Subjects Heard Health Division overviews

SENATE COMMITTEE ON HUMAN RESOURCES

Wednesday February 6, 1991 Hearing Room A 3:15 p.m. Tapes 19 - 21 MEMBERS PRESENT:Sen. Bill McCoy, Chair Sen. Cliff Trow, Vice-Chair Sen. Shirley Gold Sen. Bill Kennemer Sen. Paul Phillips STAFF PRESENT:Janice J. Fiegener, Committee Administrator Mike Meriwether, Research Assistant Michael Sims, Committee Assistant Andra Woodrum, Page WITNESSES: Mike Skeels, Administrator, Health Division Art Keil, Health Division Kevin Concannon, Director, Department of Human Resources Chad Cheriel, Assistant Director, Office of Health Policy Meredith Cote, Long-Term Care Ombudsman

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TAPE 19, SIDE A

004 CHAIR McCOY: Calls the meeting to order at 3:20 p.m.

018 MIKE SKEELS, ADMINISTRATOR, HEALTH DIVISION (EXHIBIT A): Gives overview of Health Division and details Exhibit A. -Prevention is the Division's #1 priority: immunization, helmets and seat belts, prevention of teen pregnancy, and the like.

-Changes in public health have not come through great breakthroughs but through routine measures, particularly preventive ones.

-Public health has shifted its focus to chronic, behavior-caused diseases.

068 SEN. PHILLIPS: But you still focus on trying to address more common but still serious diseases measles, hepatitis, other infectious diseases.

077 SKEELS: I didn't mean to gloss over those, but we've come a long way since the 19th century in dealing with infectious diseases - cholera, smallpox, etc. Now, we need to shift to diseases that are preventable through behavioral modification. We need better behavioral-science information; we need to immunize people behaviorally, get them to make better choices. I like to see changes in behaviors - for example, cigarette smoking is on the decline in this country in part because of public-health messages.

-Continues detailing Exhibit A.

135 SEN. TROW: I think, increasingly, you're suggesting local health-departments should do these things. Is there some tendency on the part of your agency to take things back from them and do them yourself - inspections of one kind or another, etc.?

139 SKEELS: I'm not thinking right now of any examples of things we've taken back. There are 12 counties which have not taken delegation for environmental-health authority. That authority involves inspections of restaurants, tourist facilities, swimming pools, etc.

143 SEN. TROW: I was thinking of Benton County. And it seems like I've been hearing from the Benton County Health Department that there's something you're taking back that they've been regulating. I can't remember what that is.

148 CHAIR McCOY: How does it work out in the other counties? Are you getting good performance from the counties in carrying out the delegated responsibilities through you?

152 SKEELS: There's wide range of support for local health-departments by their county commissions. We have some counties that are doing an extraordinarily good job, including providing extensive primary-care systems or outreach for people who are at risk, etc. Then there are other counties which use a more skeletal approach and a barely keeping their noses above water. And we have everything in between.

161 CHAIR McCOY: For those who are barely doing it, what could you do to bring them up to date?

163 SKEELS: One thing I've done, in a couple of cases, was to meet with county commissioners and tell them why I think public health is so important to the citizens, and to encourage them to provide support to their local health-department. I've certainly used a carrot instead of a stick; what I've tried to do is persuade them that this is a fundamental public service they've a responsibility to provide. We haven't come to the point of taking back delegation of publichealth authority, although we could do that in an extreme case.

171 CHAIR McCOY: How much money flows to the counties? Senate Committee on Human Resources Februflry C, 1991 - Page 3

172 SKEELS: I can provide you with a county-by county profile; it's on a per-capita basis. The counties get 55 cents per capita in state general-fund monies for public health. That is uncategorical, discretionary money. We also provide some categorical state monies, and a fair amount of Federal money comes through us to them as well. Then they also are dependent on local tax revenues, and if you look at the funding mix of the various local health-departments, you see a lot of disparity as well. Some are quite dependent upon state money; some are fairly independent of state money, and there are lots of different variations. I'd be happy to give you that county-by-county if you'd be happy to see it. 184 SEN. TROW: Isn't it true that for public-health activities, in addition to state funding usually there is county participation as well? And with Measure 5, I'm wondering whether the county participation is going away, or is in trouble - are we going to have dilution of services? I don't know if the state can afford to pick up a greater portion of the cost these days, with all the other things. 192 SKEELS: That's absolutely right. Local health-departments are faced with a double whammy they're going to be losing perhaps some state-level support, and they're certainly going to be losing their local tax-base support as well. Some counties will be hit harder than others, depending upon their tax structure. For instance, Multnomah County's proposed budget was a very difficult one and there were some hard decisions to make there. It's clear that they will be experiencing some marked cuts. 200 SEN. TROW: At the same time, they'll have more people on the streets because of other cuts in needed services. It'll be a more difficult society to manage. 202 SKEELS: Continues to detail Exhibit A. 286 SEN. TROW: Where are the revenue-raising bills in the legislative process?

287 SKEELS: They were drafted by the Executive Department. They've not yet been introduced. They were part of a large number of bills of this type which were drafted by the Executive Department. 292 SEN. TROW: Fee increases have become somewhat of a budget issue, and especially if they're substituting for general-fund monies. These fee increases are doing that?

