SENATE COMMITTEE ON HUMAN RESOURCES

Wednesday March 6, 1991 Hearing Room A 3:15 p.m. Tapes 36 -37 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 MEASURES CONSIDERED: Introduction of LC drafts 3832, 3908, 3916, 3917, 3921, 3924 SB 274 - Relating to maternity care, PH SB 318 - Relating to geographic distribution of maternity care personnel, PH

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TAPE 36, SIDE A

005 CHAIR McCOY: Calls the meeting to order at 3:16 p.m.
007 MOTION: SEN. TROW moves to introduce LC drafts 3832, 3908, 3916, 3917, 3921 and 3924 (Exhibit A). VOTE: Hearing no objection, Chair McCoy so moves. ~ . Senate Committee on lluman Resources March 6, 1991 - Page 2

(Tape 36, Side A) PUBLIC HEARING ON SENATE BILLS 274 AND 318 WITNESSES: Ian Timm, Maternity Access Coalition E. Paul Kirk, Oregon Health Sciences University (OHSU) Mary Ann Curry, Oregon Healthy Mothers/Healthy Babies Coalition Karen Whitaker, OHSU Office of Rural Health Flo Rhea, Tuality Community Hospital, HillSB oro Demi Rewick, Sacred Heart Hospital, Eugene Mary Murphy, Conference of Local Health Officials Donna Clark, Oregon Health Division Rebecca Landau, Office of Health Policy Nancy MacMorris-Adix, Oregon Nurses Association

024 JANICE J. FIEGENER, COMMITTEE ADMINISTRATOR: The bills were introduced at the request of the Maternity Care Access Work Group, which met during the 1989-90 interim at the request of the Interim Joint CommiKee on Health Care. The Work Group spent several months investigating maternity-care access at the local level, and was charged with making legislative recommendations.

Today, we have 2 bills that are the result of their hard work. SB 274 looks at developing a statewide maternity-care plan and has 2 main purposes: establish a statewide planning commission based on counties coming together and developing plans, then making recommendations from the local level that generate out to the state. SB 318 requires an analysis of maternity-care personnel needs, currently and projected to the year 2000. It also requires a look at geographic distribution and training needs.

039 IAN TIMM, MATERNITY ACCESS COALITION (EXHIBITS B, B-1): Details Exhibit B.

075 SEN. TROW: Is the 2-year budget of $250,000, and $500,000 for technical assistance for maternity-access initiative grants, in the Governor's 1991-93 budget? 076 TIMM: No. I listed it under other provisions, and we've had discussions about alternative revenue sources. We recognize that anything with a fiscal impact is going to be flagged, in this era of Measure 5. Also, new revenue sources will be scrutinized pretty closely. We believe the savings to be achieved by improving the

maternity-care delivery system are great and that this deserves passage and support, even if it would require general-fund revenues. 098E. PAULKIRK, M.D., CHAIR, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, OREGON HEALTH SCIENCES UNIVERSITY (OHSIJ); DIRECTOR, STATE PERINATAL PROJECT (EXHIBIT C): Details Exhibit C. 163 MARY ANN CURRY, OREGON HEALTHY MOTHERS/HEALTHY BABIES COALITION (EXHIBITS D, D-1): Details Exhibits D and D-1. 228 KAREN WHITAKER, OHSU OFFICE OF RURAL HEALTH (EXHIBIT E): Details Exhibit E.

