventional sexual issues, the touchy subject of homsexuality allowed bias to condone inaction.

That sexual behavior wasn't the only route of transmission of AIDS had been suspected for some time. It became evident when people whose only risk factor was a blood transfusion during surgery or the use of blood products for hemophiliac came down with the symptoms of the disease. The nation began to panic -- the blood supply was no longer safe.

The isolation of the virus and a relatively inexpensive test to detect antibodies to it slowly reassured the nation about the safety of its blood supply. But the test spawned new controversy and division as some argued vehemently that it be used to identify those who could infect others.

The traditional approach of containment would not work because AIDS continued its sinister evolution. Having first surfaced in the gay community, it began to devastate intravenous substance abusers and impact poor communities -- many of whom are disproportionately minority communities. To compound the tragedy, significant numbers of children began to be born infected, from infected mothers who abused drugs or had sexual relations

with men who did. Education programs which had proved so effective with white, middle-class gay men have had little impact on populations now affected by AIDS who differ because of addiction behavior, economic class or culture.

AIDS has no known cure. Current treatments show little more promise than extending life for a year or two. Those afflicted can be gravely disabled, many are dependent for long periods of time. They are sure to test the capacity of our health care systems.

We can, and indeed we must, provide care for the dying and hope for those who live each day to its fullest despite their HIV status. We have an equal responsibility to those who are not now infected. AIDS can be prevented. For an official not to present the information that can save the lives of his or her constituents in an effective and relevant way, could be a dereliction of their sworn duty.

Perhaps the urgency of our task would be made clearer if we remember that AIDS doesn't just kill gays. AIDS doesn't just kill junkies. AIDS doesn't just kill poor people. AIDS kills Americans.

OVERVIEW

The NACo Task Force on HIV Infection and AIDS was appointed in February, 1988. The work of this group was to have several implications: for county officials across the country, for advocacy efforts by NACo and by county government, and for future NACo policy and action in regard to related issues such assistance abuse, long term care, and appropriate health care for children, especially indigent children. The group adopted several purposes:

- to make recommendations to the NACo Board of Directors on appropriate federal, state, and local roles required to address the HIV epidemic;

- to provide advice and recommendations to counties on appropriate personnel policies to address HIV infection in the county workplace;

- to encourage all county officials to become familiar with the issue by providing them with sound information on this disease, its transmittal, prevention and treatment approaches;

- to encourage local officials to become positive leaders in their communities to minimize fears and direct appropriate preparations for addressing HIV Infection and persons with AIDS.

At its first meeting, the group agreed to form three working subgroups:

The County Role in the Community Response
Workplace Policies
State/Federal Roles

Over the next six months, the group met three more times, including site visits to San Francisco and to South Florida. An interesting measure of the reality with which we were concerned is the extent to which our semantics changed over the short course of our efforts. When we began our work in March 1988, we spoke

knowingly of "AIDS" and "AIDS victims." By the end of April we had changed our name to a task force on "HIV infection and AIDS" and discarded "victims" for "persons with AIDS." In the appendix, a chronology of the Task Force activities is presented.

The detailed recommendations that follow focus on the following four policy goals:

1) To end the AIDS epidemic. This goal involves the range of education and prevention, concerns and research toward a cure;
2) To assure access to care for all persons with HIV infection. This goal involves the range of treatment services needed by persons with HIV infection;
3) To protect the human rights of all persons. This goal was considered extremely important as it addresses concerns both for the persons with AIDS and those who do not have the disease.
4 To assure adequate funding for the full continuum of AIDS prevention/treatment services. The keyword here is "adequate;" the group recognizes the need to fund necessary services, not jeopardize other needed health care, and work with severely constrained resources.

THE TASK FORCE FINDINGS

THE COUNTY'S ROLE IN THE COMMUNITY'S RESPONSE TO HIV INFECTION AND AIDS

The response of county government as an institution, especially the response of county elected officials, can be a significant factor shaping the response of county citizens in addressing and confronting the problematic issues of behavior and values involved in the HIV infection epidemic.

A major role of the county in the community response involves providing leadership in a number of significant ways, notably:

- in education efforts to end the spread of the disease;
- in advocacy efforts and support to assure access to health care services and adequate funding;
- as a model and advocate to ensure the human rights of all persons are protected.and
- insuring that all health care providers in the community assume their fair share of providing services through the continuum of care needed.

First and most urgently, county government should assume responsibility for developing a local plan to address the AIDS epidemic. The plan should be developed with input from community based organizations, representatives of service providers, particularly hospital and health care providers, high risk communities, private sector, religious community, ethnic and cultural groups, health officials, law enforcement, and other appropriate interested citizens. A person or organization should be clearly identified to be responsible for the coordination of these groups, and as a referral for general information.

The Task Force recommends that counties include in their local AIDS response plan:

o Focus on high risk behavior;

o Encouragement for public and private employers to provide AIDS education including attention to individual responsibility to prevent becoming infected;

o Training for specialized staff such as emergency service personnel, hospital personnel, correctional facility staff, and health professionals that will enable them to continue to carry out their professional duties at minimum risk;

o Educational programs on prevention of sexually Transmitted diseases, including HIV infection, in all schools, including institutions for higher education;

o Encourage the participation of high risk segments of the communities such as ethnic minorities, religious organizations, and other interested and concerned community groups in the development and distribution of a variety of types of educational materials which are targeted to various groups in the community by using language which is frank and culturally relevant for each of those groups;

o Media industry participation, both in designing specialized AIDS education and training efforts as well as reaching the broader public;

o Extensive use of print and electronic media which have enormous potential for being effective vehicles of communication in AIDS education efforts;

o Available information in public service settings such as pre-natal clinics, clinics for sexually transmitted diseases, drug abuse treatment centers, and family planning centers;

o Expand and strengthen home health care services, the health care delivery system will be severely strained by the AIDS epidemic. Overuse of acute care facilities to treat persons with AIDS will be costly and unnessary;

o Emphasize the risk of AIDS in existing substance abuse programs and develop new and expanded focus in programs for high risk substance abuse;

o Advocacy, and support for advocacy efforts, through appropriate channels to both state and federal government for policies and programs to enable local efforts to respond more effectively and efficiently to the HIV epidemic. In particular, the following policies are recommended:

1. The establishment of a single class for HIV infection so that all persons so affected maybe eligible to receive publicly supported services and treatment if necessary;

2. Examination of relevant county policies and support for changing state general relief policies especially those which would exclude infected single persons or childless couples from receiving assistance and the expanded use of Medicaid waivers to support the use of community based and home health care for persons with AIDS;

3. Attention to insurance treatment of persons with AIDS and HIV sero-positivity, including enforcement of anti-discrimination laws, prohibition of in appropriate screening, and careful attention to the appropriate use of actuarial methods.

The county can be the most persuasive leader by being a model in discouraging ignorance and promoting the use of accurate, sensitive information. County governments have available resource in their own personnel: the county health department. Officials should rely on their health officials for accurate information and clinical expertise and should support their efforts to provide this information to the community. County government can play a significant role here as model by having a comprehensive education program in place, by routinely providing education to their own elected officials, and by having a workplace policy in place for addressing the needs of workers with AIDS and those who work with persons with AIDS.

The only reliable way known to avoid contracting AIDS is to not engage in high-risk behavior. It is morally indefensible not to equip people with the information they need to protect themselves from contracting the disease.

County government has an obligation to inform their citizens, directly or through appropriate arrangements, of the types of behavior that might cause them to contract AIDS. The county role in this regard can focus on the promotion and support of public education programs aimed at clarifying the causes of HIV/AIDS

infection and promoting non-judgmental and unstigmatized behavior changes aimed at eliminating the disease.

Clear concise and easily understood information that is culturally sensitive to the groups being addressed must include up-to-date, reliable information, including the fact that there is no known cure for AIDS.

WORKPLACE POLICIES.

The policy goals of this aspect of the county government response will depend on the ability of counties to control and manage their own workplace and influence other public and private entities in their community. They will consist primarily of policies to assure the availability of education and prevention programs for county employees that incorporate protection and sensitivity for human rights, and to promote and encourage the availability of similar programs throughout the community.

All counties should have a policy on AIDS in the workplace. This is one of the most effective ways in which county government can be a model to its community. This policy should reflect the following principles in the areas of general policy considerations, education, and health programs:

General Policy Considerations:

- AIDS policy in the workplace should include procedures to be used in cases involving employees with the disease, thought to have the disease, or concerned about any aspect of the disease in their workplace.

- The development of this policy should include all affected groups and related organizations. Of particular importance might be persons expert in working with high-risk behavior, labor and trade unions, and professional groups.

- County government should not require an HIV test as a condition of employment.

- Confidentiality should be assured, and anonymity if requested, for all persons with HIV infection and AIDS. All testing should be voluntary. These rights should be assured by an ordinance if applicable and apply to all county employees.

- Hospitals and other health care institutions should consider current scientific thought in their development of guidelines governing the assignment of health care workers who are infected with HIV.

- o County workplace policies should focus on destigmatizing the disease. This could be accomplished by not using the word "victim", and the use of positive terminology such as promoting the possibility and practicality of behavior modification as a means of controlling the spread of the disease.

- o Non-discrimination policies must be a part of an excellent education program. A balance must be achieved that includes consideration of the rights of confidentiality and rights of workers and rights of institutions charged with protection of the public welfare. County attorneys should be included to assure attention to legal issues.

Education:

- o Education and training of all employees should be the fundamental foundation of workplace policies;

- o Materials should be in simple, specific and frank language;

- o Counties should have information available on where employees may obtain HIV testing and counseling services and employees should be assured of complete confidentiality when seeking counseling or medical referral assistance;

- o Special risks should be addressed in workplace settings of particular concern, or perceived concern, deserve special attention such as jails, health care facilities, high public contact jobs; and

- o Counties must allocate the necessary staff to support AIDS related training and education activities.

Health Programs:

- o County governments should have comprehensive employee health programs;

- o Employee health benefits should be the same for treating AIDS or AIDS related conditions as any other life-threatening conditions;

- o No distinction should be made between HIV positive as a disease and AIDS or ARC for the purposes of insurance

protection or allowable reimbursement. County health benefits policies should not allow testing as a condition of insurance coverage.

- o There should be non-judgmental treatment available for substance abuse, through a mechanism such as employee assistance programs.

- o Voluntary contact tracing should be increased as rapidly as possible.

FEDERAL AND STATE ROLES

The county role in this regard is to act as advocate, through appropriate national and state organizations, for the enactment of federal and state policies and programs to address the needs presented by this disease. The policy goals to be achieved include the full range from education to prevent the spread of the disease, assuring access to services to treat it, civil rights protections for all persons, research to develop a vaccine and a cure, and adequate funding to support these activities.

Specific goals were identified as follows:

FEDERAL RESPONSIBILITIES:

Federal funding for prevention, education and treatment available to local government and community based entities. The federal government should serve as the catalyst for a national educational campaign aimed at the general public. There are two levels on which the federal government could act on this issue:

1) Congressional action to provide funding to assist local government and local health departments to provide appropriate education and training programs.

2) Adopt policies and procedures for its own workforce and the programs and facilities under its own jurisdiction. Such policies should incorporate sound public health practices and explicitly recognize the role of local government in both their formulation and implementation.

Policies and procedures for the federal workplace;

Improvement of the testing and approval process for drugs to obtain more timely release of alternative therapies and

elimination of inappropriate treatments; just as there is an obligation to promote work on therapies that offer hope, so is there an equally compelling obligation to stamp out false hope by imposing harsh penalties for the promotion of fraudulent therapies and methods of treatment;
Improve coordination of federal responsibilities including research so that efforts are reinforcing and not duplicative;

Coordination of protections and benefits and waivers for innovative programs in federal entitlement programs, especially Medicaid, Medicare, Supplemental Security Income and disability-related status for these programs in terms of the reality of the continuum of the HIV infection;

Legislation to extend federal anti-discrimination protection to people who are HIV positive in the areas of housing, employment, jobs and insurance;

Legislation that requires AIDS be treated as all other diseases for health insurance purposes.

Guarantee confidentiality of HIV testing. Assuring nondiscrimination and confidentiality are critical components of any effort at assuring access to care,because they determine the success of the testing and counseling programs essential to identify the persons who need care. The federal role in this regard could be complemented on a state and county level.

Broaden and centralize data collection and dissemination on both disease and treatment trends.

Assure that federal reimbursement is available for services needed by persons who have been infected by HIV and are financially and medically in need of those services.

Strengthen federal efforts to curb substance abuse, and drug trafficking. More treatment slots should be available and more levels of treatment available for those in need. Condoms and disinfectants for syringes (e.g. beach) should be available.

STATE RESPONSIBILITY:

A unified, centralized response to HIV infection, with a central office or agency responsible.

States should examine their own participation in funding and treatment programs and reexamine State standards and criteria including those for Medicaid, Aid to Families with Dependent Children, and the use of Medicaid waivers.

Adopt policies and procedures for its own workforce and workplaces.

Responsibility for testing, including strong counseling components, and the encouragement of voluntary contact tracing;

Develop curriculum requirements for all schools on AIDS prevention education, including institutions of higher education. State leadership should be directed at the demographic realities of the state, and target high risk groups as well as populations and school systems.

Materials should be developed to be effective for the audience to which they are directed. This review of materials could take place at a state or local level, or use the approach of local advisory groups, based on counties or regional groups of counties, to feed into a state-level agency.

Develop policies for incarcerated populations;

State health departments should take a leadership role in the development of public health policy to provide guidelines and guidance for local jurisdictions;

Criminal laws and sanctions for persons infected with HIV should be based on sound public health policies;

Initiate and fund alternatives within the criminal justice system which recognize the unique concerns surrounding the sentencing and rehabilitation of persons who are HIV positive;

States in their role as insurance regulators should enact and enforce anti-discrimination laws and create funding mechanisms that make insurance coverage for persons with AIDS related conditions feasible.

Protection from unproven treatment and techniques should be provided. Unethical treatment approaches should be vigorously prosecuted. This shall include inappropriate testing.

The states should provide technical assistance for local jurisdictions; to establish AIDS response plans.

Define AIDS so as not to preclude appropriate and necessary services in day care and nursing homes.

The funding issue was viewed in terms of supplementing existing funds. Realistic rates that accurately reflect the costs of delivering services/ should be set for all levels of care so that persons may receive appropriate services. A realistic scope of benefits must be allowed that would include outpatient, home care, acute and sub-acute. Insurance coverage, and catastrophic insurance protection, should be available to persons without prejudice on the basis that actuarial data across a broad groups does not justify exclusion of persons with HIV infection or AIDS. If necessary, risk pools of appropriate magnitude should be established to spread risk across groups.

IMPLEMENTATION PLAN
FOR THE RECOMMENDATIONS OF THE NACO TASK FORCE ON HIV INFECTION AND AIDS

Membership Education and Information

1. On-going articles in County News;

2. General session speakers at the Annual, Legislative,and Human Services Conferences on this topic (i.e., implications of the AIDS epidemic on our society), as well as workshops;

3. Nation-wide distribution of the approved Task Force recommendations through a special County News Insert (or see #3 of Role of Counties).

State/Federal Response.

1. Assign staff lobbying responsibilities at the federal level based on NACo's position;

2. Join with coalitions with similar positions to effect change based on NACo's position;

3. Distribute NACo's positions on needed state initiatives to state associations and request that their association review NACo's positions regarding the state role and make this part of their legislative package;

4. Distribute the Board's policy and report to other public interest groups and appropriate Congressional committees,staff and federal administrative offices.

AIDS in the Workplace Policy.

1. Through articles in County News, highlight the approved recommendations and offer to send a packet of model policies to any county on request;

2. Highlight "model policies" and print each in different issues of County News;

3. Include an occasional article in County News on "why counties need a personnel policy covering AIDS."

Role of Counties in Addressing AIDS

1. Continuous articles in NACo County News on the AIDS epidemic and specific county's approaches. This should include feature articles on both small as well as large county responses.

2. Identify a specific NACo staff person to refer AIDS-related concerns and make this person available to consult with counties in solving problems.

3. Seek Foundation funding, if funds are not available in NACo's budget, to print the approved report and mail to every County Board.

Seek funding generally to support on-going efforts to inform county officials regarding issues related to HIV infection.

CONCLUSION

The HIV epidemic has raised new and often difficult issues in law, ethics, education, government, medicine and human services. This is the human side of the disease -- the side which either spurs others to action or the side which people who are at low risk of infection can choose to ignore.

Public officials, however, cannot choose to ignore the other side of the HIV epidemic -- its fiscal cost. In the areas of our nation already hard hit, it is staggering. San Francisco, for example, has already had to divert resources from other services to meet the needs of its HIV population.

In just three years -- 1991 -- more than 100,000 of those Americans now infected, but well, will remain alive, but symptomatic. The direct annual bill for their care will be in the billions. The indirect cost to the American economy will be in the tens of billions.

Persons with AIDS are an increasingly dependent population as intravenous drug abusers and minority populations account for a larger and larger share of the grim C.D.C. statistics. County governments will be stuck with a large portion of the bill for their care.

In most states, medical assistance for the poor, general assistance programs and indigent care are partially, if not completely, county responsibilities. If compassion isn't enough to spur every county official to action, paying the bill for the tens of thousands of dollars each person with AIDS can run up in a year out to.

What can we do to ease the burden? In six short months, the Task Force has not had enough time to consider every aspect of this issue. It is a significant one which deserves further study either by this Task Force or by a Steering Committee on the Association as the Board of Directors deems fit. We have been able to reach these general conclusions:

o Where state or federal programs set rates for the care of persons with HIV infection, they must accurately reflect the costs of delivering services. Similarly, they should encourage early

intervention which may prolong life and not apply only when a person is severely ill.

o Funding programs and reimbursement rates should encourage a continuum of care, including less costly alternatives to hospital stay such as outpatient care and home care. Similarly, distinctions between acute and sub-acute care in hospitals should be provided for. In general, as with any other long-term care situation, persons with HIV infection should be cared for and treated in the least restrictive environment.

o Insurance coverage, and catastrophic insurance protection, should not be terminated because of HIV infection on the basis that actually, this risk ought to be accounted for when spread over a large group.

The best answer, though, to containing costs of care for persons with HIV infection is to invest whatever amount is required now to develop effective treatments, vaccines and a cure.

The National Association of Counties Task Force on HIV Infection and AIDS

Chair

Diane Ahrens
Chair, Board of Ramsey
County Commissioners
Courthouse, Suite 316
St. Paul, MN 55102
612-298-4145

Health and Education Steering Committee

Dot Kearns
Board of Commissioners
Guilford County
201 S. Eugene Street - Box 3427
Greensboro, NC 27402
919-373-3351

Suzanne L. Krueger
Deputy Director-Intergovernmental Relations
DeKalb County Planning Department
One Callaway Square, Room 308
Decatur, GA 30030
404-371-2155

Barbara Shipnuck
County Supervisor
Monterey County
P. O. Box 1004
Salinas, CA 93901
408-424-8611 Ex. 488

Human Services Steering Committee

Kay Beard
Commissioner
Wayne County
726 City-County Building
Detroit, MI 48226
313-224-0902

Herb Stout
Commissioner
Wake County
P. O. Box 50
Raleigh, NC 27602
919-755-6160

George Drumwright
Deputy County Manager
County of Henrico
P. O. Box 27032
Richmond, Virgiana 23273
804-747-4206

Intergovernmental Affairs Steering Committee

Lawrence Pernick
County Commissioner
Oakland County
29315 Pine Tree Drive
Southfield, MI 48076
313-356-7120

Taxation and Finance Steering Committee

Philippe Gille, representing
The Honorable Andy O'Rourke
County Executive
Westchester County
Michaelian Office Building
148 Martine Avenue, 9th Floor
White Plains, NY 10601
914-285-2917

Health Officials (NACHO)

Charles Konigsberg, Jr, MD, MPH
County Public Health Unit Director/
District Health Program Office Supervisor
District 10, Broward County Health Unit
2421 SW Sixth Avenue
Fort Lauderdale, FL 33315
305-467-4811
305-752-0808 (H)

Hospital Administrators

Juel Jones, representing
Bernard W. Weinstein
Commissioner of Hospitals
Westchester County Medical Center,
Valhalla, NY 10595
914-285-7021

Mental Health Directors

Lynn Ferrell
Executive Director, Health Services
Polk County
619 Fleming Building
Des Moines, IA 50301
515-243-4545

County Administrators

Marie Schook
Mecklenburg County
P. O. Box 31787
Charlotte, NC 28231
704-336-2472

County Attorney

William Trevorrow
Guilford County Attorney's Office
Old Courthouse Building
P. O. Box 3427
Greensboro, NC 27402
919-373-3852

Black County Officials (NOBCO)

Westley Sholes
Deputy Director
Los Angeles County Health Department
313 North Figueroa Street, Rm 928
Los Angeles, CA 90012
213-974-8136

State Association Directors

John Torbert
Executive Director
Kansas Association of Counties
. SW Seventh Street
Topeka, KS 66603
913-233-2271

Social Services Director

John Battistoni
Commissioner of Social Services
Dutchess County
60 Market Street
Poughkeepsie, NY 12601
914-431-5315

Others

Clyde A. Burtenshaw
Commissioner
Bonneville County, District 3
Courthouse, 605 No. Capital Avenue
Idaho Falls, Idaho 83401
208-529-0036 (h)
208-529-1360 (w)

Peter Kenney
County Commissioner
County of Clear Creek
P. O. Box 2000
Georgetown, CO 80444
(303) 569-3251 (w)
(303) 569-5777 (h)

Jim Greenwald
County Commissioner
County of Sarasota
P. O. Box 8
Sarasota, FL 33578
(813) 365-1000

Kathleen Nicols
Supervisor
Dane County
837 East Johnson Street
Madison, WI 53703
608-256-7619
608-266-4114

Aggie Leitheiser
State-Local HIV Liaison
Minnesota Department of Health
717 SE Delaware Street
P. O. Box 9441
Minneapolis, MN 55440
612-623-5709

W. J. Brakke
Rock County Board of Commissioners
417 West Bishop
Box 71
Luverne, MN 56156

Resource

George E. Hardy, Jr., MD, MPH
Assistant Director
Washington Office
Centers for Disease Control
200 Independence Avenue, SW
Room 714B
Washington, DC 20201
202-245-8598

Robert Fordham
Associate Deputy Director
State and Local User Liaison
18-05 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
202-443-5660

DATE SUBMITTED_____

(For Clerk's Use)
Meeting Date 8-11-88
Agenda No. R-2

50-51
J161

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: Deed/Order For County Road Purposes

Informal Only*_____ (Date) Formal Only X_____ (Date)

DEPARTMENT Environmental Services DIVISION Transportation

CONTACT Dick Howard TELEPHONE 3599

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD_____

BRIEF SUMMARY

88-140

SE 302ND AVENUE/COUNTY ROAD NO. 663

Deed for Road Purposes from Chaud R. and Deborah J. Spitzer. Order Accepting Deed conveying property for county road purposes.

Director of DES recommends said deed be accepted and recorded in Multnomah County Deed Records, together with the EXHIBIT "A", which is attached to said deed.

ACTION REQUESTED:

/ / INFORMATION ONLY / / PRELIMINARY APPROVAL / / POLICY DIRECTION /X/ APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA_____

IMPACT:

/ / PERSONNEL

/ / FISCAL/BUDGETARY

/ / General Fund

Other DEED/ORDER/EXHIBIT TO BE RECORDED IN MULTNOMAH COUNTY DEED RECORDS.

BOARD OF COUNTY COMMISSIONERS
1988 AUG -2 PM 4:2
MULTNOMAH COUNTY OREGON

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER:

BUDGET/PERSONNEL _____ /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts)

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

3706V

8/11/88

RECEIVED FROM JANE McGARVIN

CLERK, BOARD OF COUNTY COMMISSIONERS · MULTNOMAH COUNTY, OREGON

RECORDING ENGINEERING ZONING

ORDER #88-140 ACCEPT DEED FOR CO RD 663 - SE 302nd Avenue FROM Chaud R & Deborah J Spitzer -Item 88-224

R-2

MULTNOMAH COUNTY
OREGON

1988 AUG 16 AM 11:25

BOARD OF
COUNTY COMMISSIONERS

DEED TO BE RECORDED

PLEASE SIGN & RETURN THIS RECEIPT TO COMMISSIONERS OFFICE

8/11/88

RECEIVED FROM JANE McGARVIN

CLERK, BOARD OF COUNTY COMMISSIONERS · MULTNOMAH COUNTY, OREGON

RECORDING ENGINEERING ZONING

ORDER #88-140 ACCEPT DEED FOR CO RD 663 - SE 302nd Avenue FROM Chaud R & Deborah J Spitzer -Item 88-224

062125

R-2

DEED TO BE RECORDED

Form CC-2 PLEASE SIGN & RETURN THIS RECEIPT TO COMMISSIONERS OFFICE

BOARD OF
COUNTY COMMISSIONERS

1988 AUG 17 PM 3:23

MULTNOMAH COUNTY
OREGON

08-15-88
NO 0.001

621.25
★ NO
5530 NO A

8/11/88

RECEIVED FROM JANE McGARVIN

CLERK, BOARD OF COUNTY COMMISSIONERS · MULTNOMAH COUNTY, OREGON

RECORDING ENGINEERING ZONING

ORDER #88-140 ACCEPT DEED FOR CO RD 663 - SE 302nd Avenue FROM Chaud R & Deborah J Spitzer -Item 88-224

R-2

DEED TO BE RECORDED

PLEASE NOTE: ACCEPTANCE OF THIS RECEIPT IS ACKNOWLEDGED

57
J761

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Mr. Paul Yarborough, Director
Department of Environmental Services
2115 SE Morrison
Portland, OR

Dear Mr. Yarborough:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

In the matter of ratification of an agreement for right-of-way services with the Oregon Highway Division for acquisition of required property and/or right-of-way for various County projects as authorized in the approved budget and/or by Board Order; and authorizes the Director of the Department of Environmental Services to request services and deposit required funds in accordance with the agreement R-3

Commissioner Casterline explained this is a five year contract with the State, and is a new way of doing business which will save both time and money. She moved, duly seconded by Commissioner Anderson, unanimously

ORDERED that said intergovernmental agreement be ratified.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin by Barbara E. Jones
Jane McGarvin
Clerk of the Board

jm
cc: Budget
Finance
Purchasing
Carrier Weber

DATE SUBMITTED_____

(For Clerk's Use)
Meeting Date 8-11-88
Agenda No. R-3

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: _____

Informal Only*_____ (Date)

Formal Only_____ (Date)

DEPARTMENT Environmental Services DIVISION Transportation

CONTACT Bob Pearson TELEPHONE 3838

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD_____

BRIEF SUMMARY

Agreement for right-of-way services with the Oregon Highway Division for acquisition of required property and/or right-of-way for various County projects as authorized in the approved budgets and/or Board Orders. Recommend the Board authorize the Chair to execute said agreement and Board further authorize the Director, Department of Environmental Services to request services and deposit required funds all in accordance with the agreement.

ACTION REQUESTED:

/ / INFORMATION ONLY / / PRELIMINARY APPROVAL / / POLICY DIRECTION /X/ APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA_____

IMPACT:

/ / PERSONNEL

/ / FISCAL/BUDGETARY

/ / General Fund

Other Road Fund

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER: _____

BUDGET/PERSONNEL _____

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts) _____

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

3706V

DATE SUBMITTED_____

(For Clerk's Use)
Meeting Date_____
Agenda No._____

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: _____

Informal Only*_____ (Date)

Formal Only_____ (Date)

DEPARTMENT Environmental Services DIVISION Transportation

CONTACT Bob Pearson TELEPHONE 3838

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD_____

BRIEF SUMMARY

Agreement for right-of-way services with the Oregon Highway Division for acquisition of required property and/or right-of-way for various County projects as authorized in the approved budgets and/or Board Orders. Recommend the Board authorize the Chair to execute said agreement and Board further authorize the Director, Department of Environmental Services to request services and deposit required funds all in accordance with the agreement.

ACTION REQUESTED:

/ / INFORMATION ONLY / / PRELIMINARY APPROVAL / / POLICY DIRECTION /X/ APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA_____

IMPACT:

/ / PERSONNEL

/ / FISCAL/BUDGETARY

/ / General Fund

Other Road Fund

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER: _____

BUDGET/PERSONNEL _____

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts) _____

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

3706V

PD 92

MULTNOMAH COUNTY OREGON

CONTRACT APPROVAL FORM

(See instructions on reverse side)

TYPE I

- ☐ Professional Services under $10,000
- ☐ Revenue
- ☐ Grant Funding
- XX ☐ Intergovernmental Agreement

☐ Amendment to above, Number _____
(Original Contract Amount _____)

TYPE II

- ☐ Professional Services over $10,000 (RFP, Exemption)
- ☐ PCRB Contract
- ☐ Maintenance Agreement
- ☐ Licensing Agreement

☐ Amendment to above, Number _____
(Original Contract Amount _____)

Contact Person Bob Pearson Phone 3838 Date 7-11-88

Department Environmental Services Division Transportation Bldg/Room 425

Description of Contract Agreement for right-of-way services with the Oregon Highway Division for acquisition of required property and/or right-of-way on various County projects as authorized in the approved budgets and/or Board Orders.

RFP/BID # _____ Date of RFP/BID _____ Date of Exemption _____

Reviewed For ☐ MBE ☐ FBE Participation Contractor is ☐ MBE ☐ FBE

Contractor Name Oregon Highway Division
Mailing Address Transportation Bldg.
Salem, OR
Phone _____
Employer ID# or SS# _____

Effective Date Upon Signing

Termination Date Five years after signatures

Total Amount of Agreement $ _____

Payment Terms
☒ Lump Sum $ deposit in Oregon Local Government
☐ Monthly $ Investment Pool.
☐ Other $ _____

☐ Requirements contract-requisition required
Purchase Order No. _____

Required Signatures:

Department Head _____ Date _____

Purchasing Director _____ Date _____
(Type II Contracts Only)

County Counsel _____ Date _____

Budget Office _____ Date _____

County Executive/Sheriff _____ Date _____

TRANSACTION CODE	P O	AGENCY		PO DATE (m m d d y y)	ACCOUNTING PERIOD (m m y y)	BUDGET FY (y y)	ACTION ☐ Original Entry (E) ☐ Adjustment (M)

VENDOR CODE	VENDOR NAME	TOTAL AMOUNT	$

LINE NO.	CONTRACT NUMBER	FUND	AGENCY	ORGANIZATION	ACTIVITY	OBJECT	SUB OBJ	REPT CATEG	DESCRIPTION	AMOUNT	INC/DEC IND
		150	030	6110		8300				$	
										$	
										$	
										$	

WHITE – PURCHASING CANARY – INITIATOR PINK – CLERK OF THE BOARD GREEN – FINANCE GOLDENROD – BUDGET

AGREEMENT FOR RIGHT OF WAY SERVICES

THIS AGREEMENT, made and entered into by and between MULTNOMAH COUNTY hereinafter called "COUNTY," and the STATE OF OREGON, by and through its DEPARTMENT OF TRANSPORTATION, Highway Division, hereinafter called "STATE:"

W I T N E S S E T H:

RECITALS:

1. County proposes to construct various county road projects as approved by the Board of County Commissioners, which will include the acquisition of real property. The entire work involved is hereinafter referred to as "Projects."

2. This agreement does not apply to any projects constructed with federal aid which will be done by separate agreement.

3. County has the authority to enter into agreement with State in connection with accomplishing the Projects and shall enter into and execute this agreement during a duly authorized session of the Board of County Commissioners.

4. County is willing and able to finance right-of-way acquisition and relocation costs and all expenses incurred by the acquisition program.

5. State has a Right-of-Way staff capable of performing, or contracting for, the real property acquisition phase for the Projects and is also capable of assisting County in preliminary phases leading up to the acquisition phase of the Projects.

6. County and State propose to enter into this agreement for the purpose of employing State to perform services in the acquisition phase and other phases preliminary thereto for the Projects. County and State hereby pledge complete cooperation with each other in order to accomplish the Projects.

NOW THEREFORE, the premises being in general as stated in foregoing RECITALS, it is agreed by and between the parties hereto as follows:

I.

County agrees to and hereby does employ State, and State agrees to act for County in performing the services hereinafter called for in this agreement in connection with the projects as they occur during the term of this agreement. The parties hereto mutually agree to the following:

II.

THINGS TO BE DONE:

A. Preliminary Phase

1. State will provide estimate of real property costs, moving costs, additives, incidentals and demolition when required.

B. Acquisition Phase

1. General

a. Both parties will strictly follow the laws, policies and procedures of the "Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970," Federal Aid Highway Program Manual, Volume 7, and State of Oregon Right-of-Way Manual, Official Publication 74-4.

b. County will pay all costs of real property, temporary easements, and cost of services as set out in General Provisions.

c. State will provide County with a status report of the individual projects when requested.

2. Legal Descriptions

a. County will provide sufficient surveys, vesting deeds, map and other data.

b. County will write legal descriptions, prepare property map, and assign file numbers obtained from State.

c. County to specify use to be made of property (nature of interest to be acquired) (duration of interest, if not perpetual).