294 SKEELS: Yes. 295 SEN. TROW: Okay. So good luck with them; I'm sure it's important for you to get them. But there is some reluctance, basically on the part of the House of Representatives, to move them. 300 SEN. PHILLIPS: Do you know if you have a constituency advocating against, or for, these revenue-raising measures? Have you circulated into groups and tried to build any kind of support base of those who will have to pay the fees?

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308 SKEELS: There are a lot of groups favoring the continuation of maternal and child health services to the poor. They're supporters. I can't speak for any of the professional organizations, but I can tell you this would have a financial impact on anyone who uses an Xray machine in their practice.

316 SEN. PHILLIPS: Have you solicited input from those who have these in their facilities, as to whether they will support this new fee increase?

320 SKEELS: The Oregon Dental Association will not support it. 322 SEN. PHILLIPS: I was hopeful that if you reached out to them in advance, you might get a more positive response. 324 SKEELS: We did; we asked them early on how they felt about it. In fact, I think we were about to ask them, and were told they would not support the fee increase, before we asked them. -Continues detailing Exhibit A.

346 SEN. TROW: Would anyone else perform drug-lab cleanups?

347 SKEELS: No.

-SEN. TROW: So it's not going to be done? 348 SKEELS: We and the Department of Environmental Quality are the two agencies that are involved with making sure that the hazardous materials from these illegal drug-labs get removed, and that the house or other building in which the lab was situated is adequately cleaned, and certifled as such for habitation. This is a very expensive activity for people who must have their property cleaned up. There is no agency, other than the Health Division and/or DEQ, that would do this. 358 SEN. TROW: Will it be done at all, then?

359 SKEELS: According to my very recent information, we're negotiating with the real-estate interests in this. There is the possibility that we could pass the cost of this along to the property owner, the person who has been renting to the illegal-drug manufacturers, rather than have the public pay for the cleanup. 366 CHAIR McCOY: What's the usual cleanup

fee?

367 SKEELS: It's in the range of $5,000 - or more, depending on the size and level of contamination, and whether it's confined to one room or the whole house. But they have to go in and take up all the floor covering, take out the walls - there are a lot of very toxic chemicals that are used. 373 CHAIR McCOY: So what do you do when you have a landlord living in California, whom you have difficulty catching up with, and those places remain boarded up for months and months and months, and flnally the people can't move in anyway? . . _ These nunutes contain materials which paraphrase ant/or summarize statements mate during this session. Only text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceetings, please refer to the tapes. Senate Committee on Humao Resources February 6,1991- Page S

380 ART KEIL, OREGON HEALTH DIVISION: We've had meetings, and our staff has been working with the people. We've discussed things like a property-transfer fee. We have a 12page document of all Oregon properties that have been identified by police as having been used for illegal-drug manufacturing. So it's an issue of somewhere around $400,000, as I recall. We also license contractors that do this work, then we certify that the home has been done to publichealth standards. We've met since the session started to try and re-fund the program; we've met with Senator Jim Hill who's very interested. It's not a dead issue but was on our cut list. 398 CHAIR McCOY: Will you keep us informed, as well?

399 KEIL: Yes. 400 SEN. TROW: But if you find no other funds for it, you will just cease performing this function. 401 KEIL: Unfortunately, that is correct. 402 SEN. TROW: And no one else will be doing it.

-KEIL: No. 403 SEN. TROW: How many properties are on that list of identified drug-lab sites?

404 KEIL: It's a 12-page document, single-spaced, just listing properties all over the state probably not thousands of them, but hundreds. 412 SKEELS: Continues detailing Exhibit A. TAPE 20, SIDE A 012 CHAIR McCOY: Regarding well testing - when wells are brought in, do the owners have them tested initially, and then do you go around periodically and test them? 016 SKEELS: We have a statewide system of testing and certifying drinking-water systems for public and community supplies and so forth. This deals specifically with cases where a well must be specifically certified as safe before a real-estate transaction can take place. So this is done for reasons of commerce and public safety and health.

-Continues detailing Exhibit A. 029 CHAIR McCOY: We've been led to believe that it's very important to be sure that X-ray machines are not leaking. You're on the committee; we've had people come and tell us how bad that could be. It's a health hazard not only for people working there but also possibly for a larger area, a larger group of people. 035 KEIL: The 1989 Legislature approved an increase in X-ray licensing fees from $15 to $30. Unfortunately, the Governor's proposed 1991-93 budget is asking for $100, so it compounds the problem we're facing.

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-Continues detailing Exhibit A. 041 SEN. PHILLIPS: Last time, I remember there was quite a bit of rancor over doubling the X-ray licensing fee but everything went just fine; they got over it and everybody paid it. Now, we're going to go even further but the money raised doesn't have anything to do with the service provided because, as you said, you're going to reduce the actual service provided. Correct me if I'm wrong, but I want to make sure I heard that correctly.

048 KEIL: This does not go to the $100, which is based on a Senate bill, as I recall. With the $100 fee, we would go back to the level at which it would be appropriate. 052 SEN. PHILLIPS: So the fee increase does go to provide service? 053KEIL: Yes, if it went to $100.