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318 SEN. TROW: Are there some areas, perhaps in the rural areas, but also in the metropolitan areas, where the situation is acute and care is really not there? 321 WHITAKER: The most desperate area we've been able to identify from our data consistently is northwest Oregon - Clatsop, Columbia, Lincoln, Polk and Yamhill counties. Certainly, the closure of the St. Helens hospital last year is going to contribute to making that even worse. None of this data would capture any effect from that hospital closure. For example, in the first part of the report (page 4), we're looking at total deliveries in the hospitals in an area, and comparing those to births to residents in that area, and seeing if there is adequate capacity in the county for the deliveries. Columbia County already had a deficit of 347 - 95 births in the hospital, and 442 to births to women in Columbia County. Now, all those women have to go outside the county in order to have a hospital birth. We think that's definitely a glaring, outstanding problem. 344 SEN. TROW: I'm looking at Polk County, and see a deficit of 509. What does that mean? 346 WHITAKER: That means there were 129 babies delivered at Valley Community Hospital (Dallas), but 638 women in Polk County had babies during the year. Most of those women likely went to Salem to deliver their babies. 350 SEN. TROW: So you're not tracking those who are going someplace else for hospital care? 351 WHITAKER: No. In some instances, the data actually points out some positive things. It shows that perinatal care is being regionalized to some extent. But we also don't know what women those were - were they on Medicaid and couldn't access physicians in Dallas, for example? Were they from special population groups? We also don't know for sure where they went to get their care. 360 SEN. TROW: So there is no way of finding those things out? 361WHITAKER: Rebecca Landau did a really good study a few years back on where Medicaid women went to get their care, and may be able to comment on the Medicaid side of it. She found Medicaid women were traveling really inordinate distances outside their counties to get care sometimes. She may want to answer those questions.

382 FLO RHEA, ADMINISTRATOR, TUALITY COMMUNITY HOSPITAL, HILLSB ORO: I want to talk about the barriers to getting, setting up and getting operational with a comprehensive pre-natal and delivery service for low-income and indigent women. I've been intimately involved with that for 2 years. , In the late fall of 1988 Ellis McCarter, director of the Washington County Department of Health and Human Services, called together the providers in the county - who had never sat down together to talk about maternity services - to come and talk about the barriers to care, about the fragmented, inadequate and dangerous system that we were working with, and to see if we could come up with something that would offer better opportunities for a high-risk population socially,

economically, educationally in terms of communication, and all those issues. I've been at Tuality Hospital 11 years, and we've probably had 6 meetings of parts of this provider system over those years, but never everybody in the same room.

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And we would sort of stick a finger in the dike by saying that we'd take those Virginia Garcia Memorial Health Clinic patients, but we want their records to come with them, because they were coming without records. Or we'll ask our doctors to rotate and take this indigent patients out of the emergency room. Or the clinic that was part of the Washington County Health Department's pert-natal program was providing pre-natal care, but asking clients to find someone to deliver them and they weren't having any success doing that. Or they were allocated or assigned to a provider who was unreachable for them at the time of labor, because of transportation or whatever, so we had a bad system that wasn't giving good service. We were delivering these babies in the hospitals but under very risky circumstances and, I think, with a total lack of dignity for the patients. They didn't come with a relationship, they didn't know who was going to deliver their babies - or if anybody was going to deliver it.

So the upstart of all this is that Healthy Start came about after almost 2 years of effort on the part of all these providers, with the donation of significant services in-kind from each of the providers in terms of research, development and planning - putting into place a vision or dream of what this clinic could be. And with contributions in hard dollars from the county and the hospitals, and in-kind services from OHSU and the Virginia Garcia clinic. Once we took the plunge and hired an executive director, it took 9 months to open the doors. It required finding funding. We (I'm a member of the board and feel very invested in Healthy Start) have had to depend on significant grant monies; we're looking for $300,000 for the second year of operations. That isn't yet in sight, but we'll do that. We've been able to get through the first year and will probably be able to break even. That is because the providers have continued to contribute either dollars or in-kind contributions - the hospitals, the county, OHSU and the Garcia clinic. So it hasn't been easy. SB 274 would facilitate that kind of planning by offering some resources to, if nothing else, provide some consultation and staff. We were sort of the blind leading the blind, as none of us ever had done this before. It would have been easier if we had someone with experience in setting up this kind of project to kind of lead us through the steps. In retrospect, we could have made it a lot easier than we did, but we kind of went up some blind alleys. So I just want you to be cognizant of how difficult it is to do this without some outside support, and possibly in areas where you don't have providers who are able to contribute funds to get this effort off the ground. SB 274 would help to make this happen in other settings where it is as desperately needed as it was in Washington County. One thing we discovered was that Washington County doesn't have a high percentage of indigent women. But if you're one of those indigent women, it's a very serious problem for you.