3. Real Property and Title Insurance

a. State will order preliminary title reports and title insurance at the appropriate times.

b. State will provide encumbrance report.

c. County will determine which encumbrances are objectionable.

d. County will approve sufficiency of title.

4. Appraisal Process

   a. State will appraise real property to be acquired.

   b. State will make appraisal reviews by qualified senior appraiser.

   c. Appraiser(s) to testify in court whenever and if need arises.

5. Negotiation

   a. State will handle this function including the preparation of the option forms. Property will be purchased in the name of Multnomah County.

   b. All monetary offers are to be made to the land owner in writing at the reviewed and approved figure. Offers and options above the approved figure are to have advance approval by County and options are to be accompanied by an administrative review justification.

6. Relocation

   a. State will provide replacement housing benefit computations, moving cost estimates, incidental cost estimates, and relocation review service as required.

   b. State will provide all relocation services to relocatees, process all claims and pay promptly.

   c. State will promptly establish an appeal procedure whereby displacees are informed of the procedure at the outset of negotiations.

   d. State will provide necessary evidence at relocation appeal hearing.

7. Property Management

   a. State will take possession of properties for the County.

   b. County will handle disposal of any improvements or excess land.

   c. County will carry insurance to protect County's interest on all acquired improvements.

C. Closing phase

1. State will process options and settlements and secure approval of County.

2. State will draw deeds in the name of Multnomah County and obtain necessary releases and satisfactions, and have them executed. County will have them recorded.

3. State will make payments for all property, incidental expenses and relocation claims.

4. State will provide County with copies of all pertinent letters, title reports, deeds, and other recorded documents, and obligations of real property acquisition.

D. Condemnation

1. State will handle entire condemnation action and will condemn in the name of the State.

III.

GENERAL PROVISIONS:

The acquisition and relocation will be in full accordance with the "Uniform Relocation and Real Property Acquisition Policies Act of 1970" (Public Law 91-646).

State shall keep records of its actual costs and expenses, by project, incurred in performing the agreed Right of Way Services for the projects under the terms of this agreement. The County agrees to pay total cost of salaries and payroll reserves of State Employees, per diem, the rental of equipment and a 10% surcharge.

An advance deposit which shall be 100% of the total estimated acquisition cost of all parcels in a given total project shall be made by the County before it performs any services required herein other than preliminary cost estimates.

State records for the costs and expenses shall be available to County for auditing at any reasonable time. The billing for cost and expenses is to be done by the State Accounting Section as described on Exhibit "A" attached.

State will not discriminate on the grounds of race, color, natural origin or sex and comply with code of Federal Regulations, Appendix C, Title 49, Part 21 and 25.

It is mutually agreed that any change in this agreement must have the approval of the County Representative and Right-of-Way Engineer and Chief Counsel of the Oregon State Highway Division.

Notwithstanding anything else in this agreement, the intent is that County has employed State as an independent contractor for its services with regard to the provisions set forth herein.

IV.

TERM:

This agreement shall become effective upon signing and acceptance and extends through June 30, 1993, unless sooner terminated under the provisions hereof.

V.

TERMINATION:

This agreement may be terminated prior to the expiration of the agreed term:

A. By mutual written consent of the parties;

B. By either party upon 30 days written notice to the other, effective upon delivery of written notice by certified mail or in person.

VI.

FUNDING:

This agreement is for projects authorized by the Board of County Commissioners in an approved or amended budget, or by special Board order.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed on the date and year hereafter written.

The State Highway Engineer, acting under delegated authority from the Oregon Transportation Commission, authorized the Right-of-Way Manager to approve and execute this contract on behalf of the Commission.

Dated this _____ day of _____, 1988.

APPROVED AS TO LEGAL SUFFICIENCY

Cynthia X Carter
Assistant Attorney General

Date 6-14-88

State of Oregon, by and through its DEPARTMENT OF TRANSPORTATION, Highway Division

Steven Green, Right of Way Manager

AS TO FORM

LAURENCE KRESSEL

Deputy County Counsel

MULTNOMAH COUNTY, by and through its elected officials

By: Gladys McCoy, County Chair

EXHIBIT "A"

ACCOUNTING BILLING PROCEDURE

The Oregon State Highway Division, Accounting Section, will handle outside billings as per agreement. The State Highway Division accounting is done by computer, using an account-numbering system. The project will be given a four-digit major classification number. Capital costs and acquisition expenses, if any, will be shown by additional three-digit function numbers. All charges and credits to the project are to be made to one of the following function numbers:

286 Research and Testify for Litigation
407 Appraisal
409 Miscellaneous
411 Property Management Expense
412 Title Costs and Recording Fees
413 Taxes
414 Negotiation Expenses
415 Relocation Computation
418 Credits for Cooperative Payments Received
432 Manage Appraisals
439 R/W File Processing, Clerical and Related
470 Relocation Advisory Assistance
471 Inspection of Replacement Housing
707 Relocation Incidental Expenses
712 Relocation Moving Expense - Individuals and Families
713 Relocation Moving Expense - Business
714 Relocation Moving Expense - Farms
715 Relocation Moving Expense - Nonprofit
909 Legal Descriptions
913 Right-of-Way Liaison and Relocation Plans
930 Engineering Products (Maps)

All bills rendered by the Highway Accounting Section has an attachment using the same function numbers giving both parties to the contract accurate detailed information on costs and expenses. If other function numbers are used besides those above, the amount will be shown with an explanation of the reason.

In addition, a second attachment will be given with a different breakdown. Items such as salaries, equipment rental, per diem, etc., will be shown. The totals on each of the attachments will be the same.

51-52
J161

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Mr. Paul Yarborough, Director
Department of Environmental Services
2115 SE Morrison
Portland, OR

Dear Mr. Yarborough:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

In the matter of ratification of an intergovern-)
mental agreement with the Tri-County Metropolitan)
Transportation District (Tri-Met) to establish)
conditions for removal of unused railroad facil-)
identified and reconstruction of abandoned crossing on)
SE Division Street at approximately SE 198th)
Avenue R-4)

Commissioner Casterline explained that the crossing on Division at 198th is deteriorating, and has caused a hazardous condition for traffic. She moved approval, duly seconded by Commissioner Kafoury.

Commissioner Kafoury said Mr. Howell wished to speak on this matter, and Commissioner Anderson added since he might not be able to come today, he had asked the matter be continued a week.

Commissioner Casterline said she has a copy of his comments, and explained Mr. Howell's concern is regarding a Metro study to continue the Southeast Corridor line; and that he assumes the matter being considered is the same; but they are two different projects.

Dick Howard, Transportation, explained the agreement allows Tri-Met to reopen the crossing at any time; and the purpose of the agreement is to remove existing ties and rails that are not suitable for transit use. Crossing signals are obsolete and cannot be not approved for continued use. He said the PUC will approve the closure with the condition that there is an option for reopening. This project is a traffic safety measure, and a cost saving measure for

those who transport hazardous materials, and for busses required to stop at the crossing. He recommended the agreement be approved, and said Mr. Howell is concerned about using the crossing for the Southeast Corridor, but that will involve a different rail line.

The Board directed Mr. Howard to contact Mr. Howell to discuss the matter.

Jim Howell, 3325 NE 45th, arrived at this time and explained there is a plan to have a rail bus line going from Gresham (using the Bell Road Line) to Milwaukie, and connecting to the Tillamook branch of the SPS line from Milwaukie to Lake Oswego, Beaverton, and Hillsboro. The Southeast Corridor study researched traffic needs along Johnson Creek Boulevard, and shows considerable ridership could be expected should a rail line be installed. He feels it is premature to tear up a crossing at this time, and recommended waiting until those issues can be resolved. He said this project has nothing to do with light rail proposals for I-205, but is a proposal to tie those lines together.

Commissioner Casterline again explained reasons for removing the crossing, and said it can be reopened at any time.

Following discussion, the motion was considered, and it is unanimously

ORDERED that said intergovernmental agreement be ratified.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin
Jane McGarvin
Clerk of the Board

jm
cc: Budget
Finance
Purchasing
Harriet Weber
Transportation

DATE SUBMITTED_____

(For Clerk's Use)
Meeting Date 8-1-88
Agenda No. R-4

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: Intergovernmental Agreement

Informal Only*_____ (Date)

Formal Only_____ (Date)

DEPARTMENT Environmental Services DIVISION Transportation

CONTACT Dick Howard TELEPHONE Ext. 3599

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD_____

BRIEF SUMMARY

Intergovernmental agreement establishing conditions for closing the unused railroad crossing on SE Division Street at SE 198th Avenue.

ACTION REQUESTED:

/ / INFORMATION ONLY / / PRELIMINARY APPROVAL / / POLICY DIRECTION / / APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA 5 minutes

IMPACT:

/ / PERSONNEL

/ / FISCAL/BUDGETARY N.A.

/ / General Fund

Other_____

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER:

BUDGET/PERSONNEL /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts)

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

3706V

DATE SUBMITTED_____

(For Clerk's Use)
Meeting Date_____
Agenda No._____

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: Intergovernmental Agreement

Informal Only*_____ (Date) Formal Only_____ (Date)

DEPARTMENT Environmental Services DIVISION Transportation

CONTACT Dick Howard TELEPHONE Ext. 3599

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD_____

BRIEF SUMMARY

Intergovernmental agreement establishing conditions for closing the unused railroad crossing on SE Division Street at SE 198th Avenue.

ACTION REQUESTED:

/ / INFORMATION ONLY / / PRELIMINARY APPROVAL / / POLICY DIRECTION / / APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA 5 minutes

IMPACT:

/ / PERSONNEL

/ / FISCAL/BUDGETARY N.A.

/ / General Fund

Other_____

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER:

BUDGET/PERSONNEL _____ /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts)

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

3706V

PD 92

MULTNOMAH COUNTY OREGON

CONTRACT APPROVAL FORM

(See instructions on reverse side)

TYPE I

- ☐ Professional Services under $10,000
- ☐ Revenue
- ☐ Grant Funding
- ☒ Intergovernmental Agreement

___ Amendment to above, Number _____
(Original Contract Amount _____)

TYPE II

- ☐ Professional Services over $10,000 (RFP, Exemption)
- ☐ PCRB Contract
- ☐ Maintenance Agreement
- ☐ Licensing Agreement

___ Amendment to above, Number _____
(Original Contract Amount _____)

Contact Person Dick Howard Phone Ext. 3599 Date _____

Department Environmental Services Division Transportation Bldg/Room 425

Description of Contract Establishes conditions for removal of unused railroad facilities and reconstruction of abandoned crossing on SE Division Street at approximately SE 198th Avenue

RFP/BID # NA Date of RFP/BID NA Date of Exemption NA

Reviewed For ☐ MBE ☐ FBE Participation Contractor is ☐ MBE ☐ FBE

Contractor Name TriCounty Met. Transp. Dist.
Mailing Address 4012 SE 17th Avenue/Ptld 97202
Attention: Mark Wehrly
Phone 238-5871
Employer ID# or SS# _____

Effective Date on approval

Termination Date N.A.

Total Amount of Agreement $ 0

Payment Terms
- ☐ Lump Sum $ no charge
- ☐ Monthly $ _____
- ☐ Other $ _____

☐ Requirements contract-requisition required
Purchase Order No. _____

Required Signatures:

Department Head _____ Date 1-27-88

Purchasing Director _____ Date _____
(Type II Contracts Only)

County Counsel _____ Date _____

Budget Office _____ Date _____

County Executive/Sheriff _____ Date _____

TRANSACTION CODE	P O	AGENCY		PO DATE (m m d d y y)	ACCOUNTING PERIOD (m m y y)	BUDGET FY (y y)	ACTION ☐ Original Entry (E) ☐ Adjustment (M)
VENDOR CODE	VENDOR NAME				TOTAL AMOUNT	$	

LINE NO.	CONTRACT NUMBER	FUND	AGENCY	ORGANIZATION	ACTIVITY	OBJECT	SUB OBJ	REPT CATEG	DESCRIPTION	AMOUNT	INC/DEC IND
										$	
										$	
										$	
										$	

WHITE - PURCHASING CANARY - INITIATOR PINK - CLERK OF THE BOARD GREEN - FINANCE GOLDENROD - BUDGET

Contract No. 88-844P

CONTINUING CONTROL AGREEMENT

THIS AGREEMENT is made and entered into by and between MULTNOMAH COUNTY, a homerule political subdivision of the State of Oregon (hereinafter referred to as "County") and the TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON, a public transit agency (hereinafter referred to as "Tri-Met").

W I T N E S S E T H

WHEREAS, Tri-Met is the owner of a railroad right-of-way, which is described in that certain deed recorded in Book 1712, Page 1160 of the Real Property Records of Multnomah County, Oregon, and

WHEREAS, said railroad right-of-way tracks cross Multnomah County Roads 3081 and 3320, known as S. E. Division Street, near their intersection with S. E. 198th Avenue, in Multnomah County, Oregon, and

WHEREAS, the parties wish to remove the railroad tracks at said crossing without prejudice to the rights of Tri-Met to reinstate the crossing in the future, and

WHEREAS, this Agreement is necessary to satisfy the continuing control requirements of the Urban Mass Transportation Administration (hereinafter referred to as "UMTA"), and

WHEREAS, this inter-governmental agreement is authorized by the provisions of ORS Chapter 190, 203 and 267;

NOW, THEREFORE, in consideration of the foregoing declaration and of mutual promises and the terms and conditions set forth hereinafter, the parties hereto agree as follows:

1. Tri-Met hereby permits County to remove the trackway and incidental appurtenances along the length of the Tri-Met railroad right-of-way, as described in Book 1712, Page 1160 of the Multnomah County Real Property Records, where said right-of-way crosses over the right-of-way of County Roads 3081 and 3320. County may dispose of the removed materials in its discretion. Tri-Met reserves the right to sell the cantilevered flashing-light warning equipment at the crossing to a third party; if so sold, County shall have no responsibility for removal of said equipment, and shall grant Tri-Met or its assignee any necessary permits to effectuate its removal.

2. County shall, in any subsequent reconstruction of said county roads, install a curb-cut and grant Tri-Met necessary permits to permit Tri-Met vehicular access to its railroad right-of-way at a location to be agreed upon by the parties.

3. County hereby grants to Tri-Met the right, and Tri-Met reserves the right under any and all existing crossing permits, to reinstate trackway and railroad service on a temporary or permanent basis at said railroad crossing, at Tri-Met's expense, at any time, and upon reasonable notice to County.

4. To satisfy the continuing control requirements of UMTA as set forth in 49 U.S.C. Sec. 1602(a)(2)(A)(ii) and the grant agreement under which Tri-Met purchased said railroad right-of-way, the County agrees to take no action that would interfere with Tri-Met's use of the railroad right-of-way and said crossing as part of its transportation system. Provided, however, that this paragraph shall not prevent County from regulating the location and relocation of public or private highway or transportation facilities in the right-of-way of said county roads not unreasonably inconsistent with said Tri-Met use.

5. If any public body acquires or succeeds Tri-Met, Tri-Met's interest, rights and obligations created by the Agreement shall be assignable by Tri-Met or UMTA to the public body that acquires or succeeds Tri-Met.

DATED this _____ day of _____, 1988.

MULTNOMAH COUNTY

By_____
Chair, Board of County Commissioners

Approved as to form:

By_____
John L. DuBay
Assistant County Counsel

TRI-COUNTY METROPOLITAN TRANSPORTATION DISTRICT OF OREGON

By_____

Title: General Manager

Approved as to form:

By_____
Mark A. Wehrly
Contracts and Legal Services

The Oregonian

FRIDAY, JANUARY 29, 1988

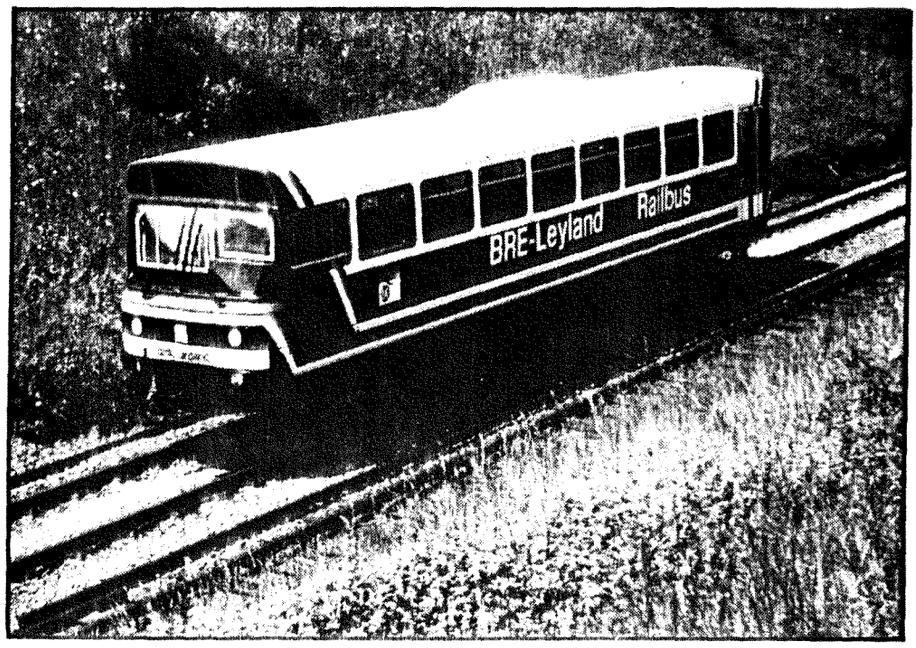
Submitted to Bd 8/11/88 by Jim Howell

IN MY OPINION

Railbus alternative suggested

Growing suburbs, underutilized tracks make plan workable

By JIM HOWELL



A railbus is a diesel-powered passenger vehicle that runs on railroad tracks.

A railbus system could be a low-cost alternative to the expensive freeway bypasses being proposed by the Metropolitan Service District to solve suburban traffic growth and congestion over the next two decades.

A railbus is a diesel-powered passenger vehicle, about the size of a large bus, that runs on rails rather than paved roads. Railbuses allow rapid implementation of a rail transit system by using abandoned or underused freight tracks, because no costly electrification system is needed. The vehicles cost up to 70 percent less than light-rail vehicles, are less costly to maintain and can be operated at about the same cost as standard buses.

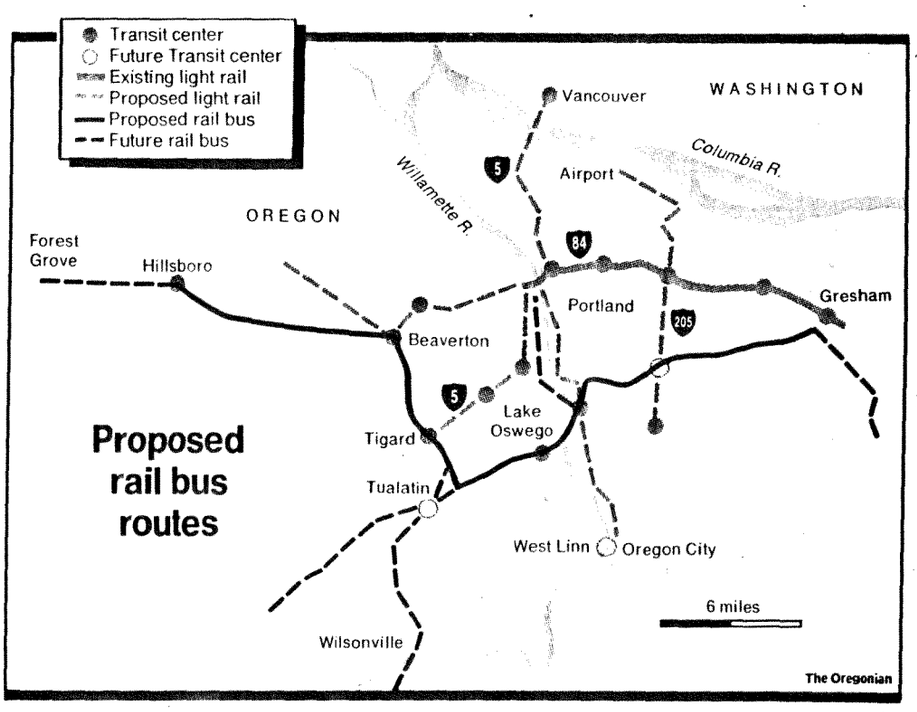
Railbuses are not a substitute for light rail, which is more appropriate for heavily used radial corridors such as the Gresham-downtown Portland MAX line or the other four radial routes proposed by Metro. They are quite suitable, however, for circumferential transit service where the lower initial demand could not justify the high initial capital cost of light rail.

There is an existing underutilized rail corridor that could provide an ideal transportation bypass south of Portland between Gresham and Hillsboro. This corridor includes sections of two rail lines. These are the Portland Traction Co. from Gresham to Milwaukie, and the Tillamook branch of the Southern Pacific railroad from Milwaukie to Hillsboro. Both lines are for sale.

If this corridor was developed as a railbus system, it would provide direct connections among Gresham, Milwaukie, Lake Oswego, Tigard, Beaverton and Hillsboro. The track is adjacent to or very close to several existing and proposed bus transit centers, which would allow convenient bus-to-rail or future rail-to-rail transfers.

Regional land-use plans assume that the preponderance of residential, industrial and commercial growth will occur in suburban locations. In order for our transit system to contribute meaningfully to reduced air pollution and reduced traffic congestion, it must aim for this suburban market.

The rail lines could be purchased and improved by the Oregon Department of Transportation, Metro or Tri-Met, using funds from the sale of municipal revenue bonds. The railbuses could be purchased by the Transportation Department or Tri-Met with the aid of federal matching grants under the Urban Mass Transportation Administration.



Freight service could still be provided by private carriers during the nighttime hours when railbuses are not running. This is done on sections of the light-rail line in San Diego (the "Tijuana Trolley"). Revenue from the freight operations could pay for track maintenance and also help pay off the bonds.

Railbuses could be implemented much sooner than the proposed highway bypasses. This 35-mile route could do much to relieve suburban traffic snarls, because — unlike the existing bus system that operates in traffic — the railbuses would bypass congestion on their own right of way.

The only major construction involved would be a connection between the Portland Traction line and the Tillamook branch line just north of Milwaukie.

This system would attract substantial ridership because travel times would be as short or shorter than by automobile, and much shorter than by bus. The existing railroad bridge across the Willamette River between Milwaukie and Lake Oswego would provide a definite time advantage over automobiles or trips between the southeastern and southwestern suburbs.

Diverting commuters to the railbus would greatly reduce traffic congestion on Johnson Creek Boulevard, Tacoma Street and the Sellwood Bridge. Traffic also would be reduced on Powell, Holgate and Woodstock boulevards in Portland, and on Harrison Street, King Road and Highway 224 in Milwaukie and Clackamas County. By implementing the railbus system, we can avoid the high cost and neighborhood-degrading effects of constructing a new highway bridge across the Willamette River.

During the next two decades, growth of traffic in our region will require nearly $3 billion of highway construction in order to ward off gridlock, yet planners have been able to identify less than $1 billion from existing highway funding sources during that period. We can choose higher taxes or reduced mobility, or we can seek a less expensive combination of alternatives.

Planners should now take the next step and consider rail as an alternative to costly circumferential freeway bypasses slicing through the suburbs and carrying sprawl out to the farmlands.

Jim Howell, a former Tri-Met transportation planner, is president of a private bus company, Citizens Better Transit Inc.

52
J/61

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Sheriff Fred Pearce
12240 NE Glisan
Portland, OR

Dear Sheriff Pearce:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

In the matter of ratification of an Intergovern-)
mental Agreement with Portland Community College)
and Sheriff's Office to allow for GED testing for)
inmates at the Multnomah County Correctional)
Facilities R-5)

Upon motion of Commissioner Kafoury, duly seconded by Commissioner Casterline, it is unanimously

ORDERED that said intergovernmental agreement be ratified.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin
Jane McGarvin
Clerk of the Board

Finance
Purchasing
Harriet Weber

DATE SUBMITTED _____

(For Clerk's Use)
Meeting Date 8-11-88
Agenda No. R-5

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: Intergovernmental Agreement AUG 01 1988

Informal Only* _____ (Date) **Formal Only** _____ (Date)

DEPARTMENT Sheriff's Office **DIVISION** _____

CONTACT Bill Wood **TELEPHONE** ~~255-3600~~ 248-5145

***NAME(s) OF PERSON MAKING PRESENTATION TO BOARD** _____

BRIEF SUMMARY Should include other alternatives explored, if applicable, and clear statement of rationale for the action requested.

Intergovernmental Agreement with Portland Community College to allow for GED testing for inmates at the Multnomah County correctional facilities

(IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REVERSE SIDE)

ACTION REQUESTED:

☐ INFORMATION ONLY ☐ PRELIMINARY APPROVAL ☐ POLICY DIRECTION ☒ APPROVAL

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA _____

IMPACT:

PERSONNEL

☐ FISCAL/BUDGETARY

☐ General Fund

Other _____

BOARD OF COUNTY COMMISSIONERS
1988 AUG -2 PM 4:27
MULTNOMAH COUNTY OREGON

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER: Sally Anderson/mw

BUDGET / PERSONNEL See CAF /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts) See CAF

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

1984

52
5/101

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Mr. Duane Zussy, Director
Department of Human Services
426 SW Stark
Portland, OR

Dear Mr. Zussy:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

In the matter of ratification of an Intergovern-)
mental Agreement with Oregon Adult and Family)
Services Division, whereby the dates for the)
distribution of savings to County are extended an)
additional three months from August 31, 1989 to)
November 30, 1989 R-6)

Upon motion of Commissioner Anderson, duly seconded by Commissioner Kafoury, it is unanimously

ORDERED that said agreement be ratified.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin
Jane McGarvin

cc: Budget
Finance
Purchasing
Harriet Weber
Health

DATE SUBMITTED _____

(For Clerk's Use)
Meeting Date 8-11-88
Agenda No. R-6

REQUEST FOR PLACEMENT ON THE AGENDA *

Subject: RATIFICATION OF INTERGOVERNMENTAL AGREEMENT

Informal Only* _____ (Date) Formal Only _____ (Date)

DEPARTMENT Department of Human Services Office of County Chair DIVISION Health

CONTACT Scott Clement TELEPHONE 3674

*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD Duane Zussy/Scott Clement

BRIEF SUMMARY Should include other alternatives explored, if applicable, and clear statement of rationale for the action requested.

Ratification of an intergovernmental agreement with Oregon Adult and Family Services Division whereby the dates for the distribution of savings to County are extended an additional three months from August 31, 1989 to November 30, 1989.

COPY OF AMENDMENT IS AVAILABLE AT THE CLERK OF THE BOARD

(IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REVERSE SIDE)

ACTION REQUESTED:

☐ INFORMATION ONLY ☐ PRELIMINARY APPROVAL ☐ POLICY DIRECTION ☒ RATIFICATION

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA _____

IMPACT:

PERSONNEL

☐ FISCAL/BUDGETARY

☐ GENERAL FUND

OTHER 0

BOARD OF COUNTY COMMISSIONERS
1988 AUG -4 AM 9:48
MULTNOMAH COUNTY
OREGON

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER: Duane Zussy (ac)

BUDGET / PERSONNEL: David C. Warren /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts) _____

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

PD 92

MULTNOMAH COUNTY OREGON

CONTRACT APPROVAL FORM

(See instructions on reverse side)

TYPE I

- ☐ Professional Services under $10,000
- ☒ Revenue
- ☐ Grant Funding
- ☒ Intergovernmental Agreement

— Amendment to above, Number 101119
(Original Contract Amount _____)

TYPE II

- ☐ Professional Services over $10,000 (RFP, Exemption)
- ☐ PCRB Contract
- ☐ Maintenance Agreement
- ☐ Licensing Agreement

— Amendment to above, Number _____
(Original Contract Amount _____)

Contact Person Jim Kennedy/Scott Clement Phone 3674 Date _____

Department Human Services Division Health Bldg/Room 160/8

Description of Contract This house keeping amendment to the Physician Care Organization (PCO) Intergovernmental Agreement extends the dates of state's distribution of savings to county - referenced in the original contract - an additional three months in keeping with the current three month contract extension from August 31, 1989 to November 30, 1989.

RFP/BID # _____ Date of RFP/BID _____ Date of Exemption _____

Reviewed For ☐ MBE ☐ FBE Participation Contractor is ☐ MBE ☐ FBE

Contractor Name Adult & Family Services
Mailing Address 422 Public Service Building
Salem, OR 97310
Phone 378-5581
Employer ID# or SS# _____

Effective Date August 12, 1988

Termination Date September 30, 1988

Total Amount of Agreement $ 0

Payment Terms
- ☐ Lump Sum $ _____
- ☐ Monthly $ _____
- ☐ Other $ _____

☐ Requirements contract-requisition required
Purchase Order No. _____

Required Signatures:

Department Head _____ Date _____

Purchasing Director _____ Date _____
(Type II Contracts Only)

County Counsel _____ Date _____

Budget Office _____ Date _____

County Executive/Sheriff _____ Date _____

TRANSACTION CODE	P O	AGENCY		PO DATE (m m d d y y)	ACCOUNTING PERIOD (m m y y)	BUDGET FY (y y)	ACTION ☐ Original Entry (E) ☐ Adjustment (M)
VENDOR CODE		VENDOR NAME			TOTAL AMOUNT	$	

LINE NO.	CONTRACT NUMBER	FUND	AGENCY	ORGANIZATION	ACTIVITY	OBJECT	SUB OBJ	REPT CATEG	DESCRIPTION	AMOUNT	INC/DEC IND
	101119	156	010	0700					2600 Rev. Source	$ 0	
		156	010	0800					2600 Rev. Source	$ 0	
		156	010	0850					2600 Rev. Source	$ 0	
		156	010	0900					2600 Rev. Source	$ 0	

WHITE – PURCHASING CANARY – INITIATOR PINK – CLERK OF THE BOARD GREEN – FINANCE GOLDENROD – BUDGET

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH SERVICES DIVISION
426 S.W. STARK STREET, 7TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3674

MEMORANDUM

TO: Gladys McCoy
Multnomah County Chair

VIA: Duane Zussy, Director
Department of Human Services

FROM: Billi Odegaard, Director Billi (Bwo)
Health Services Division

DATE: July 22, 1988

SUBJECT: Amendment to Intergovernmental Agreement
With Adult and Family Services Division

Retroactive: This state-initiated amendment to the Physician Care Organization Agreement between Multnomah County and the state of Oregon was received by the county July 20, 1988, and immediately prepared for processing. The state had requested that a signed agreement be returned by August 5, 1988, with the effective date of the amendment established as August 18, 1988. We are anticipating that county processing of the amendment will not be completed by August 18, 1988.

Recommendation: The Health Division and the Department of Human Services recommends County Chair approval and County Board ratification of this amended intergovernmental agreement with Oregon Adult and Family Service Division for the period August 18, 1988, to September 30, 1988.

Analysis: Earlier this year the state announced its intention to shift the term of PCO agreements from July 1 through June 30 to a October 1 through September 30 term. This amendment to Section 14 m of the Agreement alters the formula for distribution of savings realized through our participation as

a PCO contractor to fit the new term of the PCO agreement. In other words, this amendment is essentially a "housekeeping" measure to establish consistency within the Agreement.

Background: Multnomah County first entered into a Physician Care Organization Agreement with the state of Oregon in 1985. Under the Agreement, the county is provided a monthly prepayment for the provision of health services to an enrolled population of recipients of Aid to Families with Dependent Children. The current prepayment or capitation amount is $28.95 per enrollee per month. We currently have just over 3,600 individuals enrolled in our Physician Care Organization (Multicare PCO).

AFS Contract No. 70410-2

Amendment Number Two To
Physician Care Organization Agreement

This is an Amendment to Agreement between Multnomah County Department of Human Resources and Adult and Family Services Division (Division) of the State of Oregon and is effective August 12, 1988.

WHEREAS, the formula for determining and making a distribution of savings is revised to meet the term of the Contract extension previously agreed to in Amendment Number One.

1. Section 14 m. is amended to add: The savings methodology in effect for the initial December 1, 1987 through June 30, 1988 contract period applies to the contract extension period of July 1, 1988 through September 30, 1988. Savings will be determined at the end of this period using the same methodology applied to the December 1, 1987 through June 30, 1988 contract period.

   Savings for the period of July 1, 1988 through September 30, 1988 shall be distributed as follows:

   1) Division shall pay Contractor an interim payment of 75% of anticipated savings no later than May 31, 1989.

   2) Division shall make final payment to Contractor no later than November 30, 1989.

All other provisions in the original Agreement, or in modifications to the original Agreement remain in effect.