054 SEN. PHILLIPS: You're telling me it would cost $100 as a licensure fee to cover the cost of the inspection. 055 SKEELS: Part of that program was general-funded. The general-funding was taken out, to be back-filled with fee increases. 058 SEN. PHILLIPS: That much, I knew. But I wanted to make sure that fee increase is actually going to cover the cost of providing the service. 059 SKEELS: That's not the case. This will generate fees to support radiation-control activities in the Health Division. A large portion of that will deal with licensure of the equipment, and preventing the kind of leakage that you described. It also will support some general radiationcontrol activities that relate to environmental monitoring, reacting to problems when they occur, and more general radiation-control activities. But I am not telling you that it costs us $100 each to license these things. I think what Art Keil meant, in the more general sense, is that it will be used for radiation-control activities, which is what the statute allows. 074 SEN. TROW: These are listed under service reductions. And you say delay inspection of X-ray machines. Will inspection be delayed regardless of whether that fee is approved or not? 076 SKEELS: We have, I think, 4 positions - one of which is vacant right now. We're deciding not to fill that position, which will mean a longer interval before an inspector could get out.

080 SEN. TROW: So there is a service reduction here, and it's going to take longer to get these Xray machines inspected -if at all? 082 SKEELS: Yes, they will be inspected. But it genuinely will take longer, and is a genuine service reduction.

-Continues to detail Exhibit A. 093 SEN. TROW: Could elimination of this physician in the HIV-related laboratory conceivably result in someone dying?

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094 SKEELS: Not really, in that this is an almost-uniformly fatal disease anyway. The issue is one of emotional hardship, service to people who are feeling very vulnerable at a very difficult time for them. It's more an issue of sensitivity and humanity, I believe, than of a medical outcome. -Continues to detail Exhibit A. 130 CHAIR McCOY: What is the ratio of spending for school-based health clinics? Do you

put in so much, with the school contributing so much? 132 SKEELS: That's correct. We provide, I believe, about 75% of the total funding, from state general funds. And, for example, Multnomah County operates several school-based clinics of its own, entirely with its own funds. Those clinics happen to be on Multnomah County's cut list as well, by the way. They happened to arrive at the same conclusion, independently I'm told. 137 CHAIR McCOY: They're not cutting them all, are they? 138 SKEELS: I don't believe so. -SEN. McCOY: But you're cutting them all out?

139 SKEELS: Yes. 140 SEN. GOLD: How many clients does that represent?

143 SKEELS: I don't have that readily available but will get it for you. The clinics are being brought up to capacity, and the numbers for the first year are a little bit misleading, but it's certainly in the thousands - thousands and thousands of client visits. There are 13 local clinics, operated by local health-departments all over the state. We went to local health-departments with this issue; in fact, we sent them our proposed cuts and asked them what they thought. Particularly, we asked about the school-based clinics. We see these as the best-case example of how local health-departments can reach out to people in the community. They're health departments without walls.

But it came down to a choice between cutting these and cutting some of the other core services that are offered in other local health-departments. We asked which they would prefer to cut if they could and they said they'd prefer to cut the school-based health clinics. The alternative would have been fewer pre-natal visits, fewer maternal and child health-clinics, fewer other kinds of core health-department services. We got to the point in this exercise where we needed more than $1 million in additional funds and this was the program that ended up on the list.

167 SEN. GOLD: Is there any way that this could be turned to a fee-based service?

169 SKEELS: Unfortunately, the clients being served are underage and are not very affluent themselves. Teenagers are a medically-underserved population. The very young and older folks tend to be better taken care of than teenagers, and that's partly for economic reasons. My own sense is that fees probably would not get us out of this bind.

177 KEIL: I think that's correct. The clinics are used for chronic disease and treatment services for youngsters whose families cannot pay for medical services, or who do not have insurance on their own. So the clinics cover a large number of those people.

181 SEN. GOLD: The clinics also serve those who don't want their families involved.

182 KEIL: Sometimes, yes. 184 SEN. TROW: As I look at your overall budget, I see some reduction in general-fund monies from what you asked for, but a little more than you got last time. You have other funds,

depending on whether you get these fee-based bills passed. The Federal government gave a bit more money this time. Your total budget and staff have increased. Why do we have to cut the medical-lab technician and the microbiologist for hepatitis control? Have we expanded the staff to do other things at the expense of these programs?

195 SKEELS: Although there are increases in dollars, they don't cover the inflationary increases. 197 SEN. TROW: I understand that. How about the staff? You're cutting these programs, yet have more staff than before. What accounts for that?

200 SKEELS: We've cut the services-and-supplies budget as well. I don't want you to think we've just cut staff and left the rest in place.

202 SEN. TROW: I know you have, and I know this is a real problem.

203 SKEELS: I think I'm telling the truth when I say that the staff increases have been in the Federalfunds and other-funds areas, not in the general-fund areas. We've grown in Federallyfunded HIV programs and activities, in some of our fee-supported activities such as Vital Records and the like. I can give you a more satisfactory answer when we get to the Ways and Means sub co mm ittee . 210 SEN. TROW: I'm not being critical; I'm just really regretting to see these microbiologists go away. And I see a staff increase, and I hope it's not administrative staff or anything like that.