TAPE 37, SIDE A 001 DEMI REWICK, SACRED HEART HOSPITAL PRE NATAL CLINIC, EUGENE (EXHIBITS F, F-1, F-2): Details Exhibits F, F-1 and F-2.

049 MARY MURPHY, CONFERENCE OF LOCAL HEALTH OFFICIALS (EXHIBITS F, F-1): When you are able to form local coalitions to meet unique community needs, you get more babies with healthy beginnings and sign)ficant savings in costs to society. The Washington and Lane county pre-natal programs are the kinds of programs that could be possible through SB 274. -Continues detailing Exhibits F and F-1. - These minute' contain material. which paraphrase ant/or summarize statemer~ mate during this session. Only text enclosed in quotation marks report a speaker's exact word.. For complete contents of the proceedings, please refer to the tapes. Senate Committee on llumso Remurce. March C, 1991- Page S

104 DONNA CLARK, DIRECTOR, MATERNAL/CHILD HEALTH PROGRAM, HEALTH DIVISION (EXHIBIT G): Details Exhibit G. 162 SEN. TROW: What could we do with SB 274 if we couldn't put a lot of money into it? Is it still useful to have, with no money this time but perhaps the promise of money in the future? 167 CLARK: If we had the policy statement around this commitment, and also had the commission that still would have this charge, we could get started on that. But I think it's going to take more resources in the community to make the ultimate difference, because that's where the clients are and where the services and barriers are. 172 SEN. TROW: If you filled in the blanks in the bill with the amount of general-fund dollars that are really necessary, what would that be? 174 CLARK: We scaled it back from the original legislative concept. I think we could do something if we had $500,000 for special projects at the local level, for services and program development. Then probably between $200,000 and $250,000 for technical-assistance staff and to support the commission. 180 SEN. TROW: So a total of $750,000 would do an adequate job?

181 CLARK: It would get us a good start.

183 REBECCA LANDAU, STATE OFFICE OF HEALTH POLICY (EXHIBIT H): Details Exhibit H. 253 SEN. TROW: You know something about the commission that's been working on prioritizing very expensive health care. And hopefully, if we can implement SB 27 (1989 session) at some point down the road, get a Federal waiver and all of that, we would have money maybe to extend out and buy down the list of that amount of care. Where would pre-natal care come on that list? Do you know enough to say would we be buying this amount of care for most every person we need to have the care for? 264 LANDAU: Quite frankly, I'm not sure where maternity care falls on the prioritization list. 267 KIRK: Maternity services are defined as all credible neo-natal services, and all maternity services are listed above 100. 274 SEN. TROW: That means they probably would be funded if we had a decent amount of money. 278 NANCY MacMORRIS ADIX, CERTIFIE D NURSE MIDWIFE, SALEM, REPRESENTING OREGON NURSES ASSOCIATION (EXHIBIT I): Details Exhibit I. 364 FIEGENER: How do you envision the local technical-assistance grants working? What is the role of the Health Division?

370 CLARK: In the past, we had 34 counties spread out all over the place, and they're at different levels of expertise in terms of skills

in bringing together all the players in the community, providing resources to get the community to develop a plan. Then once they decide they want to do something, they need to establish cost, how to go about setting up the service, etc. So it really varies quite a lot. But it takes a fair amount of hard work, and sometimes having one person that can be shared between 34 counties - or 2, rather than having each of them try to buy their own, because many of them aren't able to hire staff to be just a planner or a technical expert in an area. Or we might be able to contract for certain types of expertise, to bring to a community. So by pooling our resources at the state level, it's really a service to the community. I think it's a more efficient way to use our resources. . . 399 TIMM: The Maternity Access Committee was concerned about the revenue impact of SB 274. We've been in discussion with a number of groups, and there is a bill being introduced by Rep. David McTeague, House Bill 3196, which is based on a Florida measure taxing health-club memberships to raise revenue for maternity services. We believe this is a high priority, and would be an appropriate excise tax, if you will, to raise money for teen-pregnancy services and prevention. So I would ask that you not refer SB 274 directly to Ways and Means, but hold onto it for a while until we can get the actual HB 3196 in print to study. I'm sure it can raise enough revenue to cover the amount.