AGREED
CONTRACTOR

MULTNOMAH COUNTY, OREGON

By _____
Gladys McCoy, County Chair

Date _____

STATE OF OREGON
Adult and Family Services Division

By _____
Authorized Representative

Date _____

APPROVED AS TO FORM:

LAURENCE KRESSEL
County Counsel for
Multnomah County, Oregon

By _____
Deputy County Counsel

Date _____

Reviewed by AFS Contracts Manager:

_____

Reviewed by HSS Manager:

_____

Approved as to Legal Sufficiency:

_____
Assistant Attorney General

PD 92

NOV 5 1987

MULTNOMAH COUNTY OREGON

URGENT

CONTRACT APPROVAL FORM

(See instructions on reverse side)

DHS# 248-, 87-88

TYPE I

- ☐ Professional Services under $10,000
- ☒ Revenue
- ☐ Grant Funding
- ☒ Intergovernmental Agreement

— Amendment to above, Number _____ (Original Contract Amount _____)

TYPE II

- ☐ Professional Services over $10,000 (RFP, Exemption)
- ☐ PCRB Contract
- ☐ Maintenance Agreement
- ☐ Licensing Agreement

— Amendment to above, Number _____ (Original Contract Amount _____)

Contact Person SCOTT CLEMENT/JIM KENNEDY Phone 3056/3674 Date 10-16-87

Department HUMAN SERVICES Division HEALTH Bldg/Room 160/7

Description of Contract This PCO agreement increases the per capita rate from $24.86 to $29.19.

RFP/BID # _____ Date of RFP/BID _____ Date of Exemption _____

Reviewed For ☐ MBE ☐ FBE Participation Contractor is ☐ MBE ☐ FBE

Contractor Name ADULT & FAMILY SERVICES
Mailing Address 422 PUBLIC SERVICE BLDG
SALEM, OR 97310
Phone 378-5581
Employer ID# or SS# _____

Effective Date DECEMBER 1, 1987

Termination Date JUNE 30, 1988 JG

Total Amount of Agreement $ REQUIREMENTS

Payment Terms
- ☐ Lump Sum $ _____
- ☐ Monthly $ _____
- ☒ Other $ ~~$29.19 PER MEMBER PER~~ MONTH

☐ Requirements contract-requisition required
Purchase Order No. _____

Required Signatures:

Department Head Duane Zussy (DC) Date 10/19/87

Purchasing Director _____ Date _____
(Type II Contracts Only)

County Counsel Amanda Bir Date 11/1/87

Budget Office Tom Fronk Date 11/3/87

County Executive/Sheriff Gladys McCoy Date 11/17/87

TRANSACTION CODE	P/O	AGENCY		PO DATE (m m d d y y)	ACCOUNTING PERIOD (m m y y)	BUDGET FY (y y)	ACTION (☐ Original Entry (E) ☐ Adjustment (M))

VENDOR CODE	VENDOR NAME	TOTAL AMOUNT
GV 5273		$

CONTRACT NUMBER	FUND	AGENCY	ORGANIZATION	ACTIVITY	OBJECT	SUB OBJ	REPT CATEG	DESCRIPTION	AMOUNT	INC/DEC IND
102488	156	010	0711	0852				2600 REV. SOURCE	$ REQUIREMENTS	
			0712	0854						
			0713	0860					$	
			0714	0910						
			0715	0911					$	

At all reasonable times, Contractor and its subcontractors shall provide Division, personnel duly authorized by Division, and all duly authorized federal representatives the right of access to its facilities and to its financial and medical records in order to monitor and evaluate cost, performance, compliance, quality, appropriateness, and timeliness of services provided under this Agreement. Record inspection shall be restricted to those medical records pertaining to Medical Services provided to Members as well as to those records pertinent to determining costs payable under this Agreement. These records shall be made available for the purpose of making audit, examination, excerpts and transcriptions.

Pursuant to 45 CFR Part 74, such records shall be retained by Contractor or its subcontractor for a least 3 years after final payment is made under this Agreement or any subcontract and all pending matters are closed. Additionally, if an audit, litigation, or other action involving the records is started before the end of the 3-year period, the records must be retained until all issues arising out of the action are resolved or until the end of the 3-year period, whichever is later.

m. Savings

Two types of savings can be realized under this Agreement:

(1) Savings Related to the Capitation Fee. The first type of savings is related to the Capitation Fee. For this savings, if the sum of the Allowable Costs and all other expenses incurred by Contractor are less than the sum of the Capitation Fees, the difference will be retained by Contractor.

(2) Savings Related to Reduction in Utilization. The second source of savings is from a reduction of utilization in the hospital inpatient and hospital outpatient areas. To be eligible to receive such savings Contractor must continue this Agreement through the initial term of this Agreement. The savings from this second source will be calculated as follows:

(A) For fiscal year 1986 (July 1985 through June 1986) the following data will be collected for Contractor's Service Area -

(D) Division shall furnish Contractor the following information on a monthly basis:

(i) The number of persons enrolled.
(ii) Inpatient discharges and expenditures.
(iii) Outpatient visits (excluding lab and X-ray only) and expenditures.

This is the information which will be used as a basis for determining any savings.

(E) Savings, as determined in accordance with this provision, minus Division's administrative costs shall be distributed on a 50/50 basis: 50% to Contractor and 50% to Division. Savings shall be distributed in a two step process: 1) Division shall pay Contractor an interim payment constituting 75% of the anticipated savings no later than February 28, 1989; 2) Division shall make final payment to Contractor no later than August 31, 1989. If the amount of the interim payment exceeds the amount actually owed to Contractor, Contractor agrees to promptly reimburse Division for the amount overpaid.

n. Risk Assumption

Contractor assumes full Risk for providing the health services required under this Agreement. Contractor may obtain reinsurance; however, Contractor must retain, after reinsuring, at least 80% of the underwriting risk.

o. Membership Grievance Procedure

(1) Filing a Complaint. An oral or written complaint may be made to any employee of Contractor.

(2) Action on Complaint. Contractor must determine the action required to resolve the complaint, including transmitting complaints requiring action by other persons in the PCO to such persons. Contractor shall respond to the Member in writing for a written complaint and orally or in writing, at Contractor discretion, for an oral complaint, within 5 working days after receiving the complaint. The response shall contain the resolution of the complaint, the basis for the resolution, notification that a Member who is not satisfied with the result may seek a review of the

15. MERGER:

THIS AGREEMENT CONSTITUTES THE ENTIRE AGREEMENT BETWEEN THE PARTIES. NO WAIVER, CONSENT, MODIFICATION OR CHANGE OF TERMS OF THIS AGREEMENT SHALL BIND EITHER PARTY UNLESS IN WRITING AND APPROVED AS OUTLINED IN SECTION 5. SUCH WAIVER, CONSENT, MODIFICATION, OR CHANGE, IF MADE, SHALL BE EFFECTIVE ONLY IN THE SPECIFIC INSTANCE AND FOR THE SPECIFIC PURPOSE GIVEN. THERE ARE NO UNDERSTANDINGS, AGREEMENTS, OR REPRESENTATIONS, ORAL OR WRITTEN, NOT SPECIFIED HEREIN REGARDING THIS AGREEMENT. CONTRACTOR, BY THE SIGNATURE BELOW OF ITS AUTHORIZED REPRESENTATIVE, HEREBY ACKNOWLEDGES THAT HE OR SHE HAS READ THE AGREEMENT, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

16. SIGNATURES:

CONTRACTOR

MULTNOMAH COUNTY, OREGON

By _____
Authorized Representative
Gladys McCoy
Multnomah County Chair

Date 11/17/1987

APPROVED AS TO FORM:

LAURENCE KRESSEL
Multnomah County Counsel

By _____
Deputy County Counsel

Date 11/1/87

STATE OF OREGON
ADULT AND FAMILY SERVICES DIVISION
400 Public Service Building
Salem, OR 97310

By _____
Authorized Representative

Date 11/24/87

Reviewed by AFS Contracts Manager:

_____ 11/24/87

Reviewed by HSS Manager:

_____

Approved as to Legal Sufficiency:

_____
Assistant Attorney General

52
5161

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Mr. Duane Zussy, Director
Department of Human Services
426 SW Stark
Portland, OR

Dear Mr. Zussy:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

In the matter of ratification of Amendment #17 to the State Mental Health Grant whereby Social Services Division will receive an additional $2,603,511 to provide Community Integration Project services to severely, multi-disabled DD clients for FY 88/89 R-7

Commissioner Anderson explained this matter will care for 66 already identified patients; allows approximately $74,000 for monitoring service providers; will recruit and train providers in the care of the patients; and that patients will not be released from Fairview before programs are in place. She moved, duly seconded by Commissioner Kafoury, unanimously

ORDERED that said intergovernmental agreement be ratified.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin
Jane McGarvin
Clerk of the Board

jm
cc: Budget
Finance
Purchasing
Harriet Weber
Social Services

DATE SUBMITTED _____

(For Clerk's Use)
Meeting Date 8-11-88
Agenda No. R-7

REQUEST FOR PLACEMENT ON THE AGENDA

Subject: RATIFICATION OF INTERGOVERNMENTAL REVENUE AMENDMENT

Informal Only* _____ (Date) **Formal Only** _____ (Date)

DEPARTMENT HUMAN SERVICES **DIVISION** SOCIAL SERVICES

CONTACT SUSAN CLARK **TELEPHONE** 248-3691

***NAME(s) OF PERSON MAKING PRESENTATION TO BOARD** D. ZUSSY/G. SMITH

BRIEF SUMMARY Should include other alternatives explored, if applicable, and clear statement of rationale for the action requested.

Ratification of Amendment #17 to the State Mental Health Grant whereby Multnomah County Social Services Division will receive an additional $2,603,511 to provide Community Integration Project (CIP) services to severely, multi-disabled DD clients for FY 88/89. $2,494,416 of this revenue will be subcontracted to existing and new providers. The remaining will be used for increased staff and technical assistance/consultation services.

Budget modification DHS #3 is processed simultaneously with this amendment.

(IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REVERSE SIDE)

ACTION REQUESTED:

☐ **INFORMATION ONLY** ☐ **PRELIMINARY APPROVAL** ☐ **POLICY DIRECTION** ☒ RATIFICATION

INDICATE THE ESTIMATED TIME NEEDED ON AGENDA _____

IMPACT:

X **PERSONNEL** Adds .80 FTE PDS for three months with additional revenue expected to cover entire FY.

☒ **FISCAL/BUDGETARY** Org. 1210 increased $83,283; Org. 1215 increased $2,494,416; Org. 1270 increased $25,812.

☐ **General Fund**

Other Federal/State

1988 AUG -4 AM 9:49
BOARD OF COUNTY COMMISSIONERS
MULTNOMAH COUNTY OREGON

SIGNATURES:

DEPARTMENT HEAD, ELECTED OFFICIAL, or COUNTY COMMISSIONER: Dewane Zussy (DC)

BUDGET / PERSONNEL David C. Warren /

COUNTY COUNSEL (Ordinances, Resolutions, Agreements, Contracts) _____

OTHER _____
(Purchasing, Facilities Management, etc.)

NOTE: If requesting unanimous consent, state situation requiring emergency action on back.

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
SOCIAL SERVICES DIVISION
ADMINISTRATIVE OFFICES
426 S.W. STARK, 6TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3691

MEMORANDUM

TO: Gladys McCoy
Multnomah County Chair

VIA: Duane Zussy
Director, Department of Human Services

FROM: Gary Smith
Director, Social Services Division

DATE: July 20, 1988

SUBJECT: Recommendation to Ratify Amendment #17 to the State Mental Health Grant and Approval of the Accompanying Budget Modification

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RECOMMENDATION: Social Services Division recommends Board ratification of Amendment #17 to the State Mental Health Grant for the 87/89 biennium and approval of the accompanying budget modification DHS #3.

ANALYSIS: Amendment #17 awards an additional $2,603,511 in State Mental Health revenue designated for services related to the Community Integration Project (CIP), a state-wide effort to transfer developmentally disabled clients out of state training facilities into communities. Approximately 66 severely and multi-disabled clients will be placed in Multnomah County throughout FY 88/89. This revenue will be used to purchase vocational, residential and related CIP services from subcontract providers as well as increasing DD program staff to monitor contracts/services and case manage CIP clients.

Ratification of this amendment will bring the State Mental Health Grant total to $23,881,736 for fiscal year 88/89.

The accompanying budget modification DHS #3 appropriates $2,528,666 of this revenue. The remaining $74,845 (Local Administration) will be appropriated in a future budget modification once program staffing decisions have been made.

BACKGROUND: This amendment is one in a series of state contract amendments increasing revenue to continue implementing the Community Integration Project and to maintain these severely disabled clients in the community. Funding is tied to individual clients who will have residential, vocational, and related service placements. The impact on Multnomah County will be a tremendous and continuous need to amend existing contracts as well as initiate contracts with

new providers. Placing one CIP client in the community may affect up to 4 subcontract providers--resulting in the need to implement four separate subcontract amendments. The DD Program Office will continue to negotiate and prepare amendments and new contracts as fast as possible. However, often delays occur in receiving the revenue from the State in a timely manner and therefore will result in the need to process retroactive contracts and amendments in some cases. The County and State are working together to meet essential timelines.

The Division will continue to keep the Board updated on the progress of this state-wide project and its impact in Multnomah County. Please contact me if you have questions regarding this amendment or on the Community Integration Project.

PD 92

MULTNOMAH COUNTY OREGON

CONTRACT APPROVAL FORM

(See instructions on reverse side)

TYPE I

- ☐ Professional Services under $10,000
- ☒ Revenue
- ☐ Grant Funding
- ☒ Intergovernmental Agreement

Amendment # 17 to Contract # 101138
(Original Contract Amount 21,278,225 FY 88/89)

TYPE II

- ☐ Professional Services over $10,000 (RFP, Exemption)
- ☐ PCRB Contract
- ☐ Maintenance Agreement
- ☐ Licensing Agreement

Amendment # _____ to Contract # _____
(Original Contract Amount _____)

Contact Person Susan Clark Phone 248-3691 Date 7/20/88

Department Human Services Division Social Services Bldg/Room 160/6

Description of Contract Amendment #17 to the SMH grant increased by a net total is $2,603,511 for additional residential vocational and related services required for the Community Integration Project involving DD clients. Revenue appropriated in bud mod DHS# _____.

RFP/BID # NA Date of RFP/BID _____ Date of Exemption _____

Reviewed For ☐ MBE ☐ FBE Participation Contractor is ☐ MBE ☐ FBE

Contractor Name State Mental Health Division
Mailing Address 2575 Bittern St, NE
Salem, OR 97310
Phone 373-7827
Employer ID# or SS# NA - Revenue

Effective Date July 1,1988

Termination Date June 30,1989

Total Amount of Agreement $ 2,603,511
Appropriated in bud mod DHS# _____.

Payment Terms
- ☐ Lump Sum $ _____
- ☒ Monthly $ ALLOTMENT
- ☐ Other $ _____

☐ Requirements contract-requisition required
Purchase Order No. _____

Required Signatures:

Department Head _____ Date _____

Purchasing Director _____ Date _____
(Type II Contracts Only)

County Counsel _____ Date _____

Budget Office _____ Date _____

County Executive/Sheriff _____ Date _____

TRANSACTION CODE	P O	AGENCY		PO DATE (m m d d y y)	ACCOUNTING PERIOD (m m y y)	BUDGET FY (y y)	ACTION ☐ Original Entry (E) ☐ Adjustment (M)
VENDOR CODE		VENDOR NAME			TOTAL AMOUNT	$	

LINE NO.	CONTRACT NUMBER	FUND	AGENCY	ORGANIZATION	ACTIVITY	OBJECT	SUB OBJ	REPT CATEG	DESCRIPTION	AMOUNT	INC/DEC IND
		156	010	1210					Rev. Source 2605	$ 83,283	
		156	010	1215						$ 2,494,416	
		156	010	1270						$ 25,812	
										$	

WHITE – PURCHASING CANARY – INITIATOR PINK – CLERK OF THE BOARD GREEN – FINANCE GOLDENROD – BUDGET

NEIL GOLDSCHMIDT
GOVERNOR

Department of Human Resources
MENTAL HEALTH DIVISION
2575 BITTERN STREET N.E., SALEM, OREGON 97310-0520

1987-89 INTERGOVERNMENTAL AGREEMENT

PART I - AMENDMENT # 17

AGREEMENT FINANCIAL SUMMARY

DATE ISSUED: July 12, 1988

AGREEMENT NUMBER: 26-001

AGREEMENT PERIOD: July 1, 1987 THROUGH June 30, 1989

LOCAL GOVERNMENT UNIT: Multnomah County
426 SW Stark Street
Portland, OR 97204

	PART I-A	PART I-B	TOTAL
1987-88:	$18,691,522	$4,144,781	$22,836,303
1988-89:	$23,291,636	$4,573,060	$27,864,696
		BIENNIAL TOTAL:	$50,700,999

THIS AMENDMENT IS REFLECTED IN REVISIONS TO THE ATTACHED DOCUMENTS:

Part I - Notes and Special Conditions

Part I-A, 1987-88 & 1988-89

Part I-B, 1988-89

8331D/0174C
4/2/87

MHD/CCS#0356
Appr.
JLS
5/7/87

Multnomah County
#26-001, Amend. #17
July 13, 1988

Part I - Notes and Special Conditions

Notes

This amendment includes the following actions:

1. Local Administration (LA 01) is increased $74,845 in FY '88-89. This is a 4% enhancement of the DD funds added in #2 below.

2. Developmental Disabilities service elements are each increased in FY '88-89 by the amounts listed below, to provide community placement for 66 people discharged from a state training center as part of the Community Integration Project (CIP). This is to continue CIP services included in Amendment #12, which awarded funds only through June 30, 1988; and to add services to be phased in from July 1, 1988 through June 30, 1989.

   - Activity Center (DD 40) funds are increased $67,061 to provide 140 additional client months of service;
   - Supported Employment (DD 43) is increased $347,108 to provide 392 additional client months of service;
   - Case Management (DD 48) is increased $25,243 to provide 532 additional client months of service;
   - Residential Facilities (DD 50) funds are increased $1,313,205 to provide 532 additional client months of service;
   - Transportation (DD 53) is increased $118,514 to provide 532 additional client months of service.

3. Start-up funds for Community Integration Project slots are added in Part I-B in FY '88-89 as follows: $8,750 for DD 40; $64,750 for DD 43; and $274,200 for DD 50.

4. Unexpended CIP funds from '87-88 are transferred to '88-89 to enhance the rates for 3 residential and 2 supported employment slots for 3 CIP people served by a particular provider as approved by the DIVISION. This enhancement is for the month of July 1988 only, and changes Part I-A as shown below. Required units of service are not affected by this change.

   - DD 40 and DD 50 are reduced in '87-88 by $1,400 and $7,404 respectively;
   - DD 43 and DD 50 are increased in '88-89 by $1,400 and $7,404 respectively.

5. DD service elements are further increased in '88-89 as listed below to meet critical service needs of 2 particular individuals as approved by the DIVISION:

   - o DD Residential Facilities (DD 50) funds are increased by $42,342. This is to provide two additional slots, one to start July 1, 1988, and the other October 1, 1988.

   - o Case Management (DD 48) is increased $569 and one slot effective July 1, 1988.

6. Early Intervention (DD 55) is increased $249,682 in 1988-89. This is to add 68 slots based on the number of children enrolled in March, 1988, and to increase the rate per slot as a result of added Chapter I and school funding available for these services.

7. DD Special Projects (DD 57) funds are awarded in the amount of $8,438 in '88-89 for COUNTY participation in training in the area of developmental disabilities.

These actions increase the 1987-89 Agreement $2,594,707 to $50,700,999.

Special Conditions

17.1 Funds awarded for Community Integration Project slots in Note #2 above are subject to the following conditions:

   (a) Items (a) through (d) in Special Condition 12.2 (Amendment #12) apply to funds for CIP services included in this amendment;

   (b) COUNTY shall submit a budget worksheet, showing estimated costs of each individual's service needs, for all 66 clients initially selected for placement in the slots included in this amendment. Those individual plans must be submitted to the DIVISION on or before September 1, 1988. Assessments of individual client needs and related estimate of service costs serve as the basis for service element allocations. COUNTY is not required to track expenditures for individual clients. COUNTY is only required to account for expenditures related to service elements as specified in Parts II and III of this Agreement.

17.2 If the individuals for whom DD funds are awarded in Note #5 are terminated from service, the DIVISION may reduce the funding for affected elements to recoup the amounts intended for the designated clients, effective the date of service termination.

17.3 Funds awarded under Special Projects (DD 57) in Note #7 are subject to the following requirements, all of which must be accomplished prior to June 30, 1989:

(a) COUNTY shall send one individual to all sessions of the intensive behavior training program to be conducted on behalf of the DIVISION by the University of Oregon (15 days of training time and 10 days of follow-up). Participation must result in the establishment of behavior training programs for at least 3 people being served in DIVISION-funded programs for developmental disabilities.

(b) COUNTY shall conduct two 2-day training sessions based on the intensive training program referenced above. Representatives from a minimum of 5 DIVISION-funded DD residential and/or vocational programs must attend each session.

(c) COUNTY shall field test DIVISION-developed Values Training materials at a minimum of 5 DIVISION-funded programs.

(d) COUNTY shall identify and report training needs for COUNTY providers of services for people with developmental disabilities. COUNTY shall involve a representative work group in the accomplishment of this task.

17.4 Start-up funds awarded in this amendment are subject to the requirements in Exhibit #1.

MULT89A1/2B (7/13/88)

IN WITNESS WHEREOF, THE PARTIES HERETO HAVE CAUSED THIS AMENDMENT TO BE EXECUTED BY THEIR AUTHORIZED OFFICERS.

MULTNOMAH COUNTY:

By_____ _____
Gladys McCoy Date
Multnomah County Chair

STATE MENTAL HEALTH DIVISION:

By_____ _____
Dan Barker Date
Manager, Community Contracts

APPROVED AS TO FORM:
Laurence Kressel
Multnomah County Counsel

By_____ _____
Deputy County Counsel Date

Exhibit #1

Special Conditions For Start-Up Funds

Start-up funds awarded in this amendment will be paid as reimbursement for actual expenditures and are subject to the following terms and conditions:

1. Reimbursement for all expenditures is contingent on Division approval of a line-item budget showing proposed expenditure of Division funds and an expenditure report which documents actual expenditures. The Division may provide cash in advance following approval of the line-item budget. An expenditure report is due at the Division 90 days after services are initiated. Instructions for submitting budgets, expenditure reports and other documents as required below are contained in the Financial Procedures Manual.

2. Expenditures for personal services or services and supply items shall be documented in an expenditure report which shows actual expenditures by employee and position and uses the same service/supply categories contained in the line-item budget.

3. Expenditures for furnishings and fixtures shall be documented in an expenditure report, accompanied by an inventory and receipts for all items which cost over $100 and the address of the facility in which each item will be located and used.

4. Expenditures for vehicles, computers and other special equipment shall be documented in an expenditure report, accompanied by receipts for all items purchased and a security interest in favor of the Division for each item which exceeds $1,000 in cost.

5. Items purchased under Items 3 and 4 above must be used for purposes described in this award for the expected useful life of the item or five years, whichever is less, except as follows:

   a. Prior approval is obtained from the Division for an alternative use;

   b. The equipment is lost or rendered useless for reasons other than negligence on the part of the county or a county subcontractor;

   c. Division funds for operation of programs or services in the facility are discontinued.

   Failure of the county/contractor or its subcontractors to comply with terms stated above shall result in repayment to the Division of a prorated share of the award based on the length of time the equipment was used for purposes described in this amendment. The Division may, at its discretion, require repossession of the equipment in lieu of repayment. Any repayment will occur as otherwise provided in this Agreement.

6. Expenditures for facility renovation or other capital projects shall be documented in an expenditure report accompanied by receipts for all materials and services. An amount equal to 15% of the project cost may be withheld by the Division pending approval of the cost report and completion of the work to the Division's satisfaction.

7. Expenditures for real property shall be subject to a trust deed in favor of the state which shall only be released by the Division upon devotion of these premises to delivery of services approved by the Division under terms in the trust deed. All transactions must be accomplished through a licensed escrow agent acting on instructions provided by the Division.

8. Division may disallow expenditures which are not documented or secured to the Division's satisfaction as described above and in the Financial Procedures Manual. Recovery of any such unauthorized expenditures shall occur as otherwise provided in this Agreement.

0343E
11/18/87

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-A

As Of: 07/12/88 1987-88

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

Mental Health Division Service Elements	SE Number	Agreement Amount	Change	Revised Amount	Revised Units
LOCAL ADMINISTRATION	LA 01	610,397	0	610,397	0.0
Subtotal: LA		610,397	0	610,397	
CTS - CHILDREN	MED 22	314,653	0	314,653	99.0
COMM SUPPORT SERVICE	MED 23	3,897,890	0	3,897,890	1,176.0
COMM HOSPITAL SERVIC	MED 24	417,753	0	417,753	284.0
NON-HOSPITAL CRISIS	MED 25	1,132,416	0	1,132,416	2,951.0
CTS - ADULT	MED 27	21,814	0	21,814	14.0
RCF	MED 28	800,565	0	800,565	197.0
PRECOMMITMENT	MED 29	488,981	0	488,981	1,222.0
PSRB	MED 30	113,129	0	113,129	32.0
SEMI-INDEPENDENT LIV	MED 33	176,544	0	176,544	96.0
CPS PROJECT	MED 37	109,770	0	109,770	105.0
SUPPORTED EMPLOYMENT	MED 38	8,332	0	8,332	10.0
CSS-HOMELESS	MED 39	79,839	0	79,839	0.0
Subtotal: MED		7,561,686	0	7,561,686	
ACTIVITY CENTER	DD 40	1,530,227	-1,400	1,528,827	348.0
SHELTERED SERVICES P	DD 42	533,655	0	533,655	133.0
SUPPORTED WORK	DD 43	214,366	0	214,366	72.0
DD DIVERSION SERVICE	DD 44	55,315	0	55,315	0.0
SEMI-INDEPENDENT LIV	DD 47	180,493	0	180,493	9.4
CASE MANAGEMENT	DD 48	375,138	0	375,138	1,376.0
RES FACILITIES	DD 50	2,850,668	-7,404	2,843,264	239.0
EMPLOYMENT TRANSPORT	DD 53	401,443	0	401,443	518.0
EARLY INTERVENTION	DD 55	822,132	0	822,132	246.0
DD SPECIAL PROJECTS	DD 57	0	0	0	0.0
Subtotal: DD		6,963,437	-8,804	6,954,633	
ALCOHOL RESIDENTIAL	A&D 61	512,269	0	512,269	97.0
DRUG RESIDENTIAL CAR	A&D 62	328,871	0	328,871	43.0
NON-HOSP ALC. DETOX	A&D 63	570,381	0	570,381	47.0
OUTPT ALCOHOL	A&D 64	745,648	0	745,648	646.0
OUTPT DRUG-FREE	A&D 65	576,872	0	576,872	333.0

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-A

As Of: 07/12/88 1987-88

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

Mental Health Division Service Elements	SE Number	Agreement Amount	Change	Revised Amount	Revised Units
METHADONE MAINTENANC	A&D 69	499,356	0	499,356	259.0
PREVENTION & E.I.	A&D 70	89,511	0	89,511	0.0
CIRT	A&D 71	221,458	0	221,458	14.0
NON-HOSP DRUG DETOX	A&D 73	20,440	0	20,440	2.0
Subtotal: A&D		3,564,806	0	3,564,806	
AGREEMENT TOTAL		$18,700,326	-8,804	$18,691,522	

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-A

As Of: 07/12/88 1988-89

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

Mental Health Division Service Elements	SE Number	Agreement Amount	Change	Revised Amount	Revised Units
LOCAL ADMINISTRATION	LA 01	673,098	74,845	747,943	0.0
Subtotal: LA		673,098	74,845	747,943	
CTS - CHILDREN	MED 22	425,804	0	425,804	129.0
COMM SUPPORT SERVICE	MED 23	4,091,240	0	4,091,240	1,176.0
COMM HOSPITAL SERVIC	MED 24	419,590	0	419,590	284.0
NON-HOSPITAL CRISIS	MED 25	1,155,064	0	1,155,064	2,951.0
CTS - ADULT	MED 27	22,250	0	22,250	14.0
RCF	MED 28	758,353	0	758,353	177.0
PRECOMMITMENT	MED 29	498,761	0	498,761	1,222.0
PSRB	MED 30	114,973	0	114,973	32.0
SEMI-INDEPENDENT LIV	MED 33	255,822	0	255,822	121.0
CPS PROJECT	MED 37	612,222	0	612,222	105.0
SUPPORTED EMPLOYMENT	MED 38	74,438	0	74,438	10.0
CSS-HOMELESS	MED 39	239,517	0	239,517	0.0
Subtotal: MED		8,668,034	0	8,668,034	
ACTIVITY CENTER	DD 40	1,547,589	67,061	1,614,650	350.0
SHELTERED SERVICES P	DD 42	544,328	0	544,328	133.0
SUPPORTED WORK	DD 43	372,005	348,508	720,513	129.0
DD DIVERSION SERVICE	DD 44	55,514	0	55,514	0.0
SEMI-INDEPENDENT LIV	DD 47	184,103	0	184,103	9.4
CASE MANAGEMENT	DD 48	817,954	25,812	843,766	1,426.0
RES FACILITIES	DD 50	3,292,211	1,362,951	4,655,162	292.0
EMPLOYMENT TRANSPORT	DD 53	420,773	118,514	539,287	572.0
EARLY INTERVENTION	DD 55	838,575	249,682	1,088,257	314.0
DD SPECIAL PROJECTS	DD 57	0	8,438	8,438	0.0
Subtotal: DD		8,073,052	2,180,966	10,254,018	
ALCOHOL RESIDENTIAL	A&D 61	522,514	0	522,514	97.0
DRUG RESIDENTIAL CAR	A&D 62	335,448	0	335,448	43.0
NON-HOSP ALC. DETOX	A&D 63	581,789	0	581,789	47.0
OUTPT ALCOHOL	A&D 64	753,983	0	753,983	646.0
OUTPT DRUG-FREE	A&D 65	620,197	0	620,197	333.0

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-A

As Of: 07/12/88 1988-89

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

Mental Health Division Service Elements	SE Number	Agreement Amount	Change	Revised Amount	Revised Units
METHADONE MAINTENANC	A&D 69	452,767	0	452,767	260.0
PREVENTION & E.I.	A&D 70	108,616	0	108,616	0.0
CIRT	A&D 71	225,887	0	225,887	14.0
NON-HOSP DRUG DETOX	A&D 73	20,440	0	20,440	2.0
Subtotal: A&D		3,621,641	0	3,621,641	
AGREEMENT TOTAL		$21,035,825	2,255,811	$23,291,636	

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-A SUMMARY

As Of: 07/12/88 1987-88,1988-89

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

Mental Health Division Service Elements	Service Element #	1987-88 Agreement Total	1988-89 Agreement Total	Biennium Total
LOCAL ADMINISTRATION	LA 01	610,397	747,943	1,358,340
Subtotal: LA		610,397	747,943	1,358,340
CTS - CHILDREN	MED 22	314,653	425,804	740,457
COMM SUPPORT SERVICES	MED 23	3,897,890	4,091,240	7,989,130
COMM HOSPITAL SERVICES	MED 24	417,753	419,590	837,343
NON-HOSPITAL CRISIS SERVICES	MED 25	1,132,416	1,155,064	2,287,480
CTS - ADULT	MED 27	21,814	22,250	44,064
RCF	MED 28	800,565	758,353	1,558,918
PRECOMMITMENT	MED 29	488,981	498,761	987,742
PSRB	MED 30	113,129	114,973	228,102
SEMI-INDEPENDENT LIVING	MED 33	176,544	255,822	432,366
CPS PROJECT	MED 37	109,770	612,222	721,992
SUPPORTED EMPLOYMENT SERVICE	MED 38	8,332	74,438	82,770
CSS-HOMELESS	MED 39	79,839	239,517	319,356
Subtotal: MED		7,561,686	8,668,034	16,229,720
ACTIVITY CENTER	DD 40	1,528,827	1,614,650	3,143,477
SHELTERED SERVICES PROGRAM	DD 42	533,655	544,328	1,077,983
SUPPORTED WORK	DD 43	214,366	720,513	934,879
DD DIVERSION SERVICE	DD 44	55,315	55,514	110,829
SEMI-INDEPENDENT LIVING	DD 47	180,493	184,103	364,596
CASE MANAGEMENT	DD 48	375,138	843,766	1,218,904
RES FACILITIES	DD 50	2,843,264	4,655,162	7,498,426
EMPLOYMENT TRANSPORTATION	DD 53	401,443	539,287	940,730
EARLY INTERVENTION	DD 55	822,132	1,088,257	1,910,389
DD SPECIAL PROJECTS	DD 57	0	8,438	8,438
Subtotal: DD		6,954,633	10,254,018	17,208,651
ALCOHOL RESIDENTIAL CARE	A&D 61	512,269	522,514	1,034,783
DRUG RESIDENTIAL CARE	A&D 62	328,871	335,448	664,319
NON-HOSP ALC. DETOX	A&D 63	570,381	581,789	1,152,170
OUTPT ALCOHOL	A&D 64	745,648	753,983	1,499,631
OUTPT DRUG-FREE	A&D 65	576,872	620,197	1,197,069
METHADONE MAINTENANCE	A&D 69	499,356	452,767	952,123
PREVENTION & E.I.	A&D 70	89,511	108,616	198,127