213 SKEELS: No, I can guarantee you it's not anything like that. It's a matter of increasing otherfund and federal-fund categories, and decreasing general funds.

217 SEN. PHILLIPS: I'd like you to explore Senator Gold's question about fees a bit more. It's by no mistake that most consumer marketing is targeted at young teenagers, because they have a higher proportion of discretionary income than most other segments of society. Now, albeit the group that we want to attack does not fit into the mold I just described. Some of them may. And there s a psychological impact in that if you pay for something, you're more likely to cherish it or pay attention to it. It may not be a revenue-generator in the sense of making lots of money and being able to support these things, but I would encourage you to look at some of these things as an avenue, as long as it's not high enough that it discourages participation but rather that it cements some kind of a psychological bond.

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Frankly, in my district (eastern Washington County suburbs) there are some good neigHB orhoods where some of the kids have more income than I. It doesn't apply to everybody; the social engineers out there will criticize me for making those kinds of statements. But there are some younger members of the population with good funds that may be available, and I'd like to have you see if there is a way to look at that.

241 SEN. KENNEMER: Why there is no staff reduction in school-based clinic support? The surely must be some support staff involved.

246 SKEELS: There are no staff. It's entirely pass-through money -

through us to local health . departments. We have no state-level staff at all. We had intended, through decision package, to expand the program and had given some thought to trying to put one position in at the state level for evaluation support, and one thing and another, and that turned out not to be possible.

256 JANICE J. FIEGENER, COMMITTEE ADMINISTRATOR: In looking at your budget, there's a $1 million increase for family planning targeted to teens. Then, there is the $1.1 million elimination for school-based clinics. Could it appear that there's some kind of tradeoff? Was that the intention?

264 SKEELS: The way this budget evolved, $1 million in family-planning services was added to our budget after we'd already gone before the Goldschmidt-Roberts transition team and our budget was, from our perspective, finalized. We'd generated and passed through the transition team everything you see on this list except the $1 million. It was after some money was freed up from the judiciary and the legislative branches, and given to human resources, that the $1 million was added back. That's everything I know about how the decision was made; no one has said to me that this is any kind of a tradeoff.

279 SEN. TROW: Was family-planning services one of your decision packages?

282 SKEELS: It was not a decision package, per se. We had a decision package that dealt with teen pregnancy-prevention enhancement. It didn't look exactly like this.

288 SEN. TROW: But you're prepared to carry this one out? 293 SEN. TROW: What about the AIDS epidemic? Are we dealing with it realistically, and are we able to cope? Is the situation getting worse?

297 SKEELS: That's a very complex question. I might be serving you better if I came back to you with a full answer, or brought back someone who could tell you.

300 CHAIR McCOY: Yes, and please bring us up to date on figures.

303 SKEELS: There have been about 1,000 cases of AIDS in Oregon so far. Even if there are no more transmissions of the virus, we will have 10,000 to 15,000 people developing AIDS during the next few years. We are, we think, making an impact on that transition through behavior modification. But it's difficult to know at this point exactly what the impact has been. I'd like to come back before you and speak to that, if I may. . These minutes contain materials which paraphrase and/or summarize itatements made during this session. Only text enclosed in quotation marks rcport a speaker's exact words. For complete contents of the proceeding., please refer to the tape.. Senate Committee on Human Resourca February 6, 1991 - Page 10

318 HOWARD KLINK, PUBLIC AFFAIRS DIRECTOR, MULTNOMAH COUNTY HUMAN SERVICES: I've been close to the teen-clinic program since its inception. I don't have information with me, but am prepared to respond to questions. 329 SEN. TROW: If the Health Division makes this cut in support, what happens to the clinics? 332 KLINK: In Multnomah County we are operating 7 school-based clinics. We had funding for two additional ones, that would have opened this month, and that funding was cut in anticipation of Measure 5 cuts. Two of the existing clinics, at Jefferson and Grant high schools in Portland, received partial state

funding. As far as state cuts are concerned, those clinics would be eliminated. Doctor Skeels also mentioned that Multnomah County also has on its list of at-risk programs all of our locally-funded teen clinics (the county must make $24 million in Measure 5-related cuts). They're also an extremely high priority item for the county commissioners to add back on the budget, should alternative revenue-sources become available. 349 SEN. TROW: Are those sources likely to become available? 350 KLINK: It's not clear at this point. There's much discussion; the board just completed a publichearing process with overwhelming support for maintaining the teen-clinic program. We've also got 2 primary-care clinics on our cut list because of Measure 5, as well as about three-quarters of our community-health nurse program - front-line field nurses in the community. So we have massive cuts that we're looking at. The county just finished the public-hearing process and will be going into discussions of add-back priorities, alternative revenue-sources, etc. I'm not predicting the future at this point. 369 SEN. TROW: Does the community understand what this means, in terms of providing all these services? 372 SKEELS: I think one reason there's been such a strong emergence of public support at the hearings is that there is a segment of the community that has been very supportive from the beginning. They fought hard against lots of opposition early on to get these programs in and in place. Then there's another segment that was skeptical. Many of them have become converted, because their children and relatives have been involved with the clinics and had health-care provided, and teen pregnancies prevented - lots of good, measurable outcomes.