TAPE 36, SIDE B 002 CHAIR McCOY: How many health clubs are in the state?

003 TIMM: I don't know. The Legislative Fiscal Office has been looking into that, to prepare the estimates for this bill. 004 CHAIR McCOY: Are they going to put the tax on the health club, membership in the health club, or both? 006 TIMM: I'm not sure how they've looked at it. Our committee has been working with Howard Klink of the Multnomah County Department of Human Resources on some of the details. I haven't seen those details. 008 SEN. TROW: You want us to hold this bill in committee until they get it worked out, but my guess is that a bill like this has to get through the House Revenue Committee. I'm not at all sure a bill like this could get through that committee, and right now, we in Ways and Means are working on the Health Division's budget. At some point, I think, this concept ought to be discussed down there, relative to this bill. I don't know whether the bill can get down there quickly; I would like to send it down so we can at least discuss the concept. I don't think it makes a lot of sense to wait for a bill like that to move through the whole process. Even if it gets out of the House committee, it's got to pass the House, come to the Senate and pass the Senate. We could wait the whole session for it.

019 CHAIR McCOY: What kind of a time frame were you talking about, Ian?

020 TIMM: I think it should be printed within a week, and we'd know a little bit more about what it's chances are. . These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes. Senate Committee on Human Resources March 6, 1991- Page 7

022 CHAIR McCOY: Is he getting the runs on it? 023 TIMM: It's been in the hopper for a month or more. As I understood it, there was a lot of stuff backed up in Legislative Counsel.

025 CHAIR McCOY: Maybe next Wednesday (March 13)?

026 TIMM: I hope so.

-CHAIR McCOY: Just keep in touch, then, with the office.

027 SEN. TROW: Let me advise those of you who are interested in the bill, then, that the Health Division's budget is being heard in the Ways and Means subcommittee tomorrow (March 7). Maybe some of you will want to come talk about the concepts, so the committee understands what is in the bill. 032 SEN. PHILLIPS: I would echo Senator Trow's concerns. I think holding the bill on the faith that something Representative McTeague is having drafted up, that has to go through a process that is backwards. If they're going to meet, they should meet in the Ways and Means process and get this down there for discussion as soon as possible. Basing it on what-ifs and what-fore and what-may-bes is a bad way to move forward, because some time next August, you'll end up saying what happened. I don't think that's a wise planning process. Unless Representative McTeague has some unknown commitment from committee chairs and the Speaker of the House that no other legislator has been able to get thus far this session, it would be naive to believe that the process should be held up for shallow promises.

043 TIMM: I appreciate your comments. I think some committee members were concerned they'd be having the same perceptions in August with a direct referral to Ways and Means also.

046 SEN. PHILLIPS: It could be. But you've got to play the odds. If you don't play it right, you're going to be left out completely and waiting on whatever McTeague has said. He knows something we don't. 048 SEN. TROW: I'm on the Ways and Means subcommittee that's dealing with this, and the concept certainly is worthy of discussion with the subcommittee. I'm hoping that can be done and sending the bill down would make sense. Maybe after you discuss it tomorrow, we can get some reading as to whether it makes sense.

054 SEN. McCOY: I wish we'd have known this. We would have talked with Representative McTeague before we put this on, to see what the feasibility of getting the funds really is.

-Closes hearing on SB 274.

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(Tape 36, Side B) PUBLIC HEARING. SENATE BILL 318 WITNESSES: Ian Timm, Maternity Access Coalition Lois Davis, OHSU Donna Clark, Oregon Health Division Karen Coville, Oregon Society of Physician Assistants Jim Carlson, Oregon Medical Association