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-A SUMMARY

As Of: 07/12/88 1987-88,1988-89

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

Mental Health Division Service Elements	Service Element #	1987-88 Agreement Total	1988-89 Agreement Total	Biennium Total
CIRT	A&D 71	221,458	225,887	447,345
NON-HOSP DRUG DETOX	A&D 73	20,440	20,440	40,880
Subtotal: A&D		3,564,806	3,621,641	7,186,447
AGREEMENT TOTAL		$18,691,522	23,291,636	$41,983,158

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-B

Page: 1
As Of: 07/12/88

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

1987-88

Reimburse Source	MHD Service Element	Service Element #	Agreement Amount	Change	Revised Amount	Revised Units
MEDICAID	OUTPT ALCOHO	A&D 64	91,160	0	91,160	121.0
MEDICAID	OUTPT DRUG-F	A&D 65	78,151	0	78,151	103.0
MEDICAID	METHADONE MA	A&D 69	147,290	0	147,290	195.0
MEDICAID	CTS - CHILDR	MED 22	546,169	0	546,169	191.0
MEDICAID	COMM SUPPORT	MED 23	2,066,314	0	2,066,314	629.0
MEDICAID	NON-HOSPITAL	MED 25	87,680	0	87,680	228.0
MEDICAID	CTS - ADULT	MED 27	52,243	0	52,243	35.0
MEDICAID	SEMI-INDEPEN	MED 33	32,629	0	32,629	25.0
MEDICAID	CPS PROJECT	MED 37	89,854	0	89,854	45.0
	Subtotal:		3,191,490	0	3,191,490	
IDF	DUII DIV I	A&D 67	5,280	0	5,280	0.0
IDF	DUII DIV II	A&D 68	139,480	0	139,480	0.0
IDF	CONVICTED I	A&D 77	800	0	800	0.0
IDF	CONVICTED II	A&D 78	90,000	0	90,000	0.0
	Subtotal:		235,560	0	235,560	
AFC	DD NON-REL.	DD 58	218,710	0	218,710	106.0
AFC	DD RELATIVE	DD 59	76,490	0	76,490	37.0
AFC	AFC MED	MED 34	152,172	0	152,172	80.0
	Subtotal:		447,372	0	447,372	
START-UP	ACTIVITY CEN	DD 40	21,000	0	21,000	0.0
START-UP	SUPPORTED WO	DD 43	22,000	0	22,000	0.0
START-UP	RES. FACILIT	DD 50	124,411	0	124,411	0.0
START-UP	RCF	MED 28	2,399	0	2,399	0.0
START-UP	CPS PROJECT	MED 37	100,549	0	100,549	0.0
	Subtotal:		270,359	0	270,359	
AGREEMENT TOTAL			$ 4,144,781	0	$ 4,144,781	

OREGON STATE MENTAL HEALTH DIVISION
Amendment To Agreement for Community Mental Health Services
PART I-B

As Of: 07/12/88

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

1988-89

Reimburse Source	MHD Service Element	Service Element #	Agreement Amount	Change	Revised Amount	Revised Units
MEDICAID	OUTPT ALCOHO	A&D 64	92,983	0	92,983	121.0
MEDICAID	OUTPT DRUG-F	A&D 65	79,714	0	79,714	103.0
MEDICAID	METHADONE MA	A&D 69	148,736	0	148,736	193.0
MEDICAID	CTS - CHILDR	MED 22	557,092	0	557,092	191.0
MEDICAID	COMM SUPPORT	MED 23	2,165,623	0	2,165,623	629.0
MEDICAID	NON-HOSPITAL	MED 25	89,434	0	89,434	228.0
MEDICAID	CTS - ADULT	MED 27	53,288	0	53,288	35.0
MEDICAID	SEMI-INDEPEN	MED 33	95,258	0	95,258	45.0
MEDICAID	CPS PROJECT	MED 37	265,057	0	265,057	45.0
	Subtotal:		3,547,185	0	3,547,185	
IDF	DUII DIV I	A&D 67	5,425	0	5,425	0.0
IDF	DUII DIV II	A&D 68	142,330	0	142,330	0.0
IDF	CONVICTED I	A&D 77	855	0	855	0.0
IDF	CONVICTED II	A&D 78	93,790	0	93,790	0.0
	Subtotal:		242,400	0	242,400	
AFC	DD NON-REL.	DD 58	211,680	0	211,680	106.0
AFC	DD RELATIVE	DD 59	68,880	0	68,880	37.0
AFC	AFC MED	MED 34	155,215	0	155,215	80.0
	Subtotal:		435,775	0	435,775	
START-UP	ACTIVITY CEN	DD 40	0	8,750	8,750	0.0
START-UP	SUPPORTED WO	DD 43	0	64,750	64,750	0.0
START-UP	RES. FACILIT	DD 50	0	274,200	274,200	0.0
START-UP	RCF	MED 28	0	0	0	0.0
START-UP	CPS PROJECT	MED 37	0	0	0	0.0
	Subtotal:		0	347,700	347,700	
AGREEMENT TOTAL			$ 4,225,360	347,700	$ 4,573,060	

OREGON STATE MENTAL HEALTH DIVISION
Agreement for Community Mental Health Services
PART I-B SUMMARY

As Of:07/12/88

CONTRACTOR: MULTNOMAH COUNTY AGREEMENT NO: 26-001 AMD #: 17

1987-88,1988-89

Reimburs. Source	MHD Service Element	Service Element #	1987-88 Agreement Total	1988-89 Agreement Total	Biennium Total
MEDICAID	OUTPT ALCOHO	A&D 64	91,160	92,983	184,143
MEDICAID	OUTPT DRUG-F	A&D 65	78,151	79,714	157,865
MEDICAID	METHADONE MA	A&D 69	147,290	148,736	296,026
MEDICAID	CTS - CHILDR	MED 22	546,169	557,092	1,103,261
MEDICAID	COMM SUPPORT	MED 23	2,066,314	2,165,623	4,231,937
MEDICAID	NON-HOSPITAL	MED 25	87,680	89,434	177,114
MEDICAID	CTS - ADULT	MED 27	52,243	53,288	105,531
MEDICAID	SEMI-INDEPEN	MED 33	32,629	95,258	127,887
MEDICAID	CPS PROJECT	MED 37	89,854	265,057	354,911
	Subtotal:		3,191,490	3,547,185	6,738,675
IDF	DUII DIV I	A&D 67	5,280	5,425	10,705
IDF	DUII DIV II	A&D 68	139,480	142,330	281,810
IDF	CONVICTED I	A&D 77	800	855	1,655
IDF	CONVICTED II	A&D 78	90,000	93,790	183,790
	Subtotal:		235,560	242,400	477,960
AFC	DD NON-REL.	DD 58	218,710	211,680	430,390
AFC	DD RELATIVE	DD 59	76,490	68,880	145,370
AFC	AFC MED	MED 34	152,172	155,215	307,387
	Subtotal:		447,372	435,775	883,147
START-UP	ACTIVITY CEN	DD 40	21,000	8,750	29,750
START-UP	SUPPORTED WO	DD 43	22,000	64,750	86,750
START-UP	RES. FACILIT	DD 50	124,411	274,200	398,611
START-UP	RCF	MED 28	2,399	0	2,399
START-UP	CPS PROJECT	MED 37	100,549	0	100,549
	Subtotal:		270,359	347,700	618,059
AGREEMENT TOTAL			$ 4,144,781	4,573,060	$ 8,717,841

52
J161

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Mr. Duane Zussy, Director
Department of Human Services
426 SW Stark
Portland, OR

Dear Mr. Zussy:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

Request of the Director of Human Services for approval of Budget Modification DHS #3 reflecting additional revenues in the amount of $2,569,155 from State Mental Health Grant to Social Services various line items, and adds employees, to implement Amendment #17 R-8

Upon motion of Commissioner Anderson, duly seconded by Commissioner Kafoury, it is unanimously

ORDERED that said request be approved, and budget modification be implemented.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By _____
Clerk of the Board

jm
cc: Budget
Finance
Social Services
Employee Relations

BUDGET MODIFICATION NO. DHS #3

(For Clerk's Use) Meeting Date 8/11/88
Agenda No. R-8

1. REQUEST FOR PLACEMENT ON THE AGENDA FOR _____ (Date)

DEPARTMENT Human Services DIVISION Social Services
CONTACT Susan Clark TELEPHONE 248-3691
*NAME(s) OF PERSON MAKING PRESENTATION TO BOARD D. Zussy/G. Smith

SUGGESTED
AGENDA TITLE (to assist in preparing a description for the printed agenda)

Budget Modification DHS #3 increases DD Operations, DD Contracts and DD Case Management budgets by $8,438, $2,494,416 and $25,812 respectively to reflect additional revenue received in Amendment #17 to the State Mental Health Grant.

(Estimated Time Needed on the Agenda)

2. DESCRIPTION OF MODIFICATION (Explain the changes this Bud Mod makes. What budget does it increase? What do the changes accomplish? Where does the money come from? What budget is reduced? Attach additional information if you need more space.)

[x] PERSONNEL CHANGES ARE SHOWN IN DETAIL ON THE ATTACHED SHEET

Budget modification DHS #3 requests Board approval to increase the DD Operations, Contracts and Case Management budgets by a net total of $2,528,666 to reflect additional revenue received in Amendment #17 to the State Mental Health Grant. The increase is directly tied to Multnomah County's participation in the statewide Community Integration Project (CIP). Specific changes include:

DD Operations increased $8,438 to fund a .80 FTE PDS for three months to provide training and technical assistance to staff and providers in individualized community placements of CIP clients. (Additional state revenue will be forthcoming to continue funding this position the remaining of the FY.)

DD Contracts increased by $2,494,416 in Pass Through to subcontract for additional CIP residential, vocational and associated services.

DD Case Management increased by $25,812 in Professional Services to purchase outside consultation and technical assistance services required to implement CIP.

$74,845 in Local Administration revenue also awarded in Amendment #17 will be appropriated in a future budget modification when program staffing needs have been determined.

3. REVENUE IMPACT (Explain revenues being changed and the reason for the change)

Net increase of $2,528,666 in State Mental Health Grant. Contract DHS #113-17. Service reimbursement F/S to Insurance increased by $703; Service reimbursement F/S to CGF increased by $19,893; County General Fund increased by $19,893 (Indirect charges)

DHS Contract Amendment #113-17 - schedule at same time

4. CONTINGENCY STATUS (to be completed by Finance/Budget)

_____ Contingency before this modification (as of _____) $_____
(Specify Fund) (Date)

After this modification $

Originated By	Date	Department Director	Date
Susan Clark	7/21/88	Duane Zussy (DC)	7/25/88
Finance/Budget		Employee Relations	Date
David C. Boyer		Susan Daniell	8/2/88
Board Approval			Date
Barbara J. Fox			8/11/88

OREGON
MULTNOMAH COUNTY
1988 AUG -4 AM 9:50
COUNTY COMMISSIONERS
BOARD OF

3156B-1

ADITURE
SACTION EB [ ] GM [ ] TRANSACTION DATE_____ ACCOUNTING PERIOD _____ BUDGET FY____

ument Number	Action	Fund	Agency	Organi-zation	Activity	Reporting Category	Object	Current Amount	Revised Amount	Change Increase (Decrease)	Sub-Total	Description
		156	010	1210			5100			6,160		Increase Permanent
		156	010	1210			5500			1,575		Increase Fringe
		156	010	1210			5550			703		Increase Insurance
		156	010	1210			7100			599		Increase Indirect (.071)
											9,037	Total Org. 1210
		156	010	1215			6060			2,494,416		Increase Pass Through
		156	010	1215			7100			17,461		Increase Indirect (.007)
											2,511,877	Total Org. 1215
		156	010	1270			6110			25,812		Increase Professional Svcs.
		156	010	1270			7100			1,833		Increase Indirect (.071)
											27,645	Total Org. 1270
		400	040	7231			6520			703	703	Increase Insurance Fund
		100	010	0104			7608			19,893	19,893	Cash Transfer to F/S Fund
EXPENDITURE CHANGE											2,569,155	TOTAL EXPENDITURE CHANGE

UE
ACTION RB [ ] GM [ ] TRANSACTION DATE_____ ACCOUNTING PERIOD _____ BUDGET FY____

ment Number	Action	Fund	Agency	Organi-zation	Activity	Reporting Category	Revenue Source	Current Amount	Revised Amount	Change Increase (Decrease)	Sub-Total	Description
		156 156	010 010	1210 1215			2605 2605			8,438 2,494,416		State Mental Health Grant State Mental Health Grant
		156 156	010 010	1270 1210			2605 7601			25,812 599		State Mental Health Grant County General Fund
		156 156	010 010	1215 1270			7601 7601			17,461 1,833		County General Fund County General Fund
		400 100	040 045	7231 7410			6602 6602			703 19,893		Svc. Reimb. F/S to Insur. Svc. Reimb. F/S to CGF
REVENUE CHANGE											2,569,155	TOTAL REVENUE CHANGE

PERSONNEL DETAIL FOR BUD MOD NO. DHS#3

5. ANNUALIZED PERSONNEL CHANGES (Compute on a full year basis even though this action affects only a part of the fiscal year.)

		Annualized		
FTE Increase (Decrease)	POSITION TITLE	BASE PAY Increase (Decrease)	FRINGE Increase (Decrease	TOTAL Increase (Decrease)
.80 FTE	Program Development Specialist	19,714	4,980 2,186	26,880
TOTAL CHANGE (ANNUALIZED)		19,714	4,980 2,186	26,880

6. CURRENT YEAR PERSONNEL DOLLAR CHANGES (calculate costs or savings that will take place within this fiscal year; these should explain the actual dollar amounts being changed by this Bud Mod.)

		Current FY		
Full Time Positions, Part-Time, Overtime, or Premium	Explanation of Change	BASE PAY Increase (Decrease)	FRINGE Increase (Decrease	TOTAL Increase (Decrease)
Full Time	Add .80 PDS for 3 months*.	6,160	1,575 703	8,438

*Additional revenue will be forthcoming from the State to continue funding this position at a .80 FTE for the entire FY.

8-11-88

RECEIVED FROM JANE McGARVIN

CLERK, BOARD OF COUNTY COMMISSIONERS · MULTNOMAH COUNTY, OREGON

BUDGET

BUDGET MODIFICATION DHS #3 APPROVED.

R-8

C.R

Form CC-2 PLEASE SIGN & RETURN THIS RECEIPT TO COMMISSIONERS OFFICE

BOARD OF
COUNTY COMMISSIONERS

1988 AUG 16 PM 12:57

MULTNOMAH COUNTY
OREGON

53-54
J161

MULTNOMAH COUNTY OREGON

BOARD OF COUNTY COMMISSIONERS
ROOM 605, COUNTY COURTHOUSE
1021 S.W. FOURTH AVENUE
PORTLAND, OREGON 97204

GLADYS McCOY • Chair • 248-3308
PAULINE ANDERSON • District 1 • 248-5220
GRETCHEN KAFOURY • District 2 • 248-5219
CAROLINE MILLER • District 3 • 248-5217
POLLY CASTERLINE • District 4 • 248-5213
JANE McGARVIN • Clerk • 248-3277

August 11, 1988

Mr. Duane Zussy, Director
Department of Human Services
426 SW Stark
Portland, OR

Dear Mr. Zussy:

Be it remembered, that at a meeting of the Board of County Commissioners held August 11, 1988, the following action was taken:

Order in the matter of approving a Request for Credentials and Requests for Proposals for Emergency Ambulance Service (Continued one week from August 4) R-9

Laurence Kressel, County Counsel, explained the Board adopted an Ambulance Plan last week whereby the County would be divided into two areas to be served by separate franchise awards. The documents which would implement the plan are the Request for Credentials and Request for Proposals. The County Counsel office and the Emergency Medical Services (EMS) have reviewed the latest drafts of these documents, but the documents are not yet ready as promised at Tuesda's Informal. However he feels there are some areas not yet clear that involve policy. He submitted draft language he prepared at the request of the Board at Tuesday's Informal meeting regarding affirmative action and Medical Advisory Board recommendations. He advised the Board no motion was necessary, but only an agreement among Board members was necessary to have the language included in documents to be considered next week. He was instructed to include the language involving Affirmative Action Officer's review of the RFC and RFP. He stated the change for the Medical Advisory Board would be that MAB recommendations would be sent directly to the Board rather than to the EMS Policy Board.

Joe Acker recommended the Board not change the process, and explained his reasons.

The Board expressed its view that medical responsibility would not be removed from the Medical Advisory Board, but that MAB recommendations would be considered by the Commissioners before

decisions were made, thereby placing responsibility for policy where it should be.

Mr. Acker reported there is a Medical Advisory Board meeting tomorrow, and he will advise the MAB of the Commissioners decision, and will report to the Commissioners if they're are further concerns.

Mr. Kressel read the new proposed language for affirmative action, and said the RFC requires each applicant to have an affirmative action plan that meets Federal guidelines. Those who have submitted requests would receive points for affirmative action plans in place. He described how those points would be determined. The new language offers a process whereby a company that does not have an affirmative action plan may discuss goals and objectives and explain why they do not have a plan. However, this business entity will not receive the full ten points for a plan. Future commitment to affirmative action will be necessary, and must be detailed and in measurable terms. Robert Phillips, County Affirmative Action Officer, was not at the meeting yesterday so he will need to review this language.

Donna Cameron, attorney representing Buck Medical Services, stated she has a copy of the proposed language, and that she has concerns about awarding points. Standards that can be achieved are necessary and must be measurable. She suggested using the following language: "the company has proved they have taken every reasonable, lawful step they could to meet the goal". In response to Commissioner Kafoury's question, she said the Board should realize that companies don't set goals unless there is a significant disparity already existing in a job group. She recommended a standard be set for the affirmative action officer to apply for "good faith". She explained Federal guidelines apply to those companies who are of a certain size, and/or contract with the government or government subcontractors. She said she is concerned about standards in the RFP because they are too low, and said the language for awarding points needs to be tightened.

Following discussion, Gary Oxman, County Health Officer, reported the draft language was intended to allow applications for companies who did not have a plan, but who provide informal processes for affirmative action. He presented some proposed language.

Commissioner Anderson suggested rather than use his language, Donna Cameron's suggested "every reasonable and legal steps" be used.

Ms. Cameron suggested replacing the 2nd paragraph with a provision that "if the entity has not had an affirmative action plan

because it was not required to have one, is not in violation of Federal guidelines, and has no under-utlization of women or minorities, it can still receive the award".

The Board agreed to let County Counsel and the Affirmative Action Officer write the final language using the proposed language as a guide.

Mr. Acker read the language to allow proposed implementation of methods to improve efficiency and effectiveness of the EMS system. "The proposal will explain, in full detail, the suggestions of how to improve the efficiency and effectiveness of the system; and the proposal would have to be consistent with the Code, the ASA Plan, and the EMS Rules. The evaluation would include the following: "The proposal does increase the effectiveness and efficiency of the EMS system. The proposal would be consistent with the Code and the Rules of the Plan, and the proposal that meets the above criteria would be awarded up to 10 points." This language would be added to Business Practices, Section 5.

The Board directed Mr. Kressel to use the language in the RFP, ASA I & II documents.

Following discussion, Mr. Acker explained statistics on all 911 dispatches and transports for the last two years, broken into four week increments, will be included in the RFP information along with data for hospital destination and call origination according to geo-code. No information is known about collection percentages or information regarding projected ASL or BSL transport calls will be provided by the County. Assumptions for these projections will be required of all applicants. Once the credentialing process is complete, Requests for Proposals will be mailed, and the credentialing committee will hold a pre-bid conference.

Commissioner Anderson discussed changing EMS staffing patterns for credentialing and evaluation committees; and said though she feels they need to be at meetings, they should not serve as Chair of committees.

Mr. Kressel explained why he had not prepared language for this matter.

Franna Ritz, Purchasing, reported there is not usually a chairman of the committee designated for evaluation meetings, but Program Chairmen are often facilitators.

Commissioner McCoy said she feels neither Purchasing nor EMS staff should be voting members or chair of committees.

Following discussion, it was decided EMS and Purchasing staff will serve as non-voting members, and committees will select their own Chair or Facilitator.

Upon motion of Commissioner Kafoury, duly seconded by Commissioner Anderson, it is unanimously

ORDERED that the above-entitled matter be continued until Thursday, August 18, 1988 at 9:30 AM in Room 602 of the County Courthouse.

Very truly yours,

BOARD OF COUNTY COMMISSIONERS

By Jane McGarvin
Jane McGarvin
Clerk of the Board

jm
cc: County Counsel
Health Protection
Emergency Medical Services

R-9
8/11/88

MULTNOMAH COUNTY OREGON

DEPARTMENT OF GENERAL SERVICES
COUNTY COUNSEL SECTION
1120 S.W. FIFTH AVENUE, SUITE 1400
P.O. BOX 849
PORTLAND, OREGON 97207-0849
(503) 248-3138

M E M O R A N D U M

TO: Jane McGarvin
Clerk of the Board (101/606)

FROM: Larry Kressel
County Counsel

DATE: August 10, 1988

RE: Order Adopting RFC and RFPs for Ambulance Plan

Attached is the amended order adopting the RFC and RFPs. Please circulate this to the Board of County Commissioners for the August 11 meeting. The RFC and RFPs will be delivered separately.

2155R/dp
Attachment

BEFORE THE BOARD OF COMMISSIONERS

FOR THE COUNTY OF MULTNOMAH

In the Matter of Approving a Request for Credentials and Requests for Proposals for Emergency Ambulance Service	))))))	ORDER APPROVING REQUEST FOR CREDENTIALS AND REQUESTS FOR PROPOSALS FOR EMERGENCY AMBULANCE SERVICE FOR MULTNOMAH COUNTY

WHEREAS, the EMS Policy Board recommended adoption of an Ambulance Plan that divides Multnomah County into two ambulance service areas and has recommended that the service providers be selected by a competitive [bid] process; and

WHEREAS, the Board of Commissioners has adopted the Plan; and

WHEREAS, in order to implement the plan, it is necessary to issue a Request for Credentials (RFC) and Requests for Proposals (RFPs) to potential service providers; and

WHEREAS, the Emergency Medical Services Policy Board has reviewed such documents and has recommended approval of them, NOW THEREFORE

IT IS HEREBY ORDERED that the RFC AND RFPs, dated August 11, 1988, attached hereto and marked Exhibits A, B and C are approved.

BOARD OF COUNTY COMMISSIONERS
MULTNOMAH COUNTY, OREGON

By _____
Gladys McCoy
Multnomah County Chair

APPROVED AS TO FORM:

LAURENCE KRESSEL, COUNTY COUNSEL
FOR MULTNOMAH COUNTY, OREGON

By _____
Laurence Kressel
County Counsel

1393R/dm
081088:4:1

R-9
8/11/88

Add: 5B(C)

10 pts. The proposer is encouraged to propose implementation of methods to improve the efficiency and effectiveness of the Multnomah EMS system. The proposal should explain in full detail the suggestion and how it will improve the efficiency and effectiveness of the system. The proposal must be consistent with the MCC, ASA Plan, and EMS rules.

5B(E) The proposal does increase the effectiveness and efficiency of the EMS system. The proposal is consistent with the MCC, EMS rules, ASA Plan. The proposal which meets the above criteria will be awarded up to ten points.

DRAFT

[4571E-m]

5) the top wage in the wage scale for EMT-4s must be at least 10% above $22,000, the top wage for EMT-4s in Multnomah County.

For each percentage point the proposal is above the required minimum starting salary, three points will be given to a maximum of 30 points.

d. 10 points. The proposal demonstrates the proposing entity's history of commitment to affirmative action hiring and promotion and continues that commitment.

A proposing entity will receive 10 points if it meets each of the following criteria. Fewer points may be awarded if some but not all the criteria are met. The evaluation and scoring shall be done by the Multnomah County Affirmative Action Officer, who shall report the results to the evaluation committee.

R-9
8/11/88
approved by committee

RFP CRITERION FOR AFFIRMATIVE ACTION

d. 10 points. The proposal demonstrates the proposing entity's history of commitment to affirmative action hiring and promotion and continues that commitment.

A proposing entity will receive 10 points if it meets each of the following criteria. Fewer points may be awarded if some but not all the criteria are met.

(1) If the proposing entity has had an affirmative action plan in place prior to submitting its proposal, it shall demonstrate that for the prior plan year it has set annual hiring goals as required by United States Executive Order 11246 and its implementing regulations, and has met at least 95 percent of each such goal. If a goal has not been met, the entity shall describe the good-faith effort it made to attain the goal.

If the proposing entity has not had an affirmative action plan in place prior to submitting its proposal, it shall demonstrate that (a) it was exempt from the affirmative action plan requirements imposed by federal law and (b) notwithstanding the exemption, it has made good faith efforts during the previous year to adopt and implement affirmative action policies throughout its operations.

The plans or regulations efforts referred to above must be those of the specific corporate entity, governmental bureau, or organizational group that is proposing to deliver the ambulance services; plans or efforts of parent or related corporations or of states, counties, or cities, but not specifically of the proposing agency itself, are not acceptable.

(2) The proposing entity must also provide information confirming that, for at least the past three years, it has neither (a) paid more than $2,000 to settle a discrimination claim made by a current or former employee nor (b) had such a claim determined or adjudicated to be valid, whether or not yet paid.

(3) The proposing entity must also demonstrate that it is committed to carry out affirmative action policies during the contract period. Evidence of this commitment may consist of the following: (a) the plan required under the credentialing document is detailed and stated in

measurable terms, and (b) the entity proposes a system for reporting periodically to the county on its compliance with the plan.

R-9
8/11/88
approved (
as amended

Proposed alternative on RFP evaluation procedure as requested by Comm. Anderson (new language is underlined, bracketed language is deleted):

RFP p.____

6. If the MAB concludes that the proposal does not meet a minimum requirement, or scores the proposal so that it is no longer the highest ranking, it will so state in a written report to the EMS PAB [evaluation committee]. The report will explain the basis for the MAB's reccomendation [action. The evaluation committee will then submit the next ranked proposal to the MAB]

7. The EMS Policy Advisory Board will review only the proposal ranked highest by the evaluation committee [and approved by the MAB]. The review will be based on the RFP. Following that review, the Advisory Board will adopt a report and reccomendation to the Board of County Commissioners. The report will indicate whether the Advisory Board agrees or disagrees that the proposal has been correctly evaluated by the evaluation committee and MAB.

8. The Board of County Commissioners will receive the reports and reccomendations of the evaluation

committee, the MAB and the EMS Policy Advisory Board. The County Commission intends to review only the proposal ranked highest by the evaluation committee [and approved by the MAB]. The County Commission may accept the proposal or reject it as the public interest so requires.

10. If the Board accepts the proposal, it will award a franchise for the affected ASA to the successful proposer. If the Board does not accept the proposal it may request further review by the evaluation committee, MAB or Advisory Board, submission of the next ranked proposal or group of proposals or it may terminate or indefintely suspend the proceedings without an award."

Submitted by
Commissioner Canterbury
8/9/88-

10 POINTS Initiatives to Improve the Quality of the System

Evaluation Committee would be able to award up to 10 discretionary points. Concept similar to the demonstration grants in the BIT program,i.e. open-ended category with emphasis on innovative approaches to reducing response time, producing higher quality medical care, maintaining well-trained personnel,operating in a safe environment etc.

Initiatives would have to be PROSPECTIVE- companies could not use existing programs to qualify or gain an advantage.

Examples: job experience programs for school-age kids, risk management plan to cut claims, EMT training programs, adaptation of communication technology to reduce response time.

The penalty for increased price (loss of points) should mitigate against any overall increase in the bid price for ALS/BLS.

I. The Plan

Pursuant to State law, Multnomah County has adopted an emergency ambulance services plan. The plan divides the County into two ambulance service areas (ASAs). The County intends to award exclusive franchises for each area in order to obtain efficient and effective service for all citizens.

II. The Purpose of Request for Credentials

Franchise proposals will only be accepted from qualified applicants. The criteria in this document establish those qualifications. Once applicants are qualified in accordance with this document, they will be permitted to respond to Requests for Proposals (RFPs) for the two ASAs.

III. Nature of Contracts to be Awarded

Separate franchises will be awarded for two ASAs (see map attachment F). Each franchisee will provide exclusive Advanced Life Support (ALS) responses to all 9-1-1 generated emergency calls in an ASA. Although a qualified applicant may ~~propose to serve both~~ submit proposals for each of the ASAs, the

plan requires that each ASA will be served by a different provider.

County policy contemplates future award of a single franchise for the entire County. At present, however, the option is not legally permissible due to a ruling by the Multnomah County Circuit Court.

IV. Term of Contracts

The two franchise contracts will be for terms of four years each. The expected start date for this service is no later than July 1, 1989. The contracts will will be included as appendixes to the RFPs.

V. Description

The area to be served is all of Multnomah County, divided into two ASAs. (See map attachment F.) This includes the cities of Portland, Gresham, Wood Village, Troutdale, and Fairview and unincorporated Multnomah County. The response area will be approximately 465 square miles. The population base in Multnomah County, according to the latest census, is 566,200. In addition, the population of Multnomah County increases

VI. Credentialing Evaluation and Appeal Procedure

An organization wishing ~~To have the opportunity~~ to respond to the RFP ~~the applicant~~ must first meet the minimum credentialing requirements set forth herein. ~~Each~~ Response to the credentialing document will be evaluated by a credentialing committee. The committee consists of ~~the Emergency Medical Services Director~~, a representative of the County Medical Advisory Board, a citizen-at-large, a Multnomah County Medical Society representative, a Multnomah County representative of small business, and an Emergency Medical Technician Paramedic. ~~This~~ credentialing committee will be selected by the County ~~governing guidelines~~ body. If an organization wishes ~~the applicant intends~~ to submit proposals for both ASAs, a separate credentialing document must be completed for each ~~ASA~~.

VII. Outline of ~~Procedure~~ Credentialing Procedure (see sect. on XII)

After considering all timely submissions,

1. ~~The~~ The credentialing committee will adopt a report listing the applicants meeting the credentialing requirements and those not meeting the requirements. The report will describe the reasons any applicant ~~did~~ does not meet the requirements.

2. The ~~committee~~ report will be filed with the Multnomah County Purchasing Director and mailed to each applicant by certified mail.

3. An applicant may appeal a decision of the credentialing committee to the Board of County Commissioners. An appeal must be filed with the Director of Purchasing on or before the tenth business day after the committee report is filed with the Purchasing Director. Late appeals will not be considered. Appeals must be in writing.

4. The Board of County Commissioners will consider all timely appeals. Each appellant will be notified by the clerk of the board in writing of the time and place of an appeal hearing.

   The Board may consider any evidence pertinent to whether the appellant meets the credentialing requirements. At the conclusion of an appeal hearing, the Board will rule on whether the appellant meets or does not meet the credentialing requirements. The ruling will be accompanied by a

written order setting forth the basis for the Board's decision. The order will be mailed to the appellant by certified mail.

VII. RFP Evaluation procedure

The procedure for evaluating proposals submitted by qualified applicants and for awarding franchises for the two ASAs are set forth in each RFP. See these documents for details.

VIII. Policy on Credentialing and Franchising Procedure

The County intends to review timely applications in a fair and open manner. The goal is to provide efficient and effective emergency ambulance services to the public. select providers who will give the most

The criteria and procedures contained in the RFC and the RFPs will guide the selection procedure.

Although the franchise process is legislative in nature, and therefore is not subject to quasi-judicial rules of procedure, applicants should not have private contacts or discussions with members of any reviewing committee or Board, including the Board of Commissioners, once applications for credentialing or franchise award are submitted. If a private contact occurs, the affected

committee or Board member should make a public disclosure at the next available public meeting, or in any event, prior to the final action by the County. The disclosure should indicate (1) the date of the contact and the identity of the person initiating it and (2) the nature of the contact, i.e., the information given or obtained.

IX. Contract Monitoring

The Emergency Medical Services Office will monitor franchisees for compliance with the franchise contracts, ~~as well as~~ the County Code and the implementing rules. Compliance with medical requirements will also be monitored by the physician-supervisor and the Medical Advisory Board.

The Emergency Medical Services office will maintain a process for quality assurance. The process will seek to prevent breakdowns in quality as well as to identify and correct existing problems. A submcommittee of the Medical Advisory Board will carry out the quality assurance guidelines of the Medical Advisory Board (see attachment H).

A rate committee will review proposed rate increases or decreases. Pursuant to the County Charter, the committee will be created by ordinance. The committee will consist

INSERT IN RFP PAGE 13
d. Commitment to affirmative action in hiring and promotion.

10 pts.

INSERT IN RFP PAGE 54:

d.
10 points. The proposal demonstrates the proposing entity's history of commitment to affirmative action hiring and promotion and continues that commitment. To receive the total points, the proposing entity must meet the following criteria:

(1)If the proposing entity has had a plan in place prior to its proposal, its history shall include a demonstration that for the prior plan year it has set annual hiring goals as required by United States Executive Order 11246 and its implementing regulations, and has met at least 95 percent of each such goal. If a goal has not been met, the entity shall explain what good-faith effort to attain the goal. & has been made

(2)The proposing entity must also provide information confirming that, for at least the past three years, it has neither (a) paid more than $2,000 to settle a discrimination claim made by a current or former employee nor (b) had such a claim determined or adjudicated to be valid, whether or not yet paid.