In response to Senator Phillips' question about fees: We have explored the question in depth, and have become increasingly aggressive about identifying Medicaid-eligible students and generating Medicaid billing. I think approximately 3% of our budget is generated by Medicaid billing right now. We've explored the possibility of charging some kind of student fee, and we've run various scenarios and calculations as to what kind of funding that would generate. Roughly half of the kids that come into the clinic - and I believe this is true statewide as well - have no access to any source of health care, which generally means they're uninsured. But when we've looked at even charging a student fee, it doesn't generate any sign)ficant offset for the level of funding we've provided, at least at the levels we've looked at. It's a minimal offset, and not one to be discounted entirely. It's one that doesn't pay for the program.

418 SEN. PHILLIPS: I guess I'm satisfied that we found out it would do a little bit, but not everything. We didn't expect it to do that. If there was a way to perhaps target it for sexeducation issues or other preventive things, maybe that would be a way to do it. Something is better than nothing. 430 SEN. TROW: Do the schools have a school-nurse program, or anything like that? 431 KLINK: Yes. The Portland Public Schools have an extensive school-nurse program, in cooperation with the Multnomah Education Service District. Because most of the practitioners in that program are registered nurses, they're more limited in their powers of prescription authority and diagnostic authority than are nurse-practitioners who staff and operate the clinics. We have a broad range of health services available, and work in close cooperation with

the school-nurse programs, because they've been around a long time. 443 SEN. TROW: Are those in jeopardy too? 444 KLINK: I'm not as familiar with the relationship of that program to reductions in basic schoolsupport and how that would relate, so I can't address that.

450 SEN. GOLD: What about closures of primary-care clinics? 453 KLINK: The two that are on Multnomah County's at-risk list are the Mid-County clinic, newly opened at Southeast 122nd and Division; and the Burnside clinic downtown, serving primarily homeless and street people.

TAPE 19, SIDE B 030 KEVIN CONCANNON, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES: When we look at public expenditures in our state, especially as we look at our Ballot Measure 5 environment, we cannot help but be struck by the fact that the major increases in costs during the past decade have come on the health-care side of human resources. When many of our programs have had very modest annual increases, we've been faced with double-digit increases on the health-care side. It's a major area of legitimate inquiry for the Legislature and for the Governor. The Office of Health Policy has been a source of major information not only within the state but outside Oregon, with some documentation collected here.

I think the Committee today will find the graphs are straightforward, and I think they're rather striking when you look at the message they convey about both occupancy and cost per patient, and increased health-care cost compared to the cost of living generally. That can't help but get one's attention.

050 CHAD CHERIEL, ASSISTANT DIRECTOR, OFFICE OF HEALTH POLICY (EXHIBIT B): Details Exhibit B.

075 SEN. TROW: Is the cost of health-care mostly a function of the market? Senate Committee on Human Resourca February 6,1991- Page 12

076 CHERIEL: It is a function of a number of things that took place in the market. Those included financial incentives that provided different sets of motivations for hospitals to practice medicine, both in- and out-patient care.

082 SEN. TROW: Does it mean fewer people are being served by hospitals?

083 CHERIEL: I would not necessarily translate it into that. It is primarily to show that the volume of business that hospitals are handling today is less, in terms of in-patient activity, than it has teen in the past.

086 SEN. TROW: You don't admit out-patients? -CHERIEL: I could bring back to you some additional information that will plug in the outpatient volume information. 088 SEN. TROW: When you talk about admissions, those who are out-patients are never admitted, right?

089 CHERIEL: That's right. -Continues detailing Exhibit B.

107 SEN. KENNEMER: A licensed bed, theoretically, is how many beds they can have in the facility, right? So, a staffed bed - how do you figure that out? Are they overstaffing? Are these active beds that are in potential use? I'm trying to figure out how you come to that distinction of a staffed bed. 113 CHERIEL: A number of things that go on in the hospital industry occasionally turn out to be a numbers game. This relates to staffed beds, licensed beds, uncompensated care-dollars and

so forth. What we are able to report are actual numbers that hospitals submit to us, as part of an annual survey we do. In that survey instrument, we ask for both the number of beds they claim they are capable of setting up if they have to in their licensing program, and the staffed beds they claim they are able to set up on a regular basis to serve patients. Now there is a problem in that not all licensed beds are available for patient care. Some facilities have gone through a process of de-licensing - downsizing - and others have not. But this still is some indication of the level of occupancy.

131 SEN. KENNEMER: I'm just trying to figure out how valid a statistic we have here. What is the capacity, and what are they doing with that? And is there really waste, or is that just how they operate? I mean, I may have a warehouse that could hold twice as much product, not necessarily real wasteful. That's unclear to me. 140 SEN. TROW: What implication should we draw from this graph? For instance, I could draw the inference that since hospitals are only half full, we probably have too many hospitals. Should I infer that?

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144 CHERIEL: One other piece of information contained in that is that there is, in fact, excess capacity in hospitals, in terms of hospital beds, whether you look at staff beds or licensed beds. The importance of that really is that every time they built a hospital bed, it cost the payors - patients, third-party payors - approximately $150,000 per bed. That's the actual average construction cost.