068 TIMM (EXHIBIT D): Details Exhibit.

122 LOIS DAVIS, OHSU DIRECTOR OF GOVERNMENT RELATIONS: OHSU supports

the bill. Obviously, access to adequate maternity care is a key health issue for all Oregonians - obviously for the mothers and the babies and the families associated with that. We do feel that we're already on the way to achieving the goals of the bill. Karen Whitaker already has shared with you the report. We have a lot of the data. We do know a good deal about what's happening out there. Obviously, we can learn more - there's value to working with the other organizations to get their specific viewpoints. So I wouldn't say we're all the way there, but we are on the way. There are 2 notes of caution, though, before I turn it over to Karen. First, this plan - like any other plan - will cost money. I'd like be able to sit up here and say we can do it for nothing, but especially with the Measure 5 environment and very limited resources, there will be some sort of a price tag. To be honest, it's a little hard to give a firm number - totally determine what the bill intends for us to do, the scope of it. We made an estimate of about $40,000, if a really comprehensive plan is proposed - hiring a person to work on it, etc. We are hopeful that some of the health-planning Federal grants Karen is applying for through the Office of Rural Health might be a source of funding for that. That's a little iffy for us to bank on, since that money doesn't yet exist and we probably won't know until probably by July 1 whether we indeed have received the grants, so we're a little nervous about putting all of our eggs in one basket. But clearly, if we did get that money, if you're looking at health delivery and health planning for the state, obviously maternity access would be a key component, so it makes some sense. Secondly, in reading the bill, we're reading the distribution language to refer to desirable or needed distribution, as opposed to guaranteeing. History has shown there is no way of compelling or forcing a provider to locate in any particular area. We can sit down with the experts, and everyone can agree we need or believe we need X number of nurse-practitioners, we need X number of obstetricians and gynecologists, and we'd like to see them in these particular areas. But one cannot force a provider, any more than any other professional, to locate in a specific area. We are doing things to help provide incentives and encouragement. The Area Health Education Centers Program, with which I think most of you are familiar, is designed to encourage providers to practice in rural areas by setting up training sites in those areas. There are the physician tax credit and other proposals on the table, including the Rural Health Extension Network which we're working on at OHSU. But it is important to remember not to fool ourselves that we can develop a plan that will somehow guarantee we will have exactly the number of providers we want in each precise area of the state.

167 CLARK (EXHIBIT E): Details Exhibit E.

196 SEN. TROW: Basically, then, are we seeing that it's already being done?

197 CLARK: We've done this on a fairly regular basis, I think; at least that's my understanding according to the spirit of the bill. We do it every two years. This is the first time we've done a specific maternity report, but we do a physician-manpower report every 2 years.

202 SEN. TROW: Based on this data, could you prepare a plan for how to

remedy the problem of provider inadequacy?

203 CLARK: Senator Trow, that's a big leap.

204 SEN. TROW: Do you need more data to do that, then? You don't have the adequate data?

206 CLARK: We have data.

-SEN. TROW: OK, it's just that developing the plan would take more resources than you have. 207 CLARK: It sometimes is labor-intensive to derive the data. As Lois said, the plan itself involves some intangible things: How do you attract a physician to a rural area? How do you persuade certified nurse-midwives to locate in rural areas? What do you do about areas with no capacity whatsoever, like parts of northwest Oregon? We certainly can come up with recommendations, look at numbers and tell you what the ideal numbers should be - Tables 11A through 11G in the report (Exhibit E) give you an idea of what those numbers should be, area by area, in the state where the deficits are. How to achieve those ideal numbers is a very big leap obviously, we can't coerce people to go.

We have incentives which the 1989 Legislature provided us. We have tax credits for physicians, nurse-practitioners and physician-assistants to practice in rural areas. We're looking at a bill later this week in the Trade and Economic Development Committee which would add some loanscholarship repayment monies to some of those incentives. We're providing technical support to rural clinics and rural hospitals. It's a very complex issue and they all fit together, but certainly that's something we're committed to continuing to do. This basically would require us to put all of our efforts in a report and present it to the 1993 Legislature - direct it in a more focused way, probably.

235 CHAIR McCOY: Who is getting the grant money?

236 DAVIS: We hope to be getting some Federal grant money. There is a Federal program available; it's a health-networking grant and we're applying for it. That would give us some money for statewide rural-health, community-based health planning. Certainly, the maternity-care needs of each community would be a very important part of that health planning. How successful we will be in obtaining that grant I can only speculate; obviously,I'm optimistic about it and hope I can be successful.