(3)The proposing entity must address in detail how it proposes to continue its affirmative action program.

An entity that does not meet the above three criteria may be given fewer or no points.

[2145R]

8/04/88

REQUEST FOR CREDENTIALS

911 Ambulance Contract
Multnomah County, Oregon

This document is intended to determine the qualifications of applicants to furnish emergency ambulance service to Multnomah County, Oregon and its inclusive incorporated municipalities.

EXHIBIT A

Contents:

I. The Purpose of this Request for Credentials

Multnomah County will be seeking proposals for emergency ambulance services in Multnomah County. Proposals will only be accepted from qualified applicants which will be determined by the criteria set out in this document.

II. Nature of the Contracts to be Awarded

There will be two contracts awarded for two ambulance service areas (ASA) (see map attachment F) to answer all 9-1-1 generated emergency calls within Multnomah County. The applicants must expect to provide Advanced Life Support (ALS) responses to all 9-1-1 generated emergency calls. An applicant may make proposals on both ASAs but will be awarded only one contract.

III. Term of Contract

The contract will be for a term of four years. The expected start date for this service is no later than July 1, 1989. The contract will include all customary standard provisions required by state public contracting law as well as county contract requirements, including, but not limited to insurance requirements, indemnification and budgetary limitations.

IV. Description

The area to be covered by this contract is all of Multnomah County divided into two ASA's. (See map attachment F.) This includes the cities of Portland, Gresham, Wood Village, Troutdale, and Fairview and unincorporated Multnomah County. The response area will be approximately 465 square miles. The population base in Multnomah County, according to the latest census, is 566,200. In addition, the population of Multnomah County increases during the day, because Portland and Multnomah County are the hub of a tri-county area and non-residents come into Portland to work or shop.

Multnomah County is currently served by 14 general and acute care hospitals. A trauma program is in place with OHSU and Emanuel Hospitals designated as level 1 trauma hospitals. An interim trauma program has been in place since February of 1985. Trauma statistics are available from this program and will be provided to potential proposers after completion of credentialing.

The current system within Multnomah County is governed by Multnomah County Code (MCC) and its rules (see Attachments b and c). MCC and its existing rules will probably not change substantially for the contractor. All applicants must become familiar with MCC and its rules which set forth requirements for response time, licensing, staffing, dispatch, mutual aid, trauma program, medical direction, and penalties.

Mutual aid is available in the fringe areas of Multnomah County by rule under MCC. Because of the rural nature and geographical barriers in the extreme East and West ends of the County, applicants are encouraged to use mutual aid agreements to meet minimum response time requirements.

The current Multnomah County system uses four private ambulance service providers who are assigned ambulance service areas under the Oregon Revised Statutes. These current providers meet all Advanced Life Support criteria as set forth in MCC and its rules. In addition, a first responder program is available throughout the County by Portland Fire Bureau, and the fire departments of Gresham, Corbett, Skyline, and Sauvie Island. Gresham Fire Department, and Portland Fire Bureau are each Advanced Life Support first responders maintaining a total of eight ALS first responder rescues in their operations. First responders are governed under MCC and its rules.

Currently, all 911 call-answering and dispatch is provided from a central location in the County, through a contract between the Office of Emergency Medical Services and the Bureau of Emergency Communications. The Emergency Medical Services dispatch system functions under standard operating procedures, triage guidelines, pre-arrival instructions, and other medical administrative areas as determined by the Office of Emergency Medical Services. A computerized dispatch system is currently used, and information from this system is provided as a part of this credentialing document. Triage guidelines and pre-arrival instructions are similar to the Emergency Medical Priority Dispatching system. Dispatchers are trained to the emergency medical dispatch level as recognized by the State of Oregon.

The Office of Emergency Medical Services is responsible under Multnomah County Code (MCC) for the development of Basic Life Support and Advanced Life Support protocols. These protocols are attached for your information (d and e). Applicants must know the requirements of these protocols, which are not expected to substantially change when contractors are chosen.

The current Emergency Medical Services system uses a contract arrangement with the Hooper Detoxification Center to respond to and arrange transportation for some man-down calls in the central City area. These are calls which may be telephone-triaged as being alcohol-related, and they are not responded to by normal first responder or ALS ambulance. This has reduced the number of no patient transports in the inner-City area. The contractor for ASA 1 will be required to contract with the Hooper Center to offer this service. A subsidy will be offered which will pay for a portion of the cost of this service.

The total number of responses for 1986 was 31,140. The total number of transports was 21,175.

V. Contract System Requirements

The responsibilities of the contractor and the office of Emergency Medical Services under the proposed contract for ambulance service for 911 calls for Multnomah County are outlined below.

Contractor Responsibilities:

1. The contractor for each ASA must furnish all vehicles and Advanced and Basic Life Support equipment per rule. This material is detailed in MCC and its rules. Also attached for the applicant's information are the ORS requirements (attachment G) which must be met.

2. The contractor for each ASA must furnish all mobile communications equipment. Currently the Multnomah County Emergency Medical Services program functions on UHF and VHF. The contractor for each ASA must furnish VHF mobile communications equipment capable of operating on 155.340 mhz with a digital encode capability. In addition, the contractor for each ASA must furnish mobile communications equipment for communication on Med-Nets 1, 4, 7, and 9. This mobile communications equipment must also provide for the technician to speak over the Med-Net radio from the patient compartment of the ambulance. Also UHF paging capability must be a part of the contractor-provided system. The paging on Med-Net-9 will be used for ambulance crew alerting and dispatch.

3. The contractor for each ASA must furnish all personnel needed to carry out the requirements of this contract. The personnel requirements are detailed in Multnomah County Code (MCC) and its rules. The requirement is two EMT IV's Oregon-certified on each Advanced Life Support ambulance. In addition, the contractor must furnish personnel sufficient for supervisory, billing and collection, and administrative functions.

4. The contractor for each ASA must furnish $42,500 per year paid in quarterly payments to provide for medical administrative costs of the system. This amount may increase or decrease based upon proposals from the physician supervisor RFP. Currently ORS requires that each EMT above the level of 2 function with an immediate physician supervisor. The County will provide the physician supervisor for the contractors at a total cost of $85,000 (2 ASAs), as previously mentioned. The contractors will not be required to carry liability insurance for the physician supervisor.

5. The contractor for each ASA must provide liability insurance to meet the minimum ORS and Multnomah County requirements as stated in Section VIII paragraph M.

6. The contractor for ASA 1 will contract with Hooper Center to provide inebriate outreach services.

EMS Responsibilities:

1. The Emergency Medical Services office shall furnish dispatch by 911 call-takers and dispatchers. This also includes the maintenance of the Med-Net radio system.

2. Provision of on-line medical control through a contract.

3. Physician supervisor for all 911 activities as detailed previously.

4. Liability provisions for the physician supervisor.

5. Support of continuing education for EMT's will be provided through a contract.

6. A taxi fund is administered by EMS, this allows for indigent ambulatory patients to be moved by paid-cab to a hospital, when their medical condition requires care, but not the services of an ambulance.

7. A subsidy will be paid to the contractor for ASA 1. The subsidy is intended to underwrite the major portion of the cost of inebriate outreach services.

VI. Credentialing Evaluation Process

To have the opportunity to respond to the RFP the applicant must meet minimum credentialing requirements which are detailed further in this document. If the applicant intends to propose for both ASA's, a separate credentialing document must be completed for each ASA. The applicants must use a different population and capital source for each credentialing. An applicant credentialed for both ASA's must have a total population served in VIII B of 250,000 and a total capitalization of $550,000 in VIII C.

Upon completion of the credentialing phase the successful applicants will be presented with a Request For Proposal which sets certain minimum requirements and a mechanism for evaluation of each of those requirements. A point-ranking process will be followed for those responses which meet all the minimum requirements.

The credentialing process and the Request For Proposal have been prepared by the RFP Construction committee. This committee was chosen by the Emergency Medical Services Policy Board at its December 15, 1986, meeting. That committee is made up of the Emergency Medical Services Director, a representative of the Medical Advisory Board, a citizen-at-large, a Multnomah County Medical Society representative, a representative of County Counsel, a Multnomah County representative of small business, and an Emergency Medical Technician-Paramedic representative. This committee will conduct the credentialing evaluation and the pre-proposal hearing for all potential proposers.

The evaluation of the RFP will be made by another committee, composed of the EMS director, Medical Advisory Board member, two citizens-at-large, Multnomah County Medical Society representative, County Purchasing representative, and Emergency Medical Technician representative. All the members of this committee with the exception of the Emergency Medical Services director, will be different from the previously mentioned committee. The Medical Advisory Board will review and make recommendations to the evaluation committee concerning the selected provider's medical areas of the proposal.

The monitoring process for the contract will be through the Emergency Medical Services office. In addition, the Medical Advisory Board will provide contractor monitoring in the medical areas in concurrence with the single physician supervisor as contracted by the Office of Emergency Medical Services. Quality assurance as designed and accepted by the Medical Advisory Board and as detailed in an attached document (attachment H) will remain in existence as a subcommittee of the Medical Advisory Board. System accountability will be the responsibility of the Medical Advisory Board and the Emergency Medical Services office. The Emergency Medical Services office will maintain a prospective and retrospective quality assurance process with regard to both medical and system accountability issues. A citizens' rate committee will review proposed rate increases or decreases and will have the responsibility for semiannual public hearings and rate reviews for the contractor. This rate review committee will be made

up of representatives of the contractor as well as representatives of the general public. This committee will not be able to make final determination on rate increases or decreases but will have the ability to recommend these changes to the Emergency Medical Services Policy Board and the Multnomah County Board of Commissioners.

VII. Reimbursement

The proposed Multnomah County Emergency Medical Services system as described here will be paid for by the user; the contractors must not expect any subsidy from Multnomah County or any of the incorporated cities within this jurisdiction. Except that the contractor in ASA 1 will receive a subsidy to assist in funding inebriate outreach services.

VIII. RFP Organization

The Request For Proposal will be organized in six areas; personnel, communications, medical, equipment, business practices, safety net. The RFP will describe minimums under each of these component areas which must be met by each proposer and will ask proposers to provide information as to how the minimum requirements will be met and to state any additional services the proposer will provide to improve the level or quantity of service established by the minimum requirements.

The RFP will allow a proposer to propose for only one of the two ASA's or for both ASA's. If the proposer is proposing for both ASA's, each proposal will be provided separately and judged on its merits as a "stand alone" proposal.

The proposer will be awarded only one ASA. If the proposer is top-ranked for both ASAs the evaluation committee will recommend which ASA the proposer will serve, based on the best interest of the community.

IX. Submission Process

Applicants for the credentialing process must provide all information as requested in this document to:
Multnomah County Purchasing, 2505 SE 11th Avenue, Portland, Oregon 97202, telephone number (503) 248-5111, contact person Franna Ritz.

All information must be submitted with no fewer than 15 copies three-hole punched. Late applications will not be accepted.

The following is general information which must be addressed on the initial pages of an applicant's credentialing document. If this information is not provided the applicant will not be credentialed.

- Name and address of organization.
- Name of organization's liaison for the credentialing process.
- List of names, addresses, and share of ownership of all owners of the organization.
- Brief narrative description of the organization's holdings together with the organization's chart depicting the company's infrastructure.
- List of financial interests of the organization or parent company in other related businesses and a description of those related businesses.
- Brief narrative description of services currently provided by the applicant.
- Brief history of the organization's involvement in delivery of Advanced Life Support services over the last ten years.

X. Minimum Credentialing Requirements

The following minimum credentialing requirements must be met by each applicant. A recommended method of how to demonstrate each of these minimum credentialing requirements is included in a narrative following the requirement. The information must be provided in the credentialing document in the order listed here. If the applicant expects to propose for each ASA, a separate credentialing document must be provided for each. The "second" credentialing document can refer to the specific areas of the first document in all areas except VIII A2, VIII C, and VIII H.

A. The applicant must meet either 1 or 2 below:

1. The applicant must have been licensed by Multnomah County to provide ambulance service for the calendar years of 1986 and 1987 and during that period must have provided advanced life support care as defined by the Multnomah County advanced life support and basic life support protocols. The necessary experience may have been gained as a first responder at the ALS level or by providing ALS transport in Multnomah County.

2. If the applicant does not meet number 1 above, the applicant must have served a population of at least 125,000 with primary (exclusively served with at least 90 percent of the care and transport) advanced life support services for the last two calendar years. The population must be contiguous (may cross geopolitical lines) and be verified by census data.

The applicant must furnish proof of ambulance licensure within Multnomah County, if it has such, or documentation of advanced life support service to a population of at least 125,000 to meet the above credentialing requirements.

Proof of requirements having been met must be furnished by attached census data and proof from the jurisdictions served that the ambulance supplier is the primary provider of Advanced Life Support in those areas for the required period of time.

If the required information is not furnished or the data does not support the minimum population base and length of service, the applicant will not be credentialed.

B. The applicant must have a response time to the previously served population base of no greater than 8 minutes 90 percent of the time. This must be calculated from the most recent 12 months. If a different response time standard is in place, it must be stated but converted to the 8 minute/90 percent scale. The existing response time required in the former system must be currently met or exceeded. This must be for the last 12 months.

The state, region, county, or city regulator of the operation used to qualify under Section VIII paragraph A above must provide documentation which establishes that the above mentioned response time was met.

If there is no regulator of response times, the applicant must furnish validated information establishing the satisfaction of the requirement; the validity of the information must be by a sworn statement attached to the response time material. If the required information is not provided or the information demonstrates a deficiency in response-time, the applicant will not be credentialed.

C. The applicant must demonstrate sufficient existing capital or credit to establish the ability to operate this system with little or no cash flow for 45 days. The amount demonstrated must be no less than $225,000. This amount may be made up of either assets to be dedicated to the system or credit line. Accounts receivable may be used if the income is dedicated to the Multnomah County contract. The accounts receivable must be no more than one year old and discounted 40 percent.

Documentation must be provided from a recognized source (CPA, bank, other lending institution) stating that the applicant can meet the above requirement. If the required information is not provided or the minimum capital is not available the applicant will not be credentialed.

D. The applicant must provide an audited or reviewed operating statement for the last two fiscal years and the most recent balance sheet (within 12 months). If this information is marked as proprietary it will remain confidential information and not be a part of the public record.

This information must be provided in such a way that it adequately provides information as to the financial stability of the applicant. The information need not include more than the information for the company which is serving the population used in Section VIII, paragraph A above.

The exception to this is if a joint venture or consortium of operators process is used. (See paragraph H.)

If the required information is not provided or the statements show unsound business practices the applicant will not be credentialed.

E. The applicant must provide information which verifies its current business structure, and its having met the appropriate state legal requirements for establishing such a structure (corporate certificate, articles of incorporation).

Applicants not meeting the legal requirements in the area used in Section VIII, paragraph A, will not be credentialed.

F. A Dunn and Bradstreet rating, if available.

A Dunn and Bradstreet rating must be provided if available and it must be the most current.

If a Dunn and Bradstreet rating is not available this must be so noted.

If an applicant does not provide a Dunn and Bradstreet rating when it is available, the applicant will not be credentialed. The lack of a Dunn and Bradstreet rating in and of itself will not disqualify an applicant in the credentialing process.

G. The applicant must present demonstrated billing experience to include billing practices with no less than a 60 percent collection rate. Also, the ability to work with third party payors as evidenced by letters from the Medicare and Medicaid fiscal agents must be demonstrated. If the applicant does not possess this billing experience, a proposed billing process must be explained and any present or past parallel billing experience must be included.

The applicant must provide proof from a CPA that current experience is at least a 60 percent or above collection rate in the population served in Section VIII, paragraph A. Also needed is a letter from the Medicare and Medicaid fiscal agents for the area served in Section VIII, paragraph A, stating that the applicant is performing adequately in billing procedures.

Failure to supply proof of the collection rate or having a collection rate lower than 60 percent will cause the applicant to fail credentialing if it is currently providing billing activities. Failure to supply proof of satisfactory billing procedures from Medicare and Medicaid fiscal agents will cause the applicant to fail the credentialing process if it is currently providing billing activities. In the absence of the applicant's providing billing activities, the applicant must provide a detailed description of the billing process it will use, and it must provide the educational process it will use to acquaint personnel with third-party billing methodology. Failure to provide the description of billing practice process or educational process or its insufficiency to adequately accomplish billing will cause the applicant to fail the credentialing process.

H. A consortium of operators may apply as an applicant. Each individual member of such an applying consortium must meet all minimum credentialing requirements listed (below/above) except that a pooling of capital or credit will be allowed to meet the $225,000 required in Section VIII, paragraph C. Each individual member of that consortium must, not later than at the time it submits its credentialing materials, contractually accept equal liability with all other consortium members for all compliance with legal and contractual requirements if the consortium receives the contract, and joint and several liability with each other

consortium member for any tort, rule infraction, or penalty, and must guarantee that all legal and contractual requirements will be met. Written documents confirming the precise nature of the legal relationship between the members of the consortium must be furnished. The structure of the consortium must be fully explained. The consortium's legal counsel (who must be admitted to practice in Oregon) must provide an opinion letter confirming without qualification that the consortium agreement is valid, binding, and not illegal under state or federal laws.

In the event that the required information is not provided, the applying consortium will not be credentialed.

I. The applicant must provide ALS and triage protocols from the system used in the credentialing population. These protocols must demonstrate a level of medical care similar to that of the current Multnomah County system.

The Advanced Life Support protocols must be included as a part of the credentialing document. The Advanced Life Support protocols must be clear and concise and describe the relationship of off-line and on-line medical direction or control.

Triage protocols which are used for telephone answering, and/or field triage from Basic Life Support to Advanced Life Support or Advanced Life Support to Basic Life Support must be included. These protocols must also include any pre-arrival instructions which are used by EMS call-takers and dispatchers as well as any other pertinent information. In the event that the required information is not provided, the applicant will fail the credentialing process.

J. The applicant must furnish a description of medical control from the system used as a credentialing population, and this description must demonstrate a degree of medical control similar to that of the present Multnomah County system.

The description of medical control must include off-line and on-line medical control. Current quality assurance must also be included as a portion of the description of off-line medical control.

In the event of failure to provide a description of medical control, the applicant will not be credentialed.

K. The applicant must furnish the drug list from the system used as the credentialing population and it must be at least equal in content to the drugs needed to provide Advanced Life Support as listed in the Advanced Life Support protocols in Section VIII, paragraph I.

The drugs carried on each ambulance must be provided under this heading and listed as to the dosage carried. In addition, a listing of IV fluids must also be considered part of this requirement.

In the event of failure to provide the drug list or failure of the drug list to provide for pre-hospital care according to the standards as set forth in the Advanced Life Support protocols in Section VIII, paragraph I, the applicant will fail credentialing.

L. The applicant must furnish a letter or letters from state, regional, or local authorities stating that it has been in substantial compliance with all rules and regulations in all areas served for the past two years.

Letters must very clearly state that the applicant has been in substantial compliance. All infractions which may be noted by state, regional, or local authorities must be fully explained. In addition, a letter from the applicant reflecting on the circumstances for each infraction noted must be provided.

Failure to provide these letters or failure of the applicant to be in substantial compliance will cause the applicant to fail in the credentialing process.

M. The applicant must provide proof of liability insurance coverage carried for credentialing in the amounts of: combined single limit for bodily injury and property damage (vehicular) $500,000 minimum, malpractice $1,000,000, and umbrella liability $1,000,000. If the applicant uses self-insurance, proof of the self-insurance must be provided. Also the self-insured must provide proof that its program meets all of the legal requirements of the state in which it is legally based.

Proof of insurability to the minimum stated or required by the credentialing population system must be provided by the applicant's insurance company. If the credentialing population system does not require insurance at the current stated amounts, the applicant must provide a letter from its insurance agent stating that the applicant is able to obtain insurance at the amounts stated.

Failure to provide proof of insurability, self-insurance, or enough information to assure proof of insurability will cause the applicant to fail the credentialing process.

N. The applicant must present proof of maintenance of an affirmative action plan and provide evidence of good-faith efforts to comply with Presidential Executive Order 11246, the rules and regulations promulgated thereunder by the Office of Federal Contract Compliance Programs, and other relevant Department of Labor rules and regulations.

The plan must be that of the specific corporate entity, governmental bureau, or organizational group that is proposing to deliver the ambulance service; plans of parent or related corporations, or of states, counties, or cities, but not specifically of the proposing agency itself, are not acceptable.

If the applicant has not previously been required to prepare such a plan, then it must do so, and must submit the opinion of legal counsel that its plan does fully comply with the foregoing requirements. The applicant's must include a copy of the plan. If the Department of Labor has audited the plan, proof must also include its final comments of the plan as presented (that is, its certificate of compliance or its show cause letter).

The applicant shall not be credentialed if it fails to provide such proof.

Applicants must provide a copy of this plan or documentation that states their position in implementation of an affirmative action or EEO rules plan. In the event of failure to provide a copy of this plan, or the required information for plan implementation, the applicant will not be credentialed.

O. The applicant must provide a description of the peer review process and internal quality assurance program which is used in the credentialing system (Section VIII, paragraph A).

The program and process must demonstrate a method for identifying problems by prospective and retrospective review and the specific measures which are undertaken to solve the problems. The following areas must be considered by the process: response times in excess of the standard of the system, substandard EMT performance, EMT deviation from protocols or on-line medical direction disputes at the scene, or billing irregularities. In addition, the process for handling (including outcome) complaints from the medical community and public must be described.

The applicant must include for the past two years any and all correspondence from any system-wide quality assurance process and outcome within the ambulance operation which the quality assurance process has caused. In addition, any significant protocol deviations, lack of following medical direction (on-line or off-line) or patient death where questionable care was rendered by the EMT, must be provided (name of patient, EMT, date, location, or any other identifying factors deleted).

If the information required is not fully provided or the information demonstrates that the applicant has no peer review process or internal quality assurance, the applicant will not be credentialed. If the information demonstrates noncompliance with medical control, response time criteria, or a substandard quality of pre-hospital care as evidenced by many protocol deviations or high patient morbidity or mortality, the applicant will not be credentialed.

XI. Notification of Completion of Credentialing Process

Purchasing will notify each applicant in writing by approximately _____ as to the outcome of the credentialing process.

Any applicant that fails the credentialing process may appeal that action to the Board of County Commissioners via the Multnomah County Purchasing Director within five days of written notification.

A. BRIEF DESCRIPTION OF PORTLAND-MULTNOMAH COUNTY EMS SYSTEM

1.	Population served:	566,200
2.	Political units:	Multnomah County, cities of Portland, Gresham, Troutdale, Fairview, and Wood Village
3.	EMS calls per year:	31,000 in 1986
4.	Notification and dispatch:	911 is available throughout the County. Medical calls received via 911 are transferred to EMS Central Dispatch. Through the use of a computer aided dispatch system, requests for medical assistance are triaged and the appropriate ambulance and fire units are dispatched. EMS dispatchers provide pre-arrival instructions to callers over the telephone until aid arrives.
	Average Process Time;	88 seconds. This includes non-emergency calls.
5.	Response:	
	First Responders:	75+ apparatus are operated by the 5 fire departments with the County. The personnel on these units all have received at least Crash Injury Management training with the majority trained and certified as EMT-I. All departments provide first response to life-threatening medical emergencies. Five fire departments respond to all medical emergencies. Five fire departments respond to all medical calls. Two fire departments have a total of eight transport capable ALS rescue units. In addition, two ALS first responder fire apparatus are used.

6. Public accountability (see organizational chart attached):

A. Multnomah County passed an EMS Ordinance in 1980 which authorized a Policy Board to oversee licensing and recommend rulemaking in an EMS system.

B. The City of Portland and the East County cities of Gresham, Fairview, and Wood Village signed agreements with Multnomah County in 1980 authorizing enforcement of the ordinance. The City of Fairview signed an agreement in 1985.

C. The EMS Policy Board is composed of the Multnomah County Executive, a Portland City Commissioner, and a representative of the mayors of the East County cities.

D. The Policy Board meets approximately two times per year in public hearings to recommend to the Board of County Commissioners the amendment, adoption, or repeal of administrative rules concerning the EMS system.

E. The City-County Office of EMS is responsible for the administration of the EMS Ordinance and Rules.

F. A Medical Advisory Board composed of four physicians, a nurse, and two paramedics must approve all rules to be adopted by the Policy Board which directly concern patient care. To date, the Board has written a standard set of ALS Treatment Protocols, as well as protocols concerning the use of on-line medical control.

7. Medical Accountability:

Off-Line Medical Control:

A. The ambulance contractor(s) and the fire departments will have the same EMS physician supervisor.

B. A uniform set of Treatment Protocols has been adopted by rule for use by all ALS providers in the system.

C. All providers must use the Treatment Protocols written by the Medical Advisory Board.

On-Line Medical Control

A. The Oregon Health Sciences University (OHSU) provides a single and centralized source of physician advice to paramedics in the field via UHF radio and telephone.

Quality Assurance

A. A quality assurance committee does provide for random sample and specific case review with regard to call dispatch, appropriateness of patient care, and hospital use. (See attachment h.)

8. CPR Training:

The following organizations and groups conduct regular CPR Training in the community:

American Red Cross
American Heart Association
Area Hospitals
Private Companies

9. Present Providers:

AA Ambulance
Buck Ambulance
(Willamette Falls Ambulance)
Tualatin Valley Ambulance
(Southwest Ambulance)
CARE Ambulance

Portland Fire Bureau
Gresham Fire Department
Skyline Fire Department
Sauvie Island Fire
District 14 Fire

ORGANIZATION CHART

Multnomah County Board of County Commissioners

Policy Board

County Commissioner

Portland Fire and EMS Commissioner

E. County Mayor Representative

City/County Health Officer
Director of EMS

(7) Medical Advisory Board

Provider Board
All Licensees

4 Physicians
- (1) Medical Society
- (2) Emergency Physicians Association
- (3) Medical Resource Hospital
- (4) At Large

1 Nurse
2 Paramedics

HISTORY OF EMS IN PORTLAND - MULTNOMAH COUNTY

1913	Buck Ambulance incorporated as city's first private ambulance company.
1966	City Club recommends regulation of ambulance services.
1969	Dr. Leonard Rose trains first paramedics at Buck Ambulance in cardiac defibrillation.
1971	City Club recommends adoption of county-wide ordinance.
1974	State of Oregon Established EMT training.
1975-6	Multnomah County EMS Advisory Council prepares draft of ordinance.
1978	City and County agree to establish representative EMS system.
1980	Multnomah County enacts comprehensive EMS ordinance. Portland, Gresham, Troutdale, Wood Village approve agreements.
1981	Central Dispatch initiated. Licensing begins. 911 implemented.
1982	Central Dispatch converted to computer-aided system. On-line medical control implemented. Standard Treatment Protocols adopted.
1983	Two EMT-4s required on all emergency ambulances. Ambulance districts reduced from twenty-eight to six.
1985	Trauma system implemented with nation's first computer processing of available hospitals.
1986	Rate Study Task Force recommends a single emergency ambulance provider chosen by competitive bid.
1987	Circuit Court rules on case brought against EMS by ambulance companies, judge rules County cannot be one ambulance service area and Policy Board cannot make rules.
1988	EMS ordinance revised to provide rule-making responsibility to Multnomah Board of County Commissioners.

Attachment I

The call data of calls for ambulance service through 9-1-1, formulated upon geocode base, and hour of day, compiled for the first nine four-week periods of 1987, and the data of all over-eight-minute response times by an ambulance, by geocode base and specific address, is available upon request.

This information, in a more complete form, will be a part of the RFP. The present data has not been checked for its accuracy with regard to the data itself or the actual computer printouts.

If you determine it would be beneficial for your organization to have this data, it can be obtained by contacting Multnomah County Purchasing and requesting the data. The cost for this material will be $83 plus postage and handling.

Multnomah County Purchasing
Franna Ritz, Buyer, (503) 248-5111
2505 SE 11th Ave.
Portland, OR 97202

8/04/88

Request for Proposal

for

Call Answering Ambulance Service for all
911 Generated Calls Within ASA 1 Multnomah County, Oregon

_____

Date

EXHIBIT B

Index

I. Appendix

1. Multnomah County Code 6.31.005 through 6.31.990
2. Map of Multnomah County Showing 2 Ambulance Service Areas and a description of ASA boundaries
3. Hospital listing Multnomah County
4. EMS Dispatch Information concerning calls generated
5. Basic Life Support Protocols
6. Advanced Life Support Protocols
7. Physician Supervisor RFP Description
8. Area Trauma Advisory Board Trauma Plan
9. CHIERS contract
10. Mass Casualty Incident Plan
11. Quality Assurance Plan
12. Oregon Health Division EMS rules
13. Multnomah County EMS rules
14. EMS Med-Net Communications System design
15. EMS Dispatch tape of dispatchers
16. EMS Dispatch Triage Guide
17. EMS Continuing Education Program Description
18. EMT training institutions in Multnomah County
19. EMS TAXI Program
20. EMS Dispatch SOPs
21. Multnomah County ASA plan
22. Emergency Ambulance Costing

A. STATEMENT OF PURPOSE

Multnomah County is requesting proposals for contracts to provide emergency ambulance services within Multnomah County which meet the requirements and conditions set forth in this document.

B. Program Objective

The Emergency Medical Services Office intends to obtain emergency medical care responses and transports to all 9-1-1 generated medical calls within Multnomah County ASA 1 to achieve the greatest efficiency (cost) and effectiveness (care delivery) available.

It is the policy of Multnomah County that selection of contractors who provide a service to the county will be made in an open and competitive manner.

C. Background

System Description - The EMS System in Multnomah County is governed by Multnomah County Code (MCC) 6.31.005 through 6.31.990 and Emergency Medical Services (EMS) Administrative Rules. These are a portion of the requirements which must be met for contractor consideration and ongoing compliance with the contract.

Multnomah County is 465 square miles with a population base of 566,200.

Emergency Medical Services Dispatch generated ambulance call data to include number of responses, number of transports for 1985, 1986, 1987, and until the present, is included as part of this proposal as appendix 4.

The Emergency Medical Services communications system is described in appendix 14.

Emergency Medical Services Dispatch description (see appendix 15, 16, 20).

Basic Life Support Protocols and Advanced Life Support Protocols are included as appendix 5 and 6.

The Physician Supervisor RFP and contract descriptions are included as appendix 7.

The Area Trauma Advisory Board I Trauma Plan is included as appendix 8.

The CHIERS contract and program description for ASA I are included as appendix 9.

A description of the Taxi Program is included as appendix 19.

C. Proposer Instructions

1. Respondents must submit an original and 23 complete copies of the proposal to: Purchasing Director, Multnomah County, 2505 SE 11th Avenue, Portland, OR, 97202, no later than 2:00 p.m. on _____. Late proposals will not be accepted. An optional pre-proposal conference will be held on _____ at _____. Questions to be considered at the pre-proposal conference must be submitted in writing to the Purchasing Director Multnomah County no later than _____.

2. The proposer must respond to the RFP in a format which identifies the proposal in the same manner as the RFP notations (i.e., 1 Personnel 1.A.(a)). This will allow the Evaluation Committee to use the RFP and evaluation outline. If the proposer does not follow this format, the proposal will be considered non-conforming and will not be evaluated.

3. The proposal will be evaluated using two procedures. All category A minimum requirements must be met. Those proposals meeting all of the category A requirements will then be scored in category B areas.

   If a proposal is evaluated as being non-responsive in a Category A requirements area, it will be rejected.

4. The original proposal and copies must be bound or in ring binders.

5. Award Cancellation

   Multnomah County reserves the right to cancel award of the contract at any time before execution of the contract by both parties if cancellation is deemed to be in Multnomah County's best interest. In no event shall Multnomah County have any liability for the cancellation of award. The bidder assumes the sole risk and responsibility for all expenses connected with the preparation of its proposal.

6. Clarification or Protest of Specifications

   Any proposer requiring clarification of the information or protesting any provision herein, must submit specific comments in writing to:

   Director of Purchasing
   2505 SE 11th Avenue
   Portland, OR 97202

The deadline for submitting such questions or comments is _____. If, in the director's opinion, additional information or interpretation is necessary, such information will be supplied in the form of an Addendum which will be delivered to all individuals, firms and corporations having taken out specifications and such Addendum shall have the same binding effect as though contained in the main body of the specifications. Oral instructions or information concerning the specifications or the project given out by County managers, employees, or agents to prospective bidders shall not bind Multnomah County. All Addenda shall be issued by the Purchasing Director not later than five (5) days prior to the proposal deadline.

7. Rejection of Proposals

Multnomah County reserves the right to reject any or all responses to this Request for Proposal.

8. Cost of Preparation of Response

Costs incurred by any proposer in the preparation of the response to this Request for Proposal are the responsibility of the proposer agency and will not be reimbursed by the County.

9. Equivalent Products

Product brands or models, if stated or implied by the specifications, indicate type, design, and quality desired, and shall not restrict proposer to one manufacturer. Products which meet or exceed specification requirements for design, quality, and functional utility will be considered.

If the proposal includes an equivalent item, include descriptive information brochure and/or specifications sufficient for the County to make a determination as to equivalency.