So whether you talk about licensed beds or staff beds, that's the investment society made in the past. And when you make that kind of investment, and then due to technological reasons or for financial incentive you only use half that capacity, then society has in effect wasted a lot of resources by not adequately planning, taking into account future changes and so forth. So in an indirect way, the answer to your question is that we've wasted a lot of resources in building capacity in the hospital industry.

163 SEN. TROW: Does it make since to have that capacity available in case of real emergencies?

165 CHERIEL: Health planning and policymakers have statistical formulas that will enable you to predict the optimal number of beds needed for a given population. What we have in the state of Oregon far exceeds anything that you could calculate out. 171 SEN. KENNEMER: Today someone was telling me that hospitals in British Columbia operate at 9596 of capacity. Is it fair to compare that number against this subject; are we talking about apples and oranges or the same thing? 177 CHERIEL: It probably is unfair to make that comparison, because the organization and financing and economics of the Canadian system are different from what we have in the United States. They have lengths-of-stay which are much higher. Their sizes are higher - the higher the size of the facility, the higher the occupancy that they can handle. That's just a function of the variation in census figures that occurs. So that is an unfair comparison, but it's not to say our Oregon hospitals could not operate at a much higher capacity or, conversely, could have planned to build a lot less. -Continues detailing Exhibit B.

200 SEN. TROW: Are these inflated or real dollars for gross hospital revenues between 1975 and '89? 201 CHERIEL: They haven't been adjusted for inflation.

-Continues detailing Exhibit B.

223 SEN. TROW: Are you able to break down those hospital-income figures to show which hospitals are doing well and which aren't? For instance, I have this stereotypic view that the rural hospitals are in trouble, and are not making the kind of money that the urban hospitals are making. Can you break it down?

228 CHERIEL: We're in the process of making a document for distribution that will display for you detailed information on the financial performance and utilization of each of the hospitals, as to where they are located and some trend-line information.

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To respond to your question, I'm not sure that there are any stereotypical patterns, with the exception of a few large hospitals in the state. There are some rural hospitals who are doing extremely well, in terms of bottom-line ratios. At the same time, there are some hospitals on the verge of financial collapse. As far as mid-sized hospitals, some are doing well and some poorly. But we'll make that information available to you.

242 SEN. TROW: The hospitals that are on the verge of collapse, what generally is happening to them? 244 CHERIEL: We've extensively studied small, rural hospitals in response to a request by the Ways and Means Committee, a study for which we submitted a report to the Emergency Board in May 1990. As part of that, we've been able to recognize that there are a number of factors causing hospitals to move toward closure or bankruptcy. I'd argue that the most significant factor is the loss of patients - patients who move from the local community and seek service elsewhere. That may be a function of the physician, or lack of physician, in the community. It may be the lack of availability of a particular set of services in those local hospitals, or peoples' perceptions about the nature and quality and price of products that are available in that community

261 SEN. TROW: So it's not necessarily being a rural hospital?

262 CHERIEL: That's right. In fact, we've had 11 hospital closures since the 198 0s - 5 of them in Standard Metropolitan Statistical Areas and 6 in rural areas. At least one that I'm aware of, that was doing financially well, closed because of non-financial factors. Normally, another factor is proximity to other hospitals often has some influence on the stability of the institution to attract and retain both physicians and patients. 274 SEN. KENNEMER: On this graph (Exhibit B, Page 8), you call it gross revenue. Are these total charges, including charges for what will ultimately be uncompensated care? 278 CHERIEL: Correct. 280 SEN. KENNEMER: These are all hospital charges in - what percentage would you reasonably expect them to actually secure over time? 283 CHERIEL: In the aggregate, I would think it would be very close to 75-80%, but that varies between institutions. -Continues

detailing Exhibit B. 339SEN. TROW: What do you think drives the insurance premium to increase by 21%? 346 CHERIEL: One obvious explanation, I would think, is that the industry would argue that it has to deal with the issue of uncompensated care and cost-shifting, built into the industry calculation. 356 SEN. TROW: Okay, they would say that since the charges the hospitals are making have to go up to private patients and others who do have coverage, because the hospitals are taking care of those who don't have anything, this is why this is that high. How valid is that statement?

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366 CHERIEL: Obviously, there is some validity to claims by the provider and insurance communities in that they have an obligation, and often exercise that obligation in providing charity care and other emergency care to patients. But one unfortunate situation involving healthcare policy or planning is that the only hard data we have is on hospitals. We know very little about the rest of the industry. So we have to rely on what they make available.

Part of the reason I presented this is that there's a difference between gross revenue and what they, in fact, take in after accounting for deductible. That deductible makes up for a large chunk, but at the same time, in the aggregate they are very profitable enterprises. Their bottomline ratio is around 5.1%. That will probably put them on an equal footing with the major industries of the United States. So if there was additional compensation to take care of the indigent and other unpaid clients, unless you simultaneously extract deductions and charges, you will potentially cause the bottom line and the profit margins to go up significantly. And in the health-care industry, some might argue that that's an unfair way of making significant profits that exceed any sort of norm society may want to accept. -Continues to detail Exhibit B.