247 CHAIR McCOY: What is the projection for doctors, generally, 5 to 10 years down the pike? I know there must have been some planning.

252 DAVIS: In terms of numbers? 253 CHAIR McCOY: Numbers, and what areas they'd have to be in. You can only take so many in some many fields. 254 DAVIS: At OHSU, we're in the process of doing a curricular review - looking at our curriculum and whether it's emphasizing the things that ought to be emphasized or whether there are other areas

which need to be looked at. One issue on the table is: should we be encouraging more primary-care physicians? Nationally, if you look at what Congress has done, and some of the rules coming from the Health Care Financing Administration (HCFA), there's an orientation somewhat toward primary care and away from specialties. Actually, it's not so much steering them away from specialties as encouraging them to go into primary care with the idea that needs in rural areas will be addressed. 272 CLARK: That's very true. I think, just off the top of my head, that back in about 1959 probably half or 60% of the physicians in the state were in primary care. That number has fallen now to about 25% or 26%. So the trend has been away from primary care and into things like internal medicine sub-specialties. This has created a great deal of concern both nationally and at the state level. In Oregon, it's being turned around. OHSU President Peter Kohler is very committed to training more primary-care physicians. 285 CHAIR McCOY: Are there medical schools in North and South Dakota? They would place emphasis on primary care, I would think. 287DAVIS: Definitely, yes. -One comment: The Area Health Education Centers program is designed to help encourage people to move toward primary-care disciplines. Medical students will rotate through those programs so they'll have some exposure. Then at the residency level as they go out and work in those communities, one assumes they'll become interested and invested in that community they'll be more likely to move toward primary care. 301 TlMM: I'd like to emphasize that I believe this is needed. We all applaud President Kohler's work with the Area Health Education Centers, and his continuing emphasis on increasing the number of family-practitioner residency slots available. What this aims at is making a plan for how many need to be trained, so the resources that are going into training and residency slots are targeted to the best effect. As indicated, there are a lot of complex factors, not the least of which is certification of training programs for family practitioners, obstetricians and nurse-midwives. 318 KAREN COVILLE, OREGON SOCIETY OF PHYSICIAN ASSISTANTS (EXHIBIT K): Proposes amendments to SB 318 and details Exhibit K. 403 JIM CARLSON, REPRESENTING OREGON MEDICAL ASSOCIATION (EXHIBIT L): Details Exhibit L.

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429 CHAIR McCOY: Closes hearing on SB 318. Adjourns meeting at 4:44 p.m.

Submitted by:
Michael Sims
Assistant

Reviewed by:
Janice J. Fiegener
Administrator

EXHIBIT LOG: A - LC drafts (Committee bills) 3832, 3908, 3916, 3917, 3921, 3924 - Committee staff- 21 pages B - Testimony on SB 274 - Ian Timm - 3 pages B-1- "Who Will Deliver The Babies?: A Report on Access to Delivery Services In Oregon - Ian Timm - 55 pages C - Testimony on SB s 274, 318 - E. Paul Kirk - 4 pages D - Testimony on SB 274 - Mary Ann Curry - 2 pages D-1- Testimony on SB 274 - Mary Ann Curry - 3 pages E - "The Status of Maternity Care In Oregon: A Descriptive Study" - Karen Whitaker - 53 pages F - Testimony on SB 274 - Demi Rewick - 1 page F-1- Testimony on SB 274 - Demi Rewick - 2 pages F-2- Informational brochure, Sacred Heart Hospital (Eugene) Pre-Natal Clinic - Demi Rewick - 4 pages G - Testimony on SB 274 - Donna Clark - 4 pages H - Testimony on SB 274

- Rebecca Landau - 2 pages I - Testimony on SB 274 - Nancy MacMorris-Adix - 2 pages J - Testimony on SB 318 - Ian Timm - 2 pages K - Testimony on SB 318 - Karen Coville - 6 pages L - Testimony on SB 318 - Jim Carlson - 1 page M - Testimony on SB 274 - Wendy Van Elverdinghe - 1 page N - Testimony on SB 274 - Wendy Van Elverdinghe - 1 page

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