Any variations from specifications on equivalent products must be itemized.

10. Assignment

Neither the resultant contract nor any of the requirements, rights, or privileges demanded by it may be sold, assigned, contracted, or transferred by the Contractor without the express written consent of the EMS Director of Multnomah County.

11. Nondiscrimination in Employment

The successful proposer's attention is directed to the provisions of Oregon Revised Statutes, prohibiting discrimination in employment. The proposer's attention is called to section ___ of the contract (appendix 22).

E. Proposal Elements

1-A Personnel: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 23 for evaluation criteria):

a. Two EMT-4s for each Advanced Life Support ambulance within the county. These EMT-4s must be currently Oregon Certified Emergency Medical Technician 4s.

b. At least the following minimum wage for each EMT-4 to be employed:

- A minimum salary per annum of $17,400 (based upon FLSA defined working hours).

c. Employee benefits with at least a value equal to 30% of the total gross payroll (of each EMT-4 employed in direct patient care services). The benefits must include:

1) Legally required benefits (as defined by U.S. Department of Labor).

2) Retirement program which vests in five years with all proceeds returned to vested members. The retirement program must be portable to the next contractor (see evaluation criteria).

3) Other benefits at the discretion of the employer in accordance with labor agreements.

d. The process for personnel accessibility at time of recontract. The process must address the procedure that would be followed in the event of contractor failure which provides for access to personnel during the time period between contractor notification of substandard contract performance and actual contractor failure or contract revocation.

e. A new employee hire program for the first six months of the contract which:

1) Hires EMT-4s who have worked for a Multnomah County licensee since at least July 1, 1987 with no loss of wage level or benefits accrual level for those EMT-4s hired by the new contractor.

2) Hires EMT-4s who have worked for a Multnomah County ALS licensee since July 1, 1987 in preference to other applicants. This employee preference hiring is to consider "working in Multnomah" EMT-4s as appropriate hires if they meet the contractor's knowledge and performance criteria.

f. A program for continuing education which provides the EMT-4s with adequate training to meet the minimum recertification requirements. The program must consider and incorporate:

1) Coordination with the county continuing education program as described in Appendix 17.

2) A process for recognition of quality of care problems (internal peer reviews) and the educational process to correct the recognized problems.

3) Coordination with the quality assurance program as described in Appendix 11.

4) Cooperation with the EMT training facilities located in Multnomah County. (See Appendix 18.)

1-B The proposal will be scored on how it proposes plans to reach the following system goals which are above the minimum acceptable requirements as listed for personnel (see page 24 for evaluation criteria).

a. A unit hour utilization* with highest and lowest rates acceptable to maintain EMT knowledge and skills but does not cause "job burnout." The plan as presented may consider less than 24-hour vehicles and may also consider higher pay scales for those employees at higher utilization rates. The plan must state staffing patterns by hour and day per week, the housing and standby station procedures to be used. These must be applied in 2A-0 in the system status plan. The system status plan prepared for section 2A-0 must be provided to comply with this section.

30 pts.

*Unit hour utilization is defined as the total number of transports divided by the number of staffed hours per shift (3 transports - 12 hours = .25). The proposer in considering utilization rates must use the following standards: eight minute response, twenty minute on scene time, fifteen minute hospital transport time, seventeen minute chart and clean-up time. The highest and lowest rates are evaluated with the above fixed variables. If less than 24-hour staffing is used, the unit hour utilization figures must also be listed.

b. A proposal which describes the management structure of the contractor. The proposal may consider:

1) The ratio of ambulance EMT-4s on duty to on duty field supervisors (above the level of senior EMT on the ambulance).

9 pts.

2) The names, curriculum vitae, and current job status of at least the following: operations manager, business manager, training coordinator.

15 pts.

c. A proposal which describes an employee benefit plan or pay incentive which provides a higher level of employee benefits or pay than is required. The purpose of this proposal must be to encourage employee stability as well as attracting the best EMT-4s available. Also, in-place EMT-4s with seniority of service shall be given preference in hiring and wage scale due to knowledge of the Multnomah County geography, hospitals, and EMS system.

45 pts.

2-A Communications: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 25 for evaluation criteria):

a. Each vehicle of the contractor shall be equipped with a radio which shall be used to send and receive information over the central dispatch frequencies. In addition, the radio must be able to transmit and receive on Med-1, 4, 7, 9, and 10. A personnel alerting system which will be used on Med-9 to alert the ambulance crew of their need to respond to a call is required and must be described. The radio must be capable of transmitting outside of the vehicle (porta-mobile).

b. The contractor shall promptly advise EMS Central Dispatch when a change in personnel or equipment on a vehicle results in the vehicle's classification changing from ALS or BLS. A Standard Operating Procedure accomplishing this must be provided.

c. Each morning, at a time specified by the Office of Emergency Medical Services, the contractor shall advise EMS Central Dispatch of the following for each vehicle: The present status, the EMT certification numbers of the crew members, and whether the vehicle is an ALS service. EMS Central Dispatch shall be informed immediately of any personnel changes on a vehicle. A Standard Operating Procedure accomplishing this must be provided.

d. If the contractor receives requests for emergency medical assistance from a source other than 9-1-1, the contractor must use the current Multnomah County EMS triage guidelines to process these calls. A Standard Operating Procedure accomplishing this must be provided.

e. Only EMS Central Dispatch may cancel or revise a dispatch order. Vehicles arriving at the emergency scene shall promptly advise EMS Central Dispatch of information relevant to whether a dispatch order should be canceled or revised. A vehicle which receives a cancellation order may continue to the scene of an emergency, provided that EMS Central Dispatch is so advised and the vehicle's emergency lights and siren are not employed. A Standard Operating Procedure accomplishing this must be provided.

f. The crew of each vehicle of the contractor shall promptly inform EMS Central Dispatch of the following changes in status by radio: In service at station, in service out of station, location or destination shall be stated, in service at scene of emergency, enroute to emergency scene, arrived at emergency scene, enroute to hospital or medical facility from emergency, arrived at hospital or facility from emergency scene, returned to service, out of service. A Standard Operating Procedure accomplishing this must be provided.

g. Contractor's vehicle crews shall use the ten codes attached to this RFP as Appendix 13 when communicating with EMS Central Dispatch. Each ambulance crew shall be equipped with one tone-coded pager or radio which allows direct access of EMS Central Dispatch to the ambulance crew. The contractor's ambulance crews must provide the following information to EMS Central Dispatch by radio for each ambulance responding to an emergency as directed by EMS Central Dispatch. When an ambulance is dispatched from other than its base, it shall be identified. When the ambulance is enroute to a hospital or other medical facility, the number of patients being transported, response code, and the identity of the hospital or facility shall be stated. When an ambulance does not transport a patient, the reason for this action shall be identified. The Standard Operating Procedure accomplishing this must be provided.

h. All patients requiring transport by ambulance (using the most current BLS and ALS treatment protocols) must be transported in the responding ALS ambulance but must be billed as determined by the billing procedure as defined per Appendix 19. The ALS ambulance may make appropriate use of the CHIERS and TAXI programs as described in Appendix 9 and 19.

i. EMS Central Dispatch may request an Advanced Life Support ambulance from outside Multnomah County to respond in Multnomah County to a medical emergency if the expected response time of the ambulance in Multnomah County exceeds ten minutes and the out-of-county ambulance is closer to the emergency than any other Multnomah County ambulance, and the out-of-county ambulance meets ALS ambulance requirements as established by the Oregon State Health Division. The Standard Operating Procedure accomplishing this must be provided.

j. The contractors shall utilize helicopter ambulance service in Multnomah County (Life Flight) when it is determined that transport of a seriously ill medical patient or trauma patient would be more advantageous by helicopter than by ground ambulance. A Standard Operating Procedure accomplishing this must be provided.

k. The helicopter ambulance will be requested through EMS Dispatch. A Standard Operating Procedure accomplishing this must be provided.

l. The contractor may provide ambulance service for a special event in the city or county. A Standard Operating Procedure accomplishing this must be provided.

m. At any time the contractor stands by at such an event, the contractor shall advise the EMS Office and EMS Dispatch by letter one week prior to the date of the event the following information: Date and time of the event, location of the event, name of the person responsible for arranging ambulance coverage for the event. A Standard Operating Procedure accomplishing this must be provided.

n. The contractor shall respond to 90 percent of the calls within their service area in eight minutes or less measured from the time of dispatch and until the time the unit is on the scene. Time will be calculated in minutes with any seconds over the minute considered the next minute (7 minutes 04 seconds becomes 8 minutes). The contractor is fully responsible for ambulance crews being available for notification of a call. EMS Records will be the final authority in response time determination. No area (geo-code) of the county may be consistently underserved (for a period of two or more months). A statement from the proposer which acknowledges this set of requirements and methodology for determining compliance must be provided.

o. The proposer must furnish a system status plan for a one-month period. The month must include a major holiday (Thanksgiving, Christmas, New Year, or July 4th) and the call volume must be projected based upon the provided EMS call data in Appendix 4. The system status plan must include: number of ambulances, hours which each ambulance is staffed, location of ambulances by hour of day and day of week, and number of transports per ambulance per shift expected. This information will also be used to award points in section 1B-a.

p. The contractor shall not monitor or intercept police or other radio dispatcher transmission for profit or gain. Contractor shall not fail or refuse to promptly advise Emergency Medical Services Dispatch Office of receipt of a request for emergency medical assistance or when a licensee's ambulance becomes available or non-available to respond to dispatch orders. The contractor shall not respond by ambulance to an emergency call unless so authorized by the EMS Central Dispatch Office. The Contractor shall not fail or refuse to respond to a dispatch order from EMS Central Dispatch Office when the ambulance subject to the call is available for service. The ambulance contractor shall not refuse to transport any patient in need of emergency medical care regardless of the patient's ability to pay. A Standard Operating Procedure which accomplishes this must be provided.

q. Contractor shall defend, indemnify and hold all first responders harmless from and against all claims, damages, losses, and expenses, including attorney's fees arising out of and resulting from the performance of services by first responders under the direction or control of the contractor.

Contractor shall maintain at all times during the performance of the contract comprehensive general, auto, and professional malpractice insurance endorsed to show first responders as additional named insureds. A statement from the proposer insurance agent and the "hold harmless" language must be provided which demonstrates this coverage.

r. Contractor must provide first responder transportation to the appropriate fire station from the hospital when the first responder accompanies the patient to the hospital. The transportation should be furnished in such a way that the first responder is returned to the fire station in no more than thirty minutes from hospital arrival time. A description of and the Standard Operating Procedure which accomplishes this must be provided.

s. Proposer must propose to provide mutual-aid agreements with the ambulance service in each adjoining ambulance service area. A description of, and the Standard Operating Procedure which accomplishes this must be provided.

t. Contractor must provide for no more than 5 percent per four-week period of calls to the Multnomah County ambulance service area to be answered by an out-of-Multnomah County licensed Advanced Life Support ambulance provider or the adjoining Multnomah County ASA provider unless the contractor is one and the same. A description of and the Standard Operating Procedure which accomplishes this must be provided.

3. Medical: 3.A Proposers must provide documentation describing their compliance with the following minimum requirements (see page 27 for evaluation criteria):

   a. The Multnomah County Advanced Life Support and Basic Life Support procedures and protocols must be adhered to by all working Emergency Medical Technicians.

   b. The contractor's Emergency Medical Technicians shall promptly contact the Medical Resource Hospital by UHF radio or telephone when required by the Advanced Life Support treatment protocols or an approved Medical Resource Hospital study. If the Medical Resource Hospital is not available, then the receiving hospital shall be contacted.

   c. The contractor's EMTs shall relay the following information to the MRH: Unit number, receiving hospital and estimated time of arrival, purpose of call, age and sex of patient, chief complaint, brief history, prior medical history, medications, allergies, vital signs, pertinent physical findings, treatment at the scene.

   d. At the discretion of the contractor's emergency medical technicians, the receiving hospital may also be contacted by the EMT. The EMT will transmit to the receiving hospital the following information: Unit number, age and sex of patient, estimated time of arrival, condition, chief complaint, advanced life support treatment provided.

   e. Each Advanced Life Support unit of the contractor shall have a set of treatment protocols on the unit itself at all times.

   f. Incorporates the Area Trauma Advisory Board Trauma Plan provided as an Appendix 8. All EMT-4s will be Pre-Hospital Trauma Life Support (PHTLS) or equivalent trained within six months of contract award. A description of this, and the Standard Operating Procedure which accomplishes this must be provided.

   g. Incorporates the Mass Casualty Incident Plan as attached in Appendix 10. Participates in one major drill and two mini-drills per year. A description of, and the Standard Operating Procedure which accomplishes this must be provided.

   h. Incorporates the Quality Assurance Plan attached as Appendix 11. A description of, and the Standard Operating Procedure which accomplishes this must be provided.

   i. Proposer must provide a plan which describes a first responder training program provided by the contractor at no cost to all first responders to keep the first responders aware of ambulance orientation, equipment changes, or protocol changes as they apply to the first responders.

j. Proposer must provide for the role of the EMS physician-supervisor in administrative protocols which accomplishes:
   1) Participation in hiring of EMTs.
   2) Absolute authority for all medical direction of the contractor.
   3) Scheduling of mandatory inservice.
   4) "Ride-alongs" to meet ORS requirements.
   5) Absolute authority to remove an EMT from the provider's ambulance.

   The administrative protocols for the above must be provided.

k. Proposer must provide a list of type and amount of each drug which will be carried on each ambulance and is needed to comply with ALS protocols so that two patients with the same medical or trauma problem can be treated without an ambulance restock. These drugs in type and amount are to be carried on all staffed ALS ambulances.

3B. The proposer will be scored on how it proposes plans to meet the following system goals which are above the minimum acceptable requirements for medical as above (see page 30 for evaluation criteria).

a. It is thought that a proposer's history of having a functioning peer review process will predict that the proposer will provide better emergency medical care if chosen as a contractor. The proposer must describe his peer review process. The description must be provided for the past two years (1986, 1987) and be for the credentialed population.

4-A Equipment: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 28 for evaluation criteria):

a. All ALS ambulances or BLS ambulances and equipment must meet current ORS and Multnomah County requirements for ambulances (see Appendix 1-12-13). A listing of all ambulances by make, age, mileage, modifier, and equipment contained must be provided. This must include all vehicles which are to be used in Multnomah County.

b. Provision of mobile VHF radio equipment with a dial encoder and capable of transmission on 155.340 mhz for each ALS ambulance at no less than 25 watts. The radios must be identified by make, model, and output. A copy of the FCC license for this frequency or plans for obtaining the rights to mobiles on this frequency from the Greater Portland Hospital Association must be included.

c. The following disposable equipment must be provided at no cost to the first responder agency when the first responder has cared for a transported or "charged" patient. The equipment will be exchanged on the "scene" if it does not interfere with patient care. The proposer must contact the first responder agencies to assist in this development. See Appendix 21. A field and billing Standard Operating Procedure which accomplishes this must be provided.
   1) Oxygen administration items.
   2) Suction items.
   3) Intravenous materials.
   4) Drugs.
   5) Disposable splints.
   6) Cervical collar--"stiffnecks" or equivalent

d. The following equipment must be provided which will be standardized with the first responder agencies. A Standard Operating Procedure which accomplishes this must be provided.
   1) Trunk and neck immobilizer--"K.E.D." or equivalent.
   2) Wooden long spine board.
   3) Traction splint.
   4) Scoop stretcher.
   5) Pnuematic Anti-Shock garment.

e. An agreement with the trauma centers to create a "Letterman" exchange system and an equipment cleaning program. The agreements and the Standard Operating Procedure which accomplishes this must be provided.
   1) C-collar "Stiffneck" or equivalent.
   2) Trunk and neck immobilizer "KED" or equivalent.
   3) Long spine board.
   4) Traction splint.
   5) Scoop stretcher.
   6) Pnuematic Anti-Shock garment.

4-B The proposer will be scored on how it proposes plans to meet the following system goals which are above the minimum acceptable requirements for equipment as above (see page 28 for evaluation criteria):

a. Newer front-line (non-reserve) vehicles and those which have lower mileage and meet KKK1822B. This may be done by providing type, age, mileage, and "modifier" of each ALS ambulance vehicle to be used in Multnomah County. 4 pts.

b. Preventive maintenance of ALS ambulances. 8 pts.

c. Availability of reserve ambulances and gives the number of reserve ambulances including their proposed storage location and to what extent they will be stocked when held in reserve. 8 pts.

d. Provision of up-to-date equipment with a maintenance program. This may be accomplished by providing the make, model, age of, and maintenance program for:

1. Ambulance cots.
2. Portable monitor defibrillators.
3. Portable suction.

6 pts.

5-A Business Practices: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 30 for evaluation criteria):

a. Proposer has met all minimum requirements for credentialing and will meet them throughout the contract period, as well as license and compliance with all MCC and rules throughout the contract period. The proposal must state how the proposer intends to meet these requirements throughout the contract period.

b. Have insurance coverage to at least the following minimums (with no exceptions to riders in the ambulance):

1) Combined single limit for bodily injury and property damage (vehicular), $500,000 and

2) Malpractice, $1 million and

3) Umbrella liability, $1 million and

4) Contractor shall also carry workers' compensation insurance as required by law, or the legal equivalent, for the life of the contract. Contract shall require all of its subcontractors to maintain similar insurance coverages and shall require evidence of such coverage prior to commencement of work by any such subcontractor.

A copy of the policies must be submitted for review 30 days prior to the effective date of the contract. The policy must include a 30 day notice requirement for any material change or cancellation.

Comprehensive general liability, auto, and professional malpractice insurance may be arranged under a single policy for the full limits required or by a combination of underlying policies with a balance provided by an excess or umbrella liability policy or

5) Contractors may elect to self-insure part or all of the insurance requirement. If a contractor elects to self-insure areas b-1, 2, 3, 4, contractor shall provide evidence that contractor has qualified under all state and federal requirements for self-insurance. In addition, contractor shall provide documentation verifying that a funding mechanism is in place to meet the financial responsibilities of the indemnification agreement and name and credentials of the contractor's claims administrator.

This must be demonstrated by documentation of insurability by an insurance company licensed to do business in Oregon and a proposal to purchase the insurance required or proof of self-insurance as required by ORS.

c. Information to be provided must be placed on worksheet attached as Form 1. Both costing columns and revenue columns must be completed. If either column is not full completed, the proposal will be determined non-conforming. Definitions of full, proportionate, and incremental costs are to be followed and are included in appendix 22. The first column on form 1 must provide full cost and revenue projections, and column two must provide proportional cost and revenue projections. The projections as requested below must be based upon data as provided in Appendix 4, which provides information from 1985, 1986, and most current 1987 data from EMS Central Dispatch, Multnomah County. The proposer is expected to use its own best judgment in determining the variables as requested below.

1) Cost per ALS ambulance per year and also ALS ambulance by unit hour. This must apply to appropriately staffed Advanced Life Support ambulances required in the minimums under personnel. Also, the number of ambulance units and unit hours per year should be projected. Costs must be reported on Form 1.

2) The projected call volume from all 9-1-1 generated calls and the projected transport volume from these calls. The proposer must use the figures in Appendix 4 to project these numbers. These figures must be presented on Form 1.

3) The projected volumes with ALS and BLS charged transport from the patient transport volume. The proposer must use the figures in Appendix 4 to project these numbers. These figures must be provided on the Form 1.

4) The overall collection percentage projected for the cost which involved transport. This percentage must include actual collection rate tempered with the percentage that will be less than fully collected due to assignment (Medicare) or other reimbursement. This figure must be provided on Form 1.

5) The BLS and ALS charges for all users of the system projected by the proposer. These figures must be provided on Form 1.

6) The proposer must follow the ALS/BLS charge criteria as set forth in Appendix 19. The proposal must be fully presented on the worksheet. The proposal must represent cost. If cost and revenue figures are not adequately validated the proposal will be judged non-responsive.

d. The contractor must accept the responsibility to provide standbys as requested by police and fire agencies within Multnomah County at no charge. If a patient is transported, any charge to that

patient must be based upon charges to a similar patient with no standby time charges. A Standard Operating Procedure which accomplishes this must be provided.

e. Incorporate the taxi Standard Operating Procedure as presented in Appendix 20. A Standard Operating Procedure which accomplishes this must be provided.

f. Incorporate the CHIERS Program as presented in contract form in Appendix 9. A Standard Operating Procedure which accomplishes this must be provided.

g. The authority and responsibility of the EMS Rate Review Committee as presented in Appendix 22 must be incorporated in billing and administrative Standard Operating Procedures. The Standard Operating Procedure which accomplishes this must be provided.

h. Recognize the authority of the Emergency Medical Services Office to randomly sample billings and provide these billings to the Rate Review Committee. The mechanism for action to correct bills in which the charge is questioned must be described.

i. Provide $42,500 (estimate) yearly in quarterly payments for physician supervisor services to be provided by the County. These services are detailed in Appendix 7. The proposal must detail how the provider will make the payments.

j. Plan of operation for the first six months of operation which reflects the following and recognizes the slow collection start-up problems and the need for outside resources to assist in meeting expenses:
   1) Payroll expenses
   2) Capital expenses
   3) Ancillary expenses
   4) Revenue from transports with projected timetable of receipt of income
   5) Other source or sources of revenue or assets which allow the contractor to meet expenses for the first six months.

k. Description of the billing practices which recognizes the extreme importance of billing practices in this user funded system. The plan must also recognize the importance of humane billing practices.
   1) Billing procedure for Medicare
   2) Billing procedure for third party payors
   3) Billing practices for other public parties (county, corrections, AFS, etc.)
   4) Billing practices for private parties
   5) Billing practice for overdue payments
   6) Billing practices for write-offs

l. The proposer's legal business structure must be described and must demonstrate that the structure is sound and meets all legal requirements.

m. Document the method of public and consumer education to reduce 9-1-1 abuse, but to also assist the public in understanding the EMS system and provision of public emergency care (CPR, etc.). The proposal must detail teaching and education methods to be used, as well as the delivery process.

n. Describe how a minimum of fifty hours per month of standby time free to appropriate "public" events will be provided. This is to be in addition to police and fire standbys.

o. Describe how the inebriate outreach program for the central city will be carried out using a subcontract with Hooper Detox.

5-B Business Practices - The proposer may propose plans to meet the following system goals which are above the minimum standards of the business practices (see page 31 for evaluation criteria):

a. A flat, all inclusive rate to be charged for: ALS response, BLS treatment, and BLS transport to a 911 call, and ALS response, treatment, and transport to a 911 call. The rates must consider the ALS/BLS charge standards and be reported on form 2.

The rates must reflect the maximum efficiency in the system by displaying the lowest flat rate user fees with no decrease in system effectiveness. The BLS and ALS definitions per Appendix 19 are to be the guide for user charges. A uniform charge for any person in Multnomah County transported to any hospital in the Tri-County area regardless of time of day or day of week is to be the standard for the all-inclusive rate.

1)	BLS Rate/Medicare Assignment	20 pts.
2)	ALS Rate/Medicare Assignment	30 pts.
3)	Standby Charge (private)	10 pts.

b. A history of excellence of past performance in providing advanced life support emergency medical care and transport is thought to predict a contractor's ability to provide better emergency medical care and transport. The proposer should describe and fully validate the following components of the system used for credentialing. Validation of the numbers must be provided by an organization other than the proposers for the past two years (86, 87).

1) A history of lawsuits or insurance settlements.

2) A history of collisions (which require a state accident report be filed).

3) A history of workers compensation claims.

5 pts.

6. Safety Net: 6.A Proposers must provide documentation describing their compliance with the following minimum requirements (see page 32 for evaluation criteria):

   a. Emergency ambulance service as an essential service and ensure that no interruption of service will occur in the event of a work stoppage by employees.

   b. The safety net must ensure that in the event of contractor failure (due to contract, ordinance, or financial reasons) there is no interruption in call answering. The proposal must provide for delivery of all ambulances (fully stocked) which are used to answer calls to EMS. The ambulances must be free of any encumbrances (defined as able to be used by Multnomah County to provide ambulance service with no reimbursement or remuneration to the contractor or lienholder), and be available for service to EMS for no less than 6 months. Funds to allow answering of all calls to the level expected under the contract must be provided for in the plan. These funds must provide for the dollars to support the call answering system for 45 days. The call answering system is defined for safety net purposes as personnel (two EMT-4s per ambulance), maintenance and upkeep of each ambulance to include disposable medical equipment, radio equipment, and insurance to the level of ambulance and reserve ambulances provided by the contractor over the last 60 days before failure. The funds to be used for this purpose must be immediately accessible to EMS upon contractor financial failure or revocation of the contract (based upon non-performance of contract terms and conditions) by EMS, and the details of the accessibility of the vehicles and funds must be explained in detail.

COST/REVENUE WORKSHEET Form 1

(See next page for description of (1), (2), (3), (4), (5), (6)

1. ALS ambulance cost:	Full Cost (1)	Proportional Cost to 911 (2)
Contract[2]		
Personnel		
Operations		
(_____miles @ _____)		
Administration[4]		
Capital[6]		
Insurance[3]		
Disposable Supplies		
Drugs		
All Other Expenses (depreciation, maintenance, etc.)		
Total Cost by ambulance		
Total Cost by unit hour		
Number of Ambulance Units[5]		
Number of unit hours (5)		
Inebriate outreach subcontract cost		

	Other Revenue	911 Revenue
2. Projected call volume		
Projected call transport volume		
3. Volume of BLS charged transports		
Volume of ALS charged transports		
4. Overall collection percentage		
5. BLS charge per call		
ALS charge per call		
6. Inebriate outreach subsidy		

Form 1 Cost/Revenue Worksheet Page 2

1. This must be full cost and consider all associated costs with each category. The total ambulance cost must be the best projection of total cost.

2. This must be the proportional cost which the proposer projects this contract for 911 calls will incur. Column two may be the same as column one, or it may be lower. If column two is lower than one, the proposer must explain the difference, and justify why the cost is different. This difference in cost may be attributed to: other business interests, non-911 call ambulance use, cross use of personnel. It is important that this explanation be fully explained and justified. The justification must be sufficient to allow the RFP evaluation committee to determine its validity. This must demonstrate that the 911 cost is the full cost of 911 service.

3. If self-insurance is used, the cost must be arrived at considering the past settlements and equating them to the increase in liability exposure due to the contract.

4. Must include the $42,500 per annum for physician supervisor costs, also all other administrative or training personnel costs.

5. This must be the total number of ambulance units to meet the full 911 contract for ASA 1, this number may be reflected in fractions of an ambulance if peak load staffing or other staffing patterns are followed.

6. This must also include cost of back-up or reserve ambulances and other back-up equipment.

RATE WORKSHEET Form 2

1. BLS rate with Medicare assignment.[a] _____

2. ALS rate with Medicare assignment.[a] _____

3. Standby charge for private events (in addition to transport charge if patient transported).[a] _____ hr.

[a]This is the contractor's rate for the four-year contract period. The Rate Review Committee, Emergency Medical Services Advisory Policy Board and the Board of County Commissioners may allow rate increases based upon consumer price index, dramatic increase in cost of doing business, or more stringent or added system requirements. The proposer should not consider any of the aforementioned possibilities to be a reason for guarantee of a rate increase. All rate increases must be requested by the contractor. There is no charge or reimbursement for first responders. If first responders petition the Rate Review Committee for charges, the contractor is assured no additional uncompensated cost.

F. Contract

It is the intention of Emergency Medical Services to enter into a contract no later than _____, and extending four years with a potential for renewal for a one-year term. At the option of the County, upon one hundred and eighty days written notice, the contract may be extended for the additional one-year extension. Rate and other system changes will be considered in the event of a renewal. Rate changes must be approved by the rate committee and the Emergency Medical Services Policy Board, and the Multnomah County Board of County Commissioners.

G. Evaluation Criteria

The RFP is made up of six sections. Each section has a minimum requirements section and may have a point achievement section.

A proposal, to be considered, must meet all of the minimum requirements.

The minimum requirements will be evaluated on a pass/fail basis. If the proposal fails to pass any of the minimum requirements for any section, the proposal will be rejected.

Qualifying proposals will then be awarded points based upon the requirements specified in the RFP.

The following criteria will be used by the evaluation committee to judge whether a proposal meets the minimum requirements for category area A and the number of points to be awarded for category area B.

1-A Personnel:

a. The proposal does provide for two Oregon Certified EMT 4s.

b. The proposal does provide for a minimum annual wage of $17,400 based upon first day of employment.

c. The employee benefits proposal does include:
   1) A benefits package of at least 30% of gross EMT salary.
   2) All legally required benefits.
   3) A retirement plan which is "portable" (must be able to be transferred to the next contractor with all benefits, vesting, and accrual levels intact. P.E.R.S. is considered portable for purposes of evaluation of this proposal) and meets all other requirements of the RFP will be considered as meeting this requirement.
   4) Benefits will begin the first day of employment for "Multnomah County" EMTs.

d. The personnel accessibility proposal does meet the requirements of the RFP.

e. The proposal does provide for hiring of EMT-4s currently working in Multnomah County with no loss of wage or benefit accrual levels.

f. The proposal does provide for a coordinated continuing education program as described in the RFP.

1-B a. The unit hour utilization rate must establish a minimum unit hour utilization rate of (based upon monthly staffing levels used in 2A-0):

.17 24-hour ambulance
.33 12-hour ambulance
.40 10-hour ambulance
.50 8-hour ambulance

15 points are awarded for total compliance. Each .07 below this compliance level (a composite of all used staffing levels in 2A-0) will deduct 1 point to a maximum of 15 .

b. The unit hour utilization rate should establish a maximum unit hour utilization rate of (based upon monthly staffing levels used in 2A-0):

.40 24-hour ambulance
.60 12-hour ambulance
.65 10-hour ambulance
.75 8-hour ambulance

15 points are awarded for total compliance. Each .056 below this compliance level (a composite of all used staffing levels in 2A-0) will deduct 1 point to a maximum of 15 .

c. The management structure program should address management in the following manner:
   1) An on-duty non-patient care supervisor for each twelve ALS ambulances in service will gain 9 points. Points will be awarded by using the 12 to 1 ratio as the standard, for a greater ambulance-to-supervisor ratio.

2) The curriculum vitae of the management personnel will be awarded fifteen points using the following standards for each. If the personnel do not meet the criteria, fewer or no points will be awarded.

5 Points. Operations Manager. College degree (BS or BA) with at least four years experience in ambulance service delivery and with current EMT-P status. The experience to be gained in a system of at least 20,000 emergency calls per year. (Four years additional EMS supervisory experience may be substituted for the college degree.)

5 Points. Business Manager. College degree (BS or BA) with at least four years experience in ambulance third-party billing procedures, also experience working with labor groups. The experience to be gained in a system which bills at least 10,000 patients annually. (Four years additional EMS business experience may be substituted for the college degree.)

5 Points. Training Coordinator. EMT-P, ACLS instructor, PHTLS instructor, with three years experience as a training coordinator for fifty EMT-Ps. Experience in a peer-review process, having conducted a peer-review process for fifty EMT-Ps for three years.

If a job function on which the evaluation criteria is specific is performed by another titled evaluated management position the substitution can be made and the points awarded.

3) 15 points. The proposal providing a benefit package which is five percent of the EMT-gross salary (in addition to the minimum required 30 percent) or more will receive fifteen points. If less than five percent is proposed, for each percent drop there will be three points deducted.

30 points. The proposal providing a wage package which does provide for: a base wage scale of at least ten percent over the required minimum, which includes: the same percentage increase for in "Multnomah County" hired EMTs, is raised by at least the Consumer Price Index each year of the contract, progresses in at least six steps, and be ten percent above the current top wage (22,000) in Multnomah County. For each percent the proposal is above the required minimum three points will be given for a maximum of thirty. The proposal must also include a plan to hire those "Multnomah County" EMTs who possess the most experience in the Multnomah County EMS program in preference to those EMTs with less or no experience.

2-A Communications:

a. The proposal does show each ambulance and EMT crew with UHF capability on MED 1-4-7-9-10 and personnel alerting on MED 9.

b. The proposal does state that the contractor will advise EMS dispatch of any vehicle status change.

c. The proposal does state that the contractor will advise EMS dispatch of vehicle crew and status.

d. The proposal does state that the contractor will use the Multnomah County EMS triage guide.

e. The proposal does state that the contractor will adhere to the rules as listed in the RFP 2-A e, f, g, h(1),(2), i, j, k, l, m, n, p.

f. (o) The proposal does provide a system status plan (SSP) for a one month period. There is a major holiday (New Year's, 4th of July, Labor Day, Thanksgiving, Christmas) in the month. The SSP does provide coverage for all of Multnomah County for a response time of eight minutes or less, ninety percent of the time. The judgement of this to be based upon call volume for geo-code areas of Multnomah County. The SSP must also not use mutual aid for more than five percent of the calls.

g. (q)(n) The proposal does provide liability insurance, and "return transportation" for the first responders.

h. (s) The proposal does propose mutual aid agreements with adjoining ASA's.

i. (t) The proposal does provide for no more than five percent per four-week period of the calls to be answered by mutual aid.