TAPE 20, SIDE B 026 SEN. TROW: Do other states have workable alternative strategies for Certificates of Need (CN)?

027 CHERIEL: All but about a dozen or so states still maintain the CN program. A number of other states have what are called rate-setting programs, which prescribe to the providers how much they could charge.

030 SEN. TROW: Is that more effective?

031 CHERIEL: There is a great deal of debate as to the effectiveness of one program vis-a-vis the other. Overall, rate-setting programs have been found to be somewhat successful, but that's clearly not the entire answer for cost-containment. It appears to me, maybe, that other international systems have better answers in terms of their ability to maintain costs over a lengthy period of time.

036 SEN. TROW: Such as?

037 CHERIEL: Such as Canada, Germany and others. -SEN. TROW: What kind of systems?

038 CHERIEL: I'm not trying to promote Canada. But it is very clear that in Canada, the Ministry of Health has much greater control of

capacity and overall expenditures directed to facilities, by controlling hospital budgets and dictating to the hospitals what and when they may buy or undertake new services, and build new facilities.

-Continues detailing Exhibit B.

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118 MEREDITH COTE, DIRECTOR, OFFICE OF THE LONG-TERM CARE OMBUDSMAN (EXHIBIT C): Details Exhibit C. 169 SEN. TROW: What reasons do we get from the new Governor for these cuts? The other Governor didn't recommend any kind of cut like this. 172 COTE: The rationale that was presented to me from a transition-team member was that they were cutting our budget so that the Senior and Disabled Services Division (SDSD) could provide nursing-home care services to 224 people in the 1991-93 biennium. I was somewhat puzzled by that, because if you look at the $520,000 cut, and you divide that by the 224, you get an average reimbursement of $1,100 per year. And that probably doesn't cover what it costs to provide care for someone in a nursing home under Medicaid. So in order to figure it out a little more, we called SDSD and talked to their Fiscal Services manager. He indicated there was no linkage between our budget cuts and any specific SDSD program. So all I can give you is the information I have.

189 CHAIR McCOY: Was there anybody on that transition team who has dealt with the elderly? 191 COTE: I believe so. The person who provided the information to me was Terry Rogers, and the other people I interacted with on the transition team were John Mullin, who I believe heads Clackamas County Human Services; and Elizabeth Kutza, who directs the Institute of Gerentology at Portland State University. Those individuals recommended that cut to me.

200 SEN. TROW: Was there any indication from the transition team - which recommended this cut of satisfaction with the program and what you're doing, with the outcomes of your program?

203 COTE: No. 204 SEN. TROW: Has your program grown in some Icind of excessive way over the last 5 years?

211 WAYNE NELSON, DEPUTY LONG-TERM CARE OMBUDSMAN: The evidence is clear that the program has made tremendous growth in the last 5 years. Roughly, without having data in hand, I'd say we have jumped from 70 ombudsmen - maybe even less than 70, actually and maybe 5 or 6 viable screening and recruitment committees associated with the various state health-planning areas, to a program that has 21 screening and recruitment committees, 180 ombudsmen and 40 people in the training program. So there's been a tremendous growth, and there's also tremendous qualitative improvement - very clearly identified and documented in our training records, and consequently in the performance levels of the ombudsmen themselves during the past 5 years.

227 SEN. TROW: Those figures are very impressive and good; I don't mean to discount them at all. What has happened just in terms of your full-time equivalency (FTE) - the paid staffing, over the last 5 years?

231 NELSON: In 1985, I believe, there was 2.5 FTE. In 1986, it jumped to 6.5; maybe 7. And then, the Emergency Board in March 1990 added 1.5 FTE- a volunteer-recruitment supervisor and a half-time clerical position.

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239 SEN. TROW: Clearly, over time you've grown. And the growth, I think, has come in connection with some struggles over where you were lodged and then some changes in administration, and so forth. But with the growth has come this increase in your activities, and the number of volunteers you've trained and put out there, and the effectiveness of your performance, is that right? 246 NELSON: Absolutely. -SEN. TROW: All right. Give us some idea, if you're cut back now, you've got your volunteers trained and out there, they're working, now you can cut back your staffmg and still run your program, right? 250 COTE: That's not meant to be. There's been a lot of studies of ombudsman programs nationally, and there is a direct and positive correlation between the number of paid staff and the quality and quantity of volunteers. Basically, the way the most recent study of volunteers in ombudsman programs has been couched is that the worth of volunteers in the program - that is, the determining factor in whether states have volunteer programs or not is that commitment of staff and resources to those volunteers. So what we expect as a result of that is that there will be a sign)ficant attrition in the number of volunteers in the program.

264 SEN. PHILLIPS: As one of the former state ombudsmen, I just find it unbelievable, what's going on. We finally got it to the point that we envisioned in 1981 and '83, and now we're going to gut it. And the reason you didn't hear it criticized is that it's cliffficult to criticize a successful program. In fact, it's impossible, if you're sincere about it. When you answered Senator Trow's questions about growth and FTE, how much of that - if any - were Federal dollars?