3. Medical:

a. The proposal does state that the contractor will adhere to the EMS rules as stated in the RFP in 3.A a, b, c, d, and e, and that if the contractor is not currently functioning under these rules how it will implement them.

b. (f) The proposal does incorporate the ATAB Plan and sets a date within six months when all EMT-Ps will be PHTLS or equivalent trained.

c. (g)(h) The proposal does incorporate the MCI Plan and Quality Assurance Program and that the contractor will adhere to the standards.

d. (i) The proposal does provide an adequate first responder training program at no cost to the first responder.

e. (j) The proposal does provide for a role of the physician supervisor which includes hiring participation, absolute medical control, mandatory inservice scheduling, and ride-alongs.

f. (k) The proposal does list the types and amounts of drugs to "run" two back-to-back same ALS protocol patients with no restock.

3B. A proposal which describes a peer review process history with at least the following characteristics will be awarded seven and a half points:

1) A meeting each month attended by the off-line medical director, and with at least 80 percent of the members attending.

2) A peer review process made up of representatives representing ALS, BLS, and communications (this committee is to only review ALS care).

3) A peer review process with a set of bylaws which assure patient confidentiality, rules of order, autonomy from management, and the responsibility to take action in medical areas they deem appropriate.

If the proposal describes and properly documents all of the above areas of peer review seven and a half points will be awarded. If all areas are not met, 2.5 points will be awarded for each area met for a maximum of seven and a half points.

4-A Equipment:

a. The proposal does list all the vehicles and equipment and all do meet or exceed ORS and Multnomah County standards.

b. The proposal does list VHF radio equipment (155.340 MHZ) that is capable of use for ambulance-to-hospital communications in Multnomah County. The radio license or a plan to obtain such is included.

c. The proposal does provide for first responder equipment provision for disposable items as listed in the RFP.

d. The proposal does provide for standardized equipment with first responders.

e. The proposal does provide for signed agreements with the trauma centers for a "Letterman" exchange clean equipment program.

4-B a. The proposal does recognize the need for newer low-mileage vehicles which meet KKK1822B. All ambulances less than one year of age and less than 10,000 miles, and meeting KKK1822B will be considered newer low mileage vehicles. This does not include ambulances which are considered "extras" or "backup."

4 pts.

The points award up to 4 points will be based on the percentage of ambulances which meet the newer low mileage definition.

b. The proposal provides for a preventive maintenance program and an ambulance reserve program which:

1) Provides for safety inspections every 15,000 miles until 60,000 miles, then every 7,500 miles (these to be done by an outside shop familiar with the type of vehicles used).

2) Provides maintenance to manufacturers extreme use recommendations. Provides for downtime for ambulance maintenance. Uses innovative methods to extend ambulance dependability, such as diesel engines, heavy-duty batteries, radial tires, metallic brakes, etc.

3) Provides a history of ambulance maintenance which demonstrates the ability to keep ambulances in-service with no major failures.

If the proposal satisfactorily incorporates at least the above areas, up to 8 points will be awarded.

c. Provides for a fully stocked (except for defibrillator and ALS drugs) ambulance for every three front-line (non-reserve) operating ambulances.

If the proposal meets this requirement up to 8 points will be awarded.

d. The proposal provides for up-to-date equipment.

1) Ambulance cots (Ferno model-MTS or equivalent).

2) Portable monitor-defibrillator (Life-Pak 5 or equivalent).

3) Portable suction (laerdal or equivalent).

If the equipment is of the appropriate model as shown above and a maintenance program is described and proposed which demonstrates the ability to keep the equipment operational and find faults before they affect patient care, 6 points will be given. If the equipment is not of appropriate model or up-to-date or the maintenance plan is not sufficient to keep the equipment operational, fewer or no points will be awarded using four years as the life expectancy of the equipment.

5-A Business Practices:

a. The proposal provides ample information to assure that the provider can and will meet all applicable credentialing standards, MCC and EMS rules for the contract period.

b. The proposal does provide for insurance to at least the RFP minimums.

c. The proposal does provide all of the costing and revenue projections as requested in Form 1. The cost and revenue figures are reasonable and based upon EMS figures provided. The costs are fully accounted and adequately justified where not applied to the 911 contract. The definitions contained in appendix twenty-two are followed. The cost and revenue projections used do demonstrate sound business practice, and are reasonable based upon projected staffing levels.

d. The proposal does provide for free-of-cost standbys for police and fire agencies.

e. (e)(f)(g) The proposal does recognize and integrates into the contractor's operations, the TAXI and CHIERS and Rate Study Committee.

f. (h) The proposal does recognize the EMS Office authority to sample billings and does provide a process to correct incorrect billings.

g. (i) The proposal does provide for $42,500 per annum in quarterly payments to EMS for physician-supervisor services.

h. (j) The proposal does provide a plan of operation for the first six months which considers all aspects of the RFP requirements. The plan is reasonable and does demonstrate financial soundness.

i. (k) The proposal does describe the billing practices. The billing practices are humane and encourage those who can pay to pay, but those who cannot pay are recognized and billings dealt with humanely. The billing practices also are legal and exhibit sound business practice.

j. (l) The proposal does describe the legal business structure of the contractor, and it is the same as used in the credentialing process. The business structure is legal in Oregon.

k. The proposal does describe how the inebriate outreach program will function. The description does at least equal the standards of the Hooper Detox contract (Attachment 9). There is a letter from the Hooper Center which does state that Hooper will enter into a contract with the proposer beginning July 1, 1989, if the proposer is the successful contractor.

5-B Business Practice:

a. A BLS flat rate of $150 will be awarded 20 points. For each ten dollar increase in the rate, 2 fewer points will be awarded. A flat rate of less than $150 will be awarded 1 additional point for each ten dollar decrease. A flat rate of more than $250 will be penalized by deducting 3 points for each ten dollar increase.

b. An ALS flat rate of $250 will be awarded 30 points. For each ten dollar increase in the rate, 3 fewer points will be awarded. A flat rate of less than $250 will be awarded 1 additional point for each ten dollar decrease. A flat rate of more than $350 will be penalized by deducting 3 points for each ten dollar increase.

c. A $60 charge per ambulance per hour for private standbys will be awarded 10 points. For each ten dollar increase 3 fewer points will be awarded.

d. The proposal which describes a history over the past two years in the credentialing population which meets the following criteria will be awarded seven and a half points.

1) One or fewer lawsuits or insurance settlements of more than $1,000 related to patient care per every 2,000, 911-originated responses which have resulted in a payment for settlement.

2) One or fewer collisions which require a state accident report be filed and in which the proposer's vehicle is cited, or the proposer's insurance company provides a settlement to another party, per every 1,000, 911-originated responses.

3) One or fewer Workers Compensation Claims which result in a settlement to the employee in excess of $400 per 1,000, 911-originated responses.

If the proposal does not meet all of the above areas, 2.5 points will be awarded for each of the above areas to a maximum of seven and a half points total.

ALL RATES MUST BE PROVIDED ON FORM 2 PAGE 22

6. Safety Net: 6.A.

   a. The proposal does provide for adequate ambulance coverage in the event of a work stoppage.

   b. The proposal does provide for adequate ambulance coverage per the RFP requirements in the event of contractor failure or contract revocation. The proposal does provide for ambulance turnover and use by the county and ready access for operating funds. If a performance bond is used, the bond and bonding company must meet all applicable Oregon and Multnomah County standards.

H. Evaluation Procedure

All proposals will be evaluated by the EMS Proposal Evaluation Committee. The EMS Proposal Evaluation Committee is appointed by the EMS Policy Advisory Board and the Board of County Commissioners and is made up of:

- EMS Director (non-voting)
- Representative Citizen (2) (at least one of which will have financial knowledge and experience CPA etc.)
- Medical Advisory Board Representative
- Multnomah County Medical Society Representative
- Multnomah County Purchasing Department Representative (non-voting)
- Emergency Medical Technician (outside of Multnomah County with no past or present ties to a proposer or licensee of Multnomah County)

When a consortium presents its proposal for evaluation, the consortium must clearly and in detail explain how its component entities or personnel will deliver services, equipment, or personnel in each area of activity. The Evaluation Committee shall not consider cumulative "qualifications." Only the qualifications of the person actually designated to perform the activity or the specifications of the item actually to be used are relevant when specific persons or items are at issue. When corporate or group characteristics are being reviewed, only the least qualified or least well-specified item put forward by the consortium will be considered.

During the evaluation point-award process, the Evaluation Committee may require interviews of personnel described in the proposals, and may hear oral presentations, conduct on-side visits to facilities, or both.

1) The proposals will be evaluated first to determine whether they meet the minimum requirements. Any proposals which do not meet the minimum requirements will be rejected.

2) Those proposals which meet the minimum requirements will be awarded points in the Category B areas.

3) The top-ranking proposal will be recommended to the Medical Advisory Board (MAB). If the same proposer is top-ranked for both ASAs, the evaluation committee will recommend which ASA the proposer will serve, based on the best interests of the community. This will be done by written report and recommendation indicating the committee's reasoning. The purpose of the report will be to advise the MAB and other reviewing bodies of the rationale for the recommendation and of the resolution of significant issues that arose during the evaluation process.

4) The MAB will evaluate only the top-ranked proposal. The evaluation will address the following portions of the RFP: 1-B(a), 3-A in its entirely, and 4-A (b, c, d, and e).

5) If the MAB concurs in the evaluation committee's scoring of those portions of the proposal identified in 4 above, it will so indicate in a written report and recommendation to the EMS PAB.

6) If the MAB does not concur in the scoring of the proposal, it will so state in a written report to the evaluation committee. The report will explain the basis for the MAB's action. The evaluation committee will then submit the next-ranked proposal to the MAB.

7) The EMS PAB will review only the proposal ranked highest by the evaluation committee and approved by the MAB. The review will be based on the RFP. Following that review, the EMS PAB will adopt a report and recommendation to the BCC. The report will indicate whether the EMS PAB agrees or disagrees with the reports submitted by the evaluation committee and MAB.

8) The BCC will receive the reports and recommendations of the evaluation committee, the MAB, and the EMS PAB. The BCC intends to review only the proposal ranked highest by the evaluation committee and approved by the MAB. The BCC may accept the proposal or reject it as the public interest so requires.

10) If the BCC accepts the proposal, it will award a franchise for the affected ASA to the successful proposer. If the BCC does not accept the proposal it may request further review by the evaluation committee, MAB, or EMS PAB, submission of the next-ranked proposal or group of proposals, or it may terminate or indefinitely suspend the proceedings without an award.

Ambulance Charge Standard

A BLS charge will be made for any ambulance dispatch which results in a transport and the patient is cared for with only those practices that are defined by ORS as EMT-1 practices.

An ALS charge will be made for any ambulance dispatch which results in a transport and the patient is cared for with any practice that is defined by ORS as an EMT-2, 3, or 4 level practice.

Examples:

	Charge level	
Practice	EMT-1 (BLS)	EMT-2, 3, 4 (ALS)
IV		X
Splinting	X	
CPR	X	
O_2 Administration	X	
Drugs		X
Epenephrine (Anaphylaxis)	X	
Intubation		X
Cardiac Monitoring		X
Defibrillation		X
Bag Valve Mask	X	

BLS and ALS protocols must serve as a standard of care. No patient must be denied appropriate care based upon a charge level. Also, no patient must be provided care beyond the BLS/ALS protocol standards to gain an additional charge level.

AMBULANCE RATE ACCOUNTABILITY COMMITTEE

Purpose: Review ambulance rates and billing practices for the 911 ambulance contractor. Recommend to the contractor and EMS office changes in billing procedure to correct problems. Recommend to the EMS Policy Board changes in the rate structure or billing practice of the 911 ambulance contractor based upon: public input, review of billing, advice of the EMS office, advice of the Medical Advisory Board, and upon any new or changed performance standard or pre-hospital care procedure or equipment.

Method: The committee will consider testimony from two public hearings per year. The committee will consider staff reports which review contractor billing practices. The committee will consider requests from the contractor when any change in contract requirement or modification is considered. In addition, the committee will also consider input from the Medical Advisory Board and contractor on any medically related change which may affect contractor costs.

Membership: The committee is to be appointed by the EMS Policy Advisory Board and confirmed by the Board of County Commissioners.

Consumer (four years)
Consumer (three year term)
Consumer (two year term)
EMT-4 (two year term)
Contractor (four year term)
Medical Advisory Board (two years)
Multnomah County Medical Society (two years)
EMS Director

DEFINITIONS

1.	Non-emergency	Any medical call in which there is no threat to life or limb.
2.	Emergency	Any medical call in which there is a definite or unknown threat to life or limb and time is of the essence, or that the call is placed to 911 requesting medical aid.
3.	Basic Life Support (BLS)	The level of care which an EMT-1 may provide. Usually this care will only stabilize a patient and will not result in an improvement in patient condition, i.e., patient assessment, CPR, splinting, etc.
4.	Advanced Life Support (ALS)	The level of care which an EMT-2,3, or 4 can provide. It encompasses all basic life support, plus procedures which can improve the patient's condition, i.e., defibrillation, IV, drugs, endotrachael intubation, etc.
5.	Code 1 Call	The running condition of a patient call or transport in which no lights or siren is used and the ambulance proceeds with the normal traffic flow.
6.	Code 3 Call	The running condition of a patient call or transport in which lights or siren are used and the ambulance proceeds as rapidly as possible.
7.	Private Call	A request for transport which originates at the private ambulance and must be a non-emergency requiring only Code 1 running.
8.	Emergency Medical Technician (EMT)	An individual who has completed training in the recognition and treatment of medical emergencies in a prehospital environment. The training begins at 110 hours (EMT-1) and progresses to 900+ hours (EMT-4). Certification (2, 3, 4) is provided by the Board of Medical Examiners.

9. First Responder	A responder who usually only provides BLS and can arrive on the medical scene in four minutes or less to prevent brain death in a cardiac arrest or complete bleed-out in a severe bleeding situation.
10. BLS Ambulance	An ambulance which is able to provide only BLS and is staffed with at least one EMT-1 and a driver.
11. ALS Ambulance	An ambulance which is able to provide ALS/BLS care and is staffed with two EMT 4's.
12. ALS Fire Vehicle	A vehicle operated by the Fire Department which is staffed to the state ALS level. The unit may respond either as a sole first responder or as a second first responder unit. A portion of the vehicles do have the ability to transport patients, but normally do not.
13. ASA Plan	A document required by ORS. The document provides for state overview of a process which restrains free trade. The plan consists of procedures and specifications which address the effective (coordinated service delivery) and efficient (least costly) provision of ambulance services in a county. The plan must comply with relevant OARs.

8/04/88

Request for Proposal

for

Call Answering Ambulance Service for all
911 Generated Calls Within ASA 2 Multnomah County, Oregon

_____

Date

EXHIBIT C

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15. EMS Dispatch tape of dispatchers
16. EMS Dispatch Triage Guide
17. EMS Continuing Education Program Description
18. EMT training institutions in Multnomah County
19. EMS TAXI Program
20. EMS Dispatch SOPs
21. Multnomah County ASA plan
22. Emergency Ambulance Costing

A. STATEMENT OF PURPOSE

Multnomah County is requesting proposals for contracts to provide emergency and ambulance services within Multnomah County which meet the requirements and conditions set forth in this document.

B. Program Objective

The Emergency Medical Services Office intends to obtain emergency medical care responses and transports to all 9-1-1 generated medical calls within Multnomah County ASA 1 to achieve the greatest efficiency (cost) and effectiveness (care delivery) available.

It is the policy of Multnomah County that selection of contractors who provide a service to the county will be made in an open and competitive manner.

C. Background

System Description - The EMS System in Multnomah County is governed by Multnomah County Code (MCC) 6.31.005 through 6.31.990 and Emergency Medical Services (EMS) Administrative Rules. These are a portion of the requirements which must be met for contractor consideration and ongoing compliance with the contract.

Multnomah County is 465 square miles with a population base of 566,200.

Emergency Medical Services Dispatch generated ambulance call data to include number of responses, number of transports for 1985, 1986, 1987, and until the present, is included as part of this proposal as appendix 4.

The Emergency Medical Services communications system is described in appendix 14.

Emergency Medical Services Dispatch description (see appendix 15, 16, 20).

Basic Life Support Protocols and Advanced Life Support Protocols are included as appendix 5 and 6.

The Physician Supervisor RFP and contract are included as appendix 7.

The Area Trauma Advisory Board I - Trauma Plan is included as appendix 8.

The CHIERS contract and program description for ASA I are included as appendix 9.

A description of the Taxi Program is included as appendix 19.

C. Proposer Instructions

1. Respondents must submit an original and 23 complete copies of the proposal to: Purchasing Director, Multnomah County, 2505 SE 11th Avenue, Portland, OR, 97202, no later than 2:00 p.m. on _____. Late proposals will not be accepted. An optional pre-proposal conference will be held on _____ at _____. Questions to be considered at the pre-proposal conference must be submitted in writing to the Purchasing Director Multnomah County no later than _____.

2. The proposer must respond to the RFP in a format which identifies the proposal in the same manner as the RFP notations (i.e., 1 Personnel 1.A.(a)). This will allow the Evaluation Committee to use the RFP and evaluation outline. If the proposer does not follow this format, the proposal will be considered non-conforming and will not be evaluated.

3. The proposal will be evaluated using two procedures. All category A minimum requirements must be met. Those proposals meeting all of the category A requirements will then be scored in category B areas.

   If a proposal is evaluated as being non-responsive in a Category A requirements area, it will be rejected.

4. The original proposal and copies must be bound or in ring binders.

5. Award Cancellation

   Multnomah County reserves the right to cancel award of the contract at any time before execution of the contract by both parties if cancellation is deemed to be in Multnomah County's best interest. In no event shall Multnomah County have any liability for the cancellation of award. The bidder assumes the sole risk and responsibility for all expenses connected with the preparation of its proposal.

6. Clarification or Protest of Specifications

   Any proposer requiring clarification of the information or protesting any provision herein, must submit specific comments in writing to:

   Director of Purchasing
   2505 SE 11th Avenue
   Portland, OR 97202

The deadline for submitting such questions or comments is _____. If, in the director's opinion, additional information or interpretation is necessary, such information will be supplied in the form of an Addendum which will be delivered to all individuals, firms and corporations having taken out specifications and such Addendum shall have the same binding effect as though contained in the main body of the specifications. Oral instructions or information concerning the specifications or the project given out by County managers, employees, or agents to prospective bidders shall not bind Multnomah County. All Addenda shall be issued by the Purchasing Director not later than five (5) days prior to the proposal deadline.

7. Rejection of Proposals

Multnomah County reserves the right to reject any or all responses to this Request for Proposal. The proposer will be awarded only one ASA. If the proposer is judged the "best" in both ASA's, the evaluation committee will choose which ASA the proposer will serve (based on proposer choice and point spread) and the second best proposer will be awarded the contract for the non-chosen ASA.

8. Cost of Preparation of Response

Costs incurred by any proposer in the preparation of the response to this Request for Proposal are the responsibility of the proposer agency and will not be reimbursed by the County.

9. Equivalent Products

Product brands or models, if stated or implied by the specifications, indicate type, design, and quality desired, and shall not restrict proposer to one manufacturer. Products which meet or exceed specification requirements for design, quality, and functional utility will be considered.

If the proposal includes an equivalent item, include descriptive information brochure and/or specifications sufficient for the County to make a determination as to equivalency.

Any variations from specifications on equivalent products must be itemized.

10. Assignment

Neither the resultant contract nor any of the requirements, rights, or privileges demanded by it may be sold, assigned, contracted, or transferred by the Contractor without the express written consent of the EMS Director of Multnomah County.

11. Nondiscrimination in Employment

The successful proposer's attention is directed to the provisions of Oregon Revised Statutes, prohibiting discrimination in employment. The proposer's attention is called to section ___ of the contract (appendix 22).

E. Proposal Elements

1-A Personnel: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 23 for evaluation criteria):

a. Two EMT-4s for each Advanced Life Support ambulance within the county. These EMT-4s must be currently Oregon Certified Emergency Medical Technician 4s.

b. At least the following minimum wage for each EMT-4 to be employed:

- A minimum salary per annum of $17,400 (based upon FLSA defined working hours).

c. Employee benefits with at least a value equal to 30% of the total gross payroll (of each EMT-4 employed in direct patient care services). The benefits must include:

1) Legally required benefits (as defined by U.S. Department of Labor).

2) Retirement program which vests in five years with all proceeds returned to vested members. The retirement program must be portable to the next contractor (see evaluation criteria).

3) Other benefits at the discretion of the employer in accordance with labor agreements.

d. The process for personnel accessibility at time of recontract. The process must address the procedure that would be followed in the event of contractor failure which provides for access to personnel during the time period between contractor notification of substandard contract performance and actual contractor failure or contract revocation.

e. A new employee hire program for the first six months of the contract which:

1) Hires EMT-4s who have worked for a Multnomah County licensee since at least July 1, 1987 with no loss of wage level or benefits accrual level for those EMT-4's hired by the new contractor.

2) Hires EMT-4s who have worked for a Multnomah County ALS licensee since July 1, 1987 in preference to other applicants. This employee preference hiring is to consider "working in Multnomah" EMT-4s as appropriate hires if they meet the contractor's knowledge and performance criteria.

f. A program for continuing education which provides the EMT-4s with adequate training to meet the minimum recertification requirements. The program must consider and incorporate:

1) Coordination with the county continuing education program as described in Appendix 17.

2) A process for recognition of quality of care problems (internal peer reviews) and the educational process to correct the recognized problems.

3) Coordination with the quality assurance program as described in Appendix 11.

4) Cooperation with the EMT training facilities located in Multnomah County. (See Appendix 18.)

1-B The proposal will be scored on how it proposes plans to reach the following system goals which are above the minimum acceptable requirements as listed for personnel (see page 24 for evaluation criteria).

a. A unit hour utilization* with highest and lowest rates acceptable to maintain EMT knowledge and skills but does not cause "job burnout." The plan as presented may consider less than 24-hour vehicles and may also consider higher pay scales for those employees at higher utilization rates. The plan must state staffing patterns by hour and day per week, the housing and standby station procedures to be used. These must be applied in 2A-0 in the system status plan. The system status plan prepared for section 2A-0 must be provided to comply with this section.

30 pts.

*Unit hour utilization is defined as the total number of transports divided by the number of staffed hours per shift (3 transports - 12 hours = .25). The proposer in considering utilization rates must use the following standards: eight minute response, twenty minute on scene time, fifteen minute hospital transport time, seventeen minute chart and clean-up time. The highest and lowest rates are evaluated with the above fixed variables. If less than 24-hour staffing is used, the unit hour utilization figures must also be listed.

b. A proposal which describes the management structure of the contractor. The proposal may consider:

1) The ratio of ambulance EMT-4s on duty to on duty field supervisors (above the level of senior EMT on the ambulance).

9 pts.

2) The names, curriculum vitae, and current job status of at least the following: operations manager, business manager, training coordinator.

15 pts.

c. A proposal which describes an employee benefit plan or pay incentive which provides a higher level of employee benefits or pay than is required. The purpose of this proposal must be to encourage employee stability as well as attracting the best EMT-4s available. Also, in-place EMT-4s with seniority of service shall be given preference in hiring and wage scale due to knowledge of the Multnomah County geography, hospitals, and EMS system.

45 pts.

2-A Communications: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 25 for evaluation criteria):

a. Each vehicle of the contractor shall be equipped with a radio which shall be used to send and receive information over the central dispatch frequencies. In addition, the radio must be able to transmit and receive on Med-1, 4, 7, 9, and 10. A personnel alerting system which will be used on Med-9 to alert the ambulance crew of their need to respond to a call is required and must be described. The radio must be capable of transmitting outside of the vehicle (porta-mobile).

b. The contractor shall promptly advise EMS Central Dispatch when a change in personnel or equipment on a vehicle results in the vehicle's classification changing from ALS or BLS. A Standard Operating Procedure accomplishing this must be provided.

c. Each morning, at a time specified by the Office of Emergency Medical Services, the contractor shall advise EMS Central Dispatch of the following for each vehicle: The present status, the EMT certification numbers of the crew members, and whether the vehicle is an ALS service. EMS Central Dispatch shall be informed immediately of any personnel changes on a vehicle. A Standard Operating Procedure accomplishing this must be provided.

d. If the contractor receives requests for emergency medical assistance from a source other than 9-1-1, the contractor must use the current Multnomah County EMS triage guidelines to process these calls. A Standard Operating Procedure accomplishing this must be provided.

e. Only EMS Central Dispatch may cancel or revise a dispatch order. Vehicles arriving at the emergency scene shall promptly advise EMS Central Dispatch of information relevant to whether a dispatch order should be canceled or revised. A vehicle which receives a cancellation order may continue to the scene of an emergency, provided that EMS Central Dispatch is so advised and the vehicle's emergency lights and siren are not employed. A Standard Operating Procedure accomplishing this must be provided.

f. The crew of each vehicle of the contractor shall promptly inform EMS Central Dispatch of the following changes in status by radio: In service at station, in service out of station, location or destination shall be stated, in service at scene of emergency, enroute to emergency scene, arrived at emergency scene, enroute to hospital or medical facility from emergency, arrived at hospital or facility from emergency scene, returned to service, out of service. A Standard Operating Procedure accomplishing this must be provided.

g. Contractor's vehicle crews shall use the ten codes attached to this RFP as Appendix 13 when communicating with EMS Central Dispatch. Each ambulance crew shall be equipped with one tone-coded pager or radio which allows direct access of EMS Central Dispatch to the ambulance crew. The contractor's ambulance crews must provide the following information to EMS Central Dispatch by radio for each ambulance responding to an emergency as directed by EMS Central Dispatch. When an ambulance is dispatched from other than its base, it shall be identified. When the ambulance is enroute to a hospital or other medical facility, the number of patients being transported, response code, and the identity of the hospital or facility shall be stated. When an ambulance does not transport a patient, the reason for this action shall be identified. The Standard Operating Procedure accomplishing this must be provided.

h. All patients requiring transport by ambulance (using the most current BLS and ALS treatment protocols) must be transported in the responding ALS ambulance but must be billed as determined by the billing procedure as defined per Appendix 19. The ALS ambulance may make appropriate use of the CHIERS and TAXI programs as described in Appendix 9 and 19.

i. EMS Central Dispatch may request an Advanced Life Support ambulance from outside Multnomah County to respond in Multnomah County to a medical emergency if the expected response time of the ambulance in Multnomah County exceeds ten minutes and the out-of-county ambulance is closer to the emergency than any other Multnomah County ambulance, and the out-of-county ambulance meets ALS ambulance requirements as established by the Oregon State Health Division. The Standard Operating Procedure accomplishing this must be provided.

j. The contractors shall utilize helicopter ambulance service in Multnomah County (Life Flight) when it is determined that transport of a seriously ill medical patient or trauma patient would be more advantageous by helicopter than by ground ambulance. A Standard Operating Procedure accomplishing this must be provided.

k. The helicopter ambulance will be requested through EMS Dispatch. A Standard Operating Procedure accomplishing this must be provided.

l. The contractor may provide ambulance service for a special event in the city or county. A Standard Operating Procedure accomplishing this must be provided.

m. At any time the contractor stands by at such an event, the contractor shall advise the EMS Office and EMS Dispatch by letter one week prior to the date of the event the following information: Date and time of the event, location of the event, name of the person responsible for arranging ambulance coverage for the event. A Standard Operating Procedure accomplishing this must be provided.

n. The contractor shall respond to 90 percent of the calls within their service area in eight minutes or less measured from the time of dispatch and until the time the unit is on the scene. Time will be calculated in minutes with any seconds over the minute considered the next minute (7 minutes 04 seconds becomes 8 minutes). The contractor is fully responsible for ambulance crews being available for notification of a call. EMS Records will be the final authority in response time determination. No area (geo-code) of the county may be consistently underserved (for a period of two or more months). A statement from the proposer which acknowledges this set of requirements and methodology for determining compliance must be provided.

o. The proposer must furnish a system status plan for a one-month period. The month must include a major holiday (Thanksgiving, Christmas, New Year, or July 4th) and the call volume must be projected based upon the provided EMS call data in Appendix 4. The system status plan must include: number of ambulances, hours which each ambulance is staffed, location of ambulances by hour of day and day of week, and number of transports per ambulance per shift expected. This information will also be used to award points in section 1B-a.

p. The contractor shall not monitor or intercept police or other radio dispatcher transmission for profit or gain. Contractor shall not fail or refuse to promptly advise Emergency Medical Services Dispatch Office of receipt of a request for emergency medical assistance or when a licensee's ambulance becomes available or non-available to respond to dispatch orders. The contractor shall not respond by ambulance to an emergency call unless so authorized by the EMS Central Dispatch Office. The Contractor shall not fail or refuse to respond to a dispatch order from EMS Central Dispatch Office when the ambulance subject to the call is available for service. The ambulance contractor shall not refuse to transport any patient in need of emergency medical care regardless of the patient's ability to pay. A Standard Operating Procedure which accomplishes this must be provided.

q. Contractor shall defend, indemnify and hold all first responders harmless from and against all claims, damages, losses, and expenses, including attorney's fees arising out of and resulting from the performance of services by first responders under the direction or control of the contractor.

Contractor shall maintain at all times during the performance of the contract comprehensive general, auto, and professional malpractice insurance endorsed to show first responders as additional named insureds. A statement from the proposer insurance agent and the "hold harmless" language must be provided which demonstrates this coverage.

r. Contractor must provide first responder transportation to the appropriate fire station from the hospital when the first responder accompanies the patient to the hospital. The transportation should be furnished in such a way that the first responder is returned to the fire station in no more than thirty minutes from hospital arrival time. A description of and the Standard Operating Procedure which accomplishes this must be provided.

s. Proposer must propose to provide mutual-aid agreements with the ambulance service in each adjoining ambulance service area. A description of, and the Standard Operating Procedure which accomplishes this must be provided.

t. Contractor must provide for no more than 5 percent per four-week period of calls to the Multnomah County ambulance service area to be answered by an out-of-Multnomah County licensed Advanced Life Support ambulance provider or the adjoining Multnomah County ASA provider unless the contractor is one and the same. A description of and the Standard Operating Procedure which accomplishes this must be provided.

3. Medical: 3.A Proposers must provide documentation describing their compliance with the following minimum requirements (see page 27 for evaluation criteria):

a. The Multnomah County Advanced Life Support and Basic Life Support procedures and protocols must be adhered to by all working Emergency Medical Technicians.

b. The contractor's Emergency Medical Technicians shall promptly contact the Medical Resource Hospital by UHF radio or telephone when required by the Advanced Life Support treatment protocols or an approved Medical Resource Hospital study. If the Medical Resource Hospital is not available, then the receiving hospital shall be contacted.

c. The contractor's EMTs shall relay the following information to the MRH: Unit number, receiving hospital and estimated time of arrival, purpose of call, age and sex of patient, chief complaint, brief history, prior medical history, medications, allergies, vital signs, pertinent physical findings, treatment at the scene.

d. At the discretion of the contractor's emergency medical technicians, the receiving hospital may also be contacted by the EMT. The EMT will transmit to the receiving hospital the following information: Unit number, age and sex of patient, estimated time of arrival, condition, chief complaint, advanced life support treatment provided.

e. Each Advanced Life Support unit of the contractor shall have a set of treatment protocols on the unit itself at all times.

f. Incorporates the Area Trauma Advisory Board Trauma Plan provided as an Appendix 8. All EMT-4s will be Pre-Hospital Trauma Life Support (PHTLS) or equivalent trained within six months of contract award. A description of this, and the Standard Operating Procedure which accomplishes this must be provided.

g. Incorporates the Mass Casualty Incident Plan as attached in Appendix 10. Participates in one major drill and two mini-drills per year. A description of, and the Standard Operating Procedure which accomplishes this must be provided.

h. Incorporates the Quality Assurance Plan attached as Appendix 11. A description of, and the Standard Operating Procedure which accomplishes this must be provided.

i. Proposer must provide a plan which describes a first responder training program provided by the contractor at no cost to all first responders to keep the first responders aware of ambulance orientation, equipment changes, or protocol changes as they apply to the first responders.

j. Proposer must provide for the role of the EMS physician-supervisor in administrative protocols which accomplishes:
   1) Participation in hiring of EMTs.
   2) Absolute authority for all medical direction of the contractor.
   3) Scheduling of mandatory inservice.
   4) "Ride-alongs" to meet ORS requirements.
   5) Absolute authority to remove an EMT from the provider's ambulance.

   The administrative protocols for the above must be provided.

k. Proposer must provide a list of type and amount of each drug which will be carried on each ambulance and is needed to comply with ALS protocols so that two patients with the same medical or trauma problem can be treated without an ambulance restock. These drugs in type and amount are to be carried on all staffed ALS ambulances.

3B. The proposer will be scored on how it proposes plans to meet the following system goals which are above the minimum acceptable requirements for medical as above (see page 30 for evaluation criteria).

a. It is thought that a proposer's history of having a functioning peer review process will predict that the proposer will provide better emergency medical care if chosen as a contractor. The proposer must describe his peer review process. The description must be provided for the past two years (1986, 1987) and be for the credentialed population.