275 COTE: Details chart on Page 7 of Exhibit C. -Our funding mix is determined by SDSD. -In terms of dollars spent on our ombudsman program, and as measured in terms of the number of beds covered (and we have 27,000 beds), we are about average in our 1989-91 biennial budget in terms of what other states are spending. The striking difference between our program and others is that we don't have much Federal Title III funding coming in. Most of what this state has chosen in the past has been to allocate Medicaid monies for the Ombudsman program, in lieu of Title III funding. As the testimony explains, and I could talk about in detail later, Title III is the Older Americans Act, which is the progenitor of the Ombudsman program.

306 SEN. PHILLIPS: The reason I asked that question is that it ties in to testimony we had the other day, which is particularly striking and upsetting to me, relating to cuts in Oregon Project Independence (OP1). It seems to me that you combine an issue here, dealing with long-term care, with nursing-home issues, and then we're going to cut a program that, in my mind, keeps people out of nursing homes. So they go there, and yet we're going to take away an independent advocate. It seems we're doing everything we can to be sort of the 1950s hole-in-the-ground regressive. Am I over-dramatizing this?

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325 SEN. KENNEMER: What was the difference in your 1989 budget as opposed to your '87 budget, in rough dollars? 328 COTE: Let me defer to Wayne - he was here; I was not. 331 NELSON: It seemed to me that they were roughly equivalent, maybe as adjusted for inflation. I don't have that data before me. But it seems that the first year, it was something like $289,000 and the second year, maybe it was around $300,000. But I'm not positive; I certainly could get that information to you but I don't have it today. 340 SEN. KENNEMER: I'd like that. One other thing: 2 years ago, how many ombudsmen did you have? 343 NELSON: I think we were about where we are now, though I don't know the exact number. We were clearly in the ballpark - we had a big increase in the numbers of ombudsmen with the addition of staff in 1986. The program zoomed up to between 190 and 200, 206 - it fluctuates every month, of course - but we've sort of hit a plateau at about that point. Then in March, we had the screening and recruitment supervisor come aboard, and there's been a dramatic increase in the number of applications. 357 SEN. KENNEMER: That is the criticiSMI've heard leveled at the program; that the number of volunteers has not increased over a 2-year period. That was seen as a real vital part of the program. 363 COTE: When I came into the program, there were roughly 200 volunteers on our ombudsman list. When I reformulated the job description of the field officers, so they were devoting 100% of their time in the field, we had every field officer go out and find and get to meet every one of their ombudsmen, and really work with them and make an assessment. It took a major commitment of time to do this. We found out there were people on the rolls that had just been maintained on our list that were no longer participating in the program and no longer cared to participate. We found some people whose skill level was not up to speed, so went in and trained them. There were 50 persons or more that ended up not providing ombudsman services, as a result of that process. I've been on board for the last year and a half and what we've seen is that we're right up to the level we were when I came on board. There are 197 certified ombudsmen and we have 35 more in various stages of training. We had to go back, make our list very accurate, and we're very much in tune now with all of the people on our list. Now we're moving forward. The recruitment and screening specialist has been on board since August 1990, and given a couple of months of start-up, we've had a precipitous increase in the number. In December alone, we had 15 inquiries from people wanting to know how to be an ombudsman. We've had several applications - if you look at the chart, it's just going up, up, up, at this point in time. 417 SEN. PHILLIPS: It's been a pet peeve of mine for some time that you folks haven't been as progressive in adult foster-care. Have you seen any progress in that direction? -

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422 COTE: We are, in some ways, in that we currently routinely have about 1,700 adult foster- care homes. We are providing weekly ombudsman services to 200 of those facilities. We answer 100% of all complaints

coming from those homes, so even if we don't have a volunteer assigned to go into that home, we will go in and address the complaint. The second part, and I have some real hopes for it, is that we are piloting a project in Portland/Multnomah County, to take advantage of having people split skills of the ombudsman - specialize, so we can encourage more people to participate in the program with less of a time commitment. We're hoping that by mid-year, we'll have some results that will give us some indication of where we should be going in the direction of adult foster-care. Quite frankly, that pilot allows us to stay true to the ombudsman model - resident focus. The other option we had, and I'll be making that decision at the end of the biennium, is that if the pilot does not seem to want to induce people to come into adult foster-care, then we'll have to look at where the worst homes are and make our presence known in those homes. It's a very hard message for the industry when we do that because it knows, by our presence, that there's some decisions made about their home. So I've been reluctant, for the sake of the residents, to pursue that course. 489 MOTION: Senator Gold moves that Senate Bill 114 be referred to the floor without recommendation as to passage, and that it be subsequently referred to the Senate Education Committee (EXHIBIT D).

TAPE 21, SIDE A

040 VOTE: Hearing no objection, Chair McCoy so moves. 042 CHAIR McCOY: Adjourns meeting at 5:15 p.m.

Submitted by: Reviewed by: Michael Sims Janice J. Fiegener Assistant Committee Administrator

EXHIBIT LOG: A - Health Division overview - Mike Skeels - 15 pages B - Office of Health Policy overview - Chad Cheriel - 12 pages C - Office of the Long-Term Care Ombudsman overview - Meredith Cote - 13 pages D - Letter to Senate Pres. John Kitzhaber - Sens. Bill McCoy and Shirley Gold - 1 page

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