4-A Equipment: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 28 for evaluation criteria):

a. All ALS ambulances or BLS ambulances and equipment must meet current ORS and Multnomah County requirements for ambulances (see Appendix 1-12-13). A listing of all ambulances by make, age, mileage, modifier, and equipment contained must be provided. This must include all vehicles which are to be used in Multnomah County.

b. Provision of mobile VHF radio equipment with a dial encoder and capable of transmission on 155.340 mhz for each ALS ambulance at no less than 25 watts. The radios must be identified by make, model, and output. A copy of the FCC license for this frequency or plans for obtaining the rights to mobiles on this frequency from the Greater Portland Hospital Association must be included.

c. The following disposable equipment must be provided at no cost to the first responder agency when the first responder has cared for a transported or "charged" patient. The equipment will be exchanged on the "scene" if it does not interfere with patient care. The proposer must contact the first responder agencies to assist in this development. See Appendix 21. A field and billing Standard Operating Procedure which accomplishes this must be provided.
   1) Oxygen administration items.
   2) Suction items.
   3) Intravenous materials.
   4) Drugs.
   5) Disposable splints.
   6) Cervical collar--"stiffnecks" or equivalent

d. The following equipment must be provided which will be standardized with the first responder agencies. A Standard Operating Procedure which accomplishes this must be provided.
   1) Trunk and neck immobilizer--"K.E.D." or equivalent.
   2) Wooden long spine board.
   3) Traction splint.
   4) Scoop stretcher.
   5) Pnuematic Anti-Shock garment.

e. An agreement with the trauma centers to create a "Letterman" exchange system and an equipment cleaning program. The agreements and the Standard Operating Procedure which accomplishes this must be provided.
   1) C-collar "Stiffneck" or equivalent.
   2) Trunk and neck immobilizer "KED" or equivalent.
   3) Long spine board.
   4) Traction splint.
   5) Scoop stretcher.
   6) Pnuematic Anti-Shock garment.

4-B The proposer will be scored on how it proposes plans to meet the following system goals which are above the minimum acceptable requirements for equipment as above (see page 28 for evaluation criteria):

a. Newer front-line (non-reserve) vehicles and those which have lower mileage and meet KKK1822B. This may be done by providing type, age, mileage, and "modifier" of each ALS ambulance vehicle to be used in Multnomah County. 4 pts.

b. Preventive maintenance of ALS ambulances. 8 pts.

c. Availability of reserve ambulances and gives the number of reserve ambulances including their proposed storage location and to what extent they will be stocked when held in reserve. 8 pts.

d. Provision of up-to-date equipment with a maintenance program. This may be accomplished by providing the make, model, age of, and maintenance program for:

1. Ambulance cots.
2. Portable monitor defibrillators.
3. Portable suction.

6 pts.

5-A Business Practices: Proposers must provide documentation describing their compliance with the following minimum requirements (see page 30 for evaluation criteria):

a. Proposer has met all minimum requirements for credentialing and will meet them throughout the contract period, as well as license and compliance with all MCC and rules throughout the contract period. The proposal must state how the proposer intends to meet these requirements throughout the contract period.

b. Have insurance coverage to at least the following minimums (with no exceptions to riders in the ambulance):

1) Combined single limit for bodily injury and property damage (vehicular), $500,000 and

2) Malpractice, $1 million and

3) Umbrella liability, $1 million and

4) Contractor shall also carry workers' compensation insurance as required by law, or the legal equivalent, for the life of the contract. Contract shall require all of its subcontractors to maintain similar insurance coverages and shall require evidence of such coverage prior to commencement of work by any such subcontractor.

A copy of the policies must be submitted for review 30 days prior to the effective date of the contract. The policy must include a 30 day notice requirement for any material change or cancellation.

Comprehensive general liability, auto, and professional malpractice insurance may be arranged under a single policy for the full limits required or by a combination of underlying policies with a balance provided by an excess or umbrella liability policy or

5) Contractors may elect to self-insure part or all of the insurance requirement. If a contractor elects to self-insure areas b-1, 2, 3, 4, contractor shall provide evidence that contractor has qualified under all state and federal requirements for self-insurance. In addition, contractor shall provide documentation verifying that a funding mechanism is in place to meet the financial responsibilities of the indemnification agreement and name and credentials of the contractor's claims administrator.

This must be demonstrated by documentation of insurability by an insurance company licensed to do business in Oregon and a proposal to purchase the insurance required or proof of self-insurance as required by ORS.

c. Information to be provided must be placed on worksheet attached as Form 1. The projections as requested below must be based upon data as provided in Appendix 4, which provides information from 1985, 1986, and most current 1987 data from EMS Central Dispatch, Multnomah County. The proposer is expected to use its own best judgment in determining the variables as requested below.

1) Cost per ALS ambulance per year and also ALS ambulance by unit hour. Both costing columns and revenue columns must be completed. If either column is not full completed, the proposal will be determined non-conforming. Definitions of full, proportionate, and incremental costs are to be followed and are included in appendix 22. The first column on form 1 must provide full cost and revenue projections, and column two must provide proportional cost and revenue projections. This must apply to appropriately staffed Advanced Life Support ambulances required in the minimums under personnel. Also, the number of ambulance units and unit hours per year should be projected. Costs must be reported on Form 1.

2) The projected call volume from all 9-1-1 generated calls and the projected transport volume from these calls. The proposer must use the figures in Appendix 4 to project these numbers. These figures must be presented on Form 1.

3) The projected volumes with ALS and BLS charged transport from the patient transport volume. The proposer must use the figures in Appendix 4 to project these numbers. These figures must be provided on the Form 1.

4) The overall collection percentage projected for the cost which involved transport. This percentage must include actual collection rate tempered with the percentage that will be less than fully collected due to assignment (Medicare) or other reimbursement. This figure must be provided on Form 1.

5) The BLS and ALS charges for all users of the system projected by the proposer. These figures must be provided on Form 1.

6) The proposer must follow the ALS/BLS charge criteria as set forth in Appendix 19. The proposal must be fully presented on the worksheet. The proposal must represent cost. If cost and revenue figures are not adequately validated the proposal will be judged non-responsive.

d. The contractor must accept the responsibility to provide standbys as requested by police and fire agencies within Multnomah County at no charge. If a patient is transported, any charge to that

patient must be based upon charges to a similar patient with no standby time charges. A Standard Operating Procedure which accomplishes this must be provided.

e. Incorporate the taxi Standard Operating Procedure as presented in Appendix 20. A Standard Operating Procedure which accomplishes this must be provided.

f. Incorporate the CHIERS Program as presented in contract form in Appendix 9. A Standard Operating Procedure which accomplishes this must be provided.

g. The authority and responsibility of the EMS Rate Review Committee as presented in Appendix 22 must be incorporated in billing and administrative Standard Operating Procedures. The Standard Operating Procedure which accomplishes this must be provided.

h. Recognize the authority of the Emergency Medical Services Office to randomly sample billings and provide these billings to the Rate Review Committee. The mechanism for action to correct bills in which the charge is questioned must be described.

i. Provide $42,500 (estimate) yearly in quarterly payments for physician supervisor services to be provided by the County. These services are detailed in Appendix 7. The proposal must detail how the provider will make the payments.

j. Plan of operation for the first six months of operation which reflects the following and recognizes the slow collection start-up problems and the need for outside resources to assist in meeting expenses:
   1) Payroll expenses
   2) Capital expenses
   3) Ancillary expenses
   4) Revenue from transports with projected timetable of receipt of income
   5) Other source or sources of revenue or assets which allow the contractor to meet expenses for the first six months.

k. Description of the billing practices which recognizes the extreme importance of billing practices in this user funded system. The plan must also recognize the importance of humane billing practices.
   1) Billing procedure for Medicare
   2) Billing procedure for third party payors
   3) Billing practices for other public parties (county, corrections, AFS, etc.)
   4) Billing practices for private parties
   5) Billing practice for overdue payments
   6) Billing practices for write-offs

l. The proposer's legal business structure must be described and must demonstrate that the structure is sound and meets all legal requirements.

m. Document the method of public and consumer education to reduce 9-1-1 abuse, but to also assist the public in understanding the EMS system and provision of public emergency care (CPR, etc.). The proposal must detail teaching and education methods to be used, as well as the delivery process.

n. Describe how a minimum of fifty hours per month of standby time free to appropriate "public" events will be provided. This is to be in addition to police and fire standbys.

5-B Business Practices - The proposer may propose plans to meet the following system goals which are above the minimum standards of the business practices (see page 31 for evaluation criteria):

a. A flat, all inclusive rate to be charged for: ALS response, BLS treatment, and BLS transport to a 911 call, and ALS response, treatment, and transport to a 911 call. The rates must consider the ALS/BLS charge standards and be reported on form 2.

The rates must reflect the maximum efficiency in the system by displaying the lowest flat rate user fees with no decrease in system effectiveness. The BLS and ALS definitions per Appendix 19 are to be the guide for user charges. A uniform charge for any person in Multnomah County transported to any hospital in the Tri-County area regardless of time of day or day of week is to be the standard for the all-inclusive rate.

1)	BLS Rate/Medicare Assignment	20 pts.
2)	ALS Rate/Medicare Assignment	30 pts.
3)	Standby Charge (private)	10 pts.

b. A history of excellence of past performance in providing advanced life support emergency medical care and transport is thought to predict a contractor's ability to provide better emergency medical care and transport. The proposer should describe and fully validate the following components of the system used for credentialing. Validation of the numbers must be provided by an organization other than the proposers for the past two years (86, 87).

1) A history of lawsuits or insurance settlements.

2) A history of collisions (which require a state accident report be filed).

3) A history of workers compensation claims.

5 pts.

6. Safety Net: 6.A Proposers must provide documentation describing their compliance with the following minimum requirements (see page 32 for evaluation criteria):

   a. Emergency ambulance service as an essential service and ensure that no interruption of service will occur in the event of a work stoppage by employees.

   b. The safety net must ensure that in the event of contractor failure (due to contract, ordinance, or financial reasons) there is no interruption in call answering. The proposal must provide for delivery of all ambulances (fully stocked) which are used to answer calls to EMS. The ambulances must be free of any encumbrances (defined as able to be used by Multnomah County to provide ambulance service with no reimbursement or remuneration to the contractor or lienholder), and be available for service to EMS for no less than 6 months. Funds to allow answering of all calls to the level expected under the contract must be provided for in the plan. These funds must provide for the dollars to support the call answering system for 45 days. The call answering system is defined for safety net purposes as personnel (two EMT-4s per ambulance), maintenance and upkeep of each ambulance to include disposable medical equipment, radio equipment, and insurance to the level of ambulance and reserve ambulances provided by the contractor over the last 60 days before failure. The funds to be used for this purpose must be immediately accessible to EMS upon contractor financial failure or revocation of the contract (based upon non-performance of contract terms and conditions) by EMS, and the details of the accessibility of the vehicles and funds must be explained in detail.

COST/REVENUE WORKSHEET Form 1

(See next page for description of (1), (2), (3), (4), (5), (6)

1. ALS ambulance cost:	Full Cost (1)	Proportional Cost to 911 (2)
Personnel		
Operations		
(_____miles @ _____)		
Administration(4)		
Capital(6)		
Insurance(3)		
Disposable Supplies		
Drugs		
All Other Expenses (depreciation, maintenance, etc.)		
Total Cost by ambulance		
Total Cost by unit hour		
Number of Ambulance Units(5)		
Number of unit hours (5)		
Inebriate outreach subcontract cost		

	Other Revenue	911 Revenue
2. Projected call volume		
Projected call transport volume		
3. Volume of BLS charged transports		
Volume of ALS charged transports		
4. Overall collection percentage		
5. BLS charge per call		
ALS charge per call		

1. This must be full cost and consider all associated costs with each category. The total ambulance cost must be the best projection of total cost.

2. This must be the proportional cost which the proposer projects this contract for 911 calls will incur. Column two may be the same as column one, or it may be lower. If column two is lower than one, the proposer must explain the difference, and justify why the cost is different. This difference in cost may be attributed to: other business interests, non-911 call ambulance use, cross use of personnel. It is important that this explanation be fully explained and justified. The justification must be sufficient to allow the RFP evaluation committee to determine its validity. This must demonstrate that the 911 cost is the full cost of 911 service.

3. If self-insurance is used, the cost must be arrived at considering the past settlements and equating them to the increase in liability exposure due to the contract.

4. Must include the $42,500 per annum for physician supervisor costs, also all other administrative or training personnel costs.

5. This must be the total number of ambulance units to meet the full 911 contract for ASA 2, this number may be reflected in fractions of an ambulance if peak load staffing or other staffing patterns are followed.

6. This must also include cost of back-up or reserve ambulances and other back-up equipment.

RATE WORKSHEET Form 2

1. BLS rate with Medicare assignment.[a] _____

2. ALS rate with Medicare assignment.[a] _____

3. Standby charge for private events (in addition to transport charge if patient transported).[a] _____ hr.

[a]This is the contractor's rate for the four-year contract period. The Rate Review Committee, Emergency Medical Services Policy Advisory Board, and the Board of County Commissioners may allow rate increases based upon consumer price index, dramatic increase in cost of doing business, or more stringent or added system requirements. The proposer should not consider any of the aforementioned possibilities to be a reason for guarantee of a rate increase. All rate increases must be requested by the contractor. There is no charge or reimbursement for first responders. If first responders petition the Rate Review Committee for charges, the contractor is assured no additional uncompensated cost.

F. Contract

It is the intention of Emergency Medical Services to enter into a contract no later than _____, and extending four years with a potential for renewal for a one-year term. At the option of the County, upon one hundred and eighty days written notice, the contract may be extended for the additional one-year extension. Rate and other system changes will be considered in the event of a renewal. Rate changes must be approved by the rate committee and the Emergency Medical Services Policy Board, and the Multnomah County Board of County Commissioners.

G. Evaluation Criteria

The RFP is made up of six sections. Each section has a minimum requirements section and may have a point achievement section.

A proposal, to be considered, must meet all of the minimum requirements.

The minimum requirements will be evaluated on a pass/fail basis. If the proposal fails to pass any of the minimum requirements for any section, the proposal will be rejected.

Qualifying proposals will then be awarded points based upon the requirements specified in the RFP.

The following criteria will be used by the evaluation committee to judge whether a proposal meets the minimum requirements for category area A and the number of points to be awarded for category area B.

1-A Personnel:

a. The proposal does provide for two Oregon Certified EMT 4s.

b. The proposal does provide for a minimum annual wage of $17,400 based upon first day of employment.

c. The employee benefits proposal does include:
   1) A benefits package of at least 30% of gross EMT salary.
   2) All legally required benefits.
   3) A retirement plan which is "portable" (must be able to be transferred to the next contractor with all benefits, vesting, and accrual levels intact. PERS is considerd portable for purposes of evaluation of this proposal) and meets all other requirements of the RFP will be considered as meeting this requirement.
   4) Benefits will begin the first day of employment for "Multnomah County" EMTs.

d. The personnel accessibility proposal does meet the requirements of the RFP.

e. The proposal does provide for hiring of EMT-4s currently working in Multnomah County with no loss of wage or benefit accrual levels.

f. The proposal does provide for a coordinated continuing education program as described in the RFP.

1-B a. The unit hour utilization rate must establish a minimum unit hour utilization rate of (based upon monthly staffing levels used in 2A-0):

.17 24-hour ambulance
.33 12-hour ambulance
.40 10-hour ambulance
.50 8-hour ambulance

15 points are awarded for total compliance. Each .07 below this compliance level (a composite of all used staffing levels in 2A-0) will deduct 1 point to a maximum of 15.

b. The unit hour utilization rate should establish a maximum unit hour utilization rate of (based upon monthly staffing levels used in 2A-0):

.40 24-hour ambulance
.60 12-hour ambulance
.65 10-hour ambulance
.75 8-hour ambulance

15 points are awarded for total compliance. Each .056 below this compliance level (a composite of all used staffing levels in 2A-0) will deduct 1 point to a maximum of 15.

c. The management structure program should address management in the following manner:
   1) An on-duty non-patient care supervisor for each twelve ALS ambulances in service will gain 9 points. Points will be awarded by using the 12 to 1 ratio as the standard, for a greater ambulance-to-supervisor ratio.

2) The curriculum vitae of the management personnel will be awarded fifteen points using the following standards for each. If the personnel do not meet the criteria, fewer or no points will be awarded.

5 Points. Operations Manager. College degree (BS or BA) with at least four years experience in ambulance service delivery and with current EMT-P status. The experience to be gained in a system of at least 20,000 emergency calls per year. (Four years additional EMS supervisory experience may be substituted for the college degree.)

5 Points. Business Manager. College degree (BS or BA) with at least four years experience in ambulance third-party billing procedures, also experience working with labor groups. The experience to be gained in a system which bills at least 10,000 patients annually. (Four years additional EMS business experience may be substituted for the college degree.)

5 Points. Training Coordinator. EMT-P, ACLS instructor, PHTLS instructor, with three years experience as a training coordinator for fifty EMT-Ps. Experience in a peer-review process, having conducted a peer-review process for fifty EMT-Ps for three years.

If a job function on which the evaluation criteria is specific is performed by another titled evaluated management position the substitution can be made and the points awarded.

3) 15 points. The proposal providing a benefit package which is five percent of the EMT-gross salary (in addition to the minimum required 30 percent) or more will receive fifteen points. If less than five percent is proposed, for each percent drop there will be three points deducted.

30 points. The proposal providing a wage package which does provide for: a base wage scale of at least ten percent over the required minimum, which includes: the same percentage increase for in "Multnomah County" hired EMTs, is raised by at least the Consumer Price Index each year of the contract, progresses in at least six steps, and be ten percent above the current top wage (22,000) in Multnomah County. For each percent the proposal is above the required minimum three points will be given for a maximum of thirty. The proposal must also include a plan to hire those "Multnomah County" EMTs who possess the most experience in the Multnomah County EMS program in preference to those EMTs with less or no experience.

2-A Communications:

a. The proposal does show each ambulance and EMT crew with UHF capability on MED 1-4-7-9-10 and personnel alerting on MED 9.

b. The proposal does state that the contractor will advise EMS dispatch of any vehicle status change.

c. The proposal does state that the contractor will advise EMS dispatch of vehicle crew and status.

d. The proposal does state that the contractor will use the Multnomah County EMS triage guide.

e. The proposal does state that the contractor will adhere to the rules as listed in the RFP 2-A e, f, g, h(1),(2), i, j, k, l, m, n, p.

f. (o) The proposal does provide a system status plan (SSP) for a one month period. There is a major holiday (New Year's, 4th of July, Labor Day, Thanksgiving, Christmas) in the month. The SSP does provide coverage for all of Multnomah County for a response time of eight minutes or less, ninety percent of the time. The judgement of this to be based upon call volume for geo-code areas of Multnomah County. The SSP must also not use mutual aid for more than five percent of the calls.

g. (q)(n) The proposal does provide liability insurance, and "return transportation" for the first responders.

h. (s) The proposal does propose mutual aid agreements with adjoining ASA's.

i. (t) The proposal does provide for no more than five percent per four-week period of the calls to be answered by mutual aid.

3. Medical:

a. The proposal does state that the contractor will adhere to the EMS rules as stated in the RFP in 3.A a, b, c, d, and e, and that if the contractor is not currently functioning under these rules how it will implement them.

b. (f) The proposal does incorporate the ATAB Plan and sets a date within six months when all EMT-Ps will be PHTLS or equivalent trained.

c. (g)(h) The proposal does incorporate the MCI Plan and Quality Assurance Program and that the contractor will adhere to the standards.

d. (i) The proposal does provide an adequate first responder training program at no cost to the first responder.

e. (j) The proposal does provide for a role of the physician supervisor which includes hiring participation, absolute medical control, mandatory inservice scheduling, and ride-alongs.

f. (k) The proposal does list the types and amounts of drugs to "run" two back-to-back same ALS protocol patients with no restock.

3B. A proposal which describes a peer review process history with at least the following characteristics will be awarded seven and a half points:

1) A meeting each month attended by the off-line medical director, and with at least 80 percent of the members attending.

2) A peer review process made up of representatives representing ALS, BLS, and communications (this committee is to only review ALS care).

3) A peer review process with a set of bylaws which assure patient confidentiality, rules of order, autonomy from management, and the responsibility to take action in medical areas they deem appropriate.

If the proposal describes and properly documents all of the above areas of peer review seven and a half points will be awarded. If all areas are not met, 2.5 points will be awarded for each area met for a maximum of seven and a half points.

4-A Equipment:

a. The proposal does list all the vehicles and equipment and all do meet or exceed ORS and Multnomah County standards.

b. The proposal does list VHF radio equipment (155.340 MHZ) that is capable of use for ambulance-to-hospital communications in Multnomah County. The radio license or a plan to obtain such is included.

c. The proposal does provide for first responder equipment provision for disposable items as listed in the RFP.

d. The proposal does provide for standardized equipment with first responders.

e. The proposal does provide for signed agreements with the trauma centers for a "Letterman" exchange clean equipment program.

4-B a. The proposal does recognize the need for newer low-mileage vehicles which meet KKK1822B. All ambulances less than one year of age and less than 10,000 miles, and meeting KKK1822B will be considered newer low mileage vehicles. This does not include ambulances which are considered "extras" or "backup."

4 pts.

The points awards up to 4 points will be based on the percentage of ambulances which meet the newer low mileage definition.

b. The proposal provides for a preventive maintenance program and an ambulance reserve program which:

1) Provides for safety inspections every 15,000 miles until 60,000 miles, then every 7,500 miles (these to be done by an outside shop familiar with the type of vehicles used).

2) Provides maintenance to manufacturers extreme use recommendations. Provides for downtime for ambulance maintenance. Uses innovative methods to extend ambulance dependability, such as diesel engines, heavy-duty batteries, radial tires, metallic brakes, etc.

3) Provides a history of ambulance maintenance which demonstrates the ability to keep ambulances in-service with no major failures.

If the proposal satisfactorily incorporates at least the above areas, up to 8 points will be awarded.

c. Provides for a fully stocked (except for defibrillator and ALS drugs) ambulance for every three front-line (non-reserve) operating ambulances.

If the proposal meets this requirement up to 8 points will be awarded.

d. The proposal provides for up-to-date equipment.

1) Ambulance cots (Ferno model-MTS or equivalent).

2) Portable monitor-defibrillator (Life-Pak 5 or equivalent).

3) Portable suction (laerdal or equivalent).

If the equipment is of the appropriate model as shown above and a maintenance program is described and proposed which demonstrates the ability to keep the equipment operational and find faults before they affect patient care, 6 points will be given. If the equipment is not of appropriate model or up-to-date or the maintenance plan is not sufficient to keep the equipment operational, fewer or no points will be awarded using four years as the life expectancy of the equipment.

5-A Business Practices:

a. The proposal provides ample information to assure that the provider can and will meet all applicable credentialing standards, MCC and EMS rules for the contract period.

b. The proposal does provide for insurance to at least the RFP minimums.

c. The proposal does provide all of the costing and revenue projections as requested in Form 1. The cost and revenue figures are reasonable and based upon EMS figures provided. The costs are fully accounted and adequately justified where not applied to the 911 contract. The definitions contained in appendix twenty-two are followed. The cost and revenue projections used do demonstrate sound business practice, and are reasonable based upon projected staffing levels.

d. The proposal does provide for free-of-cost standbys for police and fire agencies.

e. (e)(f)(g) The proposal does recognize and integrates into the contractor's operations, the TAXI and CHIERS and Rate Study Committee.

f. (h) The proposal does recognize the EMS Office authority to sample billings and does provide a process to correct incorrect billings.

g. (i) The proposal does provide for $42,500 per annum in quarterly payments to EMS for physician-supervisor services.

h. (j) The proposal does provide a plan of operation for the first six months which considers all aspects of the RFP requirements. The plan is reasonable and does demonstrate financial soundness.

i. (k) The proposal does describe the billing practices. The billing practices are humane and encourage those who can pay to pay, but those who cannot pay are recognized and billings dealt with humanely. The billing practices also are legal and exhibit sound business practice.

j. (l) The proposal does describe the legal business structure of the contractor, and it is the same as used in the credentialing process. The business structure is legal in Oregon.

5-B Business Practice:

a. A BLS flat rate of $150 will be awarded 20 points. For each ten dollar increase in the rate, 2 fewer points will be awarded. A flat rate of less than $150 will be awarded 1 additional point for each ten dollar decrease. A flat rate of more than $250 will be penalized by deducting 3 points for each ten dollar increase.

b. An ALS flat rate of $250 will be awarded 30 points. For each ten dollar increase in the rate, 3 fewer points will be awarded. A flat rate of less than $250 will be awarded 1 additional point for each ten dollar decrease. A flat rate of more than $350 will be penalized by deducting 3 points for each ten dollar increase.

c. A $60 charge per ambulance per hour for private standbys will be awarded 10 points. For each ten dollar increase 3 fewer points will be awarded.

d. The proposal which describes a history over the past two years in the credentialing population which meets the following criteria will be awarded seven and a half points.

1. One or fewer lawsuits or insurance settlements of more than $1,000 related to patient care per every 2,000, 911-originated responses which have resulted in a payment for settlement.

2. One or fewer collisions which require a state accident report be filed and in which the proposer's vehicle is cited, or the proposer's insurance company provides a settlement to another party, per every 1,000, 911-originated responses.

3. One or fewer Workers Compensation Claims which result in a settlement to the employee in excess of $400 per 1,000, 911-originated responses.

If the proposal does not meet all of the above areas, 2.5 points will be awarded for each of the above area to a maximum of seven and a half points total.

ALL RATES MUST BE PROVIDED ON FORM 2 PAGE 22

6. Safety Net: 6.A.

   a. The proposal does provide for adequate ambulance coverage in the event of a work stoppage.

   b. The proposal does provide for adequate ambulance coverage per the RFP requirements in the event of contractor failure or contract revocation. The proposal does provide for ambulance turnover and use by the county and ready access for operating funds. If a performance bond is used, the bond and bonding company must meet all applicable Oregon and Multnomah County standards.

H. Evaluation Procedure

All proposals will be evaluated by the EMS Proposal Evaluation Committee. The EMS Proposal Evaluation Committee is appointed by the EMS Policy Advisory Board and the Board of County Commissioners and is made up of:

- EMS Director (non-voting)
- Representative Citizen (2) (one of which will have financial expertise CPA, etc.)
- Medical Advisory Board Representative
- Multnomah County Medical Society Representative
- Multnomah County Purchasing Department Representative (non-voting)
- Emergency Medical Technician (outside of Multnomah County with no past or present ties to a proposer or licensee of Multnomah County)

When a consortium presents its proposal for evaluation, the consortium must clearly and in detail explain how its component entities or personnel will deliver services, equipment, or personnel in each area of activity. The Evaluation Committee shall not consider cumulative "qualifications." Only the qualifications of the person actually designated to perform the activity or the specifications of the item actually to be used are relevant when specific persons or items are at issue. When corporate or group characteristics are being reviewed, only the least qualified or least well-specified item put forward by the consortium will be considered.

During the evaluation point-award process, the Evaluation Committee may require interviews of personnel described in the proposals, and may hear oral presentations, conduct on-side visits to facilities, or both.

1) The proposals will be evaluated first to determine whether they meet the minimum requirements. Any proposals which do not meet the minimum requirements will be rejected.

2) Those proposals which meet the minimum requirements will be awarded points in the Category B areas.

3) The top-ranking proposal will be recommended to the Medical Advisory Board (MAB). If the same proposer is top-ranked for both ASAs, the evaluation committee will recommend which ASA the proposer will serve, based on the best interests of the community. This will be done by written report and recommendation indicating the committee's reasoning. The purpose of the report will be to advise the MAB and other reviewing bodies of the rationale for the recommendation and of the resolution of significant issues that arose during the evaluation process.

4) The MAB will evaluate only the top-ranked proposal. The evaluation will address the following portions of the RFP: 1-B(a), 3-A in its entirely, and 4-A (b, c, d, and e).

5) If the MAB concurs in the evaluation committee's scoring of those portions of the proposal identified in 4 above, it will so indicate in a written report and recommendation to the EMS PAB.

6) If the MAB does not concur in the scoring of the proposal, it will so state in a written report to the evaluation committee. The report will explain the basis for the MAB's action. The evaluation committee will then submit the next-ranked proposal to the MAB.

7) The EMS PAB will review only the proposal ranked highest by the evaluation committee and approved by the MAB. The review will be based on the RFP. Following that review, the EMS PAB will adopt a report and recommendation to the BCC. The report will indicate whether the EMS PAB agrees or disagrees with the reports submitted by the evaluation committee and MAB.

8) The BCC will receive the reports and recommendations of the evaluation committee, the MAB, and the EMS PAB. The BCC intends to review only the proposal ranked highest by the evaluation committee and approved by the MAB. The BCC may accept the proposal or reject it as the public interest so requires.

10) If the BCC accepts the proposal, it will award a franchise for the affected ASA to the successful proposer. If the BCC does not accept the proposal it may request further review by the evaluation committee, MAB, or EMS PAB, submission of the next-ranked proposal or group of proposals, or it may terminate or indefinitely suspend the proceedings without an award.

Ambulance Charge Standard

A BLS charge will be made for any ambulance dispatch which results in a transport and the patient is cared for with only those practices that are defined by ORS as EMT-1 practices.

An ALS charge will be made for any ambulance dispatch which results in a transport and the patient is cared for with any practice that is defined by ORS as an EMT-2, 3, or 4 level practice.

Examples:

	Charge level	
Practice	EMT-1 (BLS)	EMT-2, 3, 4 (ALS)
IV		X
Splinting	X	
CPR	X	
O_2 Administration	X	
Drugs		X
Epenephrine (Anaphylaxis)	X	
Intubation		X
Cardiac Monitoring		X
Defibrillation		X
Bag Valve Mask	X	

BLS and ALS protocols must serve as a standard of care. No patient must be denied appropriate care based upon a charge level. Also, no patient must be provided care beyond the BLS/ALS protocol standards to gain an additional charge level.

AMBULANCE RATE ACCOUNTABILITY COMMITTEE

Purpose: Review ambulance rates and billing practices for the 911 ambulance contractor. Recommend to the contractor and EMS office changes in billing procedure to correct problems. Recommend to the EMS Policy Board changes in the rate structure or billing practice of the 911 ambulance contractor based upon: public input, review of billing, advice of the EMS office, advice of the Medical Advisory Board, and upon any new or changed performance standard or pre-hospital care procedure or equipment.

Method: The committee will consider testimony from two public hearings per year. The committee will consider staff reports which review contractor billing practices. The committee will consider requests from the contractor when any change in contract requirement or modification is considered. In addition, the committee will also consider input from the Medical Advisory Board and contractor on any medically related change which may affect contractor costs.

Membership: The committee is to be appointed by the EMS Policy Advisory Board and confirmed by the Board of County Commissioners.

Consumer (four years)
Consumer (three year term)
Consumer (two year term)
EMT-4 (two year term)
Contractor (four year term)
Medical Advisory Board (two years)
Multnomah County Medical Society (two years)
EMS Director

DEFINITIONS

1.	Non-emergency	Any medical call in which there is no threat to life or limb.
2.	Emergency	Any medical call in which there is a definite or unknown threat to life or limb and time is of the essence, or that the call is placed to 911 requesting medical aid.
3.	Basic Life Support (BLS)	The level of care which an EMT-1 may provide. Usually this care will only stabilize a patient and will not result in an improvement in patient condition, i.e., patient assessment, CPR, splinting, etc.
4.	Advanced Life Support (ALS)	The level of care which an EMT-2,3, or 4 can provide. It encompasses all basic life support, plus procedures which can improve the patient's condition, i.e., defibrillation, IV, drugs, endotrachael intubation, etc.
5.	Code 1 Call	The running condition of a patient call or transport in which no lights or siren is used and the ambulance proceeds with the normal traffic flow.
6.	Code 3 Call	The running condition of a patient call or transport in which lights or siren are used and the ambulance proceeds as rapidly as possible.
7.	Private Call	A request for transport which originates at the private ambulance and must be a non-emergency requiring only Code 1 running.
8.	Emergency Medical Technician (EMT)	An individual who has completed training in the recognition and treatment of medical emergencies in a prehospital environment. The training begins at 110 hours (EMT-1) and progresses to 900+ hours (EMT-4). Certification (2, 3, 4) is provided by the Board of Medical Examiners.

9. First Responder	A responder who usually only provides BLS and can arrive on the medical scene in four minutes or less to prevent brain death in a cardiac arrest or complete bleed-out in a severe bleeding situation.
10. BLS Ambulance	An ambulance which is able to provide only BLS and is staffed with at least one EMT-1 and a driver.
11. ALS Ambulance	An ambulance which is able to provide ALS/BLS care and is staffed with two EMT 4's.
12. ALS Fire Vehicle	A vehicle operated by the Fire Department which is staffed to the state ALS level. The unit may respond either as a sole first responder or as a second first responder unit. A portion of the the vehicles do have the ability to transport patients, but normally do not.
13. ASA Plan	A document required by ORS. The document provides for state overview of a process which restrains free trade. The plan consists of procedures and specifications which address the effective (coordinated service delivery) and efficient (least costly) provision of ambulance services in a county. The plan must comply with relevant OAR